The Honorable Richard A. Jones

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

E.S., by and through her parents, R.S. and J.S., and JODI STERNOFF, both on their own behalf, and on behalf of all similarly situated individuals, Plaintiffs, v. REGENCE BLUESHIELD; and CAMBIA HEALTH SOLUTIONS, INC., f/k/a THE REGENCE GROUP, Defendants.	NO. 2:17-cv-1609 AMENDED COMPLAINT (CLASS ACTION)

I. INTRODUCTION

1. An estimated 48 million Americans have a hearing loss that measurably interferes with their ability to understand speech. The vast majority of those people take no action – indeed, most are likely unaware that they have a deficit. Others, though, experience a reduction in their ability to undertake important daily activities, and seek to remedy that situation through an evaluation for, and fitting of, hearing aids and/or other treatment.

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2. Hearing aids improve health and life for many people. People who wear hearing aids do so because they find that otherwise, they are significantly limited in their ability to work, participate in daily activities or to engage socially. They are rarely, if ever, sought unnecessarily because hearing aids are not comfortable, affordable, or stylish. Indeed, they are highly stigmatized as associated with old age and disability. Virtually everyone who obtains professionally prescribed and fitted hearing aids is a person with a disability within the meaning of the Affordable Care Act's Section 1557, which incorporates, through Section 504, the definitions of disability found in the Americans with Disabilities Act as amended in 2008.

3. Health policies issued by defendants Regence BlueShield and Cambia Health Solutions ("Regence") specifically exclude coverage for all treatment associated with hearing loss (*i.e.,* hearing aids, examinations and associated services) except for cochlear implants. (Hereinafter the "Hearing Loss Exclusion" or "Exclusion"). Plaintiffs initially alleged that the Exclusion violates Section 1557 of the Affordable Care Act, which bars health insurers from discriminating on the basis of disability. This Court granted defendants' motion to dismiss without leave to amend, reasoning that the Exclusion is not discriminatory because it applies both to people whose hearing loss would qualify as a disability and to people without a hearing disability.

4. The Ninth Circuit reversed and remanded the case with a directive that plaintiffs be allowed to amend to show "that the [E]xclusion is likely to predominately affect disabled persons," *Schmitt v. Kaiser,* 965 F.3d 945, 959, n. 8 (9th Cir. 2020) and that coverage for cochlear implants fails to meet the needs of most people with hearing loss. *Id.* at 959. For reasons set forth in this Amended Complaint, plaintiffs allege that virtually all people who wear professionally prescribed hearing aids are "disabled" under the

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pertinent federal definition, and that very few of those individuals with disabling hearing loss can have their needs met by treatment with cochlear implants.

5. Since this case was originally filed, the Washington Legislature has passed its own broad anti-discrimination statute that applies to health care plan design, RCW 48.43.0128. This statute prohibits all non-grandfathered health plans from discriminating on the basis of "present or predicted disability," or "health condition," in the design of benefits. *Id.* In 2020, the provision was expanded from individual and small group plans to all "non-grandfathered" health plans, with an effective date of June 11, 2020. *Id.* The statute is an additional "term" of the Regence's health plans in Washington. *See* RCW 48.18.510. Accordingly, plaintiffs plead an additional Breach of Contract claim due to Regence's ongoing violation of RCW 48.43.0128.

II. PARTIES

6. ***E.S.*** Plaintiff E.S. is the nine-year-old daughter and dependent of R.S. and J.S. and resides in King County, Washington. E.S. is insured under a Regence BlueShield insured health plan. E.S. is diagnosed with disabling hearing loss.

7. ***Jodi Sternoff.*** Plaintiff Sternoff is an adult diagnosed with disabling hearing loss who resides in King County, Washington. Sternoff is insured under a Regence BlueShield insured health plan.

8. ***Regence BlueShield.*** Regence BlueShield is an authorized health carrier based in King County and is engaged in the business of insurance in the State of Washington, including King County. Regence BlueShield is a Washington corporation that does business in the State of Washington, including King County. Regence BlueShield is a "health program or activity" that must comply with the Affordable Care Act, Section 1557.

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9. ***Cambia Health Solutions, Inc., f/k/a The Regence Group***. Cambia Health Solutions, Inc., f/k/a The Regence Group ("Cambia") is the nonprofit sole member and corporate owner of Regence BlueShield. Cambia is also the sole member and owner of other authorized health carriers engaged in the business of insurance in the State of Washington, including Regence BlueCross BlueShield of Oregon and BridgeSpan Health. Based upon information and belief, Cambia is also a "health program or activity" that must comply with the Affordable Care Act, Section 1557.

10. ***Relationship between Regence BlueShield and Cambia.*** Regence BlueShield and Cambia are "alter egos." *See McKinnon v. Blue Cross-Blue Shield of Alabama,* 691 F. Supp. 1314, 1319 (1988), *aff'd,* 874 F.2d 820 (1989). Regence BlueShield and the other authorized health carriers doing business in Washington that are wholly owned and/or managed by Cambia use the same or similar standard contracts for insured policies, and specifically, use the same or similar standard exclusions of coverage for hearing examinations, programs or treatment for hearing loss, the same standard definition of "medical necessity" and the same internal policies and procedures for determining when treatment for hearing loss is excluded. For the purpose of this Complaint, both Regence BlueShield and Cambia are referred to as a single defendant, "Regence."

III. JURISDICTION AND VENUE

11. This action arises under the Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA") § 1557, 42 U.S.C. § 18116.

12. Jurisdiction of this Court also arises pursuant to 28 U.S.C. §§ 1331, 1343. Jurisdiction for Plaintiffs' breach of contract claim arises under 28 U.S.C. § 1367.

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13. Venue is proper under 28 U.S.C. § 1391(b)(1) and (2), because, *inter alia*, a defendant resides or may be found in this district and a substantial part of the events giving rise to the claims occurred in King County, Washington.

IV. NATURE OF THE CASE

14. Plaintiffs seek to end Regence's standard discriminatory practice of categorically excluding all benefits for treatment of hearing loss, except for cochlear implants. Specifically, when this lawsuit was filed, Regence's insured health plans in Washington contain the following benefit exclusion:

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

Dkt. No. 12-1, p. 65 of 110 (emphasis added). In Regence's 2020 health plan issued to the named plaintiffs, the Exclusion is worded differently but has the same effect:

> **SPECIFIC EXCLUSIONS**
>
> **…**
>
> **Hearing Aids and Other Hearing Devices**
>
> Hearing aids (externally worn or surgically implanted) and other hearing devices are excluded. This exclusion does not apply to cochlear implants.
>
> …
>
> **Routine Hearing Examination**

See ***Appendix A,*** pp. 31-33. Regence excludes benefits for Hearing Loss even when the treatment is medically necessary to treat qualified individuals with disabilities such as the named Plaintiffs. Regence applies its Hearing Loss Exclusion even though it covers the same benefits for other health conditions, including coverage of outpatient office visits and durable medical equipment or prosthetic devices.

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15. By excluding coverage of all treatment for hearing loss (except for cochlear implants), Regence engages in illegal disability discrimination. The Affordable Care Act prohibits discrimination on the basis of disability by covered entities, including health insurers like Regence. *See* 42 U.S.C. § 18116. Specifically, Section 1557 provides that "an individual shall not, on the ground prohibited under … Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) be excluded from participation in, ***denied the benefits of*** or be subjected to discrimination under ***any health program*** or activity…." 42 U.S.C. § 18116(a) (emphasis added).

16. Regence is a covered "health program or activity" that must comply with the Affordable Care Act's § 1557.

17. Regence violates § 1557 and engages in illegal discrimination on the basis of disability by designing its health plans to include the Hearing Loss Exclusion.

18. Regence's Hearing Loss Exclusion was an intentional, deliberate act. It was done without evaluating the service for efficacy, medical necessity or whether it is experimental or investigational, as Regence does with other excluded services.

19. This lawsuit seeks remedies under the Affordable Care Act arising out of Regence's failure to comply with § 1557. It seeks a court order declaring Regence's blanket exclusion of benefits for Hearing Loss void and unenforceable, enjoining Regence from continuing to apply the Hearing Loss Exclusion and requiring corrective notice to all Regence insureds concerning its required coverage of Hearing Loss. It also seeks damages stemming from Regence's deliberate discriminatory exclusion of medically necessary care that, but for the application of its Exclusion, would otherwise be covered.

20. Regence's Hearing Loss Exclusion also violates Washington's "mini-Section 1557," RCW 48.43.0128. The Washington statute prohibits Regence from

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applying in its non-grandfathered health plans any benefit design that discriminates on the basis of disability or health condition. *Id.* This state law enters into the Regence contracts of insurance and eliminates all non-conforming terms, such as the Hearing Loss Exclusion. RCW 48.18.510.

21. This lawsuit also alleges that Regence breached its contract with Plaintiffs and the proposed class when it failed to modify its non-grandfathered health plans, including those in which Plaintiffs are enrolled, to comply with RCW 48.43.0128, by eliminating the Hearing Loss Exclusion.

V. CLASS ALLEGATIONS

22. ***Definition of Class***. The class consists of all individuals who:

> (1) have been, are or will be insured under a health insurance plan that has been, is or will be delivered, issued for delivery, or renewed by (a) Regence; (b) any affiliate of Regence; (c) predecessors or successors in interest of any of the foregoing; and (d) all subsidiaries or parent entities of any of the foregoing, at any time on or after October 30, 2014; and
>
> (2) have required, require or will require treatment for Hearing Loss other than treatment associated with cochlear implants.

23. ***Size of Class***. The class of Regence insureds who have required, require or will require treatment for Hearing Loss, excluding treatment associated with cochlear implants, is so numerous that joinder of all members is impracticable.

24. ***Class Representatives E.S. and Sternoff.*** Named plaintiffs E.S. and Sternoff are enrollees in a Regence insured health plan in the State of Washington. Both have Hearing Loss that requires treatment other than with cochlear implants. Both are "qualified individuals with a disability" under the Affordable Care Act and Section 504 of the Rehabilitation Act. Both require outpatient office visits (such as to licensed

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audiologists) and durable medical equipment and/or prosthetic devices (such as hearing aids) to treat their Hearing Loss. Regence has denied both named Plaintiffs' requests for coverage of their hearing aids and outpatient office visits to their audiologists because of Regence's blanket Hearing Loss Exclusion. Plaintiffs' claims are typical of the claims of the other members of the class. Plaintiff E.S., by and through her parents, and Plaintiff Sternoff, directly, will fairly and adequately represent the interests of the class.

25. ***Common Questions of Law and Fact***. This action requires a determination of whether Regence's Hearing Loss Exclusion violates the requirements of the Affordable Care Act's § 1557 and discriminates against Plaintiffs on the basis of their disability, Hearing Loss. Adjudication of this issue will in turn determine whether Regence may be enjoined from enforcing the Hearing Loss Exclusion, and found liable under the Affordable Care Act for injunctive relief, classwide damages and other relief. This action further requires a determination of whether Regence's Hearing Loss Exclusion violates the requirement of RCW 48.43.0128 and discriminates against Plaintiffs on the basis of their disability, Hearing Loss. Finally, this action requires a determination of whether Regence breached its contracts with Plaintiffs and the class by designing and applying a written exclusion that is rendered void and unenforceable by RCW 48.18.200(2), RCW 48.43.0128, and other Washington law.

26. ***Regence Has Acted on Grounds Generally Applicable to the Class.*** Regence, by imposing a uniform exclusion of all coverage for Hearing Loss except for cochlear implants, has acted on grounds generally applicable to the class, rendering declaratory relief appropriate respecting the whole class. Certification is therefore proper under FRCP 23(b)(2).

27. ***Questions of Law and Fact Common to the Class Predominate Over Individual Issues.*** The claims of the individual class members are more efficiently

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adjudicated on a classwide basis. Any interest that individual members of the class may have in individually controlling the prosecution of separate actions is outweighed by the efficiency of the class action mechanism. Upon information and belief, there has been no class action suit filed against these defendants for the relief requested in this action. This action can be most efficiently prosecuted as a class action in the Western District of Washington, where Regence BlueShield has its principal place of business, does business, and where E.S. and Sternoff reside. Issues as to Regence's conduct in applying standard policies and practices towards all members of the class predominate over questions, if any, unique to members of the class. Certification is therefore additionally proper under FRCP 23(b)(3).

28. ***Class Counsel***. Plaintiffs have retained experienced and competent class counsel.

VI. FACTUAL BACKGROUND

A. Regence's Hearing Loss Exclusion Predominately Affects Disabled Persons.

1. Hearing Aids Under Washington Law.

29. Washington state law defines "hearing instrument," as "any wearable prosthetic instrument or device designed for or represented as aiding, improving, compensating for, or correcting defective human hearing and any parts, attachments, or accessories of such an instrument or device," RCW 18.35.010(12). "Hearing instruments" are different from volume-amplifying "assistive listening systems," RCW 18.35.010(1). Hearing aids are "hearing instruments" within the meaning of Washington law.

30. The fitting and dispensing of hearing instruments is limited by law to licensed audiologists and licensed hearing-aid specialists. RCW 18.35.020. Audiologists must have doctoral-level education and experience, https://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/Audiologist/License

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Requirements (last visited 10/9/20) Hearing-aid specialists must have two years of college-level education plus supervised experience, RCW 18.35.040, and pass a state-mandated examination, RCW 18.35.070. Both licensed audiologists and hearing-aid specialists are defined as "hearing health care professionals." RCW 18.35.010(11).

31. For purposes of this Complaint, "hearing instrument" and "hearing aid" are used interchangeably to mean devices prescribed by hearing health-care professionals, and do not include self-prescribed and self-fitted products such as Personal Sound Amplification Products (PSAPs) or over-the-counter products marketed as "hearing aids."

32. Regence's policies in Washington exclude all ***treatment*** for Hearing Loss, except for that related to cochlear implants. As such, the Hearing Loss Exclusion applies ***exclusively*** to the fitting and dispensing of all hearing instruments by licensed hearing health-care professionals and/or surgical procedures by such professionals.

2. The Definition of Disability Under Federal and State Law.

33. For purposes of § 1557, disability" is defined and construed according to Section 504 of the Rehabilitation Act, which, in turn "incorporates the definition of disability in the Americans with Disabilities Act (ADA), as amended." 45 C.F.R. § 92.102(c).

34. The Americans with Disabilities Act, 42 U.S.C. § 12101 *et seq.*, as amended in 2008, defines "disability" as "a physical or mental impairment that substantially limits one or more major life activities ***of such individual***," 42 U.S.C. § 12102(1)(A) (emphasis added), a singular and specific reference to activities actually undertaken by the individual in question.

35. "Major life activities" include, among other things, "hearing, communicating and working." 42 U.S.C. § 12102(2)(A).

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36. The presence of a disability is to be assessed "without regard to the ameliorative effects of mitigating measures such as … hearing aids or cochlear implants." 42 U.S.C. § 12102(4)(E)(i)(I).

37. The applicable regulations state that the term "substantially limits" is to be construed "broadly," is not meant to be a "demanding standard," 29 C.F.R. § 1630.2(j)(1)(i).

38. The definition of "disability" under Washington law is broader than the ADA definition. *See* RCW 49.60.040(7)(a) ("Disability means the presence of a sensory, mental or physical impairment that: (i) [i]s medically cognizable or diagnosable; or (ii) [e]xists as a record or history; or (iii) [i]s perceived to exist whether or not it exists in fact.").

39. Under Washington law, a diagnosis of hearing loss is always a "disability" because it is a physiological disorder or condition that affects the body systems listed in RCW 49.60.040(7)(c)(i). *See Taylor v. Burlington N. R.R. Holdings, Inc.*, 193 Wn.2d 611, 617, 444 P.3d 606 (2019).

40. Under both the federal and Washington definitions of "disability," Plaintiffs E.S. and Sternoff are "disabled" due to their hearing loss.

3. Hearing and Hearing Loss.

41. Hearing involves a complex process by which sound waves are converted to vibrations that are transmitted through the eardrum to the middle-ear bones, then to the fluid-filled cochlea in the inner ear. The cochlea contains tiny hair cells that respond to specific frequencies and emit microscopic electrical impulses to the auditory nerve, from which the brain decodes the sound. https://www.asha.org/public/hearing/How-We-Hear/ (last visited 10/13/20). Hearing loss is the result of

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damage to one or more of those components. https://www.asha.org/public/hearing/Types-of-Hearing-Loss/. (last visited 10/13/20).

42. A common preliminary screening for hearing loss is a pure-tone test, in which subjects are presented with tones at different frequencies (pitches), measured in Hertzes (Hz), at increasing volume, measured in decibels (dB). The subjects are asked to indicate when they hear those tones. The threshold loudness at which a tone becomes audible is recorded on an audiogram. https://www.asha.org/public/hearing/audiogram/ (last visited 10/13/20).

