



WOODGROVE FINANCIAL

2023 Summary Plan Description

JUNE 2023 | VERSION 1.0

This Summary Plan Description (SPD) provides details of the health and welfare benefits available to eligible employees and their eligible dependents, as described in this SPD.

2023 Summary Plan Description



Looking for something?

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Introduction

Woodgrove Financial provides industry-leading benefits to help you and your family get and stay well, prepare for your future, and enjoy life's journey. Whether you are expecting a new child, looking for some legal advice for a new home, or managing a health condition, Woodgrove Financial is here to support you with benefits and resources to help you live life well.

This Summary Plan Description (SPD) provides details of the health and welfare benefits available to eligible employees and their eligible dependents, as described in this SPD. Other summary plan descriptions address health and welfare benefits that may be offered to other employees and their eligible dependents.

About the SPD

This document is intended to serve as a Summary Plan Description (SPD) as defined by the Employee Retirement Income Security Act of 1974 (ERISA) for such programs described within that are governed by ERISA. The terms and conditions of the Woodgrove Financial Corporation Welfare Plan (Plan) are set forth in this SPD, in the Woodgrove Financial Corporation Welfare Plan wrap document (the "Welfare Plan"), the Benefits@Woodgrove Financial Program, the Woodgrove Financial Healthcare Reimbursement Plan, the Woodgrove Financial Dental and Vision Care Reimbursement Plan, the Woodgrove Financial Dependent Care Reimbursement Plan, and in the insurance policies and other component plan documents incorporated into the Welfare Plan. The Welfare Plan together with this SPD and the other incorporated documents constitute the written instruments under which the Plan is established and maintained. Where there is an inconsistency or ambiguity between the terms of the Welfare Plan and the terms of a certificate of coverage for insured benefits, the terms of the certificate of coverage control when describing specific benefits that are covered or insurance-related terms. Where there is an inconsistency or ambiguity between the terms of the Welfare Plan and this SPD, the terms of the Welfare Plan control.

Receipt of this document is not a contract

While Woodgrove Financial provides a benefit program for its employees and their eligible dependents, this benefit program does not constitute a contract of or inducement for employment with Woodgrove Financial, nor does it mean future employment for Woodgrove Financial is guaranteed.

Benefits may be amended or terminated

While Woodgrove Financial expects to continue the benefits described in this document, benefits, including employer contributions, may be added, changed, and/or discontinued by Woodgrove Financial at any time. You will be notified of any benefits changes. The benefits featured in this document are listed in the Table of Contents above. The terms of this Plan can be amended in writing only, and cannot be altered, in any manner, by oral statements.

Nothing in this SPD shall be construed to require continuation of this Plan with respect to existing or future participants, dependents, or beneficiaries.

COBRA enrollees

This SPD generally applies to active employees and dependents, as well as individuals who are enrolled in continuation coverage for certain health-related benefits under the Plan through the Consolidated Omnibus Budget Reconciliation Act (COBRA). For COBRA enrollees, there are notations throughout this SPD that call out which benefits or features apply to you. For example:

The following notation generally indicates that a particular section applies to COBRA enrollees:



COBRA enrollees

The following notation generally indicates that a particular section does not apply to COBRA enrollees:



COBRA enrollees

Summary of what's available

Below is a summary of benefits available for active employees/dependents and COBRA enrollees. For detailed information, refer to each section of this SPD.

Benefit	Active employees/dependents	COBRA enrollees
Medical and prescription drugs	Yes	Yes
Vision	Yes	Yes
Dental	Yes	Yes
Flexible spending accounts	Yes	Yes, but see section for details
Other health & wellness benefits	Yes	Yes
Employee and dependent life insurance	Yes	No
Accidental death & dismemberment	Yes	No
Long-term disability	Yes	No
Legal insurance plan	Yes	No
Legal insurance survivor support	Yes	No

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Eligibility

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COBRA enrollees – see section [For COBRA enrollees](#) for applicable information

For employees

You are eligible for the benefits described in this SPD if you are a full- or part-time employee on the Woodgrove Financial U.S. payroll, and are not an intern, visiting researcher, or employee of a Woodgrove Financial retail store. For additional details, review the full definition of [eligible employee](#) and the explanation of [workers who are not eligible](#) for coverage.



You are on the **Woodgrove Financial U.S. payroll** if you are paid from the Woodgrove Financial Payroll department located in the United States and Woodgrove Financial withholds and pays U.S. employment taxes on your payroll

If you meet the following criteria, you are eligible to participate only in the Hawaii Only Plan (Premera) for medical coverage, even if you do not meet the definition of an eligible employee set forth earlier:

- An employee of Woodgrove Financial on the Woodgrove Financial U.S. payroll
- Reside in Hawaii



Additional eligibility requirements may apply to certain benefits. Review the benefit sections of this SPD for more information.

If you are rehired by Woodgrove Financial

If you are rehired by Woodgrove Financial (and again become an eligible employee) during the same plan year and within 30 days of your previous termination of employment, your election in effect at the time of termination will be reinstated. You will not be permitted to make new benefit elections solely based upon the termination and rehire. If more than 30

days have passed since your previous termination of employment, you must reenroll as a new hire and make new benefit elections.

If you transfer from another Woodgrove Financial plan

If you transfer directly from another plan sponsored by Woodgrove Financial without a lapse in coverage, the benefits of this plan will begin without any loss.

If both you and your spouse/domestic partner, or the other parent of one or more of your children, work for Woodgrove Financial

Certain rules apply if both you and your spouse, domestic partner, or the other parent of one or more of your children (regardless of your marital or domestic partnership status) work for Woodgrove Financial and are both eligible for Woodgrove Financial benefit coverage:

- For medical, vision, and dental benefits you may elect *one* of the following coverage options, but not both:
 - You may enroll in your own coverage, OR
 - You may enroll as a dependent in your spouse's/domestic partner's Woodgrove Financial coverage.
- For life insurance and accidental death and dismemberment (AD&D) benefits you have *two* coverage options:
 - You may enroll in your own coverage, AND
 - You may also be enrolled for dependent coverage through your spouse/domestic partner
- If a child is an eligible dependent of two Woodgrove Financial employees, regardless of those employees' current legal marital or domestic partnership status, only one employee can claim the child under child life insurance. Therefore, only one employee should enroll in child life insurance. An eligible child of two Woodgrove Financial employees can be enrolled only under one employee's medical, dental and vision coverage. If such employees have two children, for example, one employee could cover one child and the other employee could cover the other child on their plan.



If you and your spouse/domestic partner both work for Woodgrove Financial and enroll for coverage in the Health Savings Plan (Premera), be sure to review the additional rules that apply to Health Savings Account contributions and eligibility. Review the [Health Savings Account](#) section for more information.

If both you and your parent (or the spouse/domestic partner of your parent) work for Woodgrove Financial

Certain rules apply if both you and your parent (or the spouse/domestic partner of your parent) work for Woodgrove Financial, and you are eligible for Woodgrove Financial benefit coverage both as an employee and as a dependent child:

- For medical, vision, and dental benefits you may elect one coverage option, but not both:
 - You may enroll in your own coverage, OR
 - You may enroll as a dependent in your parent's (or the spouse/domestic partner of your parent's) Woodgrove Financial coverage.
- For life insurance and accidental death and dismemberment (AD&D) benefits you have two coverage options:
 - You may enroll in your own coverage, AND
 - You may also be enrolled for dependent coverage through your parent (or the spouse/domestic partner of your parent)

Workers who are not eligible for coverage

The following persons are not eligible to participate as employees in the plan under this SPD even if they meet the definition of an eligible employee:

- Interns and visiting researchers
- Cooperatives
- Apprentices
- Nonresident aliens receiving no U.S. source income from Woodgrove Financial
- Employees covered by a collective bargaining agreement resulting from negotiations with Woodgrove Financial in which retirement benefits were the subject of good faith bargaining and participation in this plan was not provided for
- Persons providing services to Woodgrove Financial pursuant to an agreement between Woodgrove Financial and any other individual or entity, such as a staff leasing organization (leased employees)
- Temporary workers engaged through or employed by temporary or leasing agencies
- Workers who hold themselves out to Woodgrove Financial as being independent contractors or as being employed by or engaged through another company while providing services to Woodgrove Financial
- Project-based employees. For purposes of the plan, a project-based employee is one who is hired to work on a project or series of projects, is employed for a limited term, and has signed a Project-Based Employment Agreement.
- All other workers who Woodgrove Financial does not classify as being either a full-time or part-time employee on the Woodgrove Financial U.S. payroll, even if that classification is later determined to be incorrect or is retroactively revised.

For dependents

If you enroll for coverage, you may also enroll your eligible dependents for medical, vision, dental, dependent life insurance, and accidental death & dismemberment (AD&D) coverage under the plan.

Your eligible dependents include your:

Spouse

You must be lawfully married (whether the same or opposite sex of the employee) and not legally separated. You will be considered lawfully married if either of the following is true:

- You were married in a state, possession, or territory of the U.S. and you are recognized as lawfully married by that state, possession, or territory of the U.S.; or
- You were married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the U.S. would recognize you as lawfully married.

In no event will the Plan recognize more than one spouse at any time.

Domestic partner	<p>You and your domestic partner (either of the same or opposite sex) must meet all of the following requirements:</p> <ul style="list-style-type: none">• You are each other's sole domestic partner and intend to remain so indefinitely• Neither of you is legally married• You are both at least 18 years of age and are mentally competent to consent to contract• You are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which you legally reside• You reside together in the same residence and intend to do so indefinitely (excepting a temporary residence change of not more than 90 days during which you and your domestic partner reside in separate homes)• You are mutually responsible (financially and legally) for each other's common welfare <p>For life and accidental death & dismemberment (AD&D), a domestic partner includes any person who satisfies the requirements for being a domestic partner, registered domestic</p>
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Your eligible dependents include your:

	partner, or civil union partner of an eligible employee under the law of your jurisdiction of residence.
Dependent children under age 26	<p>Includes your:</p> <ul style="list-style-type: none"> • Biological child and/or your spouse's/domestic partner's biological child • Child for whom you or your spouse/domestic partner has been named legal guardian as appointed by the courts (or recognized as guardian by the state of residence) • Legally adopted child, or child who has been placed with you for adoption, but not a foster child <p>A child's eligibility as a dependent child under age 26 does not rely on the child's financial dependency (on you or any other person), residency with you or with any other person, student status, employment, eligibility for other health plan coverage, or any combination of these factors.</p>
Incapacitated dependent children age 26 or over	<p>An incapacitated dependent is unable to sustain employment due to a developmental or physical disability that existed before the child reached age 26. The individual is chiefly dependent on you for support.</p> <p>Proof of incapacity must be submitted to the plan administrator:</p> <ul style="list-style-type: none"> • For Premera Blue Cross or Kaiser Foundation Health Plan of Washington (KFHPWA), within 90 days of the latest of the child's 26th birthday, your date of hire, or the date that you enroll the child in coverage if the child is already over age 26, and then annually thereafter • For Kaiser Permanente, within 60 days after receiving notice from Kaiser



You may be required to provide evidence of your partnership in connection with a plan audit of dependent eligibility or a claim for benefits. If desired, you may sign the [Woodgrove Financial Affidavit of Domestic Partnership](#) before a notary and retain the affidavit in your records.



Important note about tax consequences of domestic partner benefits

Domestic partners generally do not qualify as spouses or dependents for federal income tax purposes. Therefore, the value of company-provided medical, dental, and vision coverage that relate to your domestic partner, or your domestic partner's children, generally will be considered imputed income and will be taxable to you on each paycheck that the benefits are maintained. This value is subject to change from year to year as the underlying benefit values change. Tax and other withholdings will be made from your paycheck and the value of those benefits will be included in your Form W-2. During any period in which domestic partner benefits that have an imputed income are maintained by you, but you are not receiving a paycheck from the company, the company reserves the right to collect income and the employee FICA tax liability directly from you. These rules will not apply if your domestic partner satisfies the requirements to be considered your tax dependent under the Internal Revenue Code or state tax laws governing state income tax.



Coverage for a child may be provided as the result of a Qualified Medical Child Support Order (QMCSO). This is an order or judgment from a court or administrative body directing the plan to cover the child of a member as required by applicable law. Once the Plan confirms the QMCSO, coverage will begin the first day of the pay period in which the Plan receives the order unless another date is specified in the order. For more information, or to request the requirements for whether an order meets the requirements of a QMCSO, call the Woodgrove Financial QMCSO Service Center (833) 253-4929.

