SCHEDULE OF BENEFITS

Bronze HSA 5000 Preferred

After You have satisfied Your applicable Deductible, unless otherwise specified, benefits will be provided at the payment levels specified below. Please read the entire Policy for details on these benefits, specific benefit limitations, maximums and exclusions.

In-Network Calendar Year Out-of-Pocket Maximum

Single Coverage: $6,250
Family Coverage: $12,500 (The maximum Out-of-Pocket for any Insured on Family Coverage is not to exceed $6,850 for In-Network benefits. If an Insured reaches this maximum amount prior to satisfying the Family Out-of-Pocket Maximum, benefits will be paid at 100 percent of the Allowed Amount for that Insured).

Out-of-Network Calendar Year Out-of-Pocket Maximum

Single Coverage: $12,500
Family Coverage: Not applicable

In-Network Calendar Year Deductibles

Single Coverage Deductible: $5,000
Family Coverage Deductible: $10,000

Out-of-Network Calendar Year Deductibles

Single Coverage Deductible: $10,000
Family Coverage Deductible: Not applicable

An Insured who is enrolled on Single Coverage satisfies the Single Coverage Deductible by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total and meet the Single Coverage Deductible.

The Family Calendar Year Deductible is satisfied when two or more covered Family members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Deductible amount.

Benefit Payment Levels for In-Network and Out-of-Network Inside the Service Area. Please read the entire Policy for details, including definitions, of In-Network and Out-of-Network levels of benefits.

BENEFIT	IN NETWORK BENEFITS	OUT OF NETWORK BENEFITS
Office Visits – Illness or Injury	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Outpatient Laboratory and Radiology Services	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Preventive Care and Immunizations	We pay 100%, not subject to In-Network Deductible.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Other Professional Services	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Acupuncture	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Ambulance Services	After In-Network Deductible, We pay 70% and You pay 30%.	
Ambulatory Surgical Center	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Blood Bank	After In-Network Deductible, We pay 70% and You pay 30%.	
Complex Imaging – Outpatient	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Dental Hospitalization	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Detoxification	After In-Network Deductible, We pay 70% and You pay 30%.	
Diabetic Education	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Dialysis (Dialysis not related to End Stage Renal Disease.)	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Dialysis for End Stage Renal Disease (ESRD) – Inpatient	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.

Dialysis for End Stage Renal Disease (ESRD) – Outpatient (Until the first day of the first calendar month following 3 months of hemodialysis treatment or 30 days of peritoneal dialysis treatment)	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
After First Treatment Period – Outpatient Dialysis for End Stage Renal Disease (ESRD) (From and after the first day of the first calendar month following 3 months of hemodialysis treatment or following 30 days of peritoneal dialysis treatment)	We pay 100% of the Medicare allowed amount at the time of service. If You are not enrolled in Medicare Part B, You may be responsible for some balances, which will not apply to Your Out-of-Pocket Maximum.	
Durable Medical Equipment	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Emergency Room	After In-Network Deductible, We pay 70% and You pay 30%.	
Family Planning	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Genetic Testing	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Habilitative Services	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Home Health Care	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Hospice Care	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Hospital Services – Inpatient and Outpatient	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Maternity Care	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Medical Foods (PKU)	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Mental Health Services	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.

Neurodevelopmental Therapy	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Newborn Care	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Nutritional Counseling	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Orthotic Devices	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Palliative Care	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Pediatric Dental – Preventive and Diagnostic Dental Services	After In-Network Deductible, We pay 100%.	
Pediatric Dental – Basic Dental Services	After In-Network Deductible, We pay 80% and You pay 20%.	
Pediatric Dental – Major Dental Services	After In-Network Deductible, We pay 50% and You pay 50%.	
Pediatric Vision	Exam: We pay 100%, not subject to Deductible. Frames: We pay 100%, not subject to Deductible.	
Prescription Medications – from a Pharmacy	After In-Network Deductible, We pay 75% and You pay 25% for each Generic Medication on the Essential Formulary. You can receive a 5% discount if filled at a Preferred Pharmacy.	
	After In-Network Deductible, We pay 65% and You pay 35% for each Category 1 Brand-Name Medication on the Essential Formulary. You can receive a 5% discount if filled at a Preferred Pharmacy.	
	After In-Network Deductible, We pay 50% and You pay 50% for each Category 2 Brand-Name Medication on the Essential Formulary. You can receive a 5% discount if filled at a Preferred Pharmacy.	
	After In-Network Deductible, We pay 60% and You pay 40% for each Specialty Medication on the Essential Formulary. The first fill allowed at a Pharmacy. Additional fills must be provided at a Specialty Pharmacy.	

Prescription Medications – from a Mail-Order Supplier	After In-Network Deductible, We pay 80% and You pay 20% for each Generic Medication on the Essential Formulary.	
	After In-Network Deductible, We pay 70% and You pay 30% for each Category 1 Brand-Name Medication on the Essential Formulary.	
	After In-Network Deductible, We pay 60% and You pay 40% for each Category 2 Brand-Name Medication on the Essential Formulary.	
Specialty Medications – from a Specialty Pharmacy	After In-Network Deductible, We pay 60% and You pay 40% for each Specialty Medication on the Essential Formulary. The first fill allowed at a Pharmacy. Additional fills must be provided at a Specialty Pharmacy.	
Self-Administrable Cancer Chemotherapy Medications	After In-Network Deductible, We pay 70% and You pay 30% for each Medication on the Essential Formulary.	
	After In-Network Deductible, We pay 70% and You pay 30% for each Category 1 Brand-Name Medication on the Essential Formulary.	
	After In-Network Deductible, We pay 70% and You pay 30% for each Category 2 Brand-Name Medication on the Essential Formulary.	
	After In-Network Deductible, We pay 70% and You pay 30% for each Specialty Medication on the Essential Formulary. Specialty Self-Administrable Cancer Chemotherapy Medications must be provided at a Specialty Pharmacy.	
Prosthetic Devices	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Reconstructive Services and Supplies	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Rehabilitation Services	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Skilled Nursing Facility (SNF) Care	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Spinal Manipulations	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Substance Use Disorder Services	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.

Telehealth	After In-Network Deductible, We pay 70% and You pay 30%.	Not covered.
Telemedicine	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Temporomandibular Joint (TMJ) Disorders	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Transplants	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Urgent Care Center	After In-Network Deductible, We pay 70% and You pay 30%.	After Out-of-Network Deductible, We pay 50% and You pay 50%.
Adult Dental – Preventive and Diagnostic Dental Services	Not covered.	
Adult Dental – Basic Dental Services	Not covered.	
Adult Dental – Major Dental Services	Not covered.	

Asuris Direct HSA Policy

Group Number: [Group Number]

Medical Benefits

ASURIS
NORTHWEST HEALTH

Introduction

Asuris Northwest Health

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

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

Customer Service/Correspondence Address:
P.O. Box 30271
Salt Lake City, UT 84130-0271

Appeals Address:
P.O. Box 4208
Portland, OR 97208-4208

As You read this Policy, please keep in mind that references to "You" and "Your" refer to both the Policyholder and Enrolled Dependents. The terms "We," "Us" and "Our" refer to Asuris Northwest Health and the term "Policyholder" means a person who is enrolled for coverage under an Asuris Northwest Health health insurance Policy, and whose name appears on the records of Asuris Northwest Health as the individual to whom this Policy was issued. Policyholder does not mean a dependent under this Policy. Other terms are defined in the Definitions Section at the back of this Policy or where they are first used and are designated by the first letter being capitalized.

NON-GRANDFATHERED

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

POLICY

This Policy describes benefits effective **[{Month - spell out} dd, yyyy]**, for the Policyholder and Enrolled Dependents. This Policy provides the evidence and a description of the terms and benefits of coverage.

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

EXAMINATION OF POLICY

If, after examination of this Policy, the Policyholder is not satisfied for any reason with this Policy, the above named Policyholder will be entitled to return this Policy within 10 days after its delivery date. If the Policyholder returns this Policy to Us within the stipulated 10-day period, such Policy will be considered void as of the original Effective Date and the Policyholder generally will receive a refund of premiums paid, if any. (If benefits already paid under this Policy exceed the premiums paid by the Policyholder, We will be entitled to retain the premiums paid and the Policyholder will be required to repay Us for the

amount of benefits paid in excess of premiums.) We shall pay the Policyholder an additional 10 percent of the refund amount if such refund is not made within 30 days of the return of this Policy to Us**.**

NOTICE OF PRIVACY PRACTICES

Asuris Northwest Health has a Notice of Privacy Practices that is available by calling Customer Service or visiting Our Web site listed below.

[Signature Graphic**]**
[Plan President Name**]**
[Plan President Title**]**
[Plan Name**]**

Using Your Asuris Direct HSA Policy

YOUR PARTNER IN HEALTH CARE

Asuris Northwest Health is pleased that You have chosen Us as Your partner in health care. It's important to have continued protection against unexpected health care costs. Thanks to the purchase of Asuris Direct HSA, You have coverage that's affordable and provided by a partner You can trust in times when it matters most.