43. The critical metric from an audiogram is the average decibel threshold in the frequencies involving speech, which are the frequencies of 500, 1,000, 2,000 and 4,000 cycles per second, measured in Hertzes (Hz).

44. The generally accepted standard for normal hearing is a threshold of 25 dB. If the tones must be louder than 25dB to be audible, the subject has worse-than-normal hearing. An average decibel threshold greater than 25 dB in the speech frequencies is generally considered the point at which "hearing loss begins to impair communication in daily life," Lin et al., *Hearing Loss Prevalence in the United States,* Archives of Internal Medicine Vol. 14, No. 20 at pp. 1831-32, Nov. 14 (2011). https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1106004 (last visited 10/13/20). Extrapolating from actual audiograms of a large and randomly selected population, Lin et al. estimate that 48 million Americans age 12 and over have impairing hearing loss in at least one ear. The prevalence of hearing loss, and particularly sensorineural hearing loss ("SNHL"), is sharply age-related, increasing from relatively small numbers in the 12-19 age band (approximately 100,000 people nationally) to 5.7 million people age 60-69. *Id.*

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45. Based on information and belief, the proposed class includes few if any individuals over the age of 65, since most, if not all, of Washington insured Regence enrollees lose their Regence coverage when they become eligible for Medicare.

46. There are varying degrees of hearing loss, ranging from mild to profound. An individual with a speech-frequency average decibel threshold of 25-40 dB is classified as having a mild loss, and may have some difficulty hearing softly voiced sounds. A person with a moderate loss (40-70dB) will have difficulty understanding speech at normal levels, a person with a severe loss (70-90dB) will hear almost no speech and a person with a profound loss (greater then 90dB) will hear almost nothing. https://www.cdc.gov/ncbddd/hearingloss/types.html (last visited 10/13/20).

47. Most people significantly underestimate their own degree of hearing loss because they have no way of knowing what they are not hearing, unless informed by others. Based on self-reports from large-sample interviews, the U.S. Census Bureau estimates that just under 9.2 million Americans under age 65 self-reported having "serious" difficulty hearing, including 3.6 million adults who self-report as being deaf. https://www.census.gov/content/dam/Census/library/publications/2018/demo/p70-152.pdf (last visited 10/13/20) (explanatory text at p.7 and charts on pp. 21 (adults) and 31 (children)).

48. The most common form of hearing loss is sensorineural hearing loss ("SNHL"), in which the inner-ear hair cells are damaged. https://www.asha.org/public/hearing/Sensorineural-Hearing-Loss/ (last visited 10/13/20). That damage is generally not correctible through surgery or medication, and can be mitigated only through hearing aids or, in extreme cases, cochlear implants. *See* https://www.hearingloss.org/hearing-help/hearing-loss-basics/types-causes-and-treatment/ (last visited 10/13/20). Plaintiff Sternoff is diagnosed with SNHL.

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49. Conductive hearing loss occurs when damage to the outer or middle ear prevents sound from reaching the inner ear. https://www.asha.org/public/hearing/Conductive-Hearing-Loss/ (last visited 10/13/20). Conductive hearing loss can sometimes be corrected surgically, or can be addressed with a bone-anchored hearing aid (BAHA), which bypasses the damaged middle-ear structures and transmits sound directly to the cochlea and the hair cells. https://www.hopkinsmedicine.org/otolaryngology/specialty_areas/hearing/hearing-aids/baha.html (last visited 10/13/20). A BAHA is a different device than a "cochlear implant." Plaintiff E.S. is diagnosed with conductive hearing loss.

50. Some people are diagnosed with both SNHL and conductive hearing loss. *See* https://www.healthyhearing.com/help/hearing-loss/types (last visited 10/13/20).

4. Hearing Aids

51. Even people who acknowledge having "serious" hearing difficulties resist hearing aids, particularly people under 65. According to the Census Bureau, only 2.354 million people under 65 – about 25% of the 9.2 million people who self-report serious hearing difficulties – have used hearing aids. https://www.census.gov/content/dam/Census/library/publications/2018/demo/p70-152.pdf, (last visited 10/13/20) (pp. 21 (children) and 31 (adults)).

52. The Hearing Industry Association, the trade group for hearing-aid manufacturers and distributors, conducts an annual survey of its members that asks, among other things, why people do or do not purchase hearing aids. The most recent survey indicates that in addition to cost concerns, people avoid hearing aids because they consider hearing aids uncomfortable, unattractive and embarrassing, and because they believe their hearing is adequate. https://www.audiologyonline.com/

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articles/20q-understanding-today-s-consumers-26648, (last visited 10/13/20) (20Q Consumer Insights, item #4).

53. People who believe their hearing is adequate for their purposes, even if impaired, have made a determination that their own major life activities are not substantially limited by their hearing loss, and are not people with disabilities within the meaning of the Section 504 and ACA irrespective of their actual degree of hearing loss. Conversely, virtually all people who seek or obtain hearing aids do so because they have experienced limitations in their own life activities, such as hearing, communicating, learning or working, which experiences make them people with disabilities under Section 504 and ACA.

54. The needs of hearing disabled persons differ from the needs of persons whose hearing is merely impaired. Those who are disabled by their hearing loss experience its impact on their work, health and/or other daily activities of living. They seek treatment from medical professionals to ameliorate their disabling condition.

55. Conversely, those whose hearing is impaired, but does not interfere with their major life activities, do not generally seek formal treatment from medical professionals, and rarely, if ever, seek hearing instruments.

56. If, indeed, any non-disabled individuals seek coverage for hearing treatment and hearing instruments, most if not all would not be able to demonstrate that their need for the treatment meets Regence's standard for medical necessity.

57. Under the definition of "medical necessity" in Regence's plans, services to treat hearing loss are not medically necessary if they are provided (1) "primarily for the convenience of the patient," or (2) in a manner that was not in accordance with generally accepted standards of medical practice. Services for non-disabling hearing loss would be excluded under this definition of medical necessity because the services would be

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only for the convenience of the patient, and would not conform to standard medical practice

58. Thus, based upon the above data, and information and belief, if any non-disabled enrollees with hearing loss seek coverage of hearing examinations and/or hearing aids, and they meet Regence's medical necessity standards but are still subject to denial of their claims under Regence's Hearing Loss Exclusion, the number of those enrollees is extremely small, if they exist at all.

59. Excluding coverage for hearing aids and hearing treatment almost exclusively affects people with disabling hearing loss as defined by both Section 504, Section 1557 of ACA and RCW 48.43.0128.

60. Based upon the above information and information and belief, Regence's Hearing Loss Exclusion is rarely, if ever, applied to medically necessary claims submitted by non-disabled Regence enrollees. On information and belief, the internal records of Regence's denial of claim under the Hearing Loss Exclusion will show that most, if not all, individuals denied are disabled for the reasons set forth herein.

61. Even if the Hearing Loss Exclusion is applied to claims submitted by non-disabled enrollees, Regence designed the Exclusion intentionally to deny services to insureds with disabling hearing loss.

62. Given Regence's existing Medical Necessity definition which prohibits coverage that is not consistent with general medical standards, the only purpose of the Hearing Loss Exclusion is to eliminate coverage of medically necessary hearing treatment and equipment, *e.g.*, the precise coverage needed by those disabled by hearing loss.

63. The design of the Hearing Loss Exclusion, uniquely and specifically targeted at insureds with disabling hearing loss, was an intentional decision made by

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Regence to ensure that the treatment needed by disabled insureds that would not be denied under the medical necessity requirement, would nonetheless be excluded.

64. The cost of hearing evaluations and hearing aids is relatively inexpensive when compared to other treatment, including cochlear implants.

65. For example, in 2018, Washington's Medicaid program added coverage of hearing aids and hearing examinations for adults. *See* Washington Health Care Authority Fiscal Note for House Bill No. 1264 (2018), at https://fortress.wa.gov/FNSPublicSearch/GetPDF?packageID=47296 (last visited 10/12/20). Adding the benefit for nearly 1 million enrollees cost approximately $4 million annually, or just $0.33 per person per month. *Id.*

B. Cochlear Implants Do Not Serve the Needs of Most Individuals With a Hearing Disability.

66. A cochlear implant ("CI") is a mitigating measure for a limited class of people with severe to profound SNHL. A CI bypasses the damaged hair cells in the inner ear. A CI consists of an external microphone and processor that send electronic signals to an array of electrodes embedded in a filament that is threaded into the cochlea. Those electrodes substitute for the damaged hair cells by sending electronic impulses directly to the auditory nerve, creating a sensation of sound. https://www.mayoclinic.org/tests-procedures/cochlear-implants/about/pac-20385021 (last visited 10/13/20).

67. The implantation is done under general anesthesia, often but not always on an outpatient basis. The recipient must undertake a considerable effort at rehabilitation to enable the brain to make sense of the information received through the implant and "translate" it into recognizable sound.

68. CI is only available to people with severe to profound hearing loss who cannot be adequately treated with hearing aids. https://bulletin.entnet.org/article/cochlear-implantation-who-is-a-candidate-in-2018/ (last visited 10/13/20).

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69. Using the same data as the prevalence estimate referenced in ¶44, Goman and Lin determined the national prevalence of hearing loss by severity. *See* ***Appendix B,*** Adele M. Goman, Ph.D., Frank R. Lin, M.D., Ph.D., "Prevalence of Hearing Loss by Severity in the United States," AJPH October 2016, Vol. 106, No. 10. They determined that 340,000 people age 12-59 have severe or profound losses, as do 360,000 people aged 60-69. Making the extremely conservative assumption that half of the people in the 60-69 age group are under 65, that would indicate that roughly 520,000 people under 65 would be potentially eligible for a CI, or just 5.6% of the 9.2 million people under 65 with self-reported hearing losses.

70. Cochlear-implant usage in practice is far less than the number of people who might be eligible. As of 2012, the last year for which data has been located, the National Institute on Deafness and Communication Disorders found that only 58,000 U.S. adults had cochlear implants, just over 10% of those who might be eligible. https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing#:~:text=One%20in%20eight%20people%20in,based%20on%20standard%20hearing%20examinations.&text=About%202%20percent%20of%20adults,adults%20aged%2055%20to%2064 (last visited 10/13/20).

71. Cochlear-implant usage in children is higher – the NIDCD reported that 38,000 children under 18 have been implanted, or 3.2% of the 1,176,000 children with self-reported hearing loss. As the NIDCD stated, implantation is more aggressive with children because of the importance of providing access to sound during the years that speech develops.

72. Based on the data, cochlear implants treat the needs of only a very small fraction of the total population of people with hearing loss. As a result, Regence's coverage of cochlear implants serves only a very small percentage of its enrollees with

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disabling Hearing Loss. The inclusion of coverage for cochlear implants does not serve the needs of hearing disabled people as a group.

73. Regence's decision to include coverage for cochlear implants was the result of a mandate that Regence believed that it must follow, and not the result of the any desire to provide benefits to persons with disabling hearing loss.

C. E.S.'s Need for Hearing Treatment.

74. E.S. was born with a right unilateral grade 3 microtia with aural atresia. In other words, she was born without an outer ear or a properly formed middle ear on her right side. Her cochlea still function and her auditory nerve is intact, but she was born without an ear canal on her right side to allow sound to travel to her inner ear.

75. As a result of this congenital birth defect, E.S. had maximum conductive hearing loss in her right ear, and was incapable of receiving any benefit from cochlear implant or hearing aids.

76. The FDA approved treatment for patients with E.S.'s condition is a BAHA device. For very young children, the device is installed with a softband because the child is too young to have the device attached surgically.

77. In 2011, E.S.'s parents sought pre-approval from Regence for the BAHA device, fitting fee and softband, given that she was approximately 1 year old

78. Regence informed E.S.'s parents that the device would be covered, as medically necessary, without pre-authorization.

79. When the claims were submitted, however, Regence denied coverage for the BAHA, the fitting fee and softband.

80. E.S.'s parents appealed the denial and filed a complaint with the Washington Office of the Insurance Commissioner.

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81. Regence denied E.S.'s appeals, but her parents submitted an appeal to an Independent Review Organization ("IRO").

82. The IRO reviewer concluded that E.S.'s BAHA was covered as a "prosthetic device" under the Regence policy, since for a child who is born without an external ear or ear canal, the device would be considered to replace a missing body part.

83. Regence ultimately covered the BAHA, fitting fee and the softband device.

84. In 2016, E.S. required surgical reconstruction of her right ear, a procedure called Porous Implant Ear Reconstruction ("PIER"). She also required a new BAHA device to be implanted along with the PIER surgery.

85. The purpose of the PIER surgery was to reconstruct E.S.'s right ear and to remove the soft tissue and cartilage covering her internal ear canal, to allow the surgically-created external ear to act like a natural ear by funneling sound towards the portion of E.S.'s auditory system that has some function. Thus, although the PIER surgery was intended to improve E.S.'s hearing loss, it was covered as reconstructive surgery to treat a congenital anomaly. Nonetheless, Regence still denied coverage for the BAHA device which would enable E.S. to experience the medical benefit of the PIER surgery, as an excluded treatment for hearing loss.

86. As a result, Regence denied all coverage for the BAHA device even while it covered the PIER surgery ***including*** the implantation of the BAHA device.

87. E.S.'s parents appealed the Regence denial of coverage for the BAHA device, and exhausted their administrative appeals. Regence's denials were upheld based Regence's Hearing Loss Exclusion, even though E.S.'s BAHA had been covered in the past as a prosthetic and despite the medical necessity of her treatment.

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88. Specifically, the final reviewer concluded that the BAHA system was a bone conduction hearing aid and not either a cochlear implant or a prosthetic. As a result, E.S.'s second BAHA was denied under the Hearing Loss Exclusion.

89. E.S. continues to require hearing treatment at least annually, and equipment for her hearing loss.

90. Plaintiff Sternoff was also denied medically necessary hearing treatment and coverage for her hearing aid by Regence.

91. Sternoff has moderate to severe hearing loss in her left ear and wears a "cross hearing aid" that transmits sound from her left side to her hearing right ear. Her ability to recognize words in her left ear was about 40% in 2018.

92. In 2016, Sternoff's request for coverage of her cross-hearing aid totaling $4,100.00 was denied under the Regence Hearing Loss Exclusion.

93. Both E.S. and Sternoff are disabled under federal and state disability law.

D. Class-wide Allegations

94. During the relevant time periods, E.S., Sternoff and members of the class have been insured in one or more Regence insured plans.

95. Plaintiffs E.S., Sternoff and other members of the class have been diagnosed with Hearing Loss, a physical impairment that limits a major life activity so substantially as to require medical treatment. As a result, E.S., Sternoff and other members of the class are "qualified individuals with a disability." *See* 28 C.F.R. § 39.103.

96. Plaintiffs E.S., Sternoff and other members of the class have required, require and/or will require medical treatment for their Hearing Loss, excluding treatment with cochlear implants.

97. Regence is a "health program or activity" part of which receives federal financial assistance. 42 U.S.C. § 18116; 45 C.F.R. § 92.4.

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98. As a result, Regence is a "covered entity" under the Affordable Care Act, § 1557.

99. Regence provided assurances to the U.S. Department of Health and Human Services that it complies with the requirements of § 1557. *See* 45 C.F.R. § 92.5.

100. It also provided similar statements to its Washington insured enrollees, confirming that it complies with the requirements of § 1557.

101. Despite these statements and assurances, Regence has designed, issued and administered Washington health plans that exclude all benefits for Hearing Loss, except for cochlear implants. Regence continues to do so, to date.

102. The Regence health plans in which Plaintiffs are enrolled are "non-grandfathered health plans" as described in the Washington Insurance Code.

103. Regence's non-grandfathered insured health plans must comply with the requirements of RCW 48.43.0128.

104. Based upon the Hearing Loss Exclusion, Regence has denied coverage of medically necessary treatment and equipment for E.S., Sternoff and other members of the class, because the requested treatment and equipment would treat their diagnosed condition of Hearing Loss, and/or the treatment they seek is for "hearing treatment" and "hearing aids" such that the Exclusion is a form of intentional proxy discrimination.

105. Specifically, Regence designed the Hearing Loss Exclusion to target the health care needs of insureds with disabling hearing loss.

106. Non-disabled insureds rarely seek treatment for hearing loss. To the extent such insureds seek such treatment, their claims are already excluded under Regence's medical necessity exclusion. Only disabled insureds with hearing loss are denied medically necessary treatment for their condition under the Hearing Loss Exclusion.

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107. Regence does not meet the needs of disabled enrollees with hearing loss by permitting limited coverage for cochlear implants. As alleged above, cochlear implants only serve the needs of a small percentage of Regence's disabled insureds with hearing loss (approximately 5% or fewer).

108. As a result of its deliberate discriminatory actions, Regence insureds with disabling Hearing Loss, like E.S. and Sternoff, do not receive coverage for medically necessary outpatient office visits to audiologists or for medically necessary hearing aids, a type of durable medical equipment or prosthetic device.