Family members who are not eligible for coverage

The following is a list of dependents who are commonly mistaken as eligible dependents. This is not an all-inclusive list but rather common examples of ineligible dependents:

- Legally separated spouse, regardless of whether you are subject to a court order or agreement requiring you to provide them with health care coverage
- Divorced spouse, regardless of whether you are subject to a court order or agreement requiring you to provide them with health care coverage
- Parents, except as otherwise may be listed elsewhere in the SPD, regardless of whether they live with you and/or depend on you for financial support
- Grandparents, regardless of whether they live with you and/or depend on you for financial support
- Siblings, regardless of whether they live with you and/or depend on you for financial support
- Nieces, nephews, and grandchildren, regardless of whether they live with you and/or depend on you for financial support unless they meet the dependent eligibility definition described above
- Roommates
- Foster children
- Any person who is on active duty in the armed forces
- Anyone else who does not meet the definition of an eligible dependent
- Anyone for whom you fail to provide proof of eligible dependent status, if required or requested

When eligibility ends

Your eligibility for Woodgrove Financial benefits described in this SPD ends with the last day of your employment at Woodgrove Financial or the last day before you fail to satisfy the eligible employee requirements outlined above.

Eligibility for your dependents ends when your eligibility ends, or earlier if your dependent no longer meets the definition of an eligible dependent. Dependent children remain covered on the plan through the end of the month in which they turn 26.

In the event of your death, eligibility for your covered dependents ends:

- The end of the month if you die before the 15th of the month
- The 15th of the next month if you die on or after the 15th of the month



Review the [Coverage if you leave Woodgrove Financial](#) section for information on when coverage ends and your options for continuing coverage.

For COBRA enrollees

You are eligible for the benefits described in the applicable sections of this SPD if and to the extent that you are enrolled in continuation coverage under COBRA, as described in [Continuation of coverage for health and FSA benefits \(COBRA\)](#).



You may be required to provide evidence of your partnership in connection with a plan audit of dependent eligibility or a claim for benefits. If desired, you may sign the Woodgrove Financial Affidavit of Domestic Partnership before a notary and retain the affidavit in your records. To access this form, go to [http://cobra.me.Woodgrove Financial.com](http://cobra.me.WoodgroveFinancial.com) > Reference Center > Woodgrove Financial Affidavit of Domestic Partnership.

Leaves of absence

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COBRA enrollees – the Leaves of absence section does not apply

Health benefits

You may be eligible for medical, prescription drug, vision, and dental benefits while you are on an approved leave of absence as designated by the applicable Woodgrove Financial leave of absence policy.



To learn more about coverage during an approved leave of absence, review the [leave of absence policies](#) on the Benefits site.



Your coverage will remain in effect while you are on a leave of absence that complies with the Family and Medical Leave Act (FMLA).

If your eligibility for health benefits ends while you are on leave of absence (for example, where a personal leave of absence of more than 12 weeks is approved), you and your dependents may be eligible to continue coverage through COBRA provisions. Review the [Coverage if you leave Woodgrove Financial](#) section for more information.

Other benefits

Your eligibility for other benefits during a leave of absence is described below.

Benefit	Eligibility on leave
Health Savings Account	<p>Payroll deductions will continue while you are on a paid leave of absence. For unpaid leaves of absence, unless you change your election, payroll deductions that would have otherwise been taken during that period will be deducted from your first paycheck upon your return to work.</p> <p>You may withdraw HSA funds on a tax-free basis for eligible health care expenses at any time, including during a paid or unpaid leave of absence.</p>
Health FSA	<p>Payroll deductions will continue while you are on a paid leave of absence. For unpaid leaves of absence, payroll deductions that would have otherwise been taken during that period will be deducted from your first paycheck upon your return to work. However, if you are returning from FMLA Leave and you did not continue coverage while on leave, you can instead resume your participation at a reduced level and resume contributions in effect before the FMLA Leave.</p> <p>You may be reimbursed for eligible health care expenses during a paid or unpaid leave of absence.</p>
Dependent care FSA	<p>Payroll deductions will continue while you are on a paid leave of absence. For unpaid leaves of absence, payroll deductions that would have otherwise been taken during that period will be deducted from your first paycheck upon your return to work.</p> <p>Your eligibility to be reimbursed for eligible dependent care expenses depends upon your particular leave situation. For more information, refer to IRS Publication 503.</p>
Spring Health, short-term counseling, resources & referral (employee assistance program (EAP))	<p>You are eligible for EAP coverage while you are on an approved leave of absence, provided that you remain an eligible employee.</p>
Employee and dependent life insurance	<p>You are eligible for employee and dependent life insurance coverage while you are on an approved leave of absence. Payroll deductions will continue while you are on a paid leave of absence. For unpaid leaves, payroll deductions that would have otherwise been taken during that period will be deducted from your first paycheck upon your return to work.</p>
Accidental death & dismemberment (AD&D)	<p>You are eligible for AD&D insurance coverage while you are on an approved leave of absence. Payroll deductions will continue while you are on a paid leave of absence. For unpaid leaves, payroll deductions that would have otherwise been taken during that period will be deducted from your first paycheck upon your return to work.</p>
Long-term disability (LTD)	<p>Tax withholdings on imputed income for LTD continue while you are on paid leave of absence. Taxes are not withheld on imputed income for LTD benefits while on an approved long-term disability leave. If you are on unpaid leave, taxes on imputed income for LTD that would have otherwise been withheld during that period will be deducted from your first paycheck upon your return to work.</p>
Legal insurance	<p>You are eligible for legal insurance while you are on an approved leave of absence. Payroll deductions will continue while you are on a paid leave of absence. For unpaid leaves, payroll deductions that would have otherwise been taken during that period will be deducted from your first paycheck upon your return to work.</p>


If you have other health coverage (Coordination of Benefits)

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 COBRA enrollees – the Coordination of Benefits section applies

How Coordination of Benefits (COB) works

If you or your covered dependents have health benefit coverage through another employer, a government plan or Medicare, your Woodgrove Financial health plan will coordinate payments to ensure the total paid by both plans will not exceed the total amount charged. Review the following section, COB with other health plans, for more information.

If you or your covered dependents receive payments for health care from other sources, such as motor vehicle or liability insurance, your Woodgrove Financial health plan will seek to be reimbursed for benefits paid under the plan or take over your right to receive payments from the other party—this is called subrogation.

Review the [COB with other types of insurance](#) section for more information.

All of your Woodgrove Financial health benefits—medical, prescription drugs, dental, and vision—are subject to these provisions.

Examples
<ul style="list-style-type: none">• Mike works for Woodgrove Financial. His wife, Lee, is covered as a dependent on Mike’s Woodgrove Financial medical plan but also has coverage under her employer’s medical plan. Lee’s plan would provide primary coverage for her and would coordinate benefits with Mike’s plan.• Jen is in a car accident with her kids. They are injured in the accident and incur health care expenses that will be paid by the other driver’s vehicle insurance. The Woodgrove Financial plan will process any remaining expenses after the vehicle insurance has been exhausted per the plan guidelines.

COB with other health plans

The Woodgrove Financial health plan will coordinate coverage with other health plans, including:

- Medicare Part A or B
- A plan sponsored by one or more employers or employee organizations

- A government-sponsored program other than workers' compensation

One health plan determines eligible benefits first and is considered primary and then the other health plan determines its share of the remaining balance and is considered secondary. Woodgrove Financial uses certain rules to determine which plan is primary and which is secondary, as described below.



Health plans provide medical, prescription drug, dental, or vision coverage.

The primary plan is the health plan that pays benefits first.

The secondary plan is the health plan that pays the balance for eligible expenses, subject to its plan benefits and limitations.



Due to IRS regulations, specific rules apply to the Health Savings Account if you have other plan coverage. Review the [Health Savings Account](#) section of this SPD for more information.

If both you and your spouse/domestic partner work for Woodgrove Financial

If both you and your spouse/domestic partner are employed by Woodgrove Financial, you may not enroll for employee coverage and also be enrolled as a dependent on your spouse/domestic partner's coverage. You can each enroll in your own separate coverage with Woodgrove Financial or one of you can enroll as a dependent under your spouse's/domestic partner's coverage. Children may be enrolled as a dependent only on one Woodgrove Financial employee's coverage.

If your spouse/domestic partner is eligible for coverage through another plan

If you enroll your spouse/domestic partner who is eligible for health coverage through their employer, you must notify Woodgrove Financial of your decision to coordinate coverage between that plan and the Woodgrove Financial plan when you enroll. Your spouse/domestic partner can do one of the following:

- Enroll in their employer's health plan and use Woodgrove Financial coverage as the secondary plan at no charge
- Waive the coverage available through their employer and enroll as a dependent on your Woodgrove Financial plan; in this case, you will pay \$75 per pay period to use the Woodgrove Financial plan as your spouse's/domestic partner's primary coverage



This policy affects only employees whose spouse/domestic partner is eligible for health coverage through their employer. It does not affect the following groups:

- Employees who do not have a spouse/domestic partner
- Employees whose spouse/domestic partner is not employed
- Employees whose spouse's/domestic partner's employer does not provide a health plan

- *Employees whose spouse/domestic partner is not eligible for their employer's health plan*
- *Eligible dependent children enrolled in a Woodgrove Financial health plan*
- *Employees and spouses/domestic partners who are both employed by Woodgrove Financial, and one is enrolled as a dependent on the other's plan*

When Woodgrove Financial is primary or secondary

Woodgrove Financial uses the following rules to determine if the Woodgrove Financial plan is primary or secondary to other coverage.

Medicare

In most cases, the Woodgrove Financial plan is primary to Medicare, except if you have been eligible for Medicare due to end stage renal disease for more than 30 months. If you have COBRA continuation coverage under the Woodgrove Financial plan, however, Medicare is primary, except if you have been eligible for Medicare due to end stage renal disease for no more than 30 months. Medicare is also primary if and when you have been on a leave of absence and receiving disability benefits under the plan for at least 6 months. Your Woodgrove Financial plan will coordinate benefits with Medicare as required by federal law.



Visit the online guide Medicare and Other Health Benefits or call the Medicare Coordination of Benefits Contractor (COBC) at (855) 798-2627 (TTY users should call (855) 797-2627) for information about how Medicare coordinates coverage with other health plans.

Other plans

For Woodgrove Financial employees, the Woodgrove Financial plan (other than through COBRA) is always primary to other coverage, including coverage under your spouse/domestic partner's plan, COBRA, Medicaid, or TRICARE medical. COBRA coverage under the Woodgrove Financial plan is always secondary to coverage under your spouse/domestic partner's current employer's plan. Any no-fault medical coverage for motor vehicles and boats, including Medical Payment (MEDPAY), Personal Injury Protection (PIP), Medical Premises (Medprem) for homeowners' or commercial properties or excess accident and athletic policies, will be primary to the Woodgrove Financial plan.

For your spouse/domestic partner who has other coverage, the Woodgrove Financial plan is secondary unless the following conditions apply:

- If your dependent's other coverage is under COBRA, Medicaid, or TRICARE medical, the Woodgrove Financial plan is primary
- If your dependent's other coverage is under a retiree plan which has a COB provision, the Woodgrove Financial plan is primary



Kaiser Permanente will coordinate benefits with the other coverage under the coordination of benefits rules of the California Department of Managed Health Care, which are incorporated in the Evidence of Coverage.

If your dependent child has coverage through another plan

For adult dependent children covered as a subscriber under their own plan or as a dependent on a spouse/domestic partner's plan, the Woodgrove Financial plan will be secondary. In addition, if an adult dependent child is also covered on more than one parent's plan, the rules below will apply for determining the remaining order of liability.

If your dependent child is covered under both parents' plans, order of liability rules apply. For purposes of applying these order of liability rules, a stepparent's plan that covers the child but not a parent will be deemed to cover a parent. Unless a court decree states otherwise, the rules below apply for dependent children covered by Woodgrove Financial and another plan. If a dependent child is covered by individuals other than parents or stepparents, these rules will apply as if those individuals were the parents. When the rules below do not establish an order, the plan that has covered the parent for the longest period of time is the primary payer.

- **Birthday Rule** - When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary.
- When the parents are divorced, separated, or not living together, whether or not they were ever married:
 - If a court decree makes one parent responsible for the child's health care expenses or coverage, that plan is primary.
 - If a court decree assigns one parent primary financial responsibility for the child but doesn't mention responsibility for health care expenses, the plan of the parent with financial responsibility is primary.
 - If a court decree makes both parents responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
 - If a court decree requires joint custody without making one parent responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
 - If there is no court decree allocating responsibility for the child's expenses or coverage, the rules below apply:
 - The plan covering the custodial parent, first
 - The plan covering the spouse/domestic partner of the custodial parent, second
 - The plan covering the non-custodial parent, third
 - The plan covering the spouse/domestic partner of the non-custodial parent, last
- If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.
- When the rules above do not establish an order, the plan that has covered the parent for the longest period of time is the primary payer.



A child of two Woodgrove Financial employees can be enrolled under only one employee's coverage.

How Woodgrove Financial pays for secondary coverage

You and your dependents, as applicable, must follow the rules of the primary plan in order to receive secondary coverage under the Woodgrove Financial plan. When coverage for a particular item or service is denied or reduced under the primary plan, due to a failure to follow the rules of that plan, the Woodgrove Financial plan will pay nothing, even if the Woodgrove Financial plan otherwise generally provides coverage for that item or service.