Asuris Direct HSA provides You with great benefits that are quickly accessible and easy to understand, thanks to open access to Providers and innovative tools. With Asuris Direct HSA health care coverage, You will discover more personal freedom to make informed health care decisions, as well as the assistance You need to navigate the health care system.

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

Asuris Direct HSA also allows You to control Your out-of-pocket expenses, such as Coinsurance, for each Covered Service. Here's how it works - You control Your out-of-pocket expenses by choosing Your Provider under two choices called: "In-Network" and "Out-of-Network."

- **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. Also, choosing this provider option means You may be billed for balances beyond the Deductible and/or Coinsurance. This is sometimes referred to as balance billing.

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

ADDITIONAL MEMBERSHIP ADVANTAGES

With the purchase of Asuris Direct HSA health care coverage**,** You are provided with more than just great coverage. You also acquired Asuris membership, which offers additional valuable services. The advantages of Asuris membership include access to 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 **www.Asuris.com**, an interactive environment that can help You navigate Your way through health care decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE INDIVIDUAL POLICY, BUT ARE NOT INSURANCE.**

Go to **www.Asuris.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;
- 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.

CONTACT INFORMATION

- Learn more and receive answers about Your coverage or any other plan that We offer. Just call 1 (877) 508-7361 (TTY: 711) to talk with one of Our Customer Service representatives or to request information in writing. Phone lines are open Monday-Friday 6 a.m. - 6 p.m.

- **Visit Our Web site at: www.Asuris.com**.
- **For assistance in a language other than English,** please call the Customer Service telephone number.

Table of Contents

Understanding Your Benefits

In this section, You will discover information to help You understand what We mean by Your Maximum Benefits, Deductibles, Coinsurance and Out-of-Pocket Maximum. Other terms are defined in the Definitions Section at the back of this Policy or where they are first used and are designated by the first letter being capitalized.

While this Understanding Your Benefits Section defines these types of cost-sharing elements, You need to refer to the Schedule of Benefits included in the beginning of this Policy and the Medical Benefits Section to see exactly how they are applied and to which benefits they apply.

MAXIMUM BENEFITS

Some benefits for Covered Services may have a specific Maximum Benefit. For those Covered Services, We will provide benefits until the specified Maximum Benefit (which may be a number of days, visits, services, supplies, dollar amount or specified time period) has been reached. Allowed Amounts for Covered Services provided are also applied toward the Deductible and against any specific Maximum Benefit that is expressed in this Policy as a number of days, visits, services or supplies. Refer to the Medical Benefits Section to determine if a Covered Service has a specific Maximum Benefit.

OUT-OF-POCKET MAXIMUM

An important feature of this high deductible health plan is how the single and Family Out-of-Pocket Maximums work. The key is understanding the difference between "single" and "family" coverage. Single Coverage means only one person has coverage under this Policy. A Policyholder who is the only one in his or her Family who has coverage under this Policy and an Enrolled Dependent who is continuing insurance coverage on his or her own are all examples of Single Coverage. Family Coverage, on the other hand, means two or more members of the same Family have coverage under this Policy under a single application.

Insureds can meet the Out-of-Pocket Maximum by payments of Deductible and/or Coinsurance as specifically indicated on the Schedule of Benefits. There are two Out-of-Pocket Maximum amounts: one for In-Network benefits and another for Out-of-Network benefits. Benefits, Deductibles and Out-of-Pocket Maximums accrued under one level of benefits do not also accrue to the other level of benefits. Ambulance Services, Blood Bank, Detoxification, Emergency Room, Pediatric Dental Services and Prescription Medications will always apply toward the In-Network Out-of-Pocket Maximum amount regardless of whether the Provider of these services is In-Network or Out-of-Network. Additionally, services provided by a Provider that has an effective participating contract with Us but is not designated as an In-Network Provider (as further defined in the Definitions Section at the back of this Policy) will apply to the In-Network Out-of-Pocket Maximum amount. All Essential Benefits (ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management and pediatric services) will accrue to either the In-Network or Out-of-Network maximum according to whether You have received those services In-Network or Out-of-Network. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach this Policy's Out-of-Pocket Maximum.

Once You reach the Out-of-Pocket Maximum for In-Network benefits, In-Network benefits will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year. Once You reach the Out-of-Pocket Maximum for Out-of-Network benefits, Out-of-Network benefits will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year.

There is one Family Out-of-Pocket Maximum amount for In-Network benefits. The Family Out-of-Pocket Maximum for a Calendar Year is satisfied when two or more Family members' Deductibles and/or Coinsurance for Covered Services for that Calendar Year total and meet the Family's Out-of-Pocket Maximum amount.

PERCENTAGE PAID UNDER THIS POLICY (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 the billed charges or the Allowed Amount. The percentage We pay varies, depending on the kind of service or supply You received and who rendered it. Refer to the Schedule of Benefits to understand what Coinsurance amounts You are responsible for.

We do not reimburse Providers for charges above the Allowed Amount. However, 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, however, may bill You for any balances over Our payment level in addition to the applicable Deductible and/or Coinsurance amount. See the Definitions Section for descriptions of Providers.

DEDUCTIBLES

We will begin to pay benefits for Covered Services in any Calendar Year only after the Calendar Year Deductible is satisfied. There are two Calendar Year Deductible amounts: one for In-Network benefits and another for Out-of-Network benefits. Deductibles accrued under one level of benefits do not also accrue to the other level of benefits. An Insured who is enrolled on Single Coverage satisfies the Single Coverage Deductible by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total and meet the Single Coverage Deductible. Ambulance Services, Blood Bank, Detoxification, Emergency Room, Pediatric Dental Services, and certain Prescription Medications will apply toward the In-Network Deductible amount.

Additionally, services provided by a Provider that has an effective participating contract with Us but is not designated as an In-Network Provider (as further defined in the Definitions Section at the back of this Policy) will apply to the In-Network Deductible amount.

There is one Family Calendar Year Deductible amount for In-Network benefits. The Family Calendar Year Deductible is satisfied when two or more covered Family members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Deductible amount. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not count toward the Deductible.

HOW CALENDAR YEAR BENEFITS RENEW

Many provisions in this Policy (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.

Some benefits in this Policy have a separate Maximum Benefit based upon an Insured's Lifetime and do not renew every Calendar Year. Those exceptions include teaching doses of Self-Administrable Injectable Medication and hospice respite care and are further detailed in the Medical Benefits Section of this Policy.

Medical Benefits

In this section, You will learn about Your Policy's benefits and how Your coverage pays for Covered Services. There are no referrals required before You can use any of the benefits of this coverage, including women's health care services. For Your ease in finding the information regarding benefits most important to You, We have listed these benefits alphabetically, with the exception of the Preventive Care and Immunizations, Office Visits – Illness or Injury and Other Professional Services benefits.

All covered benefits, including the following Essential Health Benefits, are explained in this Medical Benefits Section. Benefits are provided after satisfaction of the Deductible specified on the Schedule of Benefits and are subject to the limitations, exclusions and provisions of this Policy:

- Ambulatory patient services - See the Office Visits – Illness or Injury; Other Professional Services; Ambulatory Surgical Center; Dental Hospitalization; Dialysis; Family Planning; Home Health Care; Hospice Care; Hospital Care - Inpatient and Outpatient; Nutritional Counseling; and Urgent Care Center benefits for a description of covered benefits.
- Emergency services - See the Ambulance Services and Emergency Room (Including Professional Services) benefits for a description of covered benefits.
- Hospitalization - See the Ambulatory Surgical Center; Dental Hospitalization; Dialysis; Hospital Care - Inpatient and Outpatient; Skilled Nursing Facility (SNF) Care and Transplants benefits for a description of covered benefits.
- Maternity and newborn care - See the Office Visits – Illness or Injury; Other Professional Services; Ambulatory Surgical Center; Hospital Care – Inpatient and Outpatient; Maternity Care; and Newborn Care benefits for a description of covered benefits.
- Mental health and substance use disorder services, including behavioral health treatment - See the Acupuncture; Ambulatory Surgical Center; Detoxification; Hospital Care – Inpatient and Outpatient; Mental Health Services; and Substance Use Disorder Services benefits for a description of covered benefits.
- Prescription drugs - See the Preventive Care and Immunizations and Prescription Medications benefits for a description of covered benefits.
- Rehabilitative and Habilitative services and devices - See the Durable Medical Equipment; Habilitative Services; Orthotic Devices; Other Professional Services; Prosthetic Devices; and the Rehabilitation Services benefits for a description of covered benefits.
- Laboratory services - See the Other Professional Services and Blood Bank benefits for a description of covered benefits.
- Preventive and wellness services and chronic disease management - See the Other Professional Services and Preventive Care and Immunizations benefits for a description of covered benefits.
- Pediatric services including dental and vision care - See the Pediatric Dental and Pediatric Vision benefits for a description of covered benefits.

To be covered, medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Also, a Provider practicing within the scope of his or her license must render the service. Please see the Definitions Section in the back of this Policy for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service under this Policy.

NOTE: You are required to obtain preauthorization from Us in advance of all inpatient services received from non-contracted Providers or a penalty will apply. Refer to the Preauthorization provision of the Policy and Claims Administration Section for requirements and exceptions.