109. Regence excludes all coverage for outpatient office visits and durable medical equipment to treat Hearing Loss, even though it covers outpatient office visits, durable medical equipment and prosthetic devices for other medical conditions.

110. The application of Regence's Hearing Loss Exclusion denies individuals with disabling Hearing Loss the benefits and health coverage available to other insureds, based on their disability, Hearing Loss.

111. As a direct result, Plaintiffs E.S., Sternoff and members of the class have paid out-of-pocket for medically necessary treatment for their Hearing Loss, including audiology examinations and hearing aids. Other class members have been forced to forgo needed medical treatment due to Regence's conduct.

112. Plaintiff E.S. has pursued her administrative appeal rights under her Regence health plan, to no avail. While any further administrative appeal would be futile, no such appeal is required before this § 1557 claim may be brought. *See* 45 C.F.R. § 92.301(a); 81 Fed. Reg. 31441.

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VII. CLAIMS FOR RELIEF:

COUNT I - VIOLATION OF AFFORDABLE CARE ACT § 1557, 42 U.S.C. § 18116

113. Plaintiffs re-allege all paragraphs above.

114. Section 1557, 42 U.S.C. § 18116 provides that "an individual shall not, on the ground prohibited under … section 504 of the Rehabilitation Act of 1973 … be excluded from participation in, denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance…."

115. Defendants receive federal financial assistance and are therefore a "covered entity" for purposes of Section 1557.

116. Plaintiffs are "qualified persons with a disability" under both Section 504 and Section 1557.

117. Persons like E.S. and Sternoff who have hearing loss are discriminated against by Regence because it applies the Hearing Loss Exclusion to deny coverage of medically necessary audiological examinations, a type of out-patient office visit, and coverage of medically necessary hearing aids, a type of durable medical equipment or prosthetic device. Under the exclusion, only or predominantly people with disabling Hearing Loss, a qualifying disability, are denied access to the benefits that they require. Out-patient office visits and durable medical equipment/prosthetic devices are covered for many other health conditions under Regence's policies.

118. As described above, Regence's Hearing Loss Exclusion treats "hearing loss" as a proxy for disabling hearing loss, since nearly all treatment sought by hearing-disabled enrollees is excluded and few, if any, non-disabled Regence enrollees are subject to the Hearing Loss Exclusion.

119. Also, as alleged above, only a very small percentage of disabled hearing loss enrollees receive the treatment they need in the form of cochlear implants.

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120. Accordingly, the Hearing Loss Exclusion is a form of proxy discrimination since the "fit" between the Hearing Loss Exclusion and disabling hearing loss is "sufficiently close" to make a discriminatory inference plausible. *See Schmitt*, 965 F.3d at 958-959.

121. The drafting and inclusion of the Hearing Loss Exclusion was an inherently intentional act. It was done for the purpose of excluding coverage for insureds with disabling hearing loss since coverage for insureds with non-disabling hearing loss would be excluded under Regence's medical necessity clause. Regence understood that the only way to exclude ***medically necessary*** services and supplies for hearing loss – services and supplies that would only be provided to disabled insureds – was to put in place a categorical exclusion.

122. The design and administration of the Hearing Loss Exclusion was an intentional choice and, at the very least, the result of deliberate indifference to the effect it would have on its insureds with disabling hearing loss.

123. This discriminatory decision directly resulted in Regence retaining money that it would otherwise would have been required to pay to cover services and equipment for disabled insureds. Regence made this calculus as part of its underwriting, and decided that its desire to retain money outweighed the medically necessary needs of its insureds with disabling hearing loss.

124. By excluding coverage of all health care related to hearing loss (except for cochlear implants), Regence has discriminated, and continues to discriminate against Plaintiffs and the class they seek to represent, on the basis of disability, in violation of Section 1557.

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COUNT II – BREACH OF CONTRACT AND VIOLATION OF RCW 48.43.0128

125. Plaintiffs re-allege all paragraphs above.

126. All Washington health plan incorporate the relevant requirements of the Insurance Code as additional terms and conditions of the contract, rendering any non-conforming terms void. *See* RCW 48.18.200(2); *Brown v. Snohomish Cty. Physicians Corp.*, 120 Wn.2d 747, 753, 845 P.2d 334, 337 (1993); *accord UNUM Life Ins. v. Ward*, 526 U.S. 358, 376 (1999).

127. RCW 48.43.0128 forbids Regence's health plans from discriminating "in its benefit design or implementation of its benefit design, … against individuals because of their … present or predicted disability, … or other health conditions" or otherwise "discriminate on the basis of …. disability."

128. RCW 48.43.0128 renders Regence's Hearing Loss Exclusion null and void, since the Exclusion is a form of benefit design discrimination targeted at disabled individuals with hearing loss. Specifically, since the plaintiffs are disabled under Washington law, and Regence's health plans are subject to RCW 48.43.0128, the Hearing Loss Exclusion discriminates against Plaintiffs and violates their insurance contract since Plaintiffs' disability is a "substantial factor" in causing the exclusion of coverage. *See Fell v. Spokane Transit Auth.*, 128 Wn.2d 618, 637, 911 P.2d 1319 (1996).

129. By excluding coverage of all health care related to hearing loss, (except for cochlear implants), Regence has discriminated, and continues to discriminate against Plaintiffs and the class they seek to represent, on the basis of disability, in violation of RCW 48.43.0128. As Regence's contracts must be construed and applied without the Hearing Loss Exclusion pursuant to RCW 48.43.0128 and Washington contract law, Regence's use of the Exclusion to deny coverage is also a breach of contract.

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VIII. DEMAND FOR RELIEF

WHEREFORE, Plaintiffs request that this Court:

1. Certify this case as a class action; designate the named Plaintiffs as class representatives; and designate SIRIANNI YOUTZ SPOONEMORE HAMBURGER, Eleanor Hamburger, Richard E. Spoonemore, and John Waldo (of counsel) as class counsel;

2. Enter judgment on behalf of the Plaintiffs and the class due to Regence's discrimination on the basis of disability under both Section 1557 and RCW 48.43.0128;

3. Declare that Regence may not apply the Hearing Loss Exclusion and/or other contract provisions, policies or practices that exclude or impermissibly limit coverage of medically necessary treatment on the basis of disability;

4. Enjoin Regence from applying the Hearing Loss Exclusion and/or other violations of the Affordable Care Act now and in the future;

5. Enter judgment in favor of Plaintiffs and the class for damages in an amount to be proven at trial due to Regence's violation of Section 1557 of the Affordable Care Act and RCW 48.43.0128 of the Washington Insurance Code, and breach of its contracts with Plaintiffs and the class;

6. Award Plaintiffs and the class their attorney fees and costs under 42 U.S.C. § 1988 and *Olympia S.S. Co. v. Centennial Ins. Co.*, 117 Wn.2d 37, 811 P.2d 673 (1991).

7. Award such other relief as is just and proper.

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DATED: October 13, 2020.

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Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on October 13, 2020, I caused the foregoing to be electronically filed with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to the following:

- **Brad S. Daniels**
  brad.daniels@stoel.com, darise.holland@stoel.com
- **Eleanor Hamburger**
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I further certify that I have mailed by United States Postal Service the document to the following non CM/ECF participants:

- (No manual recipients)

DATED: October 13, 2020, at Seattle, Washington.

/s/ Eleanor Hamburger
Eleanor Hamburger (WSBA #26478)

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APPENDIX A

2020 BOOKLET FOR:

AHLERS CRESSMAN & SLEIGHT

Regence EmployeeChoice Gold HSA 1500 Preferred

Group Number: 10018298

Regence BlueShield Medical Benefits

Regence

Know your rights under the Balance Billing Protection Act

Beginning January 1, 2020, Washington state law protects you from 'surprise billing' or 'balance billing' if you receive emergency care or are treated at an in-network hospital or outpatient surgical facility

What is 'surprise billing' or 'balance billing' and when does it happen?

Under your health plan, you're responsible for certain cost-sharing amounts. This includes copayments, coinsurance and deductibles. You may have additional costs or be responsible for the entire bill if you see a provider or go to a facility that is not in your plan's provider network.

Some providers and facilities have not signed a contract with your insurer. They are called 'out-of-network' providers or facilities. They can bill you the difference between what your insurer pays and the amount the provider or facility bills. This is called 'surprise billing' or 'balance billing.'

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

When you CANNOT be balance billed:

Emergency Services
The most you can be billed for emergency services is your plan's in-network cost-sharing amount even if you receive services at an out-of-network hospital in Washington, Oregon or Idaho or from an out-of-network provider that works at the hospital. The provider and facility cannot balance bill you for emergency services.

Certain services at an In-Network Hospital or Outpatient Surgical Facility
When you receive surgery, anesthesia, pathology, radiology, laboratory, or hospitalist services from an out-of-network provider while you are at an in-network hospital or outpatient surgical facility, the most you can be billed is your in-network cost-sharing amount. These providers cannot balance bill you.

In situations when balance billing is not allowed, the following protections also apply:

- Your insurer will pay out-of-network providers and facilities directly. You are only responsible for paying your in-network cost-sharing.
- Your insurer must:
    - Base your cost-sharing responsibility on what it would pay an in-network provider or facility in your area and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or certain out-of-network services(described above) toward your deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 30 business days.
- A provider, hospital, or outpatient surgical facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital or facility in any OTHER situation, you may still be balance billed, or you may be responsible for the entire bill.

This law does not apply to all health plans. If you get your health insurance from your employer, the law might not protect you. Be sure to check your plan documents or contact your insurer for more information.

If you believe you've been wrongly billed, file a complaint with the Washington state Office of the Insurance Commissioner at www.insurance.wa.gov or call 1-800-562-6900.

NONDISCRIMINATION NOTICE

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

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

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

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

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

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

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, 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.

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)。

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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).

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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)

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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।

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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)

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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)

Regence

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

SCHEDULE OF BENEFITS

Regence EmployeeChoice Gold HSA 1500 Preferred

This Schedule of Benefits is a part of Your Booklet and provides information regarding Your costs for Covered Services and how Provider choice affects Your out-of-pocket costs. Read the entire Booklet for a complete understanding of the benefits, limitations, exclusions, definitions, and provisions of the plan.

Your costs are subject to all of the provisions of the Booklet including the following terms: Allowed Amount, Coinsurance, Deductibles and Out-of-Pocket Maximum as explained in the Booklet.

Deductible	**In-Network**	**Out-of-Network**
Single Coverage	**$1,500**	**$5,000**
Family Coverage	**$3,000**	**$10,000**

Out-of-Pocket Maximum	**In-Network**	**Out-of-Network**
Single Coverage	**$4,500**	**$10,000**
Family Coverage	**$9,000**	**$20,000**

YOUR PROVIDERS AND OUT-OF-POCKET EXPENSES

This plan uses the following networks:

Preferred medical network
VSP Choice vision network
Participating Dental network

You have the choice of Providers and the choice You make affects Your out-of-pocket expenses.

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

for inpatient services at a Nonparticipating Facility is limited to $3,500 per day. This limit does not apply if admitted through the Emergency Room, Hospice Facility or Skilled Nursing Facility.

In-Network and Out-of-Network Benefits for Pediatric Vision

You control Your out-of-pocket expenses for Pediatric Vision services by choosing a VSP Doctor (In-Network Provider) or an Out-of-Network Provider.

- **VSP Doctor (In-Network Provider).** A VSP Doctor has a contract with VSP. When You choose a VSP Doctor, You save the most in Your out-of-pocket expenses. Choosing this Provider option means You will not be billed for balances beyond the Allowed Amount.
- **Out-of-Network Provider.** If You choose to see an Out-of-Network Provider that does not have a contract with VSP, Your out-of-pocket expenses will generally be higher than a VSP Doctor. This Provider option also means You may be billed for balances beyond the Allowed Amount (sometimes referred to as balance billing). Any amounts You pay for Out-of-Network services in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum.

	YOUR COSTS OF THE ALLOWED AMOUNT FOR SERVICES INSIDE THE SERVICE AREA	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Office Visits – Illness or Injury	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Outpatient Laboratory and Radiology Services • Diagnostic services not covered under Preventive Care and Immunizations or Complex Imaging – Outpatient	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Preventive Care and Immunizations	No charge	After Deductible, 50% Coinsurance
Other Professional Services	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Acupuncture • 12 visits per Calendar Year	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Ambulance Services	After In-Network Deductible, 20% Coinsurance	
Ambulatory Surgical Center	After Deductible, 10% Coinsurance	After Deductible, 50% Coinsurance
Blood Bank	After In-Network Deductible, 20% Coinsurance	
Complex Imaging – Outpatient	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance

	YOUR COSTS OF THE ALLOWED AMOUNT FOR SERVICES INSIDE THE SERVICE AREA	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Dental Hospitalization	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Detoxification	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Diabetic Education	After Deductible, 0% Coinsurance	After Deductible, 50% Coinsurance
Dialysis	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Durable Medical Equipment	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Emergency Room	After In-Network Deductible, 20% Coinsurance	
Gene Therapy and Adoptive Cellular Therapy • Travel expenses: $7,500 per course of treatment	After Deductible, 20% Coinsurance	Not covered
Genetic Testing	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Habilitative Services • 30 inpatient days per Calendar Year • 25 outpatient visits per Calendar Year	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Home Health Care • 130 visits per Calendar Year	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Hospice Care • 14 inpatient or outpatient respite days per Lifetime	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Hospital Care – Inpatient and Outpatient	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Maternity Care	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Medical Foods	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance

	YOUR COSTS OF THE ALLOWED AMOUNT FOR SERVICES INSIDE THE SERVICE AREA	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Mental Health Services	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Neurodevelopmental Therapy • 25 outpatient visits per Calendar Year • No limit for inpatient days	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Newborn Care	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Nutritional Counseling	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Orthotic Devices	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Palliative Care • 30 visits per Calendar Year	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Pediatric Dental – Preventive and Diagnostic Dental Services	After In-Network Deductible, 0% Coinsurance	
Pediatric Dental – Basic Dental Services	After In-Network Deductible, 20% Coinsurance	
Pediatric Dental – Major Dental Services	After In-Network Deductible, 50% Coinsurance	
Pediatric Vision Examination	No charge	50% Coinsurance, not subject to the Deductible
Pediatric Vision Hardware – Lenses	No charge	50% Coinsurance, not subject to the Deductible
Pediatric Vision Hardware – Frames	No charge for frames from the Otis & Piper Eyewear Collection. All other frames, You pay the full cost of the frame minus any discount. Refer to the Additional Discount provision in Your Booklet.	50% Coinsurance, not subject to the Deductible
Pediatric Vision - Low Vision Benefit	No charge	0% Coinsurance, not subject to the Deductible. You pay balance of billed charges.