Example

Lisa works for Woodgrove Financial and her husband, Joe, is covered as a dependent on her plan. Joe's coverage through his employer is his primary plan. Joe's primary plan requires that he obtain a referral before accessing specialty care or the plan pays nothing. If Joe doesn't seek a referral, neither his primary plan nor the Woodgrove Financial plan will pay for the charge. He cannot bypass this referral requirement and submit a charge to the Woodgrove Financial plan as the secondary payer, even if the Woodgrove Financial plan does not have the same requirement for obtaining a



Remember to tell your health care provider whether your Woodgrove Financial plan is primary or secondary to other coverage. This will prevent delays in receiving payment for your benefits.

If the Woodgrove Financial plan is secondary, it will pay its share of any remaining costs within plan guidelines after the primary plan has paid and the deductible in the Woodgrove Financial plan, if applicable, has been met. The plan administrator (Premera, Kaiser Foundation Health Plan of Washington, or Kaiser Permanente) will review the allowable charge for the primary plan and the amount the primary plan paid.

The Woodgrove Financial plan will pay, in total, the lesser of:

- The total amount the Woodgrove Financial plan would have paid if it were primary
- The allowable charge for the Woodgrove Financial plan
- The remaining balance of your provider's bill for services covered by the Woodgrove Financial plan

Payments made by the primary plan will count toward the Woodgrove Financial plan's deductible and coinsurance limits, if applicable, up to the allowed amount under the Woodgrove Financial plan.

Example

Milo works for Woodgrove Financial and his domestic partner, Bo, is covered as a dependent under Milo's plan. Bo's coverage through his employer is his primary plan. Bo has a procedure that is billed at \$1,000. Bo's primary plan has an allowed amount of \$900 for this service and pays the provider. The Woodgrove Financial plan has an allowed amount of only

How to submit a claim for secondary coverage

When obtaining care, your dependents with secondary coverage under the Woodgrove Financial plan will need to do the following:

- Present their employer's plan ID card as primary insurance
- If the provider bills secondary insurance, present the Woodgrove Financial plan ID card as well
- If the provider does not bill secondary insurance, submit the following documents to your plan administrator (Premera Blue Cross, Kaiser Foundation Health Plan of Washington, or Kaiser Permanente):
 - An Explanation of Benefits (EOB) statement from the primary plan
 - For medical services, an itemized bill from the provider, noting the remaining costs after payment from the primary plan
 - For prescriptions, a copy of the pharmacy receipt that includes the drug name and amount paid



Make sure to submit all claims within 12 months, even if no additional payment will be made. This will ensure that your spouse's/domestic partner's claims are applied to your deductible.

The Woodgrove Financial plan will not pay a claim submitted more than 365 days from the date of service. Employee and/or dependents will have 365 days from the date of the primary insurance Explanation of Benefits (EOB) to submit claims to the plan administrator (Premera, Kaiser Foundation Health Plan of Washington, or Kaiser Permanente) for consideration. If you cannot submit the claim in a timely manner due to circumstances beyond your control, the claim will be considered by the plan administrator for payment when submitted as a formal appeal.

If your coverage under the Kaiser Permanente plan is determined to be secondary, Kaiser Permanente might be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during a calendar year to pay for your out-of-pocket expenses for services that are partially

covered by either of your coverages during that calendar year. If you are entitled to a Benefit Reserve Account, Kaiser Permanente will provide you with detailed information about this account.



For assistance with COB, contact your administrator:

Premera	(800) 676-1411	Premera Claim Reimbursement Request Form External Review Request Form Prescription Claim Form
Kaiser Foundation Health Plan of Washington	(888) 901-4636	Medical, Prescription and Vision Claim Form
Kaiser Permanente	(800) 464-4000	Log on to kp.org to process your claims

COB with other types of insurance (Subrogation)

If another party may be liable or legally responsible to pay for a member's care, typically through another insurance plan, the Woodgrove Financial plan will seek to be reimbursed for amounts paid. The Woodgrove Financial plan may choose to:

- Subrogate—that is, take over—the member's right to receive payments from the other party. The member or the member's legal representative will transfer to the plan any rights the member might have to take legal action arising from the illness, sickness, or bodily injury to recover any sums paid under the plan on your behalf or that of your covered dependent. This is the plan's right of subrogation.
- Recover from the member or the member's legal representative any benefits paid under the plan from any payment you or your covered dependent is entitled to receive from the other party. This is the plan's right of reimbursement.

Examples

- Felicia was injured in a car accident. Felicia received payment for related health care expenses through the other driver's auto insurance policy. In this instance, the Woodgrove Financial plan may be able to recover medical expenses paid on the member's behalf from the auto insurer.
- Moliike became ill from food poisoning. He received a payment from the restaurant for related health care expenses through a liability policy. In this instance, the Woodgrove Financial plan may be able to recover medical expenses paid on the member's behalf from the liability policy.



The **other party** or other parties are defined to include, but not limited to, any of the following: The party or parties who caused the illness, sickness, or bodily injury

The insurer or other indemnifier of the party or parties who caused the illness, sickness, or bodily injury The member's own insurer (for example, in the case of Uninsured Motorist [UM], Underinsured Motorist [UIM], medical payments, or no-fault coverage, or, in the case of Personal Injury Protection – PIP, Medical

Payments, or Med Pay)

A workers' compensation insurer

Any other person, entity, policy, or plan that is liable or legally responsible in relation to the illness, sickness, or bodily injury

Other types of insurance that may provide health coverage might include but are not limited to:

- Personal Injury Protection (PIP) coverage
- Motor vehicle medical (Medpay) or motor vehicle no-fault coverage
- Workers' compensation, labor and industry, or similar coverage
- Any excess insurance coverage
- Medical premises coverage
- Commercial liability coverage
- Boat coverage
- Homeowner policy
- School and/or athletic policies
- Other types of liability or insurance coverage

Right of reimbursement and subrogation

The following rules apply to the Woodgrove Financial plan's right of reimbursement and subrogation:

- The Plan has a first priority with respect to its right to reimbursement or subrogation.
- The Plan has the right to 100% reimbursement in a lump sum.
- The Plan is not subject to any state laws or equitable doctrine, including but not limited to the common fund doctrine, which would purport to require the Plan to reduce its recovery by any portion of a covered person's attorneys' fees, and costs.
- The Plan's right to first priority shall not be reduced due to the member's negligence or the member's not being made whole, or attorney's fees and costs, or due to any common fund doctrine.
- Reimbursement must be made to the Woodgrove Financial plan, regardless of whether the judgment, settlement, or other payments allocate any specified amount to reimbursement for medical expenses and regardless of whether such expenses are paid prior to or after the date of such judgment, settlement, or otherwise, and regardless whether the covered person made claim for medical expenses as part of any claim or demand.
- The Plan's recovery and reimbursement amount are recoverable even if the Participant's recovery funds have been commingled with other assets and the Plan may recover from any available funds without the need to trace the source of the funds.
- The Woodgrove Financial plan may seek reimbursement from any recovery, whether by

settlement, judgment, mediation, arbitration, or any other recovery made by or on behalf of:

- A covered dependent
- The estate of any covered member, or
- Any incapacitated member
- The Plan requires the Participant's legal representative or estate to cooperate fully with the Plan and not take any actions that would prejudice the Plan's right of reimbursement.
- The Plan Administrator, in its sole discretion, or the Plan Administrator's delegate, in the exercise of its fiduciary authority, may determine whether to pursue the Plan's rights to reimbursement or subrogation.
- The Plan shall have the right to join or intervene in any suit or claim against a responsible third party brought by Participant or on the Participant's behalf.
- No Participant or his/her representatives may assign any rights or causes of action that they might have against a third-party tortfeasor, person, or entity, which would grant the covered individual the right to recover medical expenses or other damages, without the express, prior written consent of the Plan. The Plan's subrogation and reimbursement rights apply even if the Participant or covered individual has died as a result of their personal injuries and is asserting a wrongful death or survivor claim against the third party under the laws of any state. The Plan's right to recover by subrogation or reimbursement shall apply to any settlements, recoveries, or causes of action owned or obtained by a decedent, minor, incompetent, or disabled person.

Reimbursement will not exceed:

- The amount of benefits paid by the plan for the illness, sickness, or bodily injury, plus the amount of all future benefits that may become payable under the plan that result from the illness, sickness, or bodily injury. The plan will have the right to offset or recover such benefits from the amount received from the other party, and/or
- The amount recovered from the other party, or parties

If the member recovers payments from any of the sources identified above and fails to reimburse the Woodgrove Financial plan, the Woodgrove Financial plan may reduce future benefits by the amount received from the other party, or parties.

Working with the Woodgrove Financial health plan

The member or the member's legal representative must:

- Notify the Woodgrove Financial plan in writing whenever benefits are paid under the Plan that arise out of any injury, sickness or other condition that provides or may provide the Plan subrogation or reimbursement rights.
- Notify the Woodgrove Financial plan in writing of any terms or conditions offered in a settlement before accepting any settlement or recovery on a claim against the other party
- Notify the other party of the Woodgrove Financial plan's interest in the settlement established by this provision
- Cooperate fully with the Woodgrove Financial plan in asserting its subrogation and reimbursement rights
- Provide all information and sign and return all documents necessary to exercise the Woodgrove Financial plan's right under this provision within 14 business days of receiving a request from the Woodgrove Financial plan

If the member or the member's legal representative fails to cooperate fully as described above, they will be personally liable to the Woodgrove Financial plan for the amount paid on the member's behalf.

In the event that the Plan advances moneys or provides benefits for an injury, sickness, or other conditions, and the member recover moneys or benefits from a third party in the amount of the moneys or benefits advance; or in the event that there is a disagreement regarding reimbursement of the Plan's subrogation amount at the time of settlement, the Plan has an equitable lien in connection with such amounts and the member or the member's legal representative agrees to hold any recovered funds in trust or in a segregated account for the benefit of the Plan until the Plan's subrogation and reimbursement rights are fully determined.

Other Reimbursements

If you receive any payment, reimbursement, or refund from any party for any item or service that previously was furnished to you and covered by the Plan, you must notify the Plan as soon as possible. The Plan will have the right to recover from you any and all amounts paid, reimbursed, or refunded that previously were paid or reimbursed by the Plan. To the extent that any such amounts previously were paid by you (e.g., deductibles, coinsurance, or copayments), the Plan still may need to adjust your deductible and/or coinsurance or out of pocket maximum amounts as necessary to account for the subsequent payment, reimbursement, or refund to you.

Noncompliance

If the Participant receives a recovery but does not promptly segregate the recovery funds and reimburse the Plan in full from those funds, the Plan shall be entitled to take action to recover the reimbursement amount. Such action shall include, but shall not be limited to:

- a. Initiating an action against the Participant and/or the Participant's attorneys to compel compliance with this Section;
- b. Withholding or suspending benefits payable to or on behalf of the Participant and the Participant's eligible Dependents until the Participant complies or until the reimbursement amount has been fully paid to the Plan; or
- c. Initiating other appropriate actions.

If the Participant does not reimburse the Plan after receiving the recovery, the Participant shall be responsible for paying the Plan a reasonable interest per month on the reimbursement amount until the Plan receives reimbursement in full.

Conclusion of Claim

Once a Participant has settled or received an award or judgment or any type of recovery on a claim or suit against a responsible third party, the Participant shall hold any proceeds of a recovery in trust until the Plan's rights and interests in such Recovery have been resolved and satisfied.



The Woodgrove Financial plan administrator has the exclusive responsibility and complete discretionary authority to control the operation and administration of this Plan, with all powers necessary to enable it to properly carry out such responsibility, including, but not limited to, the power to construe and interpret the terms of this summary plan description and any other Plan documentation.

Section II: Enrollment

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When you may enroll or make changes



COBRA enrollees – for more information about how to enroll, as well as a link to the COBRA enrollment tool, go to [Continuation of coverage for health and FSA benefits \(COBRA\)](#) section.

You may make benefit elections for you and your eligible dependents using the Benefits Enrollment tool at the following times:

- As a new employee, within 30 calendar days of your hire date
- During the annual open enrollment period in November for coverage effective the following January 1
- If you experience a [qualifying life event](#), you can make limited changes to your benefits during the year

Otherwise, you cannot make changes to your benefit elections until the next annual open enrollment period.



You may use the [Benefits Enrollment tool](#) at any time to review your benefits information and update your beneficiary designations. The Benefits Enrollment tool lists your benefit options, the amount Woodgrove Financial pays for your coverage, and the amount (if any) you pay.



You may make changes to your Health Savings Account contributions at any time on the [Benefits Enrollment tool](#).

How to enroll

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COBRA enrollees – the How to enroll section does not apply

Charge for spouse/domestic partner medical coverage

When you enroll your eligible spouse/domestic partner for benefits, you will need to indicate whether they are also eligible for medical coverage through their employer.