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

The Calendar Year Out-of-Pocket Maximum amounts for this Policy are specified on the Schedule of Benefits.

COINSURANCE

Coinsurance for each applicable benefit is specified on the Schedule of Benefits.

CALENDAR YEAR DEDUCTIBLES

The Calendar Year Deductible amounts for this Policy are specified on the Schedule of Benefits.

PREVENTIVE CARE AND IMMUNIZATIONS

We cover preventive care services provided by a professional Provider or facility. Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care, FDA-approved contraceptive devices and implants including the insertion and removal of those devices or implants, routine 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), and routine health screenings. Also included is Provider counseling for tobacco use cessation and Generic Medications prescribed for tobacco use cessation. See the Prescription Medications benefit for a description of how to obtain Generic Medications. Coverage for all such services is provided only for preventive care as designated below.

Covered Services for Preventive Care and Immunizations provided by a Provider that has any form of participating contract to provide services and supplies to Insureds in accordance with the provisions of this coverage will be covered as an In-Network benefit. For all other Providers, Covered Services will be provided as specified on the Schedule of Benefits.

Benefits will be covered under this Preventive Care and Immunizations benefit, not any other benefit in this Policy, 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 list of services covered under this benefit, please contact Customer Service at the phone number or Our Web site listed in the Introduction. NOTE: Covered Services that do not meet these criteria will be covered the same as any other Illness or Injury. In addition, covered expenses do not include immunizations if the Insured receives them only for the purpose of travel, occupation or residence in a foreign country.

OFFICE VISITS – ILLNESS OR INJURY

We cover office 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 (separate facility fees billed in conjunction with the office visit for example) are not considered an office visit under this benefit. For example, We will pay for a surgical procedure performed in the office according to the Other Professional Services benefit.

OTHER PROFESSIONAL SERVICES

We cover services and supplies provided by a professional Provider subject to any specified limits as explained in the following paragraphs:

Medical Services

We cover professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider, that are generally recognized and accepted non-surgical procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury. Services and supplies also include those to treat a congenital anomaly and foot care associated with diabetes.

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 will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by Out-of-Network Providers at the In-Network benefit level. However, You may be billed for balances beyond any Deductible and/or Coinsurance. Please 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, mammography and prostate screening services not covered under the Preventive Care and Immunizations benefit. NOTE: Outpatient complex imaging services are covered under the Complex Imaging – Outpatient benefit.

Diagnostic Procedures
We cover services for diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies, sleep studies and neurology/neuromuscular procedures.

Surgical Services
We cover surgical services and supplies including the services of a surgeon, an assistant surgeon and an anesthesiologist including coverage of cochlear implants.

Therapeutic Injections
We cover therapeutic injections and related supplies when given in a professional Provider's office.

A selected list of Self-Administrable Injectable Medications is covered under the Prescription Medications benefit. Teaching doses (by which a Provider educates the Insured to self-inject) are covered for this list of Self-Administrable Injectable Medications up to a limit of three doses per medication per Insured Lifetime. Teaching doses that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services. For a list of covered Self-Administrable Injectable Medications, call Customer Service or visit our Web site at **www.Asuris.com**.

ACUPUNCTURE
We cover acupuncture services provided by a professional Provider to a maximum of 12 visits per Insured per Calendar Year. Acupuncture visits that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services. (There are no visit limits for acupuncture to treat Substance Use Disorder Conditions.)

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 purpose of the transportation is not for personal or convenience purposes. Covered ambulance services include licensed ground and air ambulance Providers.

AMBULATORY SURGICAL CENTER
We cover the outpatient services and supplies of an Ambulatory Surgical Center for Injury and Illness.

APPROVED CLINICAL TRIALS
We cover Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating subject to the Deductible and/or Coinsurance and Maximum Benefits as specified in the Schedule of Benefits and the Medical Benefits and Prescription Medications benefit in this Policy. Additional specified limits are as further defined. If an In-Network Provider is participating in the Approved Clinical Trial and will accept You as a trial participant, these 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.

Definitions
In addition to the definitions in the Definitions Section, the following definitions apply to this Approved Clinical Trials benefit:

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

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

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

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

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

BLOOD BANK

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. Benefits are not available for services received in a dentist's office.

DETOXIFICATION

We cover Medically Necessary detoxification services for alcoholism and drug abuse as an Emergency Medical Condition and do not require pre-authorization or pre-notification. You may choose to see an In-Network or Out-of-Network Provider for detoxification services. See the Definitions Section of this Policy for a complete description of In-Network and Out-of-Network Providers.

DIABETES SUPPLIES AND EQUIPMENT

We cover supplies and equipment for the treatment of diabetes such as insulin, insulin infusion devices, test strips and insulin pumps under the Other Professional Services, Diabetic Education, Durable Medical Equipment, Nutritional Counseling, Orthotic Devices or Prescription Medications benefits of this Policy.

DIABETIC EDUCATION

We cover services and supplies for diabetic self-management training and education, including nutritional therapy if provided by Providers with expertise in diabetes.

DIALYSIS
We cover inpatient, outpatient, and home services and supplies for dialysis. You may choose to see an In-Network or Out-of-Network Provider for dialysis services. See the Definitions Section of this Policy for a complete description of In-Network and Out-of-Network Providers.

DURABLE MEDICAL EQUIPMENT
Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Insured's home. Examples include oxygen equipment and wheelchairs. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item. We also cover sales tax under this benefit for Durable Medical Equipment and mobility enhancing equipment, that is a Covered Service and when such equipment is not otherwise tax exempt.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)
We cover emergency room services and supplies, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. 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. However, You may be billed for balances beyond any Deductible and/or Coinsurance. Please contact Customer Service for further information and guidance. See the Hospital Care benefit for coverage of inpatient Hospital admissions.

FAMILY PLANNING
We cover certain professional Provider contraceptive services and supplies, including, but not limited to, vasectomy under this benefit.

For coverage of prescription contraceptives, please see the Prescription Medications benefit. You are not responsible for any applicable Deductible and/or Coinsurance when You fill prescriptions for FDA-approved contraceptives prescribed by Your health care Provider. For a list of such medications, please contact Customer Service at the phone number or Our Web site listed in the Introduction.

For more information on preventive services for women, including HIV screening, HPV DNA testing, tubal ligation, insertion or extraction of FDA-approved contraceptive devices, and certain patient education and counseling services, see the Preventive Care and Immunizations benefit of this Policy or for a list of covered preventive services, please contact Customer Service at the phone number or Our Web site listed in the Introduction.

GENETIC TESTING
We cover Medically Necessary services for genetic testing.

HABILITATIVE SERVICES
We cover Medically Necessary inpatient and outpatient health care services, including speech therapy, occupational therapy, physical therapy and aural therapy, and devices approved by the United States Food and Drug Administration (FDA), that are designed to help the Insured keep, learn or improve skills and functioning for daily living within the Insured's environment or to compensate for the Insured's progressive physical, cognitive and emotional illness. Chore services to assist with basic needs, vocational or custodial services are not classified as habilitative services and are not covered under this Policy. Inpatient services are limited to a maximum of 30 days per Insured per Calendar Year. Outpatient services are limited to a maximum of 25 visits per Insured per Calendar Year. Habilitative services that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services.

HOME HEALTH CARE
We cover home health care when provided by a licensed agency or facility for home health care to a maximum of 130 visits per Insured per Calendar Year. Home health care includes all services for homebound patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility. Home health care visits that are applied toward the Deductible will be applied against the Maximum

Benefit limit on these services. Durable Medical Equipment associated with home health care services is covered under the Durable Medical Equipment benefit.

HOSPICE CARE

We cover hospice care when provided by a licensed hospice care program. The only hospice limit is a maximum of 14 inpatient or outpatient respite days per Insured Lifetime. 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 Insured and allow temporary relief to family members from the duties of caring for the Insured. Respite care days that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with hospice care is covered under the Durable Medical Equipment benefit in this Policy.

HOSPITAL CARE – INPATIENT AND OUTPATIENT

We cover the inpatient and outpatient services and supplies of a Hospital for Injury and Illness (including 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. However, You may be billed for balances beyond any Deductible and/or Coinsurance. Please contact Customer Service for further information and guidance. See the Emergency Room benefit for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

MATERNITY CARE

We cover prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), Medically Necessary supplies of home birth, complications of pregnancy, and related conditions for all female Insureds (including eligible dependents of dependents who have enrolled under this Policy). There is no limit for the mother's length of inpatient stay. Where the mother is attended by a Provider, the attending Provider will determine an appropriate discharge time, in consultation with the mother. See the Newborn Care benefit to see how the care of Your newborn is covered. Coverage also includes termination of pregnancy for all female Insureds.

Certain services such as screening for gestational diabetes, breastfeeding support, supplies and counseling are covered under Your Preventive Care benefit.

MEDICAL FOODS (PKU)

We cover medical foods for inborn errors of metabolism including, but not limited to, formulas for Phenylketonuria (PKU).

MENTAL HEALTH SERVICES

We cover Mental Health Services for treatment of Mental Health Conditions.

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Mental Health Services benefit:

Mental Health Conditions means mental disorders, including eating disorders, in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association except as otherwise excluded under this Policy. 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).