	YOUR COSTS OF THE ALLOWED AMOUNT FOR SERVICES INSIDE THE SERVICE AREA	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Prescription Medications – from a Participating or Preferred Pharmacy • 90-day supply for Prescription Medications (even if packaging includes larger supply). Coinsurance is based on each 30-day supply • 90-day supply for Self-Administrable Injectable Medications • 30-day supply for Specialty Medications • Up to a 12-month supply for refills of FDA-approved contraceptive drugs (may be dispensed on-site at a Provider's office, if available) • Multi-month Dispensing: largest allowed quantity is the smallest supply as packaged by the drug maker • After Deductible, Medications found on the Naloxone Value List that are intended to treat opioid overdose are covered at no cost sharing. The list is found on Our Web site or by calling Customer Service. • Deductible waived for Medications designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medications list. These medications are not intended to treat an existing Illness, Injury, or condition. To obtain this list visit Our Web site or contact Customer Service. Contact information is available in Your Booklet.	After Deductible, 10% Coinsurance for each Preferred Generic Medication on the Drug List. You can receive a 5% discount if filled at a Preferred Pharmacy.	Not covered
	After Deductible, 25% Coinsurance for each Generic Medication on the Drug List. You can receive a 5% discount if filled at a Preferred Pharmacy.	Not covered
	After Deductible, 25% Coinsurance for each Preferred Brand-Name Medication on the Drug List. You can receive a 5% discount if filled at a Preferred Pharmacy.	Not covered
	After Deductible, 50% Coinsurance for each Brand-Name Medication on the Drug List. You can receive a 5% discount if filled at a Preferred Pharmacy.	Not covered
	After Deductible, 20% Coinsurance for each Preferred Specialty Medication on the Drug List. Preferred Specialty Medication first fill allowed at a Pharmacy. Additional fills must be provided by a Specialty Pharmacy.	Not covered
	After Deductible, 50% Coinsurance for each Specialty Medication on the Drug List. Specialty Medication first fill allowed at a Pharmacy. Additional fills must be provided by a Specialty Pharmacy.	Not covered

	YOUR COSTS OF THE ALLOWED AMOUNT FOR SERVICES INSIDE THE SERVICE AREA	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Prescription Medications – from a Mail-Order Supplier • 90-day supply for Self-Administrable Injectable Medications • 90-day supply for Prescription Medications • Up to a 12-month supply for refills of FDA-approved contraceptive drugs • Deductible waived for Medications designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medications list. These medications are not intended to treat an existing Illness, Injury, or condition. To obtain this list visit Our Web site or contact Customer Service. Contact information is available in Your Booklet.	After Deductible, 5% Coinsurance for each Preferred Generic Medication on the Drug List.	Not covered
	After Deductible, 20% Coinsurance for each Generic Medication on the Drug List.	Not covered
	After Deductible, 20% Coinsurance for each Preferred Brand-Name Medication on the Drug List.	Not covered
	After Deductible, 45% Coinsurance for each Brand-Name Medication on the Drug List.	Not covered
Self-Administrable Cancer Chemotherapy Medications • 30-day supply	After Deductible, 20% Coinsurance for each Preferred Generic and Generic Medication on the Drug List.	Not covered
	After Deductible, 20% Coinsurance for each Preferred Brand-Name and Brand-Name Medication on the Drug List.	Not covered
	After Deductible, 20% Coinsurance for each Preferred Specialty and Specialty Medication on the Drug List. Preferred Specialty or Specialty Medication must be provided by a Specialty Pharmacy.	Not covered
Prosthetic Devices	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Reconstructive Services and Supplies	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Rehabilitation Services • 30 inpatient days per Calendar Year • 25 outpatient visits per Calendar Year	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance

	YOUR COSTS OF THE ALLOWED AMOUNT FOR SERVICES INSIDE THE SERVICE AREA	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Reproductive Health Care Services • Male condoms, and brand contraceptive drugs	No charge after IRS minimum deductible; see Covered Preventive Medications in Your Booklet for more information	
• Vasectomy	No charge after IRS minimum deductible; see Covered Preventive Medications in Your Booklet for more information	After Deductible, 50% Coinsurance
• All FDA-approved contraceptive drugs, devices, products and services	No charge	
Retail Clinic Office Visits	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Skilled Nursing Facility (SNF) Care • 60 inpatient days per Calendar Year	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Spinal Manipulations • Ten spinal manipulations per Calendar Year	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Substance Use Disorder Services	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Temporomandibular Joint (TMJ) Disorders	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Transplants	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Urgent Care Center	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance
Virtual Care • Store and Forward Service • Telehealth • Telemedicine	After Deductible, 20% Coinsurance	After Deductible, 50% Coinsurance

Introduction

Regence BlueShield

Street Address:
1800 Ninth Avenue
Seattle, WA 98101

Medical/Dental Claims Address:
P.O. Box 30271
Salt Lake City, UT 84130-0271

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

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

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

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

Vision Appeals Address:
Vision Service Plan Insurance Company
Attention: Complaint and Appeals Unit
P.O. Box 997100
Sacramento, CA 95899-7100

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

This Booklet is effective January 1, 2020, or the date Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Us and makes it void.

Using Your Booklet

YOUR PARTNER IN HEALTH CARE

We are pleased that Your Group has chosen Us as Your partner in health care. It's important to have continued protection against unexpected health care costs. This plan provides coverage that's comprehensive, affordable and provided by a partner You can trust in times when it matters most. Your vision coverage is provided by Regence, in collaboration with Vision Service Plan Insurance Company (VSP) which coordinates benefits and claims processing for the Pediatric Vision portion of this plan.

The following sections may be useful to You:

- **Schedule of Benefits:** describes Your costs for Covered Services.
- **Additional Advantages of Membership:** describes other advantages of membership with Us.
- **Contact Information:** describes how to contact Us by phone or via Our Web site.
- **Understanding Your Benefits:** describes Maximum Benefits, Deductibles, Coinsurance and Out-of-Pocket Maximums.
- **Medical Benefits:** describes preauthorization and what is covered.
- **Exclusions:** describes in detail what is not covered.
- **Contract and Claims Administration:** describes how claims are submitted, what You must do if a third party is responsible for an Illness or Injury, and how benefits are paid when You have other coverage.
- **Appeals and Grievances:** describes what to do if You want to file an Appeal or a Grievance.
- **Who is Eligible, How to Apply and When Coverage Begins:** describes who is eligible to apply and when.
- **When Coverage Ends:** describes what happens when You are no longer eligible for coverage.
- **General Provisions and Legal Notices**: describes important general Contract provisions and legal notices.
- **Definitions:** describes important terms used in this Booklet and Schedule of Benefits.

ADDITIONAL ADVANTAGES OF MEMBERSHIP

Advantages of membership include access to discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to Our Web site, an interactive environment that can help You navigate Your way through health care decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE GROUP HEALTH PLAN, BUT ARE NOT INSURANCE.**

- **Go to regence.com.** It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your health care dollar. Have Your member card handy to log on. Use the secure Web site to:
  - view recent claims, benefits and coverage;
  - find a contracting Provider;
  - participate in online wellness programs and use tools to estimate upcoming healthcare costs;
  - discover discounts on select items and services*;
  - identify Participating Pharmacies;
  - find alternatives to expensive medicines;
  - learn about prescriptions for various Illnesses; and
  - compare medications based upon performance and cost, as well as discover how to receive discounts on prescriptions.

*Note 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 Us. Any such discounts or coupons are complements to the group health plan, but are not insurance.

CONTACT INFORMATION

- **Medical/Dental Customer Service:** 1 (888) 367-2112 (TTY: 711) or visit Our Web site: **regence.com** if You have questions, would like to learn more about Your plan, have not received or have lost Your member card, or would like to request written or electronic information regarding any health care plan We offer. Phone lines are open Monday-Friday 5 a.m. - 8 p.m. and Saturday 8 a.m. -

4:30 p.m. Pacific Time.

- **Vision Provider and benefit questions:** call VSP at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance), Monday-Friday 5 a.m. - 8 p.m. Saturday 7 a.m. - 8 p.m., and Sunday 7 a.m. - 7 p.m. You may also visit VSP's Web site at **vsp.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.
- **Health Plan Disclosure Information.** You may receive written or electronic copies of the following health plan disclosure information by calling the Customer Service telephone number or access that information through Our Web site at **https://www.regence.com/web/regence_individual/member-notices**. Available disclosure information includes, but is not limited to:

  - a listing of covered benefits, including prescription drug benefits;
  - a copy of the current Drug List;
  - exclusions, reductions, and limitations to covered benefits;
  - Our policies for protecting the confidentiality of Your health information;
  - cost of premiums and Member cost-sharing requirements;
  - a summary of Adverse Benefit Determinations and the Grievance Processes; and
  - lists of In-Network primary care and specialty care Providers.

Table of Contents

Understanding Your Benefits

In this section, You will find information to help You understand what is meant by Maximum Benefits, Deductibles, Coinsurance and Out-of-Pocket Maximum.

This section defines cost-sharing elements but You will need to refer to the Schedule of Benefits and the Medical Benefits section to see exactly how they are applied.

On this high deductible health plan, it is important to understand the difference between Single Coverage and Family Coverage. Single Coverage means only one person has coverage under this Contract. Examples of Single Coverage include an individual employee who has coverage under this Contract, an Enrolled Dependent who is continuing individual insurance coverage, and spouses who both work for the Group and are Enrolled Employees on separate coverage applications. Family Coverage means one or more members of the same Family have coverage under this Contract under a single application.

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, supplies, 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 Contract, regardless of the Provider rendering such service or supply.

DEDUCTIBLES

The Single Coverage Deductible is the amount You are required to pay for Covered Services in a Calendar Year before We begin to pay benefits for Covered Services. The Family Coverage Deductible is the amount one or more members of Your Family are required to pay for Covered Services in a Calendar Year before We begin to pay benefits for Covered Services. Allowed charges and eligible expenses are applied towards the Calendar Year Deductible. Single Coverage and Family Coverage Deductibles are specified on the Schedule of Benefits.

There are two Calendar Year Deductible amounts: one for In-Network benefits and another for Out-of-Network benefits. The In-Network and Out-of-Network amounts accrue separately and do not combine.

We do not pay for services applied toward the Deductible. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not count toward the Deductible. Any amount paid through use of a drug manufacturer coupon may not count toward the Deductible. Refer to the Schedule of Benefits to determine if a particular service is subject to the Deductible.

PERCENTAGE PAID UNDER THE CONTRACT (COINSURANCE)

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

We do not reimburse Providers for charges above the Allowed Amount. An In-Network Provider will not charge You for any balances for Covered Services beyond Your applicable Deductible and/or Coinsurance amount. Out-of-Network Providers may bill You for any balances over Our payment level in addition to any applicable Deductible and/or Coinsurance amount (referred to as balance billing).

BALANCE BILLING

Balance billing occurs when You are billed for balances beyond any Deductible and/or Coinsurance for Covered Services provided to You by an Out-of-Network Provider when the Out-of-Network Provider's billed amount is not fully reimbursed by Us. You will not be balance billed for emergency services or for certain non-emergency surgical or ancillary services provided by an Out-of-network Provider at an In-Network hospital or Ambulatory Surgical Center. Non-emergency surgical or ancillary services include

anesthesiology, pathology, radiology, laboratory, hospitalist, or surgical services. Any amounts You pay for emergency services or for non-emergency surgical or ancillary services will count toward Your Deductible and Out-of-Pocket Maximum.

OUT-OF-POCKET MAXIMUM

The Single Coverage Out-of-Pocket Maximum is the most You have to pay for Covered Services in a Calendar Year. The Family Coverage Out-of-Pocket Maximum is the most one or more members of Your Family have to pay for Covered Services in a Calendar Year. The Out-of-Pocket Maximum is met by payments of Deductible and/or Coinsurance as indicated on the Schedule of Benefits. 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. Out-of-Pocket Maximums are specified on the Schedule of Benefits.

Note, however, that the maximum In-Network Out-of-Pocket amount for any Member on Family Coverage will not exceed the In-Network Out-of-Pocket Maximum amount for Single Coverage. If a Member reaches this Single Coverage maximum amount prior to satisfying the Family Out-of-Pocket Maximum, benefits will be paid at 100 percent of the Allowed Amount for that Member for the remainder of the Calendar Year.

There are two Out-of-Pocket Maximum amounts: one for In-Network benefits and another for Out-of-Network benefits. The In-Network and Out-of-Network amounts accrue separately and do not combine.

Ambulance Services, Blood Bank, Emergency Room, Pediatric Dental Services and Prescription Medications will always apply toward the In-Network Out-of-Pocket Maximum amount.

Amounts You pay for non-Covered Services, amounts in excess of the Allowed Amount, and Pediatric Vision services received from an Out-of-Network Provider do not apply toward the Out-of-Pocket Maximum. Further, any reduction in Your Coinsurance 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 in this Booklet (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 annual Contract renews on a day other than January 1, any Deductible or Out-of-Pocket Maximum amounts You satisfied before the plan's renewal date will carry over into the next contract period. 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 contract during the same Calendar Year.

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

Medical Benefits

This section explains how Your coverage pays for Covered Services. Referrals are not required under this plan, and nothing contained in this Booklet is designed to restrict Your choice of Provider for care or treatment of an Illness or Injury. Most benefits are listed alphabetically.

Medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury, including chronic disease management services (except for any covered preventive care). All covered benefits are subject to the limitations, exclusions and provisions of this plan. A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service. In some cases, We may limit benefits or coverage to a less costly and Medically Necessary alternative item. See the Definitions section for descriptions of Medically Necessary and the kinds of Providers who deliver Covered Services.

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

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

Some services may require preauthorization. Contracted Providers may be required to seek preauthorization from Us before providing some services for You. You will not be penalized if the Contracted Provider does not obtain preauthorization from Us in advance and the service is later determined to be not covered. Non-Contracted Providers are not required to obtain preauthorization from Us prior to providing services. You may be liable for the cost of services provided by a Non-Contracted Provider if those services are not Covered Services nor Medically Necessary. You may request that a Non-Contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to receiving those services.

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

PREVENTIVE CARE AND IMMUNIZATIONS

We cover preventive care services provided by a professional Provider, facility, or Retail Clinic such as:

- routine physical examinations, well-baby care, women's care (including screening for gestational diabetes), and health screenings. Health screenings include screening for obesity in patients ages six and older, and appropriate referrals to comprehensive, intensive behavioral interventions to promote improvements in weight status;
- intensive multicomponent behavioral interventions for weight management;
- Provider counseling and prescribed medications for tobacco use cessation;
- preventive mammography services, including tomosynthesis;
- depression screening for all adults, including screening for maternal depression;
- immunizations for adults and children as recommended by the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA) and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- breastfeeding support and one new non-Hospital grade breast pump including its accompanying supplies per pregnancy, when obtained from a Provider (including a Durable Medical Equipment supplier), or a comparable new breast pump obtained from an approved commercial seller, even though that seller is not a Provider; and
- Food and Drug Administration (FDA) approved contraceptive drugs, devices, products and services

(including vasectomy) as described under the Reproductive Health Care Services benefit.

Benefits will be covered if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the USPSTF, the HRSA or by the CDC. In the event any of these bodies adopts a new or revised recommendation, this plan has up to one year before coverage of the related services must be available and effective under this benefit.

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

Certain FDA-approved over-the-counter contraceptives, devices, and services (including vasectomy) are subject to the minimum deductible amounts permitted by the Internal Revenue Service (IRS) on a high deductible health plan that qualifies for use with a health care savings account. For 2020, those amounts are $1,400 for Single Coverage and $2,800 for Family Coverage. This amount also will accrue to the overall Plan Deductible. For more information on FDA-approved over-the-counter contraceptives, devices, and services subject to minimum deductible amounts, visit Our Web site or contact Customer Service. You must submit a claim for reimbursement for the purchase of certain over-the-counter contraceptives.

NOTE: Covered Services that do not meet these criteria (for example, immunizations for travel, occupation or residency in a foreign country) will be covered the same as any other Illness or Injury.

OFFICE VISITS – ILLNESS OR INJURY

We cover office, home or Hospital outpatient department visits for treatment of Illness or Injury. All other professional services performed in the office, not billed as an office visit, or that are not related to the actual visit (such as separate Facility Fees billed in conjunction with the office visit) are not considered an office visit.

OTHER PROFESSIONAL SERVICES

Professional services and supplies include the following:

Diagnostic Procedures

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

Medical Services and Supplies

We cover professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider. Services and supplies also include those to treat a congenital anomaly and foot care associated with diabetes.

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

Professional Inpatient

We cover professional inpatient visits for Illness or Injury. If pre-arranged procedures are performed by an In-Network Provider and You are admitted to an In-Network Hospital, We cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by Out-of-Network Providers at the In-Network benefit level. Contact Customer Service for further information and guidance.

Radiology and Laboratory
We cover services for treatment of Illness or Injury. This includes, but is not limited to, prostate screenings, colorectal laboratory tests and mammography services not covered under the Preventive Care and Immunizations benefit. NOTE: Outpatient complex imaging services are covered under the Complex Imaging – Outpatient benefit.

Claims for independent clinical laboratory services will be submitted to this plan or any other Blue Cross and/or Blue Shield Licensee in the locale in which the referring Provider is located, regardless of where the examination of the specimen occurred. Refer to the plan network where the referring Provider is located for coverage of independent clinical laboratory services.

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

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

ACUPUNCTURE
We cover acupuncture services provided by a Provider.

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

AMBULATORY SURGICAL CENTER
We cover outpatient services and supplies of an Ambulatory Surgical Center, including professional services and facility charges, for Illness and Injury.

APPROVED CLINICAL TRIALS
If an In-Network Provider is participating in the Approved Clinical Trial and will accept You as a trial participant, benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If the 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. We cover Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating subject to any Deductible and/or Coinsurance and Maximum Benefits as specified in the Schedule of Benefits.

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

COMPLEX IMAGING – OUTPATIENT
We cover services and supplies for outpatient complex imaging for the treatment of Illness or Injury. Outpatient complex imaging is limited to the following imaging services: Computer Tomography (CT) Scan, Positron Emission Tomography (PET), Magnetic Resonance Angiogram (MRA), Single-Proton Emission Computerized Tomography (SPECT), Bone Density Study and Magnetic Resonance Imaging (MRI).

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

DETOXIFICATION
We cover Medically Necessary detoxification services.

DIABETIC EDUCATION
We cover services and supplies for diabetic self-management training and education provided by Providers with expertise in diabetes. Diabetic nutritional counseling and therapy is covered under the Nutritional Counseling benefit.

DIALYSIS
We cover inpatient, outpatient, and home services and supplies for dialysis (including outpatient hemodialysis, peritoneal dialysis and hemofiltration).

DURABLE MEDICAL EQUIPMENT
Durable Medical Equipment must be provided by a Provider practicing within the scope of his or her license and must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Applicable sales tax for Durable Medical Equipment and mobility enhancing equipment is also covered. Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Member's home. Examples include oxygen equipment, wheelchairs, and insulin pumps and their supplies. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item.