There is no charge if your spouse/domestic partner is not eligible for other medical coverage. However, if they are eligible and waive that coverage, there is an additional charge of \$75 per pay period for coverage in a Woodgrove Financial medical plan.

The charge does not apply if your spouse/domestic partner enrolls for coverage through their employer and you enroll them as a dependent in a Woodgrove Financial medical plan. The Woodgrove Financial plan will coordinate payments to ensure the total paid by both plans will not exceed the total amount charged. Review the [Coordination of Benefits](#) section for more information.

If you do not indicate whether your spouse/domestic partner is eligible for other coverage when you enroll, you will automatically be charged the additional \$75 per pay period. If you and your spouse or eligible domestic partner are both employed by Woodgrove Financial and one of you waives coverage and is enrolled as a dependent under the other employee's coverage, there is no additional charge.

Taxes and your benefits

Certain benefits will be recorded as taxable income, or imputed income, in your paycheck and W-2 statement according to Internal Revenue Service (IRS) regulation, including:

- The value of medical and dental coverage for your domestic partner and children of your domestic partner who are not your tax dependents
- Woodgrove Financial contributions to employee life insurance coverage above \$50,000
- Perks+, or PRO Club membership
- The value of long-term disability coverage

In addition, in certain limited states, Woodgrove Financial contributions and your payroll contributions to your Health Savings Account (with the Health Savings Plan) may be taxable at the state level. Consult with your personal tax adviser for more information.

Waiving coverage

You may waive coverage by signing on to the [Benefits Enrollment tool](#) and electing the waive coverage option during your enrollment period.

If you decide to waive medical or dental coverage, the next opportunity for you to change your coverage options will be during the next annual open enrollment period, unless you experience a qualifying status change as described in the [Qualifying life events](#) section.

What Woodgrove Financial pays for coverage

Woodgrove Financial contributes to the cost of your benefit coverage as follows:

Benefit	Woodgrove Financial
Medical, vision, prescription drug	Woodgrove Financial provides coverage with no monthly premium costs for you and your eligible dependents Woodgrove Financial contributes to your Health Savings Account if you're enrolled in the Health Savings Plan (Premera)
Dental	Woodgrove Financial provides coverage with no monthly premium costs for you and your eligible dependents
Spring Health, short-term counseling, resource & referral. Employee assistance program (EAP)	Woodgrove Financial provides coverage for you and your eligible dependents
Life	Woodgrove Financial provides employee life insurance coverage equal to three times your annual base pay up to a maximum 10 times your annual base pay, up to a maximum of \$4,000,000, whichever is less.
Long-term disability	Woodgrove Financial provides long-term disability coverage equal to 60% of your pre-disability monthly earnings up to a maximum of \$15,000 per month
Perks+	Woodgrove Financial provides the Perks+ benefit, which is considered taxable income to you. The Perks+ benefit allows for up to \$1,500* in reimbursement of program eligible, employee only expenses. If you live in Washington State, you can choose to enroll in Perks+, or the PRO Club. If you elect PRO Club as your Perks+ option for 2023, Woodgrove Financial will pay an annual amount of \$1,570 toward your PRO Club membership. You will be responsible for a \$40/month cost share, withheld on an after-tax basis from your paycheck. This translates into an annual membership value of \$2,050 (\$1,570 paid by Woodgrove Financial + \$480 paid by you). The amount Woodgrove Financial pays for your PRO Club benefit is also considered taxable income.

* New hires and employees newly eligible for Perks+ receive \$1,500 if first hired/eligible between January 1 – June 30, \$750 if first hired/eligible between July 1 – September 30, or \$375 if first hired/eligible between October 1 – December 31.

First-time enrollment

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COBRA enrollees – the First-time enrollment section does not apply

When to enroll

You have 30 days from your hire date to make your benefit elections or waive coverage using the [Benefits Enrollment tool](#). If you do not enroll within this 30-day enrollment period, you will automatically be enrolled in default coverage as described below.



During the enrollment process, you will need to designate beneficiaries for your life, accidental death & dismemberment, and long-term disability benefits.

When coverage begins

You're eligible for benefits on your hire date, and benefit coverage begins as follows:

Benefit	Coverage begins
Medical (including prescription drug and vision)	Your hire date
Dental	Your hire date
Flexible spending accounts (FSAs)	Your hire date
Health Savings Account (HSA)	If your coverage under the Health Savings Plan begins on the first day of the month, your HSA will be effective the same day. If your medical coverage begins after the first day of the month, your HSA becomes effective on the
Spring Health, short-term counseling, resource & referral. Employee assistance program (EAP)	Your hire date first day of the following month.
Employee and dependent life insurance	Your enrollment date (subject to satisfactory evidence of insurability (EOI) and active at work requirements for life insurance).
Accidental death & dismemberment (AD&D)	Your enrollment date

Long-term disability (LTD)	Your enrollment date
Legal insurance	Your enrollment date
Perks+	Your hire date

If you take no action (default coverage)

If you do not enroll or waive benefits through the [Benefits Enrollment tool](#), you will be enrolled only in the default coverage as summarized below. The costs of default coverage are paid in full by Woodgrove Financial and some coverage will result in taxable income to you. Note that default coverage covers only the employee and does not provide coverage for your dependents.



You have 30 days from your hire date to make your benefit coverage elections. Otherwise, your next opportunity to make changes is the annual open enrollment period or if you have a [qualifying life event](#).

Benefit	Default coverage	Taxable income
Medical, vision, prescription drug	Health Savings Plan (Premera) for employees whose principal residence is outside King County, WA, Snohomish County, WA, or Hawaii; Health Connect Plan (Premera) for employees whose principal residence is in King or Snohomish County, WA; or, Hawaii Only Plan (Premera) for employees whose principal residence is in Hawaii	No
Dental	Dental Plus	No
Life	Three times your annual base pay*	Yes
Long-term disability	60% coverage level	Yes
Perks+	Reimbursement up to \$1,500**	Yes

* The minimum coverage amount you may elect is \$50,000. Maximum default is \$750,000 – the highest amount allowable without evidence of insurability. The value of Woodgrove Financial contributions to employee life insurance coverage above \$50,000 is taxable income.

**New hires and employees newly eligible for Perks+ receive \$1,500 if first hired/eligible between January 1 – June 30, \$750 if first hired/eligible between July 1 – September 30, or \$375 if first hired/eligible between October 1 – December 31.

Open enrollment

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COBRA enrollees – the Open enrollment section does not apply

When to enroll

The open enrollment period is in November each year, and it is your opportunity to make changes to your benefit elections, including adding or deleting coverage for your dependents. You may review and submit any changes to your elections on the [Benefits Enrollment tool](#).

If you are on leave during the open enrollment period for the entirety or only a portion of open enrollment, you will be notified of open enrollment by mail. You must submit any changes to your benefit elections via the Benefits Enrollment tool or the enclosed enrollment form before the end of the enrollment period.

Typically, you cannot make changes to your benefit elections outside the annual open enrollment period. However, you can make certain coverage changes during the calendar year if you have a [qualifying life event](#).



Removing a dependent during Open Enrollment is not a COBRA qualifying event so COBRA coverage will not be made available to the dropped dependent when they lose coverage on January 1st. However, if you remove a dependent from coverage during Open Enrollment in anticipation of a future qualifying event (such as a divorce, legal separation, annulment, or dissolution of domestic partnership), the dependent will be deemed to have been enrolled in Woodgrove Financial benefits coverage on the day before the qualifying event, and therefore may become eligible for COBRA coverage after the qualifying event.

When coverage begins

The changes you make during open enrollment are effective the following January 1.

If you take no action

If you do not make changes to your benefit elections through the Benefits Enrollment tool, your current coverage will continue uninterrupted, except your participation in the flexible spending accounts (FSAs) will only continue automatically to the extent you have a

carryover from the prior plan year. In addition, lump sum HSA contribution elections do not continue automatically, and must be elected each year.

Life event enrollment

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COBRA enrollees – for qualifying life event changes, call the Woodgrove Financial COBRA Service Center at (833) 253- 4929. For additional information, go to the [Continuation of coverage for health and FSA benefits \(COBRA\)](#) section.

When to enroll

You can make certain benefit changes outside of open enrollment if you have a qualifying life event as described below. The benefit changes must be consistent with the qualifying life event you experience, as required by Federal law. You may make changes to your Health Savings Account contributions at any time, whether or not you have experienced a qualifying life event.

If you experience one of these status changes, you must make any changes to your benefit elections using the [Benefits Enrollment tool](#) or by contacting Benefits within:

- 30 days of the event that produced the change in status, or
- 60 days of the event for divorce or legal separation, or
- 90 days of the event for a marriage, the establishment of a domestic partnership, birth, or legal adoption (or placement for adoption) of a child or a child of a domestic partner



You may not change your elections in the following benefits outside of the annual open enrollment period:

- Long-term disability (LTD)
- Legal insurance



For active employees, removing a dependent during Open Enrollment is not a COBRA qualifying event so COBRA coverage will not be made available to the dropped dependent when they lose coverage on January 1st. However, if you remove a dependent from coverage during Open Enrollment in anticipation of a future qualifying event (such as a divorce, legal separation, annulment, or dissolution of domestic partnership), the dependent will be **deemed** to have been enrolled in Woodgrove Financial benefits coverage on the day before the qualifying event, and therefore may become eligible for COBRA coverage after the qualifying event.

Qualifying life events

Special enrollment events

Under the Health Insurance Portability and Accountability Act (HIPAA), you may change your medical (including prescription drug and vision) coverage if you lose other coverage or acquire a spouse or dependent. Though not required by HIPAA, Woodgrove Financial allows coverage changes for other benefits, such as dental, health care FSA, dental & vision FSA, dependent care FSA, and arrangements for domestic partners and their children if they are otherwise eligible for coverage. These special enrollment events include:

- Your marriage or establishment of your domestic partnership
- The birth or legal adoption (or placement for adoption) of a child, or a child of your domestic partner
- You or your eligible dependent becomes eligible for assistance under a Medicaid or state child health plan
- The loss of other health coverage by you or your eligible dependent, if not currently enrolled in Woodgrove Financial coverage, due to:
 - The exhaustion of COBRA coverage
 - The loss of eligibility due to change in employment
 - The end of employer contributions, resulting in a higher cost of coverage
 - The loss of eligibility for coverage under a Medicaid or state child health plan

If you experience a special enrollment event, you may make the following changes, as long as these changes are due to and consistent with the reason for the status change:

- Add medical (including prescription drug and vision) or dental coverage for yourself or your eligible dependents
 - **Note:** Adding eligible dependents to your plan or changing your medical plan may result in an increase to your annual deductible and coinsurance maximum. If you have questions, please contact AskHR@WoodgroveFinancial.com.
- Change medical coverage options |
- Begin, increase, decrease, or end participation in the flexible spending accounts (FSAs)
- Add or delete dependent life insurance coverage, except for the special enrollment events of you or your eligible dependent becoming eligible for assistance under a Medicaid or state child health plan, or the loss of other health coverage by you or your eligible dependent
- Increase/decrease employee life insurance coverage, but only in the events of your marriage, establishment of your domestic partnership, or the birth or legal adoption (or placement for adoption) of a child, or a child of your domestic partner
- Add or change between employee and family tier, and/or change the coverage amount, for accidental death and dismemberment (AD&D) coverage, but only in the event of your marriage, establishment of your domestic partnership, birth, or legal adoption (or placement for adoption) of a child, or a child of your domestic partner.

Changes to your benefit elections for these life events will take effect as of the date that you make the election change, except as follows:

- Changes to your medical, dental, and Spring Health employee assistance program coverage will take effect as of the date of the special enrollment event (marriage, birth, legal adoption, etc.). Note that if you become subject to the \$75-per-pay-period charge for spouse/domestic partner medical coverage as a result of the change, that charge will apply prospectively only, for pay periods following the date that you make the election change.
- Changes to add one or more dependents to health care or dental & vision FSA coverage will take effect as of the date of the special enrollment event (marriage, birth, legal adoption, etc.), meaning eligible expenses incurred by the newly added dependent(s) after that date may be reimbursed from the FSA. However, any change in the amount of your FSA election, and resulting payroll contributions, will take effect prospectively only, for pay periods following the date that you make the election change.
- Changes to your employee HSA contributions will take effect as of the first day of the month following the date that you make the election change

Example

Birgit is enrolled in employee only medical coverage on the Health Savings Plan. She has a baby, and within 90 days of the birth adds the baby to her medical coverage on the Health Savings Plan, moving to employee +1 coverage. That new plan tier (employee +1) begins on the baby's date of birth, which means Birgit's annual deductible and coinsurance maximum will increase effective as of the baby's date of birth due to the tier change from employee only to employee +1 coverage.