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.

NEURODEVELOPMENTAL THERAPY

We cover inpatient and outpatient neurodevelopmental therapy services. Outpatient neurodevelopmental therapy services are limited to a maximum of 25 outpatient visits per Insured per Calendar Year. Neurodevelopmental therapy services that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services. To be covered, such services must be to restore and improve function. Covered Services include only physical therapy, occupational therapy and speech therapy and maintenance services, if significant deterioration of the Insured'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. For the purpose of this benefit, "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 for all conditions including obesity, not subject to any specific visit limitation.

ORTHOTIC DEVICES

We cover benefits for the purchase of braces, splints, orthopedic appliances and orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body. We may elect to provide benefits for a less costly alternative item. We do not cover off-the-shelf shoe inserts and orthopedic shoes.

PALLIATIVE CARE

We cover palliative care to a maximum of 30 visits per Insured per Calendar Year when a Provider has assessed that an Insured is in need of palliative care services. For the purpose of this benefit, "palliative care" means specialized services received from a Provider in a home setting for counseling and home health aide services for activities of daily living. Palliative care visits that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services.

PEDIATRIC DENTAL

We cover pediatric Dental Services for Insureds under the age of 19. Coverage will be provided for an Insured until the last day of the month in which the Insured turns 19 years of age. We will pay benefits under this Pediatric Dental benefit, not any other benefit in this Policy, 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 per Insured per Calendar Year for a total of four bitewing x-rays 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.
- Diagnostic casts when Dentally Appropriate.
- Limited oral evaluations to evaluate the Insured for a specific dental problem or oral health complaint, dental emergency or referral for other treatment.
- Limited visual oral assessments or screenings, limited to two per Insured per Calendar Year, not performed in conjunction with other clinical oral evaluation services.

- Occlusal intraoral x-rays, limited to once in a two-year period.
- Oral hygiene instruction, limited to two times per Calendar Year for ages eight and under, 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 Insured per Calendar Year, beginning before one year of age.
- Problem focused oral examinations.
- Panoramic mouth x-rays, limited to one in a three-year period.
- Cleanings, limited to two per Insured per Calendar Year.
- Sealants, limited to permanent bicuspids and molars.
- Space maintainers (fixed unilateral or fixed bilateral) for Insureds 12 years of age and under, subject to the following limits:

    - re-cementation of space maintainers is covered for Insureds 12 years of age and under;
    - removal of space maintainers for Insureds under age 19; and
    - replacement space maintainers are covered when Dentally Appropriate.

- Topical fluoride application: limited to three treatments per Insured per Calendar Year. Additional topical fluoride applications 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, vestibuloplasty and residual root removal. Frenulectomy and frenuloplasty care is covered for Insureds ages six and under.
- 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, limited to the following:

    - a maximum of five surfaces per tooth for permanent posterior teeth, except for upper molars;
    - a maximum of six surfaces per tooth for teeth one, two, three, 14, 15 and 16;
    - a maximum of 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 one, two, three, 14, 15 and 16.

- General dental anesthesia or intravenous sedation administered in connection with the extractions of partially or completely bony impacted teeth and to safeguard the Insured's health (for example, a child under eight years of age). 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) limited to once per Insured per quadrant in a five-year period;
  - debridement;
  - gingivectomy and gingivoplasty limited to once per Insured per quadrant in a three-year period;
  - periodontal maintenance limited to once per quadrant in a Calendar Year for Insureds 13 years of age and older; and
  - scaling and root planing limited to once per Insured per quadrant in a two-year period for Insureds 13 years of age and older.

- 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.
  - repairs covered once in a 12-month period, per arch. The cost of repairs cannot exceed the cost of a replacement denture or a partial denture. 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 in a five-year period, per tooth, for permanent anterior teeth for Insureds 12 years of age and older;
  - 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 for Insureds 12 years of age and older;
  - stainless steel crowns for primary posterior teeth once in a three-year period; and
  - stainless steel crowns for permanent posterior teeth (excluding teeth one, 16, 17 and 32) once in a three-year period.

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

  - denture rebase, limited to one per Insured per arch in a three-year period, if performed at least six months from the seating date;
  - denture relines, limited to one per Insured 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 Insured lifetime after at least five years from the seat date; and
  - one resin-based partial denture, replaced once within a three-year period.

- Home visits, including extended care facility calls, limited to two calls per facility per provider.
- Medically Necessary orthodontic services for Insureds with malocclusions associated with:
  - cleft lip and palate, cleft palate and cleft lip with alveolar process involvement; and
  - craniofacial anomalies for hemifacial microsomia, craniosynostosis syndromes, anthrogryposis or Marfan syndrome.

- Occlusal guards for Insureds age 12 and older.
- Post-surgical complications.
- Repair of crowns is limited to one per tooth per Insured Lifetime.
- Repair of implant supported prosthesis or abutment, limited to one per tooth per Insured 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 Injury or Illness, 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, but not limited to:

- endodontic endosseous implants;
- interim endosseous implants;
- eposteal and transosteal implants;
- sinus augmentations or lift;
- 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
Except as provided in this Pediatric Dental benefit, We do not cover charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and supplies.

Occlusal Treatment
Except as provided in this Pediatric Dental benefit, We do not cover services and supplies provided in connection with dental occlusion, including occlusal analysis and adjustments.

Oral Surgery
Oral surgery treating any fractured jaw and orthognathic surgery. By "orthognathic surgery," We mean 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
Except as provided in this Pediatric Dental benefit, We do not cover services and supplies provided in connection with orthodontics, including the following services:

- 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
Except as provided under this Pediatric Dental benefit, We do not cover 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.

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

- 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; or
- 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. However, coverage for temporomandibular joint (TMJ) disorder is provided in the Medical Benefits section.

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

Veneers

DEFINITIONS
In addition to the definitions in the Definitions Section, the following definitions apply to this Pediatric Dental benefit:

Allowed Amount means:

- With respect to In-Network Dentists, the amount In-Network Dentists have contractually agreed to accept as full payment for Covered Services.
- With respect to Out-of-Network Dentists, reasonable charges for Covered Services as determined by Us.

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, please contact Us.

Covered Service 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.

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

A DENTAL SERVICE MAY BE DENTALLY APPROPRIATE YET NOT BE A COVERED SERVICE UNDER THIS POLICY.

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 Dentist who has an effective participating contract with Us to provide services and supplies to Insureds in accordance with the provisions of this Policy.

Out-of-Network Dentist means a Dentist who does not have an effective participating contract with Us to provide services and supplies to Insureds, or any other Dentist that does not meet the definition of an In-Network Dentist under this Policy.

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. So, 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.

Freedom of Choice of Dentist

Nothing contained in this Policy is designed to restrict You in selecting the Dentist of Your choice for dental care or treatment.

PEDIATRIC VISION

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

All terms and conditions of this Policy apply to this Pediatric Vision benefit, except as otherwise noted. We will pay benefits under this Pediatric Vision benefit, not any other benefit in this Policy, if a service or supply is covered under both.

Pediatric Vision Examination

We cover one routine vision screening and a comprehensive eye exam including dilation and with refraction per Insured per Calendar Year.

Pediatric Vision Hardware

We cover hardware including frames, contacts (in lieu of glasses) and all lenses and tints. Frames are covered to a maximum of one frame per Insured per Calendar Year. Spectacle lenses are covered to a maximum of one pair per Insured per Calendar Year, including polycarbonate lenses and scratch resistant coating. Low vision optical devices, aids, low vision services including comprehensive low vision evaluations and follow-up care are covered. Also covered are high power spectacles, magnifiers and telescopes. Two pairs of glasses may not be ordered in lieu of bifocals. Separate charges for fittings will not be covered under this Policy.

PRESCRIPTION MEDICATIONS

We cover Prescription Medications listed under the Essential Formulary on Our Web site. To view this Essential Formulary visit Our Web site at **www.Asuris.com**.

Essential Formulary Changes

Any removal of a Prescription Medication from Our Essential Formulary 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 Essential Formulary 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 substitution 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.

Substitution Process

Non-formulary medications are not routinely covered under your Prescription Medications benefit; however, Prescription Medication not on the Essential Formulary may be covered under certain circumstances. Non-formulary means those self-administered Prescription Medications not listed in the Essential Formulary for Your Policy.

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

- You are not able to tolerate a covered Prescription Medication on the Essential Formulary; or
- Your Provider determines that the Prescription Medication on the Essential Formulary 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 Essential Formulary dosage limitation.

The specific medication policy criteria to determine if a Prescription Medication not on the Essential Formulary is Medically Necessary are available on Our Web site. You or Your Provider may request prior authorization by calling Customer Service at the phone number listed in the Introduction, 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-formulary drug, 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 Essential Formulary will be available for coverage at the Substituted Medication on the Essential Formulary Coinsurance level determined by Your benefit 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. Please see the Appeal Process for more information on how to initiate an appeal request.