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

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)
We cover emergency room services and supplies, including outpatient charges for patient observation, medical screening examinations and treatment, routinely available ancillary evaluative services and Medically Necessary detoxification services that are required for the stabilization of a patient experiencing an Emergency Medical Condition.

"Stabilization" means to provide Medically Necessary treatment:

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

Emergency room services do not need to be pre-authorized.

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

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY
If You fulfill Medical Necessity criteria and receive therapy from a Provider expressly identified by Us as a Center of Excellence for that therapy, We cover gene therapies and/or adoptive cellular therapies and associated Medically Necessary Covered Services under this benefit. You may contact Customer Service for a current list of covered gene and cellular therapies, or to identify a Center of Excellence.

Travel Expenses
We reimburse travel expenses for covered gene therapy and/or adoptive cellular therapy provided at a Center of Excellence (limited to transportation, food, and lodging) for You and a companion (or two companions if You are under age 19) up to the combined dollar limit per course of treatment, as specified on the Schedule of Benefits. Reimbursable transportation includes only commercial airfare, commercial

train fare, or documented auto mileage (calculated per IRS allowances) to the treatment area and local ground transportation to and from treatment within that area during the course of treatment. Documentation of travel expenses should be retained for submission for reimbursement.

GENETIC TESTING

We cover Medically Necessary services for genetic testing.

HABILITATIVE SERVICES

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

Cardiac rehabilitation, pulmonary rehabilitation, respiratory therapy, and breast cancer lymphedema services are covered as any other medical condition under the applicable benefits of the plan and do not accrue to Habilitative Services benefit limits.

HOME HEALTH CARE

We cover home health care 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.

Alternative Benefits

Home health care furnished by duly licensed home health, hospice and home care agencies covered by this Contract may be substituted as an alternative to hospitalization or inpatient care if hospitalization or inpatient care is Medically Necessary and such home health care:

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

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

HOSPICE CARE

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

Respite Care

We cover respite care to provide continuous care of the Member and allow temporary relief to family members from the duties of caring for the Member.

HOSPITAL CARE – INPATIENT AND OUTPATIENT

We cover the inpatient and outpatient services and supplies of a Hospital 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 admitted to an Out-of-Network Hospital directly from the emergency room, services will be

covered at the In-Network benefit level. If services were not covered at the In-Network benefit level, contact Customer Service for further information and guidance.

MATERNITY CARE

We cover prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), Medically Necessary supplies of home birth, complications of pregnancy, termination of pregnancy and related conditions for all female Members (including eligible dependents of dependents who have enrolled under this Contract). There is no limit for the mother's length of inpatient stay. The attending Provider, if any, will determine an appropriate discharge time, in consultation with the mother.

Surrogacy

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

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

MEDICAL FOODS

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

MENTAL HEALTH SERVICES

We cover inpatient and outpatient Mental Health Services for treatment of Mental Health Conditions, including Applied Behavioral Analysis (ABA) therapy services covered for treatment of Autism Spectrum Disorders when Members seek services from licensed Providers qualified to prescribe and perform ABA therapy services.

NEURODEVELOPMENTAL THERAPY

We cover inpatient and outpatient neurodevelopmental therapy services. Such services must be to restore and improve function. Covered Services are limited to physical therapy, occupational therapy and speech therapy and maintenance services, if significant deterioration of the Member's condition would result without the service. You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN CARE

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

NUTRITIONAL COUNSELING

We cover nutritional counseling and therapy for all conditions including diabetic counseling and obesity.

ORTHOTIC DEVICES

We cover braces, splints, orthopedic appliances and orthotic supplies or apparatuses purchased to support, align or correct deformities or to improve the function of moving parts of the body. Orthopedic

shoes, regardless of diagnosis, and off-the-shelf shoe inserts are not covered.

Orthotic devices must be provided by a Provider practicing within the scope of his or her license and must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). In some cases, We may limit benefits or coverage to a less costly and Medically Necessary alternative item.

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

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

PALLIATIVE CARE

We cover palliative care when a Provider has assessed that a Member is in need of palliative care services for serious Illness (including remission support), life-limiting Injury, or end of life. "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 Member receiving palliative care remain covered the same as any other Illness or Injury.

PEDIATRIC DENTAL

We cover pediatric Dental Services for Members under the age of 19. Coverage will be provided for a Member until the last day of the month in which the Member turns 19 years of age. The BlueCard Program detailed in the Contract and Claims Administration section does not apply to this Pediatric Dental benefit. Benefits are paid under this Pediatric Dental benefit, not any other benefit, if a service or supply is covered under both.

Preventive And Diagnostic Dental Services

We cover the following preventive and diagnostic Dental Services:

- bitewing x-rays, limited to two sets (4 x-rays total) per Calendar Year;
- cephalometric films, limited to once in a two-year period;
- complete intra-oral mouth x-rays, limited to one in a three-year period;
- cleanings, limited to two per Calendar Year;
- diagnostic casts when Dentally Appropriate;
- limited oral evaluations to evaluate the Member for a specific dental problem or oral health complaint, dental emergency or referral for other treatment;
- visual oral assessments or screenings, not performed in conjunction with other clinical oral evaluation services, limited to two per Calendar Year;
- occlusal intraoral x-rays, limited to once in a two-year period;
- oral hygiene instruction, limited to two sessions per Calendar Year, if not billed on the same day as a cleaning;
- periapical x-rays that are not included in a complete series for diagnosis in conjunction with definitive treatment;
- photographic images (oral and facial) when Dentally Appropriate;
- periodic and comprehensive oral examinations, limited to two per Calendar Year;
- problem focused oral examinations;
- panoramic mouth x-rays, limited to one in a three-year period;
- sealants, limited to permanent bicuspids and molars;
- topical fluoride application, limited to three applications per Calendar Year. Additional topical fluoride applications are covered when determined Dentally Appropriate; and
- space maintainers (fixed unilateral or fixed bilateral) includes:
    - re-cementation of space maintainers;
    - removal of space maintainers; and

- replacement space maintainers are covered when Dentally Appropriate.

Basic Dental Services
We cover the following basic Dental Services:

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

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

- Endodontic benefits will not be provided for indirect pulp capping.
- Fillings consisting of composite and amalgam restorations:

  - five surfaces per tooth for permanent posterior teeth, except for upper molars;
  - six surfaces per tooth for teeth 1, 2, 3, 14, 15 and 16;
  - six surfaces per tooth for permanent anterior teeth;
  - restorations on the same tooth are limited to once in a two-year period; and
  - two occlusal restorations for the upper molars on teeth 1, 2, 3, 14, 15 and 16.

- General dental anesthesia or intravenous sedation administered in connection with the extractions of partially or completely bony impacted teeth and to safeguard the Member's health. Other services related to general anesthesia or intravenous sedation are covered as follows:

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

- Periodontal services consisting of:

  - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery), once per quadrant in a five-year period;
  - debridement;
  - gingivectomy and gingivoplasty, once per quadrant in a three-year period;
  - periodontal maintenance, once per quadrant in a Calendar Year; and
  - scaling and root planing, once per quadrant in a two-year period.

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

Major Dental Services
We cover the following major Dental Services:

- Adjustment and repair of dentures and bridges:

  - adjustments within 90 days of delivery (placement) will not be separately reimbursed;
  - the cost of repairs cannot exceed the cost of a replacement denture or a partial denture; and

  - additional repairs on a case-by-case basis and when prior authorized.

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

  - an indirect crown, for permanent anterior teeth, one per tooth in a five-year period;
  - cast post and core or prefabricated post and core, on permanent teeth when performed in conjunction with a crown;
  - core build-ups, including pins, only on permanent teeth when performed in conjunction with a crown;
  - recementations of permanent indirect crowns;
  - stainless steel crowns for primary anterior and posterior teeth, once in a three-year period; and
  - stainless steel crowns for permanent posterior teeth (excluding teeth 1, 16, 17 and 32), once in a three-year period.

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

  - adjustment and repair of dentures and bridges, limited to one per arch in a 12-month period;
  - denture rebase, limited to one per arch in a three-year period, if performed at least six months from the seating date;
  - denture relines, limited to one per arch in a three-year period if performed at least six months from the seating date;
  - one complete upper and lower denture, and one replacement denture per Lifetime after at least five years from the seat date; and
  - one resin-based partial denture, replaced once within a three-year period.

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

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

- Occlusal guards.
- Post-surgical complications.
- Repair of crowns, limited to one per tooth per Lifetime.
- Repair of implant supported prosthesis or abutment, limited to one per tooth per Lifetime.

EXCLUSIONS

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

Aesthetic Dental Procedures

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

Antimicrobial Agents

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

Collection of Cultures and Specimens

Connector Bar or Stress Breaker

Cosmetic/Reconstructive Services and Supplies

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

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

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

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

Duplicate X-Rays

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

Gold-Foil Restorations

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

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

Interim Partial or Complete Dentures

Medications and Supplies
Charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and supplies are not covered, except as explicitly provided in the Pediatric Dental benefit.

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

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

Orthodontic Dental Services
Services and supplies provided in connection with orthodontics are not covered, except as explicitly provided in the Pediatric Dental benefit, including:

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

Precision Attachments

Provisional Splinting

Replacements
Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken are not covered, except as explicitly provided in the Pediatric Dental benefit.

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

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

Services Performed in a Laboratory

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

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

Temporomandibular Joint (TMJ) Disorder Treatment
Services and supplies provided in connection with temporomandibular joint (TMJ) disorder, except as explicitly provided in the Medical Benefits section.

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

Veeners

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

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

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

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

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

Out-of-Network Dentists have not agreed to accept the Allowed Amount as full compensation for Covered

Services. You are responsible for paying any difference between the amount billed by the Out-of-Network Dentist and the Allowed Amount in addition to any amount You must pay due to Deductible and/or Coinsurance. For Out-of-Network Dentists, the Allowed Amount may be based upon the billed charges for some services, as determined by Us or as otherwise required by law.

PEDIATRIC VISION

We cover pediatric vision care for Members under the age of 19. Coverage will be provided for a Member until the last day of the month in which the Member turns 19 years of age. Covered Services are those services required for the diagnosis or correction of visual acuity and must be provided by a Physician or optometrist practicing within the scope of his or her license.

All terms and conditions apply to this Pediatric Vision benefit, except as otherwise noted. Benefits are paid under this Pediatric Vision benefit, not any other benefit, if a service or supply is covered under both.

PEDIATRIC VISION EXAMINATION

We cover routine vision screening and comprehensive eye examination services, including:

- refraction;
- dilation as professionally indicated;
- prescribing and ordering proper lenses;
- assisting in the selection of frames;
- verifying the accuracy of the finished lenses;
- proper fitting and adjustment of frames;
- subsequent adjustments to frames to maintain comfort and efficiency; and
- progress or follow-up work as necessary.

PEDIATRIC VISION HARDWARE

We cover hardware including frames, contacts (instead of glasses) and all lenses and tints. One pair of standard lenses are covered in either glass or plastic per Calendar Year, including:

- spectacle;
- single vision;
- lined bifocal;
- lined trifocal;
- lenticular;
- polycarbonate;
- scratch coating;
- UV (ultraviolet) protected lenses; or
- photochromic lenses; tinted lenses.

Also covered are high power spectacles, magnifiers and telescopes. Frames are available once per Calendar Year.

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

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

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

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

Limitations

These vision benefits are designed to cover visual needs rather than cosmetic materials. If You select any of the following extras, We will pay the basic cost of the allowed lenses and You will pay any additional costs for these options:

- optional cosmetic processes;
- anti-reflective coating;
- color coating;
- mirror coating;
- blended lenses;
- cosmetic lenses;
- laminated lenses;
- oversize lenses;
- standard, premium and custom progressive multifocal lenses; and
- contact lenses not previously described as covered.

LOW VISION BENEFIT

We cover low vision benefits for Members, including optical devices, aids, annual comprehensive low vision examinations and follow-up visits, (age 19 and under) if vision loss is sufficient enough to prevent reading and performing daily activities. You will be entitled to professional services as well as ophthalmic materials, subject to the frequency and benefit limitations of this Low Vision benefit. Consult Your VSP Doctor for more details.

Supplemental Testing

We cover supplemental testing (complete low vision analysis and diagnosis) every two Calendar Years. This includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or low vision aids where indicated.

Supplemental Aids

We cover low vision aids every two Calendar Years, including, but not limited to, optical and non-optical aids and the associated training.

EXCLUSIONS

In addition to the exclusions in the General Exclusions section, the following exclusions apply to this Pediatric Vision benefit:

Certain Contact Lens Expenses

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

Corneal Refractive Therapy (CRT)

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

Corrective Vision Treatment of an Experimental Nature

Costs for Services and/or Supplies Exceeding Benefit Allowances

Medical or Surgical Treatment of the Eyes

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

Orthoptics or Vision Training

Orthoptics or vision training and any associated supplemental testing.

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

Replacement of Lenses and Frames
Replacement of covered lenses and frames which are lost or broken when not provided at the normal intervals.

Services and/or Supplies Not Described As Covered Under This Vision Benefit

Two Pair of Glasses instead of Bifocals

GENERAL INFORMATION
Submission of Claims and Reimbursement
When You visit a VSP Doctor, the doctor will submit the claim directly to VSP for payment. If You visit an Out-of-Network Provider, however, You will need to pay the Provider his or her full fee at the time You receive the service or supply. You will need to submit a claim to VSP for reimbursement according to the benefits in this Booklet, less any Coinsurance. THERE IS NO ASSURANCE THAT PAYMENT WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR HARDWARE. Be sure the claim is complete and includes the following information:

- copy of claim receipt from the Provider, including Provider's name, address, date of service, and services performed. You may access Out-of-Network Reimbursement under My Benefits on VSP's Web site, vsp.com, to get a claim form to assist in submission of Out-of-Network Provider claims;
- Your name, date of birth, address, Regence ID number and Group's name; and
- patient's name, date of birth and relation to You.

Send to:

Vision Service Plan
P.O. Box 385020
Birmingham, AL 35238-5020

Additional Discount
You are entitled to receive a 20 percent discount toward the purchase of non-covered materials from any VSP Doctor when a complete pair of glasses is dispensed. You are also entitled to receive a 15 percent discount off of contact lens examination services from any VSP Doctor, beyond the covered exam. Professional judgment will be applied when evaluating prescriptions written by an Out-of-Network Provider. VSP Doctors may request an additional examination at a discount.

Discounts are applied to the VSP Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye examination. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THIS PEDIATRIC VISION BENEFIT, BUT ARE NOT INSURANCE.**

Limitations
- discounts do not apply to vision care benefits obtained from Out-of-Network Providers;
- 20 percent discount applies only when a complete pair of glasses is dispensed; and
- discounts do not apply to sundry items, for example, contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

PRESCRIPTION MEDICATIONS
We cover Prescription Medications listed under the Drug List, which can be viewed on Our Web site.

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

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

process, unless patient safety requires an expedited replacement.

Drug List Exception Process

Non-Drug List medications are not routinely covered under Your Prescription Medications benefit; however, Prescription Medication not on the Drug List may be covered under certain circumstances. Non-Drug List means those self-administered Prescription Medications not listed in the Drug List for Your plan.

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

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

The specific medication policy criteria to determine if a Prescription Medication not on the Drug List is Medically Necessary are available on Our Web site. You or Your Provider may request prior authorization by calling Customer Service, or by completing and submitting the form available on Our Web site. You or Your requesting Provider will be notified of Our determination no later than 72 hours following receipt of the request. If You are suffering from a health condition that may seriously jeopardize Your life, health, or ability to regain maximum function or if You are undergoing a current course of treatment using a non-Drug List medication, You or Your requesting Provider will be notified of Our determination no later than 24 hours following receipt of the request.

Once preauthorization has been approved, the Prescription Medication not on the Drug List will be covered at the Substituted Medication benefit level and will count toward Your Deductible or Out-of-Pocket Maximum.

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

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

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

Emergency Fill

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

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

Covered Prescription Medications For Treatment of Illness or Injury

Prescription Medications benefits are available for the following:

- insulin and diabetic supplies (including, but not limited to, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, urine test strips, prescriptive oral agents for controlling blood sugar levels and glucagon emergency kits, but not insulin pumps or continuous glucose monitors and their supplies), when obtained with a Prescription Order (insulin pumps and continuous glucose monitors and their supplies are covered under the Durable Medical Equipment

benefit);
- Prescription Medications;
- Emergency Fill five-day supply or the minimum packaging size available at the time the Emergency Fill is dispensed;
- Foreign Prescription Medications for Emergency Medical Conditions while traveling outside the United States or while residing outside the United States. The foreign Prescription Medication must have an equivalent FDA-approved Prescription Medication that would be covered under this benefit if obtained in the United States, except as may be provided under the Experimental/Investigational definition in the Definitions section;
- certain Prescription Medications that are administered by Your Provider as determined by the Pharmacy and Therapeutics (P&T) Committee;
- medications intended to treat opioid overdose that are on the Naloxone Value List found on Our Web site or by calling Customer Service;
- Specialty Medications (including, but not limited to, medications for multiple sclerosis, rheumatoid arthritis, cancer, clotting factor for hemophilia or similar clotting disorders and hepatitis C);
- Self-Administrable Cancer Chemotherapy Medication;
- Self-Administrable Hemophilia Factors Drugs;
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Injectable Medications) and teaching doses by which a Member is educated to self-inject; and
- growth hormones (if preauthorized).