Example

Yukio is enrolled in medical coverage on the Health Connect Plan with her spouse Chiyo. Yukio has a baby and within 90 days of the birth adds the baby to her medical coverage. She uses this qualifying event to switch from the Health Connect Plan to the Health Savings Plan. Because Yukio, her spouse, and her baby are now enrolled in medical coverage, she has employee +2 coverage on the Health Savings Plan. The new coverage begins on the baby's date of birth, so the applicable Health Savings Plan benefits (including the Health Savings Plan deductible and co-insurance maximum) also begin that day. However, any cost sharing expenses that Yukio and her spouse incurred under the Health Connect Plan for the year, prior to the baby's birth will be credited to the applicable Health Savings Plan deductible and coinsurance maximum for the remainder of the year.

Other life events

If you experience any of the following life events, you may be eligible to make limited benefit changes for yourself or your eligible dependents.

- A divorce, legal separation, or an annulment, or the dissolution of your domestic partnership
- The death of an eligible dependent
- A change in dependent child's status such that they satisfy, or no longer satisfy, the requirements for dependent status

- A change in employment for you or your spouse/domestic partner, even if this change does not affect your eligibility for coverage (gain or loss of job, change in hours worked, taking, or returning from unpaid leave)
- A change of residence for you or your eligible dependent (for example, an interstate transfer that results in a change of eligibility for a medical plan)
- You or your eligible dependent become eligible for Medicare or Medicaid
- The issuance of a qualified medical child support order (QMCSO) with respect to the health coverage for your eligible dependent child
- A significant change in dependent care cost or coverage for you or your spouse/domestic partner



You may be eligible (but not required) to make limited changes for certain life events, but you are required to remove your spouse or domestic partner dependent in the case of a divorce, legal separation, annulment, or the dissolution of your domestic partnership.

If you experience one of these other life events listed above, you may make changes to the following benefits, as long as these changes are due to and consistent with the reason for the status change:

- Add medical (including prescription drug and vision) or dental coverage for yourself
- Add or delete medical (including prescription drug and vision) or dental coverage for your eligible dependents
- Begin, increase, decrease, or end participation in the flexible spending account (FSA). (If you increase your FSA contribution, you may not be reimbursed for eligible expenses beyond your prior contribution if they occurred before the change.)
- Add or delete dependent life insurance coverage, *except* for the special enrollment events of a change of residence for you or your eligible dependent; you or your eligible dependent becoming eligible for Medicare or Medicaid; issuance of a QMCSO with respect to the health coverage for your eligible dependent child; or a significant change in dependent care cost or coverage for you or your spouse/domestic partner
- Increase/decrease employee life insurance coverage, but only in the event of your divorce, legal separation, or annulment, or the dissolution of your domestic partnership
- Add or change between employee and family tier, and/or change the coverage amount, for accidental death and dismemberment (AD&D) coverage, except for the special enrollment events of you or your eligible dependent becoming eligible for Medicare or Medicaid, issuance of a QMCSO with respect to the health coverage for your eligible dependent child, or a significant change in dependent care cost or coverage for you or your spouse/domestic partner.
- Change from PRO Club to Perks+* if you move residences out of the eligible area (Washington State) for PRO Club.

Changes to your benefit elections for these life events will take effect as of the date of the election. The one exception is for changes due to a divorce, legal separation, annulment, or the dissolution of your domestic partnership, which will take effect as of the date of the qualifying event.

*If you become newly eligible for Perks+ between January 1 – June 30 your reimbursement limit is \$1,500. If you become newly eligible between July 1 – September 30 your reimbursable limit is \$750 and if you become newly eligible between October 1 – December 31 your reimbursement limit will be \$375.



In addition to the rules above, if you are in a domestic partnership you may make changes to the dependent care or health care FSA if the change in status affects you or your child or children, but not if the change in status affects your domestic partner or your domestic partner's child or children who are not your tax dependents.

We reserve the right to request or require that you provide documentation proving the qualifying event that supports any benefit change you make under this section.

Examples of consistency rule

The benefit changes you make must be due to and consistent with the reason for the status change, as demonstrated in the following examples. The Benefits Enrollment tool will request information about your life event to determine which benefit changes meet IRS requirements.

Example

Jodi's (a Woodgrove Financial employee) family is covered by benefits through his wife's employer. If his wife loses her job, Jodi may make the following changes to his Woodgrove Financial benefits:

- Enroll or change coverage in medical and dental
- Enroll or increase coverage in the health care FSA
- Change or stop coverage in the dependent care FSA
- Enroll, change, or stop spouse life insurance coverage. Enroll for child life insurance if not previously enrolled
- Enroll or change from employee only to family AD&D coverage.

Changes are not permitted for long-term disability, legal insurance, or Perks+ outside of the annual open enrollment period.

Example

Terika and her partner adopt a baby girl. Terika may make the following changes to her benefits:

- Enroll or change medical plans, and add dependents
- Enroll in dental, and add dependents
- Enroll or increase coverage in the health care FSA
- Enroll or increase coverage in the dependent care FSA
- Enroll or change child life insurance coverage
- Increase/decrease employee life insurance coverage, or add dependent life insurance coverage for the baby
- Enroll or change from employee only to family AD&D

Changes are not permitted for long-term disability, legal insurance, or Perks+ outside of the annual open enrollment period.

Example

Joe contributes to the dependent care flexible spending account (FSA) for his stepson who lives with Joe. If Joe's wife changes from full-time to part-time work, and loses eligibility for medical and dental coverage, Joe can:

- Change his contribution to the dependent care FSA
- Enroll or add dependents to the medical and dental plans
- Enroll or increase health care FSA coverage

Changes are not permitted for long-term disability, legal insurance, or Perks+ outside of the annual open enrollment period.

Section III: Medical and prescription drugs

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Introduction

Woodgrove Financial provides comprehensive medical, vision, and prescription drug coverage for you and your family to help you get and stay well. This introduction provides an overview of these options and common plan terms and conditions. For specific information on the plans available refer to the section on each plan option.

You may not assign your legal rights or rights to any payments under this Plan, nor may you use your right to benefits as security or collateral. A designation of an authorized representative to act on your behalf will not constitute an assignment of benefits under the plan. Notwithstanding the foregoing, the Plan may choose to remit payments directly to health care providers with respect to covered services rendered to you, but only as a convenience to Participants. Health care providers are not, and shall not be construed as, either “participants” or “beneficiaries” under this Plan and have no rights to receive benefits from the Plan under any circumstances.

Your plan options

All Woodgrove Financial employees are eligible to enroll themselves and their eligible dependents for medical coverage, which includes prescription drug and vision coverage. Woodgrove Financial pays the cost of covering you and your eligible dependents on these plans, which means you pay no premiums for coverage.

Where you live determines which plans are available to you—the Health Savings Plan is a national plan (except Hawaii), the HMO and Hawaii Only plans are available only in specific states, and the Health Connect Plan is available only in specific counties in Washington State.

	Health Savings Plan (Premera)	Health Connect Plan (Premera)	Hawaii Only Plan (Premera)	Kaiser Foundation Health Plan of Washington HMO Plan	Kaiser Permanente HMO Plan
Eligible employees	Employees in all states except Hawaii	Employees in Washington (King and Snohomish counties)	Employees in Hawaii	Employees in Washington	Employees in California

If you live in an area with few or no Premera in-network providers, you are eligible for Access coverage in the Health Savings Plan

If you live in an area with few or no Premiera in-network providers, you will be enrolled for Access coverage in the Health Savings Plan. Access coverage provides in-network coverage for care with providers and facilities outside the Premiera network. Network availability is determined by the Premiera and national Blue Cross Blue Shield standard criteria. This coverage will remain in effect until a provider network is established in your area.

All of our medical plans cover services as long as they are medically necessary and provided by an eligible provider. All of the benefits for each medical plan are subject to the plan's exclusions and limitations and

each benefit may have additional eligibility criteria and exclusions and limitations. Review the following sections for each medical plan for more information on what is covered.

Visit the [vision](#) section for information about your vision coverage, which is determined by the medical plan you choose.



Medically necessary services or supplies meet certain criteria, including:

- It is essential to the diagnosis or the treatment of an illness, accidental injury, or condition that is harmful or threatening to the patient's life or health, unless it is provided for preventive services when specified as covered under the plan
- It is appropriate for the medical condition as specified in accordance with authoritative medical or scientific literature and generally accepted standards of medical practice

Review the [glossary](#) for a full definition.

How the plans work

All of the medical plans cover preventive care at 100% with in-network providers. For other care, you pay a share of the costs up to an annual maximum amount.

Each medical plan features a comprehensive network of providers and facilities where you may receive care at lower, negotiated rates. The HMO plans do not typically cover out-of-network care. The Health Savings Plan, Health Connect Plan, and Hawaii Only Plan cover in- or out-of-network care but provide more value if you use in-network providers.

In-network vs. out-of-network care

If you enroll in the Health Savings Plan, Health Connect Plan, or Hawaii Only Plan you receive the highest level of coverage and have the lowest out-of-pocket costs if you seek care from any of the providers or facilities in your medical plan's network. Additional advantages of staying in-network include:

- Your provider files claims for you directly with Premera



• Lower, negotiated rates for care and prescriptions, called the allowable charge

- Your provider accepts the allowable charge as payment in full; you are not charged any additional costs

The **allowable charge** generally is the negotiated amount that in-network providers have agreed to accept as payment in full for a covered service. Out-of-network providers may not accept the allowable charge as payment in full.

Note: The Plan will not discriminate against a health care professional or facility that acts within the scope of its license or certification under applicable state laws when choosing in-network health care professionals and facilities.

If you obtain care from an out-of-network provider or facility, services generally are covered at a lower out-of-network benefit level. Except as provided under Federal Surprise Billing Protection, the allowable charge is the least of the three amounts shown below:

- An amount that is no less than the lowest amount we pay for the same or similar service from a comparable in-network provider
- 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
- The provider's billed charges

The allowable charge may be adjusted pursuant to Premera's payment policies. For more information or assistance in determining whether or how Premera's payment policies may impact the allowable charge for a particular claim, contact Customer Service at (800) 676-1411.

Review the [glossary](#) for a full definition.

Additional considerations include:

- You may have to pay the provider and submit a claim for reimbursement
- Coverage under the plan is limited to the allowable charge; you are responsible for any amount the provider charges above the allowable charge, where applicable

Below is an example of how much you can save through the negotiated rates that you receive with in-network providers.

Out-of-network charge, subject to deductible	In-network charge (allowable charge), subject to deductible	In-network provider savings
\$150	\$100	\$50

Federal No Surprise Billing Protection

Out-of-network providers generally have the right to charge you more than the Plan's allowed amount or allowable charge for a covered service. This is called "balance billing." However, Federal law protects you from balance billing for the following types of services:

- Emergency Care from an out-of-network hospital or independent freestanding emergency department.
- Out-of-network air ambulance services
- Any services from an out-of-network provider at an in-network hospital, hospital outpatient department, critical access hospital, or outpatient surgical center, provided that the out-of-network provider may balance bill you if the provider gives you advance notice and you provide your written consent, except for the following services (for which balance billing is never permitted):
 - Surgery
 - Anesthesia
 - Pathology
 - Radiology

- Laboratory
- Hospitalist Care

Solely for purposes of determining your cost-sharing obligations for these services, the allowed amount or allowable charge is the lesser of (1) the out-of-network provider's or facility's billed charges, or (2) the Plan's median in-network rate for the same or similar service provided in the same or similar specialty in the same geographic area (or any other amount specified for this purpose under applicable law).

Please Note: These balance billing protections do not apply to any other service from an out-of-network provider or facility. If the service is not listed above, the provider or facility may bill you for, and you may be required to pay, any amounts in excess of the plan’s allowed amount for the service (and any amounts that you pay in excess of the allowed amount will not count toward any applicable deductible, coinsurance, or out-of-pocket maximum).

Plan comparison

The table below compares the four medical plans on various characteristics. For complete details, review the following sections on each medical plan.

	Health Savings	Hawaii Only Plan	Health Connect Plan (Premera)	Kaiser Foundation Health Plan of Washington	Kaiser Permanente HMO Plan
Deciding where to get care	<ul style="list-style-type: none">You decide each time you need medical care whether to use providers who are in-network or providers who are out-of-networkWhen you need care, you can choose your doctors, including specialists. You do not need a referral to receive care.		<ul style="list-style-type: none">You will be asked (but not required) to choose a Primary Care Provider from the Health Connect network for each covered family member. Your Primary Care Provider works to understand your health care needs and goals and helps coordinate your care.When you need care, you can choose your doctors, including specialists. You do not need a referral to receive care.	<ul style="list-style-type: none">You will be required to select a Primary Care Provider for each covered family member.Your Primary Care Provider directs your care, including referrals to specialists.	