The substitution process may also be used to substitute a covered Prescription Medication for another drug on the Essential Formulary if:

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

Covered Prescription Medications

Benefits under this Prescription Medications benefit are available for the following:

- diabetic supplies (including, but not limited to, insulin, 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 and their supplies), when obtained with a Prescription Order (insulin pumps and their supplies are covered under the Durable Medical Equipment benefit);
- Prescription Medications;
- 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 of this Policy;
- certain preventive medications (including, but not limited to, aspirin, fluoride, iron and Generic Medications for tobacco use cessation) according to, and as recommended by, the USPSTF, when obtained with a Prescription Order;
- all FDA-approved women's contraception methods as recommended by the HRSA;
- immunizations for adults and children according to, and as recommended by, the CDC;
- Specialty Medications;
- Self-Administrable Cancer Chemotherapy Medication;
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Compound and Injectable Medications); and
- growth hormones (if preauthorized).

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, or for immunizations, as specified above. For example, FDA-approved contraceptives, prescribed to women by their health care provider, are covered without cost sharing. For a complete list of such medications, please visit Our Web site or contact Customer Service at the phone number listed in the Introduction.

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 substitution process at the Generic Medication payment level. Please visit Our Web site or contact Customer Service at the phone number listed in the Introduction for more information.

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 Essential Formulary.

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 an Insured of Asuris Northwest Health, 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. Medications dispensed to You while You are inpatient in a Hospital, Skilled Nursing Facility, or other facility, that is not a Participating Pharmacy, will be provided under the applicable benefit.

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, simply complete a Prescription Medication claim form and mail the

form and receipt to Us. 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 Medication through the mail, simply 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 (which also includes refill instructions):

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

Insured's Right to Safe and Effective Pharmacy Services

State and federal laws establish standards to assure safe and effective Pharmacy services, and to guarantee Your right to know what medications are covered and what coverage limitations are under this Policy. If You would like more information about the medication coverage policies under this Policy, or if You have a question or a concern about Pharmacy benefits, please contact Us at 1 (877) 508-7361.

If You would like to know more about Your rights under the law, or if You think anything You have received from Us may not conform to the terms of this Policy, You may contact the Washington State Office of Insurance Commissioner at 1 (800) 562-6900. If You have a concern about the Pharmacists or Pharmacies serving You, please call the State Department of Health at 1 (360) 236-4825.

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. You can see the list on Our Web site or contact 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 certain preventive medications as specified in the Covered Prescription Medications provision:

- **Maximum 30-Day or Greater Supply Limit**
  - **Injectable Medications and 30-Day Supply.** The largest allowable quantity for Self-Administrable Injectable Medications purchased from a Pharmacy or Mail-Order Supplier, is a 30-day supply. The Coinsurance for Self-Administrable Injectable Medications purchased from a Mail-Order Supplier will be the same as if the medication was purchased from and the claim was submitted electronically by a Pharmacy.
  - **Self-Administrable Cancer Chemotherapy Medications and 30-Day Supply.** The largest allowable quantity for Self-Administrable Cancer Chemotherapy Medication purchased from a Specialty Pharmacy is a 30-day supply. Self-Administrable Cancer Chemotherapy Medications that are Specialty Medications must be filled at a Specialty Pharmacy.

- **Specialty Medications and 30-Day Supply.** The largest allowable quantity for a Specialty Medication purchased from a Specialty Pharmacy is a 30-day supply. The first fill is allowed at a Pharmacy. Additional fills must be purchased from a Specialty Pharmacy.
- **Mail-Order and 90-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Mail-Order Supplier is a 90-day supply. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities. Self-Administrable Injectable Medications are limited to a 30-day supply as indicated above.
- **Pharmacy and 90-Day Supply.** The largest allowable quantity of Prescription Medication that you may purchase from a Participating or Preferred Pharmacy is a 90-day supply. A Provider may choose to prescribe, or You may choose to purchase, some medications in smaller quantities. The Copayment and/or Coinsurance is based on each 30-day supply.

  The largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Participating or Preferred Pharmacy is the smallest multiple-month supply packaged by the manufacturer for dispensing by Pharmacies. The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The maximum supply covered for these products is a 90-day supply (even if the packaging includes a larger supply).

- **Maximum Quantity Limit**
  For certain Prescription Medications, We establish maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. We use information from the 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 will cover refills from a Pharmacy when You have taken 75 percent of the previous prescription or 70 percent of the previous topical ophthalmic prescription. Refills obtained from a Mail-Order Supplier are allowed after You have taken all but 20 days of the previous Prescription Order. If You choose to 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. You may request an exception by calling Customer Service.

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

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

Brand-Name Medications not on the Essential Formulary or Provided Through the Substitution Process

Cosmetic Purposes: Prescription Medications used for cosmetic purposes, including, but not limited to: removal, inhibition or stimulation of hair growth; retardation of aging; or repair of sun-damaged skin.

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

Non-Self-Administrable Medications

Nonprescription Medications: Medications that by law do not require a Prescription Order and which are not included in Our definition of Prescription Medications, shown below, and are not included on Our Essential Formulary.

Prescription Medications for the Treatment of Infertility

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 without Examination: We do not cover prescriptions made by a Provider without recent and relevant in-person, Telemedicine, or Telehealth examination of the patient, whether the Prescription Order is provide by mail, telephone, internet or some other means. For the purpose of this exclusion, 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

Travel Immunizations Received for Purposes of Travel, Occupation or Residence in a Foreign Country

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Prescription Medications benefit:

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

Category 1 Brand-Name Medication means all preferred brand medications that are not a Specialty Medication.

Category 2 Brand-Name Medication means other Brand-Name Medications used to treat the same or similar medical conditions either at a higher cost or determined to be of lesser value than preferred Brand-Name Medications and that are not Specialty Medications.

Compound Medication means two or more medications that are mixed together by the Pharmacist. To be covered, Compound Medications must contain a Prescription Medication that has been approved by the FDA.

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.

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

Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references (or specified by Us) as a Generic Medication. For the purpose of this definition, "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. If listings in widely accepted references are conflicting or indefinite about whether a Prescription Medication is a generic or Brand-Name Medication, We will accept the Abbreviated New Drug Application (ANDA) submission to decide.

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

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 have the capability of submitting claims electronically. To find a Participating or Preferred Pharmacy, please 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 be able to or choose not to submit claims electronically.

Prescription Medications (also Prescribed Medications) means medications and biologicals that relate directly to the treatment of an Illness or Injury, legally cannot be dispensed without a Prescription Order and by law must bear the legend: "Prescription Only" or as specifically included on Our Essential Formulary.

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

Self-Administrable Prescription Medications (also Self-Administrable Medications, Self-Administrable Injectable Medication or Self-Administrable Cancer Chemotherapy Medication) means, a Prescription Medication (including, for Self-Administrable Cancer Chemotherapy Medication, oral Prescription Medication used to kill or slow the growth of cancerous cells), determined by Us, which can be safely administered by You or Your caregiver outside a medically supervised setting (such as a Hospital, Physician office or clinic) and that does not require administration by a Provider. In determining what We consider Self-Administrable Medications, We refer to information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that We consider a relevant and reliable indication of safety and acceptability. We do not consider Your status, such as Your ability to administer the medication, when determining whether a medication is self-administrable.

Specialty Medications means medications used for patients with complex disease states, such as but not limited to multiple sclerosis, rheumatoid arthritis, cancer and hepatitis C. For a list of some of these medications, please visit Our Web site or contact Customer Service.

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, please visit Our Web site or contact Customer Service.

Substituted Medication means a Generic Medication or a Brand-Name Medication not on the Essential Formulary that is approved for coverage at the Category 2 Brand-Name Medication benefit level.

Substituted Medication also means a Specialty Medication not on the Essential Formulary that is approved for coverage at the Specialty Medication benefit level.

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 or Hospital outpatient and 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 Injury or Illness; 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 of this Policy.

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 (physical, occupational and speech therapy services only) and accommodations as appropriate and necessary to restore or improve lost function caused by Injury or Illness as specified on the Schedule of Benefits. Inpatient services are limited to a maximum of 30 days per Insured per Calendar Year. Outpatient services are limited to a maximum of 25 visits per Insured per Calendar Year. Rehabilitation services that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

SKILLED NURSING FACILITY (SNF) CARE

We cover the inpatient services and supplies of a Skilled Nursing Facility for Illness, Injury or physical disability to a maximum of 60 inpatient days per Insured per Calendar Year. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is determined to be necessary. Skilled Nursing Facility services that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services. Ancillary services and supplies, such as physical therapy, Prescription Medications, and radiology and laboratory services, billed as part of a Skilled Nursing Facility admission also apply toward the Maximum Benefit limit on Skilled Nursing Facility care.

SPINAL MANIPULATIONS

We cover spinal manipulations performed by any Provider to a maximum of ten spinal manipulations per Insured per Calendar Year. Spinal manipulations that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services. 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 Chemical Dependency Conditions, these acupuncture services do not apply toward the overall acupuncture Maximum Benefit); and
- Prescription Medications that are prescribed and dispensed through a substance use disorder treatment facility (such as methadone).

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Substance Use Disorder Services benefit:

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.

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), home health services and court ordered treatment (unless the treatment is determined by Us to be Medically Necessary).

Exclusively for the purpose of this Substance Use Disorder 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.