Covered Preventive Medications

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

You are not responsible for any applicable Deductible and/or Coinsurance when You fill prescriptions at a Preferred or Participating Pharmacy for specific strengths or quantities of medications that are specifically designated as preventive medications by the USPSTF or HRSA, or for immunizations (except for immunizations for the purpose of travel, occupation, or residency in a foreign country), as specified above.

NOTE: FDA-approved over-the-counter contraceptive drugs, devices, and products are available from a participating pharmacy without a prescription and with minimal or no cost sharing. Certain FDA-approved prescriptions (including brand-name contraceptive medications) and over-the-counter contraceptive products (including male condoms) are subject to the minimum deductible amounts permitted by the IRS on a high deductible health plan that qualifies for use with a health care savings account. For 2020, those amounts are $1,400 for Single Coverage and $2,800 for Family Coverage. This amount also will accrue to the overall Plan Deductible. For more information on FDA-approved prescriptions and over-the-counter contraceptive products subject to minimum deductible amounts, visit Our Web site or contact Customer Service. You must submit a claim for reimbursement for the purchase of certain over-the-counter contraceptives. To receive reimbursement for these items, complete a Drug Claim Form and submit to Us for processing. The Drug Claim Form may be found at https://regence.myprime.com/v/RBW/COMMERCIAL/en/forms.html.

Certain prescribed brand-name insulin drugs are made available at the Generic Medication payment level. If those designated insulin drugs are ineffective, other insulin drugs may be made available to You through Our Drug List exception process at the Generic Medication payment level. For more information, visit Our Web site or contact Customer Service.

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

Pharmacy Network Information

A nationwide network of Preferred and Participating Pharmacies is available to You. Pharmacies that participate in this network submit claims electronically. There are more than 1,200 Participating

Pharmacies in Our Washington State network from which to choose.

Your member card enables You to participate in this Prescription Medication program, so You must use it to identify Yourself at any Pharmacy. If You do not identify Yourself as a Member of Regence BlueShield, a Preferred Pharmacy, Participating Pharmacy or Mail-Order Supplier may charge You more than the Covered Prescription Medication Expense. You can find Preferred and Participating Pharmacies and a Pharmacy locator on Our Web site or by contacting Customer Service.

Claims Submitted Electronically

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

Claims Not Submitted Electronically

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

Mail-Order

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

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

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

Your Prescription Drug Rights

You have the right to safe and effective Pharmacy services. You also have the right to know what drugs are covered by Your plan and the limits that apply. If You have a question or concern about Your prescription drug benefits, contact Us at 1 (888) 367-2112 or visit Our Web site.

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

Preauthorization

Preauthorization may be required so that We can determine that a Prescription Medication is Medically Necessary before it is dispensed. We publish a list of those medications that currently require preauthorization. This list can be found on Our Web site or by contacting Customer Service. In addition, We notify Providers, including Pharmacies, which Prescription Medications require preauthorization. The prescribing Provider must provide the medical information necessary to determine Medical Necessity of Prescription Medications that require preauthorization.

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

Limitations

The following limitations apply to this Prescription Medications benefit, except for over-the-counter preventive medications, and immunizations as specified in the Covered Preventive Medications provision:

- **Day Supply Limits**
  Prescription Medications benefits are limited to the days' supply shown in the Schedule of Benefits.

- **Maximum Quantity Limit**
  For certain Prescription Medications, We establish maximum quantities other than those shown in the Schedule of Benefits. For those medications, there is a limit on the amount of medication that will be covered during a period of time. We use information from the United States Food and Drug Administration (FDA) and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your member card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service. We do not cover any amount over the established maximum quantity, except if We determine the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

- **Refills**
  We cover refills from a Pharmacy when You have taken 75 percent of the previous prescription or 70 percent of the previous topical ophthalmic prescription. However, Schedule II or III controlled substance medications may be refilled only after You have taken 85 percent of the previous prescription.

  Other than FDA-approved contraceptive drugs, refills obtained from a Mail-Order Supplier are allowed after You have taken all but 20 days of the previous Prescription Order. If You refill Your Prescription Medications sooner, You will be responsible for the full costs of these Prescription Medications and these costs will not count toward Your Deductible or Out-of-Pocket Maximum. If You feel You need a refill sooner than allowed, a refill exception will be considered at Our discretion on a case-by-case basis. Request an exception by calling Customer Service.

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

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

Manufacturer Coupons
Any reduction in Your cost-sharing resulting from the use of a drug manufacturer coupon may not count toward the Out-of-Pocket Maximum.

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 Our 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; anti-aging; repair of sun-damaged skin; or reduction of redness associated with rosacea.

Diagnostic Agents
Medications used to aid in diagnosis rather than treatment. Coverage for these medications may

otherwise be provided under the Medical Benefits section.

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

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

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

Medications not on the Drug List, Unless Provided Through the Drug List Exception Process

Non-Self-Administrable Medications
Coverage for these medications may otherwise be provided under the Medical Benefits section 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 Our 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 section. 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 United States Food and Drug Administration (USFDA)

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

Prescription Medications Not Dispensed by a Preferred or Participating Pharmacy

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

Prescription Medications with Lower Cost 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
We do not cover prescriptions made by a Provider without recent and relevant in-person or virtual care examination of the patient, whether the Prescription Order is provided by mail, telephone, internet or some other means. 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

PROSTHETIC DEVICES

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

RECONSTRUCTIVE SERVICES AND SUPPLIES

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

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

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

REHABILITATION SERVICES

We cover inpatient and outpatient rehabilitation services and accommodations to restore or improve lost function because of an Injury, Illness or disabling condition. 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.

Cardiac rehabilitation, pulmonary rehabilitation, respiratory therapy, and breast cancer lymphedema services are covered as any other medical condition under the applicable benefits of the plan and do not accrue to Rehabilitation Services benefit limits.

REPRODUCTIVE HEALTH CARE SERVICES

We cover all FDA-approved prescription and over-the-counter contraceptive drugs, devices, products, and services, including, but not limited to:

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

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

FDA-approved prescription and over-the-counter contraceptive drugs, devices, products, and services are available without a prescription and with minimal or no cost-sharing as explicitly described in both the Preventive Care and Immunizations benefit section and the Covered Preventive Medications provision. You must submit a claim for reimbursement for the purchase of certain over-the-counter contraceptive drugs, devices, and products. To receive reimbursement for these items, complete a Drug Claim Form and submit to Us for processing. The Drug Claim Form may be found at https://regence.myprime.com/v/RBW/COMMERCIAL/en/forms.html. For more information, visit Our Web

site or contact Customer Service.

RETAIL CLINIC OFFICE VISITS

We cover office visits in a Retail Clinic for treatment of Illness or Injury. All other professional services performed in the Retail Clinic, not billed as an office visit, are not considered an office visit under this benefit.

SKILLED NURSING FACILITY

We cover the inpatient services and supplies of a Skilled Nursing Facility 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. Ancillary services and supplies, such as physical therapy, Prescription Medications, and radiology and laboratory services, billed as part of a Skilled Nursing Facility admission also apply toward the Maximum Benefit limit on Skilled Nursing Facility care.

SPINAL MANIPULATIONS

We cover chiropractic and osteopathic spinal manipulations performed by a Provider. Manipulations of extremities are covered under the Neurodevelopmental Therapy and Rehabilitation Services benefits.

SUBSTANCE USE DISORDER SERVICES

We cover Substance Use Disorder Services for treatment of Substance Use Disorder Conditions, including the following:

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

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

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

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

"Covered 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 are not Covered Services by this plan. “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

We cover transplants, including Hospital or outpatient Facility Fees, transplant-related services and supplies. A transplant recipient who is covered under this plan and fulfills Medically Necessary criteria will be eligible for the following transplants, including any artificial organ transplants based on medical guidelines and manufacturer recommendations:

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

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

Transplants and related services for gene therapies or adoptive cellular therapies are covered benefits under the Gene Therapy and Adoptive Cellular Therapy benefit section.

Donor Organ Benefits

We cover donor organ procurement costs, including Hospital or outpatient Facility Fees, if the recipient is covered for the transplant under this plan. Procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ and other such Medically Necessary procurement costs.

URGENT CARE CENTER

We cover office visits for treatment of Illness or Injury. All other professional services not billed as an office visit, or that are not related to the actual visit (such as separate Facility Fees billed in conjunction with the office visit) are not considered an office visit under this benefit. We also cover outpatient services and supplies (not billed as an office visit) provided by an urgent care center.

VIRTUAL CARE

We cover virtual care services. Virtual care refers to the utilization of telehealth, telemedicine, or store and forward services received from a remote Provider, rather than an in-person office visit, for the diagnosis, treatment, or management of a covered medical condition. To learn more about how to access virtual care services, please visit Our Website or contact Customer Service.

Store and Forward Services

We cover store and forward services. "Store and forward services" mean secure one-way electronic asynchronous (not live or real-time) electronic transmission (sending) of Your medical information to a Provider which may include some forms of secure HIPAA compliant texting, chatting or data sharing. Store and forward services do not include, for example, non-secure HIPAA compliant telephone, fax, short message service (SMS) texting or e-mail communication. Your Provider is responsible for meeting applicable requirements and community standards of care.

Telehealth

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

Telemedicine

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

Employee Assistance Program

An Employee Assistance Program (EAP) is an important component of a Group-sponsored preventive care package. The EAP provides short-term, confidential counseling at no out-of-pocket expense to You. The EAP is available to You and Your immediate family, including family members living in Your home (who may or may not be enrolled in this coverage). Contact Us or Your Group for more information regarding EAP coverage and for contact information.

SERVICES PROVIDED

The following services are provided as part of the EAP package:

24-Hour Crisis Counseling

The EAP hotline number is answered by professional counselors 24 hours a day, 7 days per week.

Short-Term Counseling

If the problem can be resolved within the scope of the EAP, the counselor provides this service to the individual(s). Up to four counseling sessions will be allowed per incident. An "incident" means a separate event or events occurring in the client's life. We will allow each family member affected by an incident a total of four counseling sessions. If two or more members of the same family are seen together in a joint session, the session is counted as one visit for each attending family member. Eligible family members are those individuals living in the same residence with You.

Referral

If the counselor and client determine the problem cannot be handled in short-term counseling, the counselor will refer the individual to community resources that are best suited to address the issue.

Follow-up

When necessary and appropriate, the counselor follows up with the client after short-term counseling and/or referral to assess the appropriateness of the referral and to see if the EAP service can be of further assistance.

Employee Wellness Reward

Employees may qualify for a $100 gift card reward per Contract Year. To qualify, You, the employee:

- Must have completed within the first three months of the Contract Year:
  - a Biometric Screening from an approved Provider; and
  - Our General Health Assessment tool; and
- Must still be enrolled in the Group's health plan as of the later of the date of completion of the Biometric Screening and the date of completion of the General Health Assessment tool.

Biometric screening by a health care Provider can assist You in assessing Your health risks and identifying changes to improve Your health by providing information about Your blood pressure, glucose, cholesterol, and body mass. Approved Providers for the Biometric Screening are identified on Our Web site or by contacting Customer Service.

A General Health Assessment is a tool You complete, describing Your health practices. The General Health Assessment is found online on Our Web site or by contacting Customer Service.

The Employee Wellness Reward is only available to employees.

General Exclusions

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

PREEXISTING CONDITIONS

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

SPECIFIC EXCLUSIONS

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

Activity Therapy

Creative arts, play, dance, aroma, music, equine or other animal-assisted, recreational, or similar therapy; sensory movement groups; and wilderness or adventure programs.

Adult Dental Services

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

Assisted Reproductive Technologies

We do not cover any 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, drugs, testing or supplies, regardless of underlying condition or circumstance.

Certain Therapy, Counseling, and Training

Educational, vocational, social, image, milieu, or marathon group therapy, premarital or marital counseling, IAP/EAP 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 Member's active participation in a war or insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

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

Cosmetic Services and Supplies

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

Counseling

Counseling in the absence of Illness, except as covered under the Preventive Care and Immunizations benefit.

Custodial Care

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

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

Family Counseling
Family counseling is excluded unless the patient is a child or adolescent with a covered diagnosis, and the family counseling is part of the treatment.

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

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

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

Hearing Aids, and Other Hearing Devices
Hearing aids (externally worn or surgically implanted), and other hearing devices are excluded. This exclusion does not apply to 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 Services, Substances and Supplies
Services, substances, and supplies that are illegal as defined under 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
Treatment of infertility, including, but not limited to surgery, fertility drugs, and other medications associated with fertility treatment are excluded.

Investigational Services
We do not cover Investigational treatments or procedures (Health Interventions) and services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). We also exclude any services or supplies provided under an Investigational protocol. Refer to the expanded definition of Experimental/Investigational in the Definitions section in this Booklet. Approved clinical trials are covered under the Approved Clinical Trials benefit in the Medical Benefits section.

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

Non-Direct Patient Care
Services that are not 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 Our request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges).

Obesity or Weight Reduction/Control
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 to the extent Covered Services are required as part of the USPSTF, HRSA, or CDC requirements.

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

Personal Items
Items that are primarily for comfort, convenience, contentment, cosmetics, hygiene, environmental control, education or general physical fitness. For example, We do not cover 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.

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

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

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

Riot, Rebellion, War and Illegal Acts
Services and supplies for treatment of an Illness or Injury caused by a member's unlawful instigation and/or participation in a riot, war, insurrection, rebellion, armed invasion or aggression; or sustained by a member while in the act of committing an illegal act.

Routine Foot Care

Routine Hearing Examination

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

- childbirth-related classes including infant care; and
- instructional programs including those that teach a person how to use Durable Medical Equipment or how to care for a family member.

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family. "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 for Administrative or Qualification Purposes
Physical or mental examinations and associated services, such as laboratory or similar tests, primarily for administrative or qualification purposes. Such purposes include, but are not limited to, admission to or remaining in a school, camp, sports team, the military or other institution; athletic training evaluation; legal proceedings, such as establishing paternity or custody; qualification for employment, marriage, insurance, occupational injury benefits, licensure or certification; or immigration or emigration.

Sexual Dysfunction
Treatment, services and supplies (including medications) 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 Right of Reimbursement and Subrogation Recovery sections for more information.

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

Travel and Transportation Expenses
Travel and transportation expenses when the transportation is for personal or convenience purposes, except for travel expenses specified under the Gene Therapy and Adoptive Cellular Therapy benefit.

Varicose Veins Treatment
Treatment of varicose veins, except when there is associated venous ulceration or persistent or recurrent bleeding from ruptured veins.

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

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

Contract and Claims Administration

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

CASE MANAGEMENT

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

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims payment is due, We decide whether We will pay the Member, the Provider and Member jointly, or the Provider directly, subject to any legal requirements.

In-Network Provider Claims and Reimbursement

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

Out-of-Network Provider Claims and Reimbursement

In order for Us to pay for Covered Services, You or the Out-of-Network Provider must first send Us a claim. If the treatment is for an Injury, include a statement explaining the date, time, place and circumstances of the Injury when You send Us the claim. Be sure the claim is complete and includes the following information:

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

Our standard policy is to make payment for Out-of-Network Provider claims on joint payee checks issued to both the Member and the Provider or, with submission of sufficient documentation that the Member has already "paid in full," on checks issued solely to the Member. However, in some situations, We choose to pay the Out-of-Network Provider directly by check issued solely to the Provider.

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

Timely Filing of Claims

You must provide written proof of loss within one year after the date of service of the claim. If You can show that it was not reasonably possible to provide such proof and that such proof was provided as soon as reasonably possible, failure to furnish proof within the time required will not invalidate or reduce any claim. We will deny a claim that is not filed in a timely manner unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. You may appeal a denial in order to demonstrate that the claim could not have been filed in a timely manner, as outlined in the Appeal Process section.

Ambulance Claims

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

Claims Determinations

Within 30 days of Our receipt of a claim, We will notify You of Our action. However, this 30-day period may be extended by an additional 15 days when We cannot take action on the claim due to lack of

information or extenuating circumstances. We will notify You of the extension within the initial 30-day period and provide an explanation why the extension is necessary. If We require additional information to process the claim, We must allow You at least 45 days to provide it to Us. If We do not receive the requested information within the time We have allowed, We will deny the claim.