Health Savings	Hawaii Only Plan	Health Connect Plan (Premera)	Kaiser Foundation Health Plan of Washington	Kaiser Permanente HMO Plan
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In-network vs. out-of- network	<ul style="list-style-type: none"> Your out-of-pocket costs vary depending on whether you use in-network providers or out-of-network providers. Your costs are lower when you use an in-network provider. 	<ul style="list-style-type: none"> By utilizing the services of a provider in the Health Connect Network, you get the highest benefit coverage level (and therefore typically pay lower out-of-pocket costs). You can also see a provider in the Extended Network, but your out-of-pocket costs may be higher unless you get a referral from your PCP. You'll pay the most out-of-pocket when you see an out-of-network provider. 	<ul style="list-style-type: none"> Benefits are generally available only when utilizing the services of the HMO network providers. With few exceptions, out-of-network care is not covered.
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	Health Savings Hawaii Only Plan	Health Connect Plan (Premera)	Kaiser Foundation Health Plan of Washington	Kaiser Permanente HMO Plan
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Cost sharing	<ul style="list-style-type: none"> Preventative care is covered and paid in full, when using in-network providers. You pay 100% of your eligible expenses for medical care and prescriptions until you spend up to the amount of the deductible. If you reach the deductible, then you begin to pay a portion of the cost, called coinsurance, up to the coinsurance maximum. The coinsurance amount you pay depends on whether you seek care in or out-of-network. If you meet your deductible and then you reach your coinsurance maximum, the plan pays 100% of eligible expenses for the rest of the year. 	<ul style="list-style-type: none"> Preventative care is covered and paid in full, when using Health Connect and Extended network providers. If utilizing a Health Connect network provider, you only pay a copay for many common services such as office visits, prescriptions, and ER visits. For other services, such as hospital care and diagnostic testing, you pay coinsurance. If you see providers in the Extended network or out-of-network, you will be subject to a deductible as well as copays and coinsurance, so your out-of-pocket costs may be higher. Regardless of which providers you see, if you meet your out-of-pocket maximum, the plan pays 100% of eligible expenses for the rest of the year. 	<ul style="list-style-type: none"> Preventive care from an HMO network provider is covered and paid in full. For most services, you pay a flat copayment If you have an inpatient hospital stay, you pay 10% of the cost If you meet your out-of-pocket maximum, the plan pays 100% of eligible expenses for the rest of the year. 	<ul style="list-style-type: none"> Preventive care from an HMO network provider is covered and paid in full. For most services, you pay a flat copayment If you have an inpatient hospital stay, you pay 10% of the cost Coinsuranc e and most copayment s are limited by an annual out-of-pocket maximum
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Filing a claim	<ul style="list-style-type: none">• If using in-network benefits, your provider will file claims to the health plan on your behalf.• If using out-of-network benefits, you may be required to file a claim for reimbursement of the medical expenses.	<ul style="list-style-type: none">• If using a provider in the Health Connect or Extended Networks, your provider will file claims with the health plan on your behalf.• If using out-of-network benefits, you may be required to file a claim for reimbursement of the medical expenses.	Generally, no claim forms required.
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	Health Savings	Hawaii Only Plan	Health Connect Plan (Premera)	Kaiser Foundation Health Plan of Washington	Kaiser Permanente HMO Plan
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Coverage out of the country	<ul style="list-style-type: none"> Urgent or emergent services will be paid as emergency care. Non-emergent facility and professional services are considered out-of-network and covered at 70% of billed charges. Standard deductible and coinsurance apply. 	<ul style="list-style-type: none"> Urgent or emergent services will be paid as emergency care, subject to the emergency room \$250 copay (waived if admitted). Non-emergent facility and professional services are considered under the Extended network and covered at 60% of billed charges. Standard deductible and coinsurance would apply. 	<ul style="list-style-type: none"> Emergency situations that occur outside the country are covered as in-network. There is also a \$2000 benefit per member per year for non-emergent claims incurred outside the area.
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Deductible is the amount of covered medical costs you must pay each calendar year before the Plan begins to pay its share of allowable charges.

Copayment is a fixed, up-front dollar amount that you're required to pay for certain covered services.

Coinsurance The percentage of the allowable charge that you are required to pay for certain covered services.

Out-of-pocket maximum is the most you could pay each plan year for covered services and supplies.



If you leave Woodgrove Financial, you may be eligible to continue your health coverage. For more information, visit the [Coverage if you leave Woodgrove Financial](#) section.

Health Savings Plan (Premera)

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How the plan works

The Health Savings Plan provides comprehensive medical coverage and the flexibility to see any provider you choose.

This plan features a Woodgrove Financial-funded [Health Savings Account](#) that you can use to cover eligible health care expenses. Here’s how they work together:

- The Health Savings Plan is your **health coverage**, and provides coverage for health care that you might need during the year
- The Health Savings Account is basically a **bank account** that comes with certain tax benefits when you use it to pay for health care expenses now, or in the future

Where you can get care

With the Health Savings Plan, you have the flexibility to visit the provider or facility you choose and still have coverage. However, providers in the nationwide Premera Blue Cross Blue Shield network feature certain advantages, including:

- Your provider files claims directly with Premera
- Lower, negotiated rates for care and prescriptions
- The highest coverage levels


If you seek care with an out-of-network provider or facility, your out-of-pocket costs will be higher, and you may have to pay the provider and then submit a claim for reimbursement.

Review the [What you pay](#) section for information on coverage levels.

Finding an in-network provider

In Washington State, you can maximize your savings by using providers and facilities in the Premera network. In California, we have made an arrangement for you as a Premera Blue Cross member with Anthem Blue Cross. In order for you to maximize your in-network savings for services received in California, you will need to choose only Anthem Blue Cross network providers. Note: Blue Shield of California network providers are not considered in-network for purposes of the Health Savings Plan, unless (and to the extent) that they are also Anthem Blue Cross network providers.

Outside of Washington and California, you may use any Blue Cross and/or Blue Shield provider throughout the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands under the [BlueCard®](#) Program. Your Premera identification card tells contracting providers that you are covered through this inter-plan arrangement. It's important to note that receiving services through BlueCard does not change covered benefits, benefit levels, or any stated residence requirements of this plan.




Visit the online Premera Medical Directory to find an in-network provider in the United States or call Premera Blue Cross at (800) 676-1411.

Active employees go here...	Active dependents or COBRA enrollees go here...
Premera Medical Directory	Premera.com

Travel outside the United States

If you are traveling outside the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands and need care, you may be able to take advantage of [Blue Cross Blue Shield Global Core](#), which provides referrals to doctors and other health care providers.



Call (800) 810-BLUE (2583) for Blue Cross Blue Shield Global Core referrals to health care providers outside the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands.

If you are not using a Blue Cross Blue Shield Global Core provider, you will need to submit claim forms to Premera for reimbursement of services received outside the United States. When you submit a claim, clearly detail the services received, diagnosis (including standard medical procedure and diagnosis code, or English nomenclature), dates of service, and the names and credentials for the attending provider.

Benefits reimbursement will be calculated in U.S. dollars.

Care received outside the United States will be covered as long as the services are:

- Medically necessary
- Provided by a licensed provider performing within the scope of their license and practice
- Not deemed experimental or investigational based on the terms of this plan or medical standards in the United States

Services received outside the United States that are considered urgent or emergent including services received on a cruise ship will be paid as [emergency care](#). Non-emergent facility and professional services are considered out-of-network and covered at 70% of billed charges. Standard deductible and coinsurance would apply.



Experimental or investigational services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#) for a full definition.



Review the [What you pay](#) section for information on coverage levels.

Filling a prescription

Depending on your needs, you may fill your prescription at a retail pharmacy, pharmacy home delivery, or specialty pharmacy. Review the [prescription drug](#) benefit for more information on what is covered.



Woodgrove Financial reserves the right to change pharmacy networks at any time. Such changes will take effect on the date set by the Company, even if this information has not been revised to show the changes.

	Retail pharmacy	Home delivery	Specialty pharmacy
Coverage	Up to a 90-day supply for generic maintenance medication ; all others are up to a 30-day supply*	Up to 90-day supply* only when using Express Scripts Pharmacy Home Delivery	Up to a 30-day supply* Additional clinical support for members using specialty drugs
In-network pharmacies	Express Scripts pharmacies bill the plan on your behalf To find an Express Scripts retail pharmacy, call (800) 676-1411	Express Scripts pharmacies bill the plan on your behalf	AllianceRx Walgreens Pharmacy or Accredo Specialty Pharmacy** will bill the plan on your behalf
Out-of-network pharmacies	You will need to submit a prescription reimbursement form, with your receipt, for reimbursement	Not covered	Not covered

* Unless the drug maker's packaging limits the supply in some other way.

** Contact AllianceRx Walgreens Pharmacy at (877) 223-6447 or Accredo Specialty Pharmacy at (800) 689-6592 to get started.

The dispensing limits (or days' supply) for drugs dispensed at retail and specialty pharmacies, and through the mail-order pharmacy benefit, are described in the chart above.

Refills for a medication will be covered only when the member has used 75% of the supply of that medication, based on both of the following:

- The number of units and days' supply dispensed on the last fill or refill, and
- The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill, if applicable



A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.

Generic maintenance medications have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year. A generic prescription drug is manufactured and distributed after the brand-name drug patent of the innovator company has expired and is available at a lower cost than brand-name prescriptions. Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration and are considered by the FDA to be therapeutically equivalent to the brand-name product.

Specialty drugs are high-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply.

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended for some services and prescriptions to determine that coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Refer to the specific plan benefit for additional details.

What you pay

You pay nothing for preventive care when you use in-network providers. When you receive care or prescription drugs in other situations, such as for the treatment of illnesses, injuries, and chronic conditions, you pay a portion of the cost up to an annual maximum amount. That annual amount, called your out-of-pocket maximum, includes a deductible and coinsurance. If you use in-network providers, you'll receive the lower Premera-negotiated rate, called the allowable charge, and higher coverage levels. Examples of how the plan pays for in- and out-of-network care follow on the next page.

Premera utilizes medical and payment policies in administering coverage under this plan. The medical policies generally are used to further define medical necessity, experimental and investigative status, and other aspects for specific procedures, drugs, biologic agents,

devices, and other items and services and levels of care. These medical policies are available at <http://premera.com> or by calling Customer Service. The payment policies are used to define provider billing and payment rules and adjustments that can apply in various different settings and circumstances. These payment policies are available to you by calling Customer Service and to your provider by calling Customer Service or going to <http://premera.com> and logging into Premera's provider portal.

What you pay			
	Deductible	+ Coinsurance	= Out-of-pocket maximum
	<p>You pay 100% of your eligible expenses for medical care and prescriptions until you spend up to the amount of the deductible. Only the Premera allowable charge is applied to your deductible if you seek out-of-network care. You pay nothing for in-network preventive care.</p>	<p>If you reach the deductible, then you begin to pay a portion of the cost, called coinsurance, up to the coinsurance maximum. The coinsurance amount you pay depends on where you seek care:</p> <ul style="list-style-type: none">• In-network, you pay 10%• Out-of-network, you generally pay 30% of the allowable charge plus the difference between the provider's bill and the allowable charge; only the allowable charge is applied to your coinsurance maximum	<p>If you meet your deductible and then you reach your coinsurance maximum, you have reached your out-of-pocket maximum. From that point forward, the plan pays 100% of eligible expenses and you pay nothing for in-network health care services for the rest of the year. You will still be responsible for the difference between the provider's bill and the allowable charge if you seek out-of-network care.</p>
	\$1,500	\$1,000	\$2,500
	\$3,000	\$2,000	\$5,000
	\$3,750	\$2,500	\$6,250
Employee only			
Employee +1			
Employee +2 or more			



The allowable charge is defined differently for in-network and out-of-network providers.

- For in-network providers, the allowable charge is the negotiated amount that the provider has agreed to accept as payment in full for a covered service.
- For out-of-network providers, the allowable charge is the lowest of three amounts, as outlined in the definition of “allowable charge” in the Glossary. If you choose to use out-of-network providers, you may be responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges.

Example

Jakob needs to visit his allergist. He can choose an in-network or an out-of-network provider. Both charge \$115. Assume the allowable charge is \$100 for both the in-network and out-of-network provider.

The in-network provider accepts Premera’s allowable charge of \$100 as full payment. Jakob hasn’t yet met his deductible, so he will pay the allowable charge of \$100 to his in-network provider.

The out-of-network provider does not have the negotiated agreement with Premera, so Jakob would pay the full

Example

Mimi needs to see her podiatrist. The visit costs \$125. Mimi has met her deductible, so she'll pay just \$10 for her visit if she uses an in-network provider with a \$100 allowable charge ($\$100 \times 10\%$ coinsurance). If she visits an out-of-network provider, for whom the allowable charge is also \$100, she would pay \$55:

- 30% of the \$100 Premera allowable charge ($\$100 \times 30\%$ coinsurance = \$30)
- Plus, the difference between the out-of-network provider's bill and the allowable charge ($\$125 - \$100 = \$25$)

Example

Kunji has an ear infection. The provider visit costs \$175 and assume the allowable charge is \$150 for both an in-network and out-of-network provider. Kunji has met her out-of-pocket maximum, so she'll pay nothing if she visits the in-network provider.