TELEHEALTH

We cover telehealth (audio and video communication) office visits for primary care services and equivalent behavioral health services between the patient and an In-Network Provider specifically approved to provide telehealth. We do not cover telehealth office visits when provided by an Out-of-Network telehealth Provider. To find an approved In-Network telehealth Provider or for additional information on Covered Services, please visit Our Web site or contact Customer Service. NOTE: Telehealth services are prohibited in some states and therefore You will not be covered for these services if You attempt to access them while in one of those states. Please contact Customer Service for further information and guidance. Coverage is not provided under this benefit for all non-real-time delivery methods, including, but not limited to, store and forward solutions, e-mail or secure message exchange.

TELEMEDICINE

We cover telemedicine (audio and video communication) services between a distant-site Physician, the patient and a consulting Practitioner when the originating (distant) site is a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services.

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 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 Investigational or primarily for Cosmetic purposes.

TRANSPLANTS

We cover transplants, including transplant-related services and supplies for covered transplants. A transplant recipient who is covered under this Policy 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). Hematopoietic stem cell support may involve the following donors, i.e., either autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor) or umbilical cord blood (only covered for certain conditions).

Donor Organ Benefits

We cover donor organ procurement costs if the recipient is covered for the transplant under this Policy. Procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ and other such procurement costs that We determine.

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 (separate facility fees billed in conjunction with the office visit for example) 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. You may choose to see an In-Network or Out-of-Network Provider. See the Definitions Section of this Policy for a complete description of In-Network and Out-of-Network Providers.

General Exclusions

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

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 this Policy 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.

Conditions Caused By Active Participation In a War or Insurrection

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

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

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

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 in the Absence of Illness

Services for counseling in the absence of Illness, not expressly described in this Policy as a Covered Service, will not be covered. Examples of non-covered services: educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; Individual Assistance Program (“IAP”) services; wilderness programs; premarital or marital counseling; and family counseling when the identified patient is not a child or an adolescent with a covered diagnosis and family counseling is not part of the treatment.

Custodial Care

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

Dental Services

We do not cover Dental Services 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, for Insureds age 19 and over.

Expenses Before Coverage Begins or After Coverage Ends

Services and supplies incurred before Your Effective Date under this Policy or after Your termination under this Policy.

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.

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

Hearing Care
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.

Infertility Treatment

Investigational Services
We do not cover Investigational treatments or procedures (Health Interventions), 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. Approved clinical trials are covered under the Approved Clinical Trials benefit in the Medical Benefits Section of this Policy.

Mental Health Treatment For Certain Conditions
We will not cover treatment of paraphilias or paraphilic disorders (except gender identity disorder in children or gender identity disorder in adolescents or adults). Additionally, We do not cover any V code diagnoses, except for Medically Necessary treatment for children ages five and under for parent-child problems, neglect, abuse or bereavement. By "V code," We mean codes for additional conditions that may be a focus of clinical attention as described in the most recent edition of the DSM, that describe relational problems, problems related to abuse or neglect or other issues that may be the focus of assessment or treatment. This includes, but is not limited to, such issues as occupational or academic problems.

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

Non-Direct Patient Care
Services that are not considered direct patient care, telemedicine or telehealth, 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).

Non-Emergency Services While Outside of the United States
We do not cover services for an Illness, Injury or condition not considered an Emergency Medical Condition while outside the United States.

Obesity or Weight Reduction/Control
We do not cover medical treatment, medications, surgical treatment (including reversals), programs or supplies that are intended to result in or relate to weight reduction.

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 Comfort Items
Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, We do not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps and light boxes.

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 Insured's Provider.

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

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

Riot, Rebellion and Illegal Acts
Services and supplies for treatment of an Illness, Injury or condition caused by an Insured's **voluntary participation in** a riot, armed invasion or aggression, insurrection or rebellion or sustained by an Insured arising directly from an act deemed illegal by an officer or a court of law.

Routine Foot Care

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

- diet and weight monitoring services;
- childbirth-related classes including infant care; and
- instruction programs including those to learn how to stop smoking and programs 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. For the purpose of this provision, "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, marriage or who shares a residence with You.

Services and Supplies That Are Not Medically Necessary or Dentally Appropriate
We do not cover services and supplies that are not Dentally Appropriate for treatment or prevention of diseases or conditions of the teeth or Medically Necessary for the treatment of an Illness or Injury.

Sexual Dysfunction
Treatment of sexual dysfunction, regardless of cause, including but not limited to devices, implants, surgical procedures, and medications..

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.

Vision Care

We do not cover routine eye exam and vision hardware for Insureds age 19 and over.

Visual therapy, training and eye exercises, vision orthoptics, prism lenses, surgical procedures to correct refractive errors/astigmatism, reversals or revisions of surgical procedures which alter the refractive character of the eye.

Work-Related Conditions

Expenses for services and supplies incurred as a result of any work-related Injury or Illness, 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 Policy. 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 Third-Party Liability provision.

Policy and Claims Administration

This section explains a variety of matters related to administering benefits and/or claims, including situations that may arise when Your health care expenses are the responsibility of a source other than Us.

PREAUTHORIZATION

Contracted Providers

Contracted Providers may be required to obtain preauthorization from Us in advance for certain services provided to You. You will not be penalized if the contracted Provider does not obtain those approvals from Us in advance and the service is determined to be not covered under this Policy.

Non-Contracted Providers

Outpatient Services

Non-contracted Providers are not required to obtain preauthorization from Us in advance for outpatient services. You may be liable for costs if You elect to seek services from non-contracted Providers and those services are not considered Medically Necessary and not covered in this Policy. You may request that a non-contracted Provider preauthorize outpatient services on Your behalf to determine Medical Necessity prior to the service being rendered.

Inpatient Services

While We do not require non-contracted Providers to obtain preauthorization from Us in advance for inpatient services, We do require preauthorization in advance of receiving these services. You are responsible for obtaining preauthorization from Us in advance of inpatient services received from non-contracted Providers. You may request that the non-contracted Provider assist You with this, but the Provider is not required to do so.

All costs for inpatient services received from a non-contracted Provider that are not Medically Necessary are Your responsibility. Inpatient services received from a non-contracted Provider that are Medically Necessary will be covered according to the terms of this Policy when preauthorization is obtained. However, a penalty of $1,000 or the Allowed Amount, whichever is less, will be applied to the Allowed Amount if You fail to obtain preauthorization of Medically Necessary inpatient services from non-contracted Providers. Payment of the penalty will not be applied toward any applicable Deductible, Coinsurance or Out-of-Pocket Maximum in this Policy.

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.

ALTERNATIVE BENEFITS

To the extent mandated by Washington Administrative Code section 284-44-500, home health care furnished by duly licensed home health, hospice and home care agencies covered by this Policy may be substituted as an alternative to hospitalization or inpatient care if hospitalization or inpatient care is Medically Necessary and such home health care:

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

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

MEMBER CARD

When You, the Policyholder, enroll with Asuris Northwest Health, You will receive a member card. It will include important information such as Your identification number and Your name.

It is important to keep Your member card with You at all times. Be sure to present it to Your Provider before receiving care.

If You lose Your card, or if it gets destroyed, You can get a new one by simply calling Our Customer Service department. You can also view or print an image of Your member card by visiting Our Web site on Your PC or mobile device. If coverage under this Policy terminates, Your member card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

Our decision if We will pay the Insured, Provider or Provider and Insured jointly is made pursuant to any legal requirements. Payments are primarily issued as joint payee checks to both the Policyholder and the Provider for Out-of-Network Provider claims. The exceptions would be if an Insured submits sufficient documentation that they have "paid in full." In those circumstances We may issue payment to the Insured only. Please see the Pediatric Dental Benefit for reimbursement of claims for Out-of-Network Dentists.

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

Calendar Year and Policy Year

The Deductible and Out-of-Pocket Maximum provisions are calculated on a Calendar Year basis. This Policy is renewed, with or without changes, each Policy Year. A Policy Year is the 12-month period following this Policy's original Effective Date. A Policy Year may or may not be the same as a Calendar Year. If Your Policy is renewed during a Calendar Year and, during that Calendar Year You paid toward the Deductible or Out-of-Pocket Maximum, You get credit for those amounts under the renewed Policy for the same Calendar Year. If You choose to increase the Deductible and/or Out-of-Pocket Maximum amount during the Calendar Year, You will need to meet the new requirement minus any amount You already satisfied under the previous Policy during that same Calendar Year after You have applied to change policies and Your application has been accepted by Us.

Timely Filing of Claims

Written proof of loss must be received within one year after the date of service for which a claim is made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished 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, however, appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner.

Freedom of Choice of Provider

Nothing contained in this Policy is designed to restrict You in selecting the Provider of Your choice for care or treatment of an Illness or Injury.

In-Network Provider Claims

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

In-Network Provider Reimbursement

We will pay an In-Network Provider directly for Covered Services. These Providers 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. These Providers may require You to pay Your share at the time You receive care or treatment.

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

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

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.

Out-of-Network Provider Reimbursement
In most cases, payment is issued as a joint payee check to both the Policyholder and the Provider.