OUT-OF-AREA SERVICES

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

When You receive care outside of the geographic area We serve, You may receive it from Providers as described below. Providers contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue") as a preferred Provider are paid at the In-Network 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 Out-of-Network Provider level and may bill You for balances beyond any Deductible and/or Coinsurance for Covered Services. Some providers ("Out-of-Network Providers") don't contract with the Host Blue. We further explain below how We pay these different kinds of providers.

BlueCard Program

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

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

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

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

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

Value-Based Programs

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

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

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

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

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

Nonparticipating Providers Outside Our Service Area

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

BLUE CROSS BLUE SHIELD GLOBAL® CORE

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

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

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

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

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

CLAIMS RECOVERY

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

the Enrolled Employee or any of his or her Enrolled Dependents, even if the mistaken payment was not made on that person's behalf.

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

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

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

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

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

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

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

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

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

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

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

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

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

- By accepting benefits under this plan, You or Your representative agree to notify Us promptly (within 30 days) and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party Injuries sustained by You.
- You or Your representative agrees to cooperate with Us and do whatever is necessary to secure Our rights of subrogation and reimbursement under this Booklet. In addition, You or Your representative agrees to do nothing to prejudice Our subrogation and reimbursement rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the plan.
- If a claim for health care expense is filed with Us and You have not yet received recovery from the responsible Third Party, We may advance benefits for Covered Services if You agree to hold, or direct Your attorney or other representative to hold, the recovery against the Third Party in trust for Us, up to the amount of benefits We paid in connection with the Illness or Injury.
- You and/or Your agent or attorney must agree to serve as constructive trustee and keep any recovery or payment of any kind related to Your Illness or Injury which gave rise to the plan's right of subrogation or reimbursement segregated in its own account, until Our right is satisfied or released.
- Further, You or Your representative give Us a lien on any recovery, settlement, judgment or other source of compensation which may be had from any party to the extent permitted by law to the full cost of all benefits associated with Third Party Injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- You or Your representative also agrees to pay from any recovery, settlement, judgment or other source of compensation, any and all amounts due Us as reimbursement for the full cost of all benefits, to the extent permitted by law, associated with Third Party Injuries paid by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- In the event You and/or Your agent or attorney fails to comply with any of the above conditions, We may recover any benefits We have advanced for any Illness or Injury through legal action against You and/or Your agent or attorney.
- If We pay benefits for the treatment of an Illness or Injury, We will be entitled to have the amount of the benefits We have paid for the condition separated from the proceeds of any recovery You receive out of any settlement or recovery from any source, including any arbitration award, judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Illness or Injury for which We have provided benefits. This is true regardless of whether:

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

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

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

shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by Us in obtaining repayment.

No-Fault Coverage

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

Motor Vehicle Coverage

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

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

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

Workers' Compensation

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

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

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

Fees and Expenses

You may incur attorney's fees and costs in connection with obtaining recovery. If this plan is not subject to ERISA, We shall pay a proportional share of such attorney's fees and costs incurred by You at the time of

any settlement or recovery to otherwise reduce the amount of reimbursement paid to Us to less than the full amount of benefits paid by Us. If this plan is subject to ERISA, You may request and We may contribute an amount toward attorney's fees incurred by You at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to Us to less than the full amount of benefits paid by Us.

COORDINATION OF BENEFITS

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

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

Double Coverage

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

Primary or Secondary?

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

When This Plan is Primary

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

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

How We Pay Claims When We Are Primary

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

How We Pay Claims When We Are Secondary

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

supply all required information in a timely manner.

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

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

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

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

Appeal Process

We have delegated the Appeals process for pediatric vision benefits to VSP, though We retain ultimate responsibility over the Appeals process. The terms "We," "Us" and "Our" in this Appeal Process section refer to VSP. Appeals can be initiated through either a written or verbal request. A written request can be made by completing the form available on **vsp.com** or by sending the written request by mail to VSP at: Vision Service Plan Insurance Company, Attention: Complaint and Appeals Unit, P.O. Box 997100, Sacramento, CA 95899-7100. Verbal requests can be made by calling VSP's Customer Service department at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance).

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action by Us under the Contract and wish to have it reviewed, You may Appeal. There is one level of Internal Appeal, as well as an External Appeal with an Independent Review Organization You may pursue. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section. For Grievances or complaints not involving an Adverse Benefit Determination, refer to the Grievance Process.

APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to Us at: Appeals Coordinator, Regence BlueShield, P.O. Box 1408, Lewiston, ID 83501 or facsimile 1 (888) 496-1542. Verbal requests can be made by calling Us at 1 (888) 367-2112.

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

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

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

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

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

Internal Appeals

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

VOLUNTARY EXTERNAL APPEAL - IRO

A voluntary Appeal to an Independent Review Organization (IRO) is available to You if the Appeal involves an Adverse Benefit Determination based on Medical Necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified

under evidence-based medical criteria and only after You have exhausted the internal level of Appeal, or We have failed to provide You with an Internal Appeal decision within the requirements of the Internal Appeal process.

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

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

EXPEDITED APPEALS

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

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

You may request concurrent expedited internal and external reviews of Adverse Benefit Determinations (meaning the reviews will be done simultaneously). When concurrent expedited reviews are requested, We will not extend the timelines by making the determinations consecutively. The requisite timelines will be applied concurrently.

Internal Expedited Appeal

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

Voluntary Expedited Appeal - IRO

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

We coordinate voluntary Expedited Appeals, but the decision is made by an IRO at no cost to You. We will provide the IRO with the Expedited Appeal documentation, which is available to You or Your Provider upon request. Verbal notice of the IRO's decision will be provided to You and Your Representative as soon as possible after the decision, but no later than within 72 hours of the IRO's receipt of the necessary information. This will be followed by written notification within 48 hours of the verbal notice. Choosing the voluntary Expedited Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision, except to the extent other remedies are available under state or federal law.

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

INFORMATION

If You have any questions about the Appeal process outlined here, contact Customer Service, or write to Customer Service at the following address: Regence BlueShield, MS CS B32B, P.O. Box 1827, Medford, OR 97501-9884. If you have any questions about the VSP Appeal process, You may contact VSP's Customer Service department at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance), Monday-Friday 5 a.m. to 8 p.m., Saturday 7 a.m. to 8 p.m., and Sunday 7 a.m. to 7 p.m.

ASSISTANCE

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

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

Grievance Process

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

Call Customer Service at 1 (888) 367-2112 or write to Customer Service at the following address: Regence BlueShield, MS CS B32B, P.O. Box 1827, Medford, OR, 97501-9884.

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

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

Who Is Eligible, How to Enroll and When Coverage Begins

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

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS

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

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

Employees

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

Dependents

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

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

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

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request (and, for a non-registered domestic partner, an affidavit of qualifying domestic partnership form) to Us. Application for enrollment of a new child by birth, adoption or Placement for Adoption must be made within 60 days of the date of birth, adoption or Placement for Adoption if payment of additional premium is required to provide coverage for the child. Application for enrollment of all other newly eligible dependents must be made within 30 days of the dependent's attaining eligibility. Coverage for such dependents will begin on their Effective Dates. For a new child by

birth, the Effective Date is the date of birth. For a new child adopted or placed for adoption within 60 days of birth, the Effective Date is the date of birth, if any associated additional premium has been paid within 60 days of birth. The Effective Date for any other child by adoption or Placement for Adoption is the date of Placement for Adoption. For other newly eligible dependents, the Effective Date is the first day of the month following receipt of the application for enrollment.

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

NOTE: Due to the nature of this high deductible health plan, adding dependents after January 1 of any year may change Your coverage from Single Coverage to Family Coverage, and may change the amount of Deductible and Out-of-Pocket Maximum that applies to Your coverage.

SPECIAL ENROLLMENT

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

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

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

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

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

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

If You are already enrolled or if You declined coverage when first eligible and You subsequently marry or begin a domestic partnership, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to apply for coverage under the Contract within 60 days from the date of the qualifying event. If enrollment is requested as specified, coverage will be effective as of the first of the calendar month following the marriage or commencement of the domestic partnership.

If You are already enrolled or if You declined coverage when first eligible and have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible

children are eligible to apply for coverage under the Contract within 60 days from the date of the qualifying event:

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

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

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

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

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

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

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

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

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

ANNUAL ENROLLMENT PERIOD

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

DOCUMENTATION OF ELIGIBILITY

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

When Coverage Ends

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

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

CONTRACT TERMINATION

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

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

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

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

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

NONPAYMENT OF PREMIUM

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

FAMILY AND MEDICAL LEAVE

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

- You and Your Enrolled Dependents will remain eligible to be enrolled under the Contract during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
    - 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 FMLA leave, You must continue to pay the monthly premium through the Group on time. The provisions described here will not be available if the Contract terminates.

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

Persons entitled to coverage under this provision will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this provision.

Entitlement to FMLA leave does not constitute a qualifying event for COBRA continuation. However, a person who does not return to active employment following FMLA leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave.

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

LEAVE OF ABSENCE

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

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

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

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

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

Divorce or Annulment

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

Death of the Enrolled Employee

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

Termination of Domestic Partnership

If Your domestic partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet any of the requirements outlined in the definition of a dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the month following the date of termination of the domestic partnership. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence. This termination provision does not apply to any termination of domestic partnership that occurs as a matter of law because the parties to the domestic partnership enter into a marriage (including any entry into marriage by virtue of an automatic conversion of the domestic partnership into a marriage).

Loss of Dependent Status for an Enrolled Child

Eligibility ends on the last day of the month in which an 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

Members may be terminated for any of the following reasons. However, it may be possible to continue coverage under the Contract according to the COBRA and Non-COBRA Continuation of Coverage provisions.

Fraudulent Use of Benefits

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

Fraud or Misrepresentation in Application

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

COBRA Continuation of Coverage

COBRA is a continuation of this coverage for a limited time after certain events cause a loss of eligibility. COBRA continuation does not apply to all groups. If Your Group is subject to COBRA, COBRA continuation is available to Your Enrolled Dependents if they lose eligibility because:

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

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

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

General Rules

Generally, You or Your Enrolled Dependents are responsible for payment of the full premium for COBRA continuation, plus an administration fee, even if the Group contributes toward the premiums of those not on COBRA continuation. The administration fee is 2 percent or, during any period of extension for disability, 50 percent. In order to preserve Your and Your Enrolled Dependent's rights under COBRA, You or Your Enrolled Dependents must inform the Group in writing within 60 days of:

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

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

If You or Your Enrolled Dependents do not elect COBRA continuation coverage, coverage under the Contract will end according to the terms of the Contract and We will not pay claims for services provided on and after the date coverage ends.

Notice

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

After You and/or Your Enrolled Dependents exhaust COBRA continuation coverage, an individual policy may be available.

Non-COBRA Continuation of Coverage

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

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

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

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

- You and/or Your Enrolled Dependents fail to make payment of premiums for the coverage to the Group within its established time frame;
- three months of coverage has elapsed from the effective date of continuation coverage; or
- the Group's coverage is terminated.

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

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

After You and/or Your Enrolled Dependents exhaust non-COBRA continuation coverage, an individual policy may be available.

Conversion

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

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

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

Other Continuation Options

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

Medicare Supplement or Individual Contract

When eligibility under the Contract terminates, You may be eligible for coverage under an individual insurance policy or a Medicare supplement plan through Us. Additional information is available by contacting Customer Service.

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

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

Strike, Lockout or Other Labor Dispute

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

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

General Provisions and Legal Notices

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

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

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

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

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

- Examine without charge, at the plan administrator's office, all policy documents, including insurance policies and copies of certain documents filed by the plan administrator with the U.S. Department of Labor, such as detailed annual reports and policy descriptions.
- Obtain copies of documents governing the operation of the plan upon written request to the plan administrator. The plan administrator may make a reasonable charge for the copies.
- Continue, generally at their own expense, health care coverage of themselves, their spouses and children if coverage ends due to certain qualifying events. Review the summary plan description and governing documents of the coverage for rules and other details about such COBRA continuation rights.

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

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

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

If You Need More ERISA Information
If an employee has any questions about this statement or his or her rights under ERISA, or if he or she

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

GOVERNING LAW AND BENEFIT ADMINISTRATION

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

GROUP IS AGENT

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

LIMITATIONS ON LIABILITY

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

MODIFICATION OF CONTRACT

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

NO WAIVER

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

NONASSIGNMENT

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

NOTICES

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

receive a United States Postal Service change of address (COA) form for an Enrolled Employee, We will update Our records accordingly. Additionally, We may forward notice for an Enrolled Employee to the Group administrator if We become aware that We don't have a valid mailing address for the Enrolled Employee. Any notice to Us required in the Contract may be given by mail addressed to Our Customer Service address; however, any notice to Us will not be considered to have been given to and received by Us until physically received by Us.

NOTICE OF PRIVACY PRACTICES

We have a Notice of Privacy Practices that is available by calling Customer Service or visiting Our Web site listed below.

PREMIUMS

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

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

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

REPRESENTATIONS ARE NOT WARRANTIES

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by Us. This information will be used in accordance with Our Notice of Privacy Practices. To request a copy, visit Our Web site or contact Customer Service.

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

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

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

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

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

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

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

TAX TREATMENT

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

WE ARE NOT RESPONSIBLE FOR HEALTH SAVINGS ACCOUNT FINANCIAL OR TAX ARRANGEMENTS

While this high deductible health plan was designed for use in conjunction with a health savings account (HSA), We do not assume any liability associated with Your contribution to an HSA during any period that this high deductible health plan does not qualify for use with an HSA. An HSA is a tax-exempt account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions to such an account are tax deductible but in order to qualify for and make contributions to an HSA, You must be enrolled in a qualified high deductible health plan (and generally not be enrolled in other coverage). You are solely responsible to ensure that this plan qualifies, and continues to qualify, for use with any HSA that You choose to establish and maintain. Please note that the tax references contained in this Booklet relate to federal income tax only. The tax treatment of HSA contributions and distributions under Your state's income tax laws may differ from the federal tax treatment and differs from state to state.

We do not provide tax advice and assume no responsibility for reimbursement from the custodial financial institution under any HSA with which this high deductible health plan is used. Consult with Your financial or tax advisor for tax advice or for more information about Your eligibility for an HSA.

WHEN BENEFITS ARE AVAILABLE

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS

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

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

Definitions

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

PROVIDER DEFINITIONS
For Providers of care, we use the following terms:

Contracted Dentist means a Provider that has a contract with Us or whose contract We may access through a network leasing agreement. These Providers may or may not be in Your network.

Contracted Provider means a Provider that has a contract with Us or whose contract We may access through a network leasing agreement. These Providers may or may not be in Your network.

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

In-Network Dentist means a Contracted Dentist who is in Your Provider network. In-Network Dentists will not bill You for the amount above the Allowed Amount for a Covered Service. The Provider network for an In-Network Dentist is: Participating Dental.

In-Network Provider means a Contracted Provider that is in Your Provider network. Your Provider Network is: Preferred. In-Network Providers will not bill You for the amount above the Allowed Amount for a Covered Service. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, In-Network Providers include only Our identified Centers of Excellence for the particular therapy.

In-Network Provider, for the Pediatric Vision benefit, means a VSP Doctor. The Provider network for In-Network Pediatric Vision benefit is: VSP Choice.

Non-Contracted Provider means a Provider that does not have a contract with Us or whose contract cannot be accessed through a network leasing agreement. If a Covered Service is provided by a Non-Contracted Provider, the Provider may bill You the amount above the Allowed Amount.

Out-of-Network Dentist means a Dentist who is not in Your Provider network. You receive lower benefit coverage for services provided by Out-of-Network Providers, or the service may not be covered. Refer to the Schedule of Benefits for an explanation of the Covered Services Out-of-Network Dentists can provide.

Out-of-Network Provider means a Provider that is not In-Network. For reimbursement of these Out-of-Network Provider services, You may be billed for balances over Our payment level in addition to any Deductible or Coinsurance. Refer to the Schedule of Benefits for an explanation of the Covered Services Out-of-Network Providers can provide. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, Out-of-Network Providers include any Provider that is not one of Our identified Centers of Excellence for the particular therapy.

Out-of-Network Provider, within the Pediatric Vision benefit, 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.

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 Contract.

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, 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.

Primary Care Provider means a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who has a specialty type of general practice, family practice, internal medicine, pediatrics, geriatrics, OB/GYN and obstetrics, preventive medicine, adult medicine, women's health care practitioner or naturopath. Primary Care Provider also includes any physician assistant, nurse practitioner or advance registered nurse

practitioner if their primary specialty is one of the above and they are working under the license of an M.D. or D.O. in these specialties. Selection of a particular Provider to coordinate referrals or to receive primary care services is not required. You may change the Provider of Your care (including primary care) at any time by consulting a different Provider. If We terminate the contract of Your Primary Care Provider without cause, We will continue to cover Your Primary Care Provider, on the same terms, for at least ninety days following notice of termination.