If she visits the out-of-network provider, she'll pay \$25, the difference between the out-of-network provider's bill and the allowable charge ($\$175 - \$150 = \$25$).

Expenses covered at 100% NOT applied to the deductible or coinsurance maximum

The following services are covered by the plan at 100% and do not count toward the deductible or coinsurance maximum.

- Preventive care
- Care received through the [Spring Health, Employee Assistance Program \(EAP\)](#).

Certain other expenses are your responsibility to pay and do not count toward the annual deductible or coinsurance maximum. They include:

- Expenses incurred while the member was not covered under the plan
- Expenses for services, supplies, settings, or providers that are not covered under this plan
- Expenses in excess of annual or lifetime benefit maximums that apply to certain plan benefits. Amounts for out-of-network care in excess of the allowable charge for the service or supply.
- Coinsurance for services covered under the [Weight Management program](#)

Additionally, charges for medical services received during business travel that are applied to the deductible or coinsurance are not reimbursable business expenses.



Review information on how to track your deductible and/or coinsurance.

Active employees go here...

[My Dashboard](#) on the Benefits site

Active dependents or COBRA enrollees go here...

[Premera.com](#)

Out-of-network care with in-network coverage

You may seek out-of-network care and receive in-network coverage levels in the following situations:

Situation	Benefit coverage	What you need to do
Emergency care	Benefits are provided regardless of network status	Go to the nearest emergency facility
You cannot find the provider specialty that you need in the Premera network	If the Premera network does not include a provider specialty (such as a speech therapist) anywhere in your state, treatment at out-of-network providers may be paid at the in-network level	To confirm this coverage is available, contact Premera at (800) 676-1411
Your provider's contract with Premera is ending (continuity of care)	If you are receiving ongoing treatment for certain serious and complex medical conditions or illnesses, or pregnancy, are undergoing institutional or inpatient care, or are scheduled for nonelective surgery, you may be eligible to continue to receive in-network benefits for the current course of treatment, for up to 90 days.	To confirm this continued in-network coverage is available, and the length of the available in-network coverage extension, contact Premera at (800) 676-1411 prior to the end of your provider's contract with Premera

Annual, lifetime, and other benefit maximums

There is no overall annual or lifetime maximum in the Health Savings Plan. However, annual, lifetime, and other benefit maximums apply to certain benefits. Review the [What the plan covers](#) section for details on annual, lifetime, and other benefit maximums.



A **lifetime benefit maximum** is the most a plan will pay toward a benefit for a member. Review the [glossary](#) for a full definition.

An annual or other benefit maximum is the most a plan will pay toward a benefit for a member for services within a specified time period. Review the [glossary](#) for a full definition.

Example

There is a \$6,000 weight management program benefit maximum for the duration of the member's continuous enrollment in one or more Premera-administered health plan options.

Example

There is a \$10,000 hearing hardware maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in one or more Premera-administered health plan.

Utilization Management

All benefits under this plan are limited to covered services that are medically necessary and as set forth under Plan Benefits. Premera or its designee may review a member's medical records for the purpose of

verifying delivery and coverage of services and items. Based on a prospective, concurrent, or retrospective review, Premera may deny coverage if, in its determination, such services are not medically necessary or do not meet all criteria specified in this SPD. Such determination shall be based on established clinical criteria as described in Premera's medical policies. The medical policies are on Premera's website. You or your provider may review them at premera.com. You or your provider may also request a copy of the criteria used to make a medical necessity decision for a particular condition or procedure. To obtain this information by mail, send your request to Medical Policies Coordinator, 7001 220th Street SW MS 438, Mountlake Terrace, WA 98043-2160.

Premera will not deny coverage retroactively for services it has previously authorized and that have already been provided to the member except in the case of fraud or an intentional misrepresentation of a material fact.

What the plan covers

The tables below summarize what the Health Savings Plan covers, including what the plan pays for in- network and out-of-network care.



Services and supplies must be medically necessary and are subject to all benefit exclusions and limitations and the plan's [exclusions and limitations](#).



CTRL+Click on the benefits below to access more information.

Common benefits

These are the most commonly used benefits in the Health Savings Plan.

Benefit	In-network coverage	Out-of-network coverage
Preventive Care Including well-child care through age 18, routine gynecological exams, immunizations and preventive prescription drugs (See the Preventive Care Services list and Preventive Drug list)	Preventive services: 100% Preventive prescription drugs: 100%	Preventive services: 100% of allowable charges Preventive prescription drugs: 100%
Prescription drugs Including brand-name preventive with available generic equivalent (see the Health Savings Plan Drug Formulary and preventive care above)	90% after deductible	90% after deductible

<p>Physician services</p> <p>Including specialists and second surgical opinions rendered in the office, hospital, or other medical facility</p>	<p>90% after deductible</p>	<p>70% of allowable charges, after deductible</p>
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Common benefits		
These are the most commonly used benefits in the Health Savings Plan.		
Benefit	In-network coverage	Out-of-network coverage
Diagnostic services Benefits are provided for diagnostic services (including lab and imaging services) for health conditions or symptoms.	90% after deductible	90% of allowable charges, after deductible
Hospital inpatient care Including semi-private room and board, anesthesia, supporting services, testing, supplies, and intensive or coronary care	90% after deductible	70% of allowable charges, after deductible
Hospital outpatient care/ambulatory surgical care center Including minor surgery, X-ray and radium therapy, anesthesia, and pre-admission testing	90% after deductible	70% of allowable charges, after deductible
Urgent Care	90% after deductible	70% of allowable charges, after deductible
Rehabilitation – Physical, Occupational and Speech Therapies	90% after deductible	70% of allowable charges, after deductible
Contraception Contraceptive devices and injections administered by a physician. Prescription forms of contraception are covered under preventive care.	100%	100%
Maternity care (Other than hospital inpatient or outpatient care)	90% after deductible	70% of allowable charges, after deductible

Common benefits		
These are the most commonly used benefits in the Health Savings Plan.		
Benefit	In-network coverage	Out-of-network coverage
Maternity support	Free virtual care and on-demand support (through Maven Clinic) for new and expecting parents.	Not applicable
Mental health counseling, mental health inpatient and outpatient services, and chemical dependency treatment	Outpatient services through Spring Health administrator for the employee assistance program : <ul style="list-style-type: none"> 100% of 24 sessions per calendar year 	Not applicable
	90% after deductible for inpatient and outpatient services	90% of allowable charges, after deductible for inpatient and outpatient services

Other benefits		
The Health Savings Plan also covers these additional benefits.		
Benefit	In-network coverage	Out-of-network coverage
Ambulance (Ground or Water)	90% after deductible	90% after deductible
Air Ambulance	90% after deductible	90% of allowable charges, after deductible
Chiropractic services, acupuncture, and medical massage	90% after deductible	70% of allowable charges, after deductible
	Combined 24-visit limit per member per calendar year	
Diabetes health education	100%	100% of allowable charges
Emergency room care and professional services	90% after deductible	90% of allowable charges, after deductible
Hearing care and hardware	Exams: 90% after deductible	Exams: 70% of allowable charges, after deductible
	Hardware: 90% after deductible; \$10,000 maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in one or more Premera-administered health plan options	
Home health care	90% after deductible	70% of allowable charges, after deductible
Hospice care	90% after deductible	90% after deductible
Medical equipment and supplies	90% after deductible	90% of allowable charges, after deductible

Other benefits		
The Health Savings Plan also covers these additional benefits.		
Benefit	In-network coverage	Out-of-network coverage
Nutritional therapy	100%	100% of allowable charges
	First 12 visits per member per calendar year, calendar year visit limit waived for nutritional therapy for a diagnosed eating disorder or diabetes.	
Skilled nursing facility	90% after deductible	70% of allowable charges, after deductible
	120-day limit per member per calendar year	
Surgical weight loss treatment Covered when criteria listed in the Premera Medical Policy on Surgery for Morbid Obesity are met	90% after deductible	70% of allowable charges, after deductible
Temporomandibular joint (TMJ) dysfunction	90% after deductible	70% of allowable charges, after deductible
Transplants	90% after deductible	70% of allowable charges, after deductible
Vision therapy	90% after deductible	70% of allowable charges, after deductible
	32-visit maximum, per member, for the duration of the member's continuous enrollment in one or more Premera-administered health plan options	

Specialized benefits		
Woodgrove Financial provides these unique benefits to you through the Health Savings Plan.		
Benefit	In-network coverage	Out-of-network coverage
Autism/Applied Behavior Analysis (ABA) therapy	90% after deductible	90% of allowable charges, after deductible
Infertility	90% after deductible for coverage, within the Plan's infertility vendor (Progyny) provider network, of generally two Smart Cycles per household per Plan enrollment lifetime, and one additional Smart Cycle if neither of the first two results in a successful pregnancy	Not applicable
bookmark://_transgender_services/Gender Affirming services	90% after deductible	90% of allowable charges, after deductible

Specialized benefits		
Woodgrove Financial provides these unique benefits to you through the Health Savings Plan.		
Benefit	In-network coverage	Out-of-network coverage
Weight Management program Including comprehensive and clinically based weight management programs approved by Premera for the treatment of obesity	80% of charges up to a \$6,000 maximum for the duration of the member's continuous enrollment in one or more Premera-administered health plan options. Deductible and coinsurance maximum do not apply. The 20% coinsurance you pay will not count toward the deductible or coinsurance maximum and will continue after the deductible and coinsurance are met.	Not applicable

Plan benefits



The following pages provide details on what the plan covers. The plan's [exclusions and limitations](#), including the requirement of medical necessity, apply to these benefits.

For information about how the novel coronavirus (COVID) is covered under this plan, see [Important information due to the coronavirus pandemic](#).

24-Hour Nurse Line

The Woodgrove Financial 24-Hour Nurse Line is a confidential health-care information service for you and your dependents. The Nurse Line is available 24 hours a day, seven days a week. It provides useful, easy-to-understand health-care information that will help you to make appropriate health-care decisions.

The 24-Hour Nurse Line cannot diagnose illnesses, prescribe treatment, or give medical advice, but they can do the following:

- Provide information, coaching, and support regarding a wide range of health issues, including:
 - Aches and pains
 - Diabetes
 - High blood pressure
 - Illnesses and infections
 - Infant care
 - Immunizations

- Provide information about Woodgrove Financial-sponsored health programs such as:
 - Disability leave
 - Ergonomic assistance
 - On-site flu shots

- On-site mammogram screenings
- Smoking cessation
- Weight management
- Offer suggestions about appropriate next steps or available resources.

The average call to the 24-Hour Nurse Line lasts approximately five minutes, so that you can obtain information quickly and can move on to the next step, as advised by the 24-Hour Nurse Line nurse.

The 24-Hour Nurse Line is a service provided by Premera Blue Cross. All Woodgrove Financial covered employees and their dependents can access the 24-Hour Nurse Line.

Accessing the 24-Hour Nurse Line

The toll-free phone number for the 24-Hour Nurse Line is a consolidated phone line. From this one number, Woodgrove Financial covered employees and their dependents can access several health-care services, such as the 24-Hour Nurse Line staff of nurses, a professional counselor with the Woodgrove Financial Counseling, Assistance, Referral and Education Services (CARES) Employee Assistance Program and health-care coverage information. When you call, listen carefully to the entire greeting before you make your selection.



You can reach an experienced, registered nurse 24 hours a day, seven days a week by calling one of the following options:

- (800) 676-1411
- For deaf or hard-of-hearing access (TTY), call (800) 676-1411 then provide the number 711

Ambulance

Ground or Water

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies Air

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

This benefit covers licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat the condition when any other mode of transportation would endanger the member's health or safety. This benefit is limited to the member that requires transportation.

For air ambulance services, please see [Federal No Surprise Billing Protection](#) for special rules that apply to out-of-network air ambulance services.

Autism/Applied Behavior Analysis (ABA) therapy

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

This benefit covers behavioral interventions based on the principles of Applied Behavioral Analysis (ABA) through eligible providers.

Who is eligible

This benefit is available for members who are diagnosed with Autism Spectrum Disorder (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition / DSM-5*), or with any of the following Pervasive Developmental Disorders (*International Classification of Diseases, 10th Revision, Clinical Modification / ICD- 10-CM*):

- Autistic Disorder
- Childhood Disintegrative Disorder
- Asperger's Syndrome
- Rett's Syndrome
- Other Pervasive Development Disorder/Atypical Autism
- Pervasive Developmental Disorder unspecified

Eligible providers

Licensed providers — Medical doctors (MD); doctors of osteopathic medicine (DO); nurse practitioners (NP, ANP, ARNP, etc.); and master's-level or above mental health clinicians and occupational, physical, and speech therapists, provided that they are providing the ABA services within the scope of their practice and licensure.