Out-of-Network Providers may not agree to accept the Allowed Amount as full compensation for Covered Services. So, You are 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 for some services, as determined by Us or as otherwise required by law.

Ambulance Claims
When You or Your Provider forwards a claim for ambulance services to Us, it must show where the patient was picked up and where he or she was taken. It should also show the date of service, the patient's name and the patient's identification number.

Claims Determinations
Within 30 days of Our receipt of a claim, We will notify You of the action We have taken on it. However, this 30-day period may be extended by an additional 15 days in the following situations:

- When We cannot take action on the claim due to circumstances beyond Our control, We will notify You within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when We expect to act on the claim.
- When We cannot take action on the claim due to lack of information, We will notify You within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

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

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

CLAIMS RECOVERY
If We pay a benefit to which You or Your Enrolled Dependent was not entitled, or if We pay a person who is not eligible for benefits at all, We have the right, at Our discretion, to recover the payment from the person We paid or anyone else who benefited from it, including a Provider of services. Our right to recovery includes the right to deduct the mistakenly paid amount from future benefits We would provide the Policyholder or any 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 the experience of the pool under which You are rated. Crediting reduces claims expense and helps reduce future premium rate increases.

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

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. You can request a copy simply by calling Our Customer Service department or by visiting Our Web site.

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 calling Our Customer Service department or visiting Our Web site.

You have the right to request, inspect and amend any records that We have that contain Your personal health information. Please contact Our Customer Service department 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.

LIMITATIONS ON LIABILITY

In all cases, You have the exclusive right to choose a health care Provider. Since We do not provide any health care services, We cannot be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither Our employees nor agents. We are responsible for the quality of health care You receive only as provided by law.

In addition, We will not be liable to any person or entity for the inability or failure to procure or provide the benefits in this Policy by reason of epidemic, disaster or other cause or condition beyond Our control.

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.

Third-Party Liability

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

Here are some rules which apply in these third-party liability situations:

- If a claim for health care expense is filed with Us and You have not yet received recovery from the responsible third party, We will 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 to the extent it exceeds full compensation to You for the loss, 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 keep segregated in its own account the amount of the benefits We have paid for the condition from any recovery or payment of any kind for Your benefit or on Your behalf that is in any manner related to the Illness or Injury giving rise to Our right to reimbursement, until Our right is satisfied or released.
- In the event You and/or Your agent or attorney fails to comply with any of the above conditions, We may recover any benefits We have advanced for any Injury or Illness through legal action against You and/or Your agent or attorney.
- If We pay benefits for the treatment of an Illness or Injury, We will be entitled to have the amount of the benefits We have paid for the condition separated from the proceeds of any recovery You receive out of any settlement or recovery from any source, including any arbitration award, judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which We have provided benefits, to the extent it exceeds full compensation to You for the loss. 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 this Policy. The amount to be held in trust shall be calculated based upon claims that are incurred on or before the date of settlement or judgment, unless agreed to otherwise by the parties.

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

No-Fault Coverage

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

Motor Vehicle Coverage

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

or underinsured motorists 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 Third-Party Liability provision apply. However, We will not seek double reimbursement.

Workers' Compensation

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

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

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

Fees and Expenses

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

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when You have health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its

policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 percent of the total Allowable Expense.

This high deductible health plan was designed for use in conjunction with a health savings account (HSA), but can be maintained without an HSA. Laws strictly limit the types of other coverages that an HSA participant may carry in addition to his or her high deductible health plan. The benefits of maintaining an HSA are jeopardized if impermissible types of other coverages are maintained. We will coordinate benefits according to this coordination of benefits provision, regardless of whether other coverage is permissible under HSA law or not. It is Your responsibility to ensure that You do not maintain other coverage that might jeopardize any HSA tax benefit that You plan to claim.

Definitions

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

A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

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

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

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

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

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

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

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

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

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

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

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

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

    The Plan covering the Custodial Parent, first;

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

    The Plan covering the noncustodial parent, third; and then

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

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

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

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

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

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

Effect on the Benefits of This Plan

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

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

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

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

Appeal Process

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action by Us under this Policy and wish to have it reviewed, You may Appeal. There is one level of Internal Appeal, as well as an External Appeal with an Independent Review Organization You may pursue. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

For Grievances or complaints not involving an Adverse Benefit Determination, please refer to the Grievance Process within this Policy.

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, Asuris Northwest Health, P.O. Box 4208, Portland, OR 97208-4208 or facsimile 1 (888) 496-1542. Verbal requests can be made by calling Us at 1 (877) 508-7361.

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. Please 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.

We will provide You with any new or additional evidence or rationale considered in connection with Your Appeal. You will be given a reasonable opportunity to respond prior to the date of a final Internal Appeal decision. If You request an extension in order to respond, We will extend the final decision date for a reasonable amount of time, which will not be less than two days.

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 timeframes 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 review of Adverse Benefit Determinations. When a concurrent expedited review is 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 a panel, the members of which 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 timeframe) 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 panel-level 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, You may contact Our Customer Service department at the phone number listed in the Introduction, or You can write to Our Customer Service department at the following address: Asuris Northwest Health, P.O. Box 30271, Salt Lake City, UT 84130-0271.

ASSISTANCE

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

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

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

Appeal means a written or verbal request from an Insured or, if authorized by the Insured, the Insured's Representative, to change a previous decision made by Us concerning:

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

Expedited Appeal means an Appeal where:

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

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

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

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

Independent Review Organization (IRO) is an independent Physician review organization 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.

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

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

Pre-Service means any claim for benefits under this Policy 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 purpose of 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 purpose of the Appeal. No authorization is required from the parent(s) or legal guardian of an Insured 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.

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 Our Customer Service department at 1 (877) 508-7361 or You can write to Our Customer Service department at the following address: Asuris Northwest Health, P.O. Box 30271, Salt Lake City, UT 84130-0271.

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, please request at the time of submission.

For any complaints involving an Adverse Benefit Determination please refer to the Appeals Process Section within this Policy.

DEFINITIONS SPECIFIC TO THE GRIEVANCE PROCESS

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an enrollee'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 a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate.

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.

Who Is Eligible, How to Apply and When Coverage Begins

This section contains the terms of eligibility under this Policy for a Policyholder and his or her dependents. It also describes when coverage under this Policy begins for You and/or Your eligible dependents. Of course, payment of any corresponding monthly premiums is required for coverage to begin on the indicated dates.

WHEN COVERAGE BEGINS

Subject to meeting the eligibility requirements as stated in the following paragraphs, You will be entitled to apply for coverage for Yourself and Your eligible dependents. Coverage for You and Your applying eligible dependents will begin on the first day of the month following acceptance and approval of the application by Us.

Medicare Enrollee

To be eligible to apply, as a Policyholder, for coverage under this Policy, You must not be enrolled in a Medicare plan. Additionally, any dependent enrolled in a Medicare plan will not be eligible to apply for coverage under this Policy.

Residency Requirement

To be eligible to apply, as a Policyholder, for coverage under this Policy, You must reside in Our Service Area and continue to live in Our Service Area six months or more per Calendar Year. We routinely verify the residence of Our applicants. In order to verify Your current residency status, We may require You to provide Us with copy of:

- the front page of Your most recent income tax return;
- if You are a student, a letter from the college/university registrar noting Your local residence address; or
- alternate documentation as authorized by Us.

For the purpose of maintaining this Policy, the Policyholder must maintain a fixed permanent home within the Service Area. If it is necessary for the Policyholder to leave the Service Area for an extended period of time, the Policyholder may be required to submit appropriate documentation as proof of maintaining his or her primary residence within the Service Area during his or her absence. Treatment received in a Residential Care facility is not considered an eligibility qualification for this Residency Requirement provision.

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

Policyholder

An applicant must agree to the terms of this Policy by submitting a written application for approval and acceptance by Us. The application will be considered to be a part of this Policy. Applicants are eligible to apply under this Policy if they meet the Residency Requirement provision above at the time of application for enrollment. Applications and statements made on the application will be binding on both the applicant and dependents.

Dependents

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

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

- Your (or Your spouse's or Your domestic partner's) child who is under age 26 and who meets any of the following criteria:

  - Your (or Your spouse's or Your domestic partner's) natural child, 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, the child meets the requirements of a Disabled Dependent as defined in the Definitions Section below, 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 or an individual plan issued by Us since that birthday.

Our affidavit of dependent eligibility form is available by visiting Our Web site at **www.Asuris.com** or by calling Our Customer Service department at the number or Web site listed in the Introduction. 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 application to Us. Applications for enrollment of a new child by birth, adoption or Placement for Adoption must be made within 60 days of the date of birth, adoption or Placement for Adoption if payment of additional premium is required to provide coverage for the child. Applications for enrollment of all other newly eligible dependents must be made within 30 days of the dependent's attaining eligibility. Coverage for such dependents will begin on 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 this Policy will be provided for a newborn child for up to 21 days following birth when delivery of the child is covered under this Policy. Such benefits will not be subject to enrollment requirements for a newborn as specified here, or the payment of a separate premium for coverage of the child. Coverage, however, is subject to all provisions, limitations and exclusions of this Policy. No benefits will be provided after the 21st day unless the newborn is enrolled according to the enrollment requirements for a newborn.