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

Specialist means a Physician, Practitioner or urgent care center that does not otherwise meet the definition of a Primary Care Provider.

VSP Doctor means an optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials to Members.

GENERAL DEFINITIONS

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.

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

Allowed Amount means:

- For In-Network Providers, the amount that they have contractually agreed to accept as full payment for a service or supply.
- For Out-of-Network Providers, the amount We have determined to be reasonable charges for Covered Services or supplies. The Allowed Amount may be based upon the billed charges, as determined by Us or as otherwise required by law. The maximum Allowed Amount for facility charges for an inpatient non-emergency admission at a Nonparticipating Facility is $3,500 per day.
- For In-Network Dentists, the amount In-Network Dentists have contractually agreed to accept as full payment for Covered Services.
- For Out-of-Network Dentists, reasonable charges for Covered Services as determined by Us.
- For VSP Doctors (see definition of "VSP Doctor"), the amount that these Providers have contractually agreed to accept as full payment for a service or supply.
- For Out-of-Network Providers within the Pediatric Vision benefit, the billed amount for listed services and supplies.

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

Ambulatory Surgical Center means a distinct facility or that portion of a facility licensed by the state in which it is located, that operates primarily to provide specialty or multispecialty 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.

Appeal means a written or verbal request from a Member or, if authorized by the Member, the Member's

Representative, to change a previous decision made by Us concerning:

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

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 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; or
- Conducted under an investigational new drug application reviewed by the Food and Drug Administration or that is a drug trial exempt from having an investigational new drug application.

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

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

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

Covered Service means a service, supply, treatment or accommodation that is listed in the Schedule of Benefits and Medical Benefits section in this Booklet.

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

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 f 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.

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

- appropriate, based upon the symptoms, for determining the diagnosis and management of the condition;
- appropriate for the diagnosed condition, disease or Injury in accordance with recognized national standards of care;

- not able to be omitted without adversely affecting the Member's condition; and
- not primarily for the convenience of the Member, Member's Family or Provider.

A Dental Service may be Dentally Appropriate yet not be a covered service.

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

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

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

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

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

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

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

Expedited Appeal means an Appeal where:

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

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

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

    - Peer-Reviewed Medical Literature is scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-Reviewed Medical Literature does not include in-house publications of pharmaceutical manufacturing companies.
    - Standard Reference Compendia is one of the following: the American Hospital Formulary

Service-Drug Information, the United States Pharmacopoeia-Drug Information or other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services or the Washington State Insurance Commissioner.

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

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

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

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

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

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

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

Group means the organization whose employees may participate under this coverage.

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

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

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

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

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary External Appeals and voluntary External Expedited Appeals, through an independent contractor relationship with Us and/or through assignment to Us via state regulatory

requirements. The IRO is unbiased and is not controlled by Us.

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.

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

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.

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

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

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

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

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

Member means an Enrolled Employee or an Enrolled Dependent.

Mental Health Conditions means mental disorders, including eating disorders, included 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 Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health Provider for a covered diagnosis), and court ordered treatment (unless the treatment is determined by Us to be Medically Necessary).

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

Nonparticipating Facility means an Out-of-Network facility that does not have an effective participating contract with Us or whose contract cannot be accessed through a network leasing agreement.

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

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed. A Participating Pharmacy or Preferred Pharmacy means either a Pharmacy with which We have a contract or a Pharmacy that participates in a network for which We have contracted to have access. Participating or Preferred Pharmacies may submit claims electronically. To find a Participating or Preferred Pharmacy, visit Our Web site or contact Customer Service. A Nonparticipating Pharmacy means a Pharmacy with which We neither have a contract nor have contracted access to any network it belongs to. Nonparticipating Pharmacies may not submit claims electronically.

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.

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.

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

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

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

Preferred Specialty Medication and Specialty Medication means a medication that may be used to treat complex conditions, including, but not limited to, multiple sclerosis, rheumatoid arthritis, cancer, clotting factor for hemophilia or similar clotting disorders, and hepatitis C. Information from the manufacturer, scientific literature, practice standards, Medicare practices and other information that is considered relevant and reliable is used to determine a Specialty Medication. For a list of such medications, visit Our Web site or contact Customer Service.

Prescription Medication (also Prescribed Medication) means a medication or biological that relates directly to the treatment of an Illness or Injury, legally cannot be dispensed without a Prescription Order and by law must bear the legend: "Prescription Only" or as specifically included on Our Drug List.

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

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

Representative means someone who represents You for the Appeal. The Representative may be Your personal Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the Appeal. No authorization is required from the parent(s) or legal guardian of a Member who is an unmarried and dependent child and is less than 13 years old. For Expedited Appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative without additional authorization. Even if You have previously designated a person as Your Representative for a previous matter, an authorization designating that person as Your Representative in a new matter will be required (but redesignation is not required for each Appeal level). If no authorization exists and is not received in the course of the Appeal, the determination and any personal information will be disclosed to You, Your

personal Representative or treating Provider only.

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

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.

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

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

Schedule of Benefits means the summary of Your costs for Covered Services and network for this plan.

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

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

Service Area means the geographic area in Washington state where We have been authorized by the State of Washington to sell and market this Plan. The Service Area for this Plan are 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.

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

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

Substance Use Disorder Services mean Medically Necessary outpatient services, Residential Care,

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

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

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

We, Us and Our mean Regence BlueShield.

You and Your mean the Enrolled Employee and Enrolled Dependents.

For more information call Us at 1 (888) 367-2112

regence.com

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

APPENDIX B

Prevalence of Hearing Loss by Severity in the United States

Adele M. Goman, PhD, and Frank R. Lin, MD, PhD

Objectives. To estimate the age- and severity-specific prevalence of hearing impairment in the United States.

Methods. We conducted cross-sectional analyses of 2001 through 2010 data from the National Health and Nutrition Examination Survey on 9648 individuals aged 12 years or older. Hearing loss was defined as mild (> 25 dB through 40 dB), moderate (> 40 dB through 60 dB), severe (> 60 dB through 80 dB), or profound (> 80 dB).

Results. An estimated 25.4 million, 10.7 million, 1.8 million, and 0.4 million US residents aged 12 years or older, respectively, have mild, moderate, severe, and profound better-ear hearing loss. Older individuals displayed a higher prevalence of hearing loss and more severe levels of loss. Across most ages, the prevalence was higher among Hispanic and non-Hispanic Whites than among non-Hispanic Blacks and was higher among men than women.

Conclusions. Hearing loss directly affects 23% of Americans aged 12 years or older. The majority of these individuals have mild hearing loss; however, moderate loss is more prevalent than mild loss among individuals aged 80 years or older.

Public Health Implications. Our estimates can inform national public health initiatives on hearing loss and help guide policy recommendations currently being discussed at the Institute of Medicine and the White House. (*Am J Public Health.* 2016;106:1820–1822. doi:10.2105/AJPH.2016.303299)

Current initiatives of the Institute of Medicine[1] and the President's Council of Advisors on Science and Technology[2] are addressing hearing loss as a key public health issue given its potential impact on the cognitive, social, and physical functioning of adults.[3,4] However, existing estimates[5] of hearing loss prevalence are outdated, do not reflect current population estimates, and do not include estimates according to hearing loss severity. Updated information by hearing loss severity is important for informing policy decisions. We sought to estimate the number of people in the United States who have a hearing impairment by severity and age using audiometric data and the most currently available population estimates.

METHODS

We analyzed data from the 2001 to 2010 cycles of the National Health and Nutritional Examination Survey, an ongoing biannual epidemiological survey of a representative sample of the US noninstitutionalized population. Air-conduction pure-tone audiometry tests performed in a sound-attenuating booth (measured in decibel hearing level) were administered to a random half sample of all participants aged 20 to 69 years from 2001 to 2004, all participants aged 70 years or older in the 2005–2006 and 2009–2010 cycles, and all participants aged 12 to 19 years in the 2005–2006, 2007–2008, and 2009–2010 cycles.

The same standardized protocol for audiometric testing was followed in all cycles. Individuals were excluded if threshold data were missing for one ear or there was a difference of more than 10 decibels in a 1-kilohertz retest of the same ear. If participants did not hear the stimulus at the highest level tested (120 dB), a threshold of 125 decibels was assigned, providing a conservative estimate of their hearing and allowing an average threshold to be calculated.

A 4-frequency (0.5 kHz, 1 kHz, 2 kHz, 4 kHz) pure-tone-average threshold was calculated for each ear. World Health Organization criteria were used to classify the severity of hearing loss in each ear as mild (> 25 dB through 40 dB), moderate (> 40 dB through 60 dB), severe (> 60 dB through 80 dB), or profound (> 80 dB). In instances in which the hearing loss severity classification differed between the 2 ears, bilateral hearing loss severity was based on the better ear (i.e., mild bilateral loss was defined as one ear having mild loss and the other ear having mild or greater loss).

We estimated prevalence of hearing loss by severity over age decades. Overall hearing loss prevalence was estimated according to age decade, gender, and self-reported race/ethnicity (non-Hispanic White, non-Hispanic Black, Hispanic, other; Table A, available as a supplement to the online version of this article at http://www.ajph.org). We used 2015 US population estimates to estimate the number of people with hearing loss.[6] To account for the complex sampling design, we employed sample weights in accordance with National Center for Health Statistics guidelines.[7] Analyses were conducted in Stata version 12 (StataCorp LP, College Station, TX).

ABOUT THE AUTHORS

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RESULTS

Table 1 displays the prevalence of, and number of individuals with, hearing loss by severity and age. Across the ages of 12 through 79 years, the most prevalent type of hearing loss was mild (> 25 dB through 40 dB). Only in the oldest age bracket (> 80 years) did the prevalence of moderate hearing loss (41% in at least 1 ear, 38% bilateral) exceed that of mild loss (31% in at least 1 ear, 36% bilateral).

We estimate that 6.6 million (2.5%) Americans aged 12 years or older have severe to profound hearing loss in at least 1 ear, with three quarters of these individuals (5.0 million) being older than 60 years. Overall, we estimate that 38.2 million (14.3%) Americans aged 12 years or older have bilateral hearing loss and that 60.7 million (22.7%) have hearing loss in at least 1 ear.

In our sample, the prevalence of hearing loss was higher among older than younger individuals, and, among those aged 40 years or older, the prevalence was significantly higher among men than women ($P < .01$; Table A). The prevalence of hearing loss among Hispanics and non-Hispanic Whites was higher than the prevalence among non-Hispanic Blacks across almost all ages (Table A).

DISCUSSION

In the United States, nearly 1 in 4 individuals aged 12 years or older have hearing loss in at least 1 ear, and 1 in 7 have bilateral hearing loss. Hearing loss is more prevalent among older adults, with two thirds of individuals aged 70 years or older having bilateral hearing loss and almost three quarters having hearing loss in at least 1 ear. Hearing loss is more prevalent among men than women; one third of men aged 40 years or older are estimated to have hearing loss, compared with one fifth of women. In addition, hearing loss is less prevalent among non-Hispanic Black individuals than among individuals from other racial/ethnic groups.

A limitation of our study is that the prevalence estimates for some age and severity subcategories might be imprecise because of the small number of affected individuals in the analytic cohort. However, this limitation would not affect our overall prevalence estimates combining aggregated data across all individuals.

PUBLIC HEALTH IMPLICATIONS

Our study provides current national estimates of the prevalence of, and number of

TABLE 1—Prevalence of and Numbers of Individuals With Hearing Loss, by Age and Severity: National Health and Nutrition Examination Survey, United States, 2001–2010

Hearing Loss Category and Age, y	Prevalence, % (95% CI)					Number With Hearing Loss (Millions)				
	Mild	Moderate	Severe	Profound	Overall	Mild	Moderate	Severe	Profound	Overall
Bilateral[a]										
12–19 y	0.14 (0.04, 0.24)	0.03[b] (0.00, 0.06)	. . .[c]	0.00[b] (0.00, 0.01)	0.18 (0.07, 0.28)	0.05	0.01	. . .[c]	<0.01	0.06
20–29 y	0.34[b] (0.00, 0.88)	0.07[b] (0.00, 0.20)	. . .[c]	. . .[c]	0.42[b] (0.00, 0.97)	0.15	0.03	. . .[c]	. . .[c]	0.18
30–39 y	1.01[b] (0.18, 1.84)	0.55[b] (0.00, 1.21)	0.08[b] (0.00, 0.25)	. . .[c]	1.64 (0.23, 3.06)	0.41	0.23	0.03	. . .[c]	0.68
40–49 y	6.05 (3.71, 8.40)	0.48[b] (0.00, 1.01)	. . .[c]	. . .[c]	6.53 (4.19, 8.88)	2.46	0.20	. . .[c]	. . .[c]	2.65
50–59 y	10.48 (7.34, 13.62)	2.13 (0.79, 3.46)	0.35[b] (0.00, 0.78)	0.34[b] (0.00, 0.99)	13.29 (9.76, 16.81)	4.57	0.93	0.15	0.15	5.80
60–69 y	19.94 (15.03, 24.84)	5.85 (3.53, 8.17)	0.76[b] (0.00, 1.70)	0.25[b] (0.00, 0.75)	26.80 (22.25, 31.35)	6.92	2.03	0.27	0.09	9.31
70–79 y	35.62 (31.03, 40.22)	15.83 (13.63, 18.04)	2.86 (1.60, 4.12)	0.30[b] (0.02, 0.59)	54.62 (49.27, 59.97)	6.84	3.04	0.55	0.06	10.49
≥80 y	36.02 (32.03, 40.01)	37.92 (33.40, 42.44)	6.97 (4.94, 9.01)	0.56[b] (0.01, 1.10)	81.47 (78.12, 84.82)	3.98	4.19	0.77	0.06	9.01
Total						25.39	10.66	1.77	0.35	38.17
Loss in at least 1 ear (unilateral and bilateral)										
12–19 y	1.18 (0.77, 1.59)	0.46 (0.18, 0.74)	0.31 (0.11, 0.51)	0.01[b] (0.00, 0.03)	1.96 (1.39, 2.54)	0.39	0.15	0.10	< 0.01	0.65
20–29 y	2.32 (0.92, 3.72)	0.62[b] (0.00, 1.75)	0.02[b] (0.00, 0.05)	0.26[b] (0.00, 0.65)	3.22 (1.38, 5.07)	1.02	0.28	0.01	0.11	1.42
30–39 y	3.50 (1.91, 5.09)	1.38 (0.15, 2.62)	0.30[b] (0.00, 0.76)	0.25[b] (0.00, 0.63)	5.43 (3.28, 7.58)	1.44	0.57	0.12	0.10	2.23
40–49 y	10.02 (7.41, 12.64)	2.00 (1.01, 3.00)	0.86[b] (0.00, 1.88)	0.06[b] (0.00, 0.19)	12.95 (9.85, 16.04)	4.07	0.81	0.35	0.03	5.25
50–59 y	21.30 (16.57, 26.02)	5.49 (3.35, 7.63)	0.82[b] (0.06, 1.57)	1.08[b] (0.06, 2.10)	28.69 (23.63, 33.74)	9.30	2.40	0.36	0.47	12.52
60–69 y	29.38 (24.46, 34.29)	12.12[b] (8.62, 15.62)	2.06 (0.61, 3.51)	1.30[b] (0.29, 2.31)	44.86 (40.79, 48.92)	10.20	4.21	0.72	0.45	15.58
70–79 y	37.51 (33.10, 41.92)	21.14 (17.88, 24.40)	7.47 (5.75, 9.19)	2.04 (1.06, 3.01)	68.15 (62.78, 73.53)	7.21	4.06	1.43	0.39	13.09
≥80 y	31.42 (26.75, 36.08)	40.83 (36.42, 45.24)	13.80 (11.13, 16.47)	4.24 (2.49, 5.99)	90.29 (87.20, 93.39)	3.47	4.51	1.53	0.47	9.98
Total						37.10	16.99	4.61	2.03	60.73

Note. CI = confidence interval. Hearing loss was defined as a pure-tone average (at 0.5, 1, 2, and 4 kHz) of above 25 dB hearing level. The sample size was n = 9648.

[a]Severity of bilateral loss is based on the better ear.

[b]The unweighted number of individuals in the category is < 10.

[c]No individuals with this hearing loss severity level were observed in the sample.

individuals with, hearing loss in the United States by severity and age. These estimates can inform ongoing national public health initiatives on hearing loss and can help guide policy recommendations currently being discussed at the Institute of Medicine and the White House. AJPH

CONTRIBUTORS

Both of the authors contributed to study concept and design, analysis and interpretation of data, and the drafting of the article.

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HUMAN PARTICIPANT PROTECTION

No protocol approval was needed for this study because no human participants were involved.

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