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

If You and/or Your eligible dependents have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to enroll (except as specified otherwise below) for coverage under this Policy within 60 days from the date of the qualifying event:

- If You, Your spouse or domestic partner gain a new dependent child or, for a child, become a dependent child by birth, adoption, or Placement for Adoption;
- If You, Your spouse or domestic partner gain a new dependent child or, for a spouse or domestic partner or child, become a dependent through marriage or beginning a domestic partnership;
- Unintentional, inadvertent, or erroneous enrollment or non-enrollment resulting from an error, misrepresentation, or inaction by an officer, employee, or agent of the Washington Health Benefit Exchange (HBE) or U.S. Department of Health and Human Services;
- Can adequately demonstrate that a qualified health plan has substantially violated a material provision of its contract with regard to You and/or Your eligible dependents;
- Become newly eligible or newly ineligible for advance payment of premium tax credits or have a change in eligibility for cost-sharing reductions;
- Lose eligibility for group coverage due to: death of a covered employee, an employee's termination of employment (other than for gross misconduct), an employee's reduction in working hours, an employee's divorce or legal separation, an employee's entitlement to Medicare, a loss of dependent child status, or certain employer bankruptcies;
- Lose coverage as the result of termination of a domestic partnership;
- Permanently change residence, work, or living situation such that a health plan by which You were covered does not provide coverage in Your new service area;
- The plan by which You were covered no longer offers benefits to the class of similarly situated individuals that includes You;
- The HBE terminates Your qualified health plan coverage pursuant to 45 CFR 155.430 and any applicable 3-month grace period expires;
- Exhaust COBRA coverage due to failure of the employer to remit premium;
- Lose COBRA coverage by exceeding the lifetime limit and no other COBRA coverage is available;
- Discontinue high-risk pool coverage;
- The loss of eligibility for Medicaid or a public program providing health benefits;
- Permanently move to a new service area; or
- Loss of minimum essential coverage.

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

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

OPEN ENROLLMENT PERIOD

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

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 this Policy.

DEFINITIONS SPECIFIC TO WHO IS ELIGIBLE, HOW TO APPLY AND WHEN COVERAGE BEGINS SECTION

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

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

Disabled Dependent means a child who is and continues to be both: 1) incapable of self-sustaining employment by reason of developmental disability or physical handicap; and 2) chiefly dependent upon the Policyholder for support and maintenance.

When Coverage Ends

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

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

GUARANTEED RENEWABILITY AND POLICY TERMINATION

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

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

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

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

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

MILITARY SERVICE

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

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

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

NONPAYMENT OF PREMIUM

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

GRACE PERIOD

A grace period of 30 days will be granted for the payment of the regular monthly premium, as prescribed by Us, after payment of the first premium. During this grace period this Policy shall not be terminated, however, if the premium has not been received during the grace period, this Policy shall be terminated at the end of the month for which premium has been paid, not at the end of the grace period.

TERMINATION BY YOU

You have the right to terminate this Policy with respect to Yourself and Your Enrolled Dependents by giving notice to Us within 30 days. Coverage will end on the last day of the calendar month following the date We receive such notice so long as premium has been received for the calendar month. However, it may be possible for an ineligible dependent to continue coverage under this Policy according to the provisions below.

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 calendar month in which his or her eligibility ends so long as premium has been received for the calendar month. However, it may be possible for an ineligible dependent to continue coverage under this Policy according to the provisions below.

Divorce or Annulment

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

If You Die

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

Policy Continuation

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

Termination of Domestic Partnership

If Your domestic partnership terminates after the Effective Date, eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the calendar month following the date of termination of the domestic partnership so long as premium has been received for the calendar month. 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 who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the last day of the calendar month in which the child exceeds the dependent age limit so long as premium has been received for the calendar month.
- For an enrolled child who is no longer eligible due to disruption of placement before legal adoption and who is removed from placement, eligibility ends on the date the child is removed from placement.
- For an enrolled child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the last day of the calendar month in which the child is no longer a dependent so long as premium has been received for the calendar month.

OTHER CAUSES OF TERMINATION

Insureds may be terminated for any of the following reasons:

Fraudulent Use of Benefits

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

Fraud or Misrepresentation in Application

We have issued this Policy in reliance upon all information furnished to Us by You or on behalf of You and Your Enrolled Dependents. In the event of any intentional misrepresentation of material fact or fraud regarding an Insured, We will take any action allowed by law or Policy, including denial of benefits, termination of coverage and/or pursuit of criminal charges and penalties.

MEDICARE SUPPLEMENT

When eligibility under this Policy terminates, You may be eligible for coverage under a Medicare supplement plan through Us. Additional information is available by calling Customer Service at 1 (877) 508-7361.

General Provisions

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

PREMIUMS

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

Premium Charges

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

CHOICE OF FORUM

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

GOVERNING LAW AND BENEFIT ADMINISTRATION

This Policy will be governed by and construed in accordance with the laws of the United States of America and by the laws of the state of Washington without regard to its conflict of law rules. We are a health care service contractor that provides health care coverage to this benefit plan and makes determinations for eligibility and the meaning of terms subject to Insured rights under this benefit plan that include the right to Appeal, review by an Independent Review Organization and civil action.

MODIFICATION OF POLICY

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

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

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

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

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

NO WAIVER

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

NOTICES

Any notice to Insureds required in this Policy 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 Insured will be addressed to the Insured and/or the Policyholder at the last known address appearing in Our records. If We receive a

United States Postal Service change of address form (COA) for a Policyholder, We will update Our records accordingly. Additionally, We may forward notice for an Insured if We become aware that We don't have a valid mailing address for the Insured. Any notice to Us required in this Policy may be given by mail addressed to: Asuris Northwest Health, P.O. Box 30271, Salt Lake City, UT 84130-0271; provided, however, that any notice to Us will not be considered to have been given to and received by Us until physically received by Us.

REPRESENTATIONS ARE NOT WARRANTIES

In the absence of fraud, all statements You make in an application will be considered representations and not warranties. No statement made for the purpose of 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.

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 Policy 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 this Policy, 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 this Policy;
- the person has applied and has been accepted for coverage by Us; and
- premium for the person for the current month has been paid by the Policyholder on a timely basis.

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

WOMEN'S HEALTH AND CANCER RIGHTS

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

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

Definitions

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

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

Allowed Amount means:

- For In-Network Providers (see definition of "In-Network Provider" below), the amount that they have contractually agreed to accept as payment in full for a service or supply.
- For Out-of-Network Providers (see definition of "Out-of-Network Provider" below), the amount We have determined to be reasonable charges for Covered Services or supplies. The Allowed Amount may be based upon the billed charges for some services, as determined by Us or as otherwise required by law.

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

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

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

Custodial Care means care that is for the purpose of 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 for the purpose of separating the patient from others or preventing 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.

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

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 Insured's health, or with respect to a pregnant Insured, 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 a Policyholder's eligible dependent who is listed on the Policyholder's completed application and who has been accepted for coverage under the terms of this Policy by Us.

Essential Benefits are determined by the U.S. Department of Health and Human Services ("HHS") and are subject to change, but currently include at least the following general categories and the items and services covered within the categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.

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, Injury or Illness, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- The Scientific Evidence must show that the Health Intervention is 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. Please contact Us by calling Our Customer Service department or by visiting Our Web site 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.

Family means a Policyholder and his or her Enrolled Dependents.

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 Policy).

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.

In-Network Provider means a Provider that has an effective participating contract and an effective preferred addendum or agreement with Us or one of Our Affiliates (currently serving the states of Idaho, Oregon, Utah, and Washington) that designates him, her or it as a preferred Provider to provide services and supplies to Insureds in accordance with the provisions of this coverage. For In-Network Provider reimbursement, You will not be charged for balances beyond the Deductible and/or Coinsurance for Covered Services.

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

Lifetime means the entire length of time an Insured is covered under this Policy (which may include more than one coverage) with Us.

Medically Necessary or Medical Necessity means health care services or supplies that a Physician or other health care Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating 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 of this Policy, 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.

Out-of-Network Provider refers to Providers that are not In-Network. This term also includes reimbursement for Providers outside the area that We or one of Our Affiliates serves (outside the states of Idaho, Oregon, Utah and Washington). For reimbursement of these Out-of-Network Provider services, You may be billed for balances over Our payment level in addition to the Deductible and/or Coinsurance amount for Covered Services provided inside or outside the area that We or one of Our Affiliates serves.

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

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

Practitioner means an individual who is duly licensed to provide medical or surgical services which are similar to those provided by Physicians. Practitioners include podiatrists, chiropractors, psychologists, 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 his or her respective licenses.

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.

Rehabilitation Facility means a facility or distinct part of a facility that is licensed as a Rehabilitation Facility by the state in which it is located and that provides an intensive, multidisciplinary approach to rehabilitation services under the direction and supervision of a Physician.

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

Service Area means the counties of Adams, Asotin, Benton, Chelan, Douglas, Garfield, Grant, Ferry, Franklin, Lincoln, Kittitas, Okanogan, Pend Oreille, Spokane, Stevens, and Whitman in the state of Washington.

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.