Board Certified Behavioral Analysts — BCBAs are certified by the Behavior Analyst Certification Board. These providers have master's or doctoral degrees. For ABA services, typically a BCBA functions as a "Program Manager." The Program Manager conducts behavioral assessments, including functional analyses, and provides behavior analytic interpretations of the results. The Program Manager also designs and periodically reviews behavior analytic interventions (program development and treatment planning) and may supervise Therapy Assistants. Therapy Assistant services must be billed by the Program Manager.

Covered services

Services must be ordered by the member's treating physician to be covered. Program Manager benefits are available for time used to evaluate the member and document findings and progress reports, and to create and update treatment plans; and time used to train and evaluate the work of the Therapy Assistants working directly with the member to implement the treatment plan.

In most cases, Therapy Assistants will provide the implementation portion of the treatment plan. Therapy Assistant time may be covered for face-to-face, in-person or virtual visits with the member to perform the tasks described in the treatment plan and to document outcomes, and for time to meet with the Program Manager for training and to discuss

treatment plan issues. Therapy Assistant services that are billed by a Program Manager will be paid at the Therapy Assistant rate.

ABA services are not covered for the following:

- Babysitting or doing household chores
- Time spent under the care of any other professional
- Travel time
- Home schooling in academics or other academic tutoring

Out of network providers

You may be billed for charges assessed above the allowable charges since these providers generally have not agreed to offer discounts to members covered by this plan. Any amounts you pay for charges in excess of allowable charges, will not count towards satisfying any deductible requirements, or the coinsurance maximum that applies under this plan.



The **allowable charge** is defined differently for in-network and out-of-network providers. For in-network providers, the allowable charge is the negotiated amount that the provider has agreed to accept as payment in full for a covered service. For out-of-network providers, the allowable charge is the lowest of three amounts, as outlined in the definition of “allowable charge” in the Glossary. If you choose to use out-of-network providers, you may be responsible for paying the difference between the allowable charge and the amount your out-of-

network provider charges.

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility

and benefits at the time of service.

Services for this treatment that do not meet criteria described above are subject to retrospective denial of benefits.

Additional exclusions and limitations for autism/ABA therapy

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- This benefit is not provided for rehabilitation services (which apply under the [rehabilitation](#) benefit) or mental health services (which apply under the [mental health and chemical dependency](#) benefit).
- Benefits for services provided by volunteers, childcare providers, family members and benefits paid for by state, local and federal agencies will not be covered. Volunteer services or services provided by

a family member of the child receiving the services by or through a school, books and other training aids will also not be covered.

- Other unspecified developmental disorders or delays, or any other delay or disorder in a child's motor, speech, cognitive, or social development, are not covered under this benefit.
- This benefit covers only the allowable fees for eligible services performed by the provider and those providing interventions based on principles of ABA and/or related structured behavioral programs under the supervision of the provider. Other expenses associated with providing the treatment, such as the tuition, program fees, travel, meals, and lodging of the provider, expenses of those working under the provider's supervision, the member, and their family members, will not be covered.

Chemotherapy and Radiation Therapy

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers the following services:

- Outpatient chemotherapy and radiation therapy services, including proton beam radiation therapy when medically necessary
- Supplies, solutions, and drugs (See the [Prescription Drugs](#) benefit for oral chemotherapy drugs)

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility

and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Childbirth / Maternity Classes

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers childbirth and pregnancy educational classes, including pre-pregnancy planning, pregnancy, childbirth, and Lamaze, breastfeeding, and infant education classes. The benefit is for covered employees and dependents only, although a spouse/domestic partner not covered on the medical plan can attend with the covered individual.

Additional exclusions and limitations for childbirth / maternity classes

In addition to the plan's [exclusions and limitations](#), exercise classes, such as maternity yoga, are excluded from this benefit.

Chiropractic services, acupuncture, and medical massage therapy

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

Limit: up to 24 visits per member per calendar year chiropractic, acupuncture, and medical massage therapy (combined)

This benefit covers (1) chiropractic services from a licensed chiropractor or other provider licensed to perform chiropractic services, (2) acupuncture services provided, when medically necessary to relieve pain or to treat a covered illness, injury, or condition from a licensed acupuncturist or other provider licensed

to perform acupuncture, and (3) medical massage therapy from a provider licensed to perform medical massage therapy, with a physician's prescription. To be covered, these services must be rendered to restore or improve a previously normal physical function and delivered within the provider's scope of practice guidelines.

These covered services must be [medically necessary](#) and will be covered only when the provider is providing the service within the scope of their state license.

These covered services (chiropractic services, acupuncture, medical massage therapy) will accrue cumulatively toward the 24-visit annual maximum. For example, if you visit a chiropractor for covered services 20 times in a calendar year, you will have four visits available for covered medical massage and/or acupuncture services in that calendar year. Covered Massage Therapy services are limited to a maximum of one hour per day.

Clinical Trials

This plan covers the routine costs of a qualified clinical trial. Routine costs are the medically necessary care that is normally covered under this plan for a member who is not enrolled in a clinical trial. The trial must be appropriate for the health condition according to the trial protocol and participating provider or information submitted by the member, and the member must be enrolled in the trial at the time of treatment for which coverage is requested.

Benefits are based on the type of service received. For example, benefits for an office visit are covered under the Professional Visits and Services benefit and lab tests are covered under the Diagnostic Services benefit.

A qualified clinical trial is a phase I, II, III or IV clinical trial that is conducted on the prevention, detection or treatment of cancer or other life-threatening diseases or conditions. The trial must also be funded or approved by a federal body, such as the National Institutes of Health (NIH), the Centers for Disease Control and Prevention; the Agency for Health Care Research and Quality; the Centers for Medicare & Medicaid Services; a cooperative group or center of any of the above entities or the Department of Defense (DOD) or the Department of Veterans Affairs (VA); the VA, DOD, and Department of Energy if peer-reviewed and approved as per the Secretary of HHS; or a qualified private research entity that meets the standards for NIH support grant eligibility.

Routine patient costs in connection with a "clinical trial" does not include expenses for:

- Costs for treatment that are not primarily for the care of the patient (such as lab tests performed solely to collect data for the trial)
- The investigational item, device, or service itself

- A service that is clearly not consistent with widely accepted and established standards of care for a particular condition

Those interested in this coverage are encouraged to contact customer service at (800) 676-1411 before enrolling in a clinical trial. Customer service can help the member or provider verify that the clinical trial is a qualified clinical trial.

Contraception

In-network: 100%

Out-of-network: 100%

This benefit covers FDA-approved contraceptive devices and injections for contraceptive purposes for women when prescribed by a physician. Included are diaphragms, IUDs, and Depo Provera injections. Removal of contraceptive devices by a physician is also covered. This benefit also covers office visits and consultations related to contraception management.

All FDA-approved single-source brand and generic birth control medications are covered under the [preventive care](#) benefit at 100%.

Dental services

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers certain services from a dental provider that would otherwise be covered by this plan if performed by a physician, as long as these services are provided within the scope of the dental provider's license.



Review the [Dental plan](#) section for information on your dental benefits.

Covered services

This benefit covers treatment of serious dental issues, such as a fractured jaw, excision of a tumor or cyst of the mouth, and incision or drainage of an abscess or cyst of the mouth, when not part of the dentition (gums, teeth, teeth supporting structure).

Hospital or outpatient facility fees and skilled observation for anesthesia administration related to dental treatments may be covered by the medical benefit when the following criteria are met.

Dental treatment in a hospital or outpatient facility is required because of any of the following:

- A physician has determined that the member's medical condition would place them at undue risk if the dental treatment were performed in a dental office. Some examples, though not all inclusive, are:
 - Cardiac conditions
 - Chronic respiratory disease, such as emphysema
 - Hemophilia or other blood disease

- History of allergy to local anesthesia
- Severe anemia
- Severe hypertension
- Uncontrolled diabetes
- The severity of the dental condition prevents treatment in the dental office setting.
- General anesthesia in a dental office, hospital or outpatient facility is required because of any of the following:
 - The member has a physical or mental disability and cannot be managed with local anesthesia, intravenous (IV) or non-intravenous conscious sedation.

- The member has tried and failed other means of patient management (including premedication) in the office setting.
- Other means of patient management are contraindicated for the member.

Orthodontia services may be eligible for payment under the medical plan for dependents born with cleft/lip palate or other severe craniofacial anomalies. To qualify for benefits the condition must meet medically necessary criteria in Premera's medical policy addressing orthodontia for repair of cleft palate and other severe congenital anomalies.

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility before the service is provided. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Additional exclusions and limitations for dental services

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Services or supplies not medically necessary for diagnosis, care, or treatment of a disease, illness, or injury
- Dental care and services of a dentist, except as provided in the dental benefit. Hospital and physician services in support of all other dental care are covered only if the care meets two conditions: (1) adequate dental treatment cannot be rendered without the use of the hospital, and (2) the member has a health problem that makes it medically necessary to do the dental work at the hospital.
- Dental services for accidental injuries to the oral and maxillofacial region are covered only when the needed corrective dental repairs are certified in writing by the dental care provider as dentally necessary and are directly related to the accidental injury. Covered dental services include the repair or replacement of existing crowns, inlays, onlays, bridgework, and dentures. The treatment must be started within one year from the date of the accident.

- Benefits for services or supplies for treatment of temporomandibular joint (TMJ) dysfunction or myofascial pain dysfunction (MPD); benefits may be available under the Woodgrove Financial temporomandibular dysfunction benefit
- The medical plan does not cover any other preventive or restorative dental procedures, regardless of origin of condition

Diabetes

Diabetes health education

In-network: 100%

Out-of-network: 100% of allowable charges

This benefit covers outpatient self-management training and education for diabetes, including medical nutritional therapy by a dietitian or nutritionist with expertise in diabetes.

Livongo Diabetes Management, Diabetes Prevention, and Hypertension Programs

In-network: 100%

Out-of-network: n/a

The Livongo for Diabetes Management, Diabetes Prevention, and Hypertension Programs provide monitoring and health management support to individuals within the programs. If you qualify and enroll in any of the programs, you will receive the following benefits:

Diabetes Management

For members 13 and older who have Type 1 or Type 2 diabetes. If you qualify and join the program, you will get:

- A blood glucose meter that uses cellular technology to automatically upload blood sugar readings to a personal online account.
- A lancing device and unlimited lancets at no cost to you.
- Unlimited test strips for this meter at no cost to you. You can reorder test strips using the meter or online. The strips will be sent to you directly.
- Real-time feedback and tips based on your blood sugar readings that can help keep your levels within a healthy range.
- Coaching and support via phone, text, e-mail, or the program manager's mobile app.

Diabetes Prevention

For members 18 and older who meet pre-diabetes criteria followed by the Centers for Disease Control. The program's duration is 12 months, with an additional 12 months of access for maintenance. If you qualify and join the program, you will get:

- A cellular-connected scale that uploads readings to a personal online account.
- Real-time tips and personalized feedback on health, nutrition, or lifestyle changes to help you learn and improve.
- Unlimited coaching and support via phone, text, e-mail, or the mobile app.
- Complete CDC-recognized weight management curriculum based on in-app content and online resources.

- Periodic review of plan, self-monitoring data, and feedback from expert coach.
- Experiential learning missions covering nutrition, activity, motivation, sleep, and stress management.
- A mobile app, and device for tracking weight, steps, and achievement of health goals for food and physical activity.

Hypertension

For members 18 and older who have hypertension. If you qualify and join the program, you will get:

- A cellular-enabled blood pressure cuff that uploads blood pressure readings to a personal online account.
- Real-time tips and personalized feedback based on your blood pressure readings that can help keep your pressure within a healthy range.
- Unlimited coaching and support via phone, text, e-mail, or the mobile app. Access to online information.

These programs are available to you and your eligible dependents who qualify. The full cost of these programs will be covered by the Plan. To learn more, see if you qualify and enroll, go to <https://go.livongo.com/Woodgrove Financial>, or call Premera customer service.

Diagnostic Services

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

Benefits are provided for diagnostic services (including lab and imaging services) for health conditions or symptoms. Included in the coverage are charges for the test or scan itself and charges to interpret the results. Some examples of what's covered under this benefit are:

- Diagnostic imaging and scans (including x-ray, MRI, PET, CAT, and EKGs)
- Services that are medically necessary to diagnose infertility
- Laboratory services
- Pathology tests

Diagnostic surgeries, including scope insertion procedures, can only be covered under the Surgical Services benefit.



Prior authorization is strongly recommended for some diagnostic services. Some examples of these include but are not limited to: Genetic Testing, CAT scan, and MRI. Have your provider contact Premera to see if your service needs this pre-service review.

Emergency room care and professional services

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

This benefit covers hospital emergency room and provider charges for an emergent condition—regardless of the network status—including related services and supplies, such

as diagnostic imaging (including X- ray) and laboratory services, and surgical dressings and drugs furnished by and used while at the hospital.

Following discharge from the emergency room or hospital, eligible services will be paid based on the contracting status of the provider.

Regardless of network status, after being treated in the emergency department for an emergent condition and admitted to a hospital inpatient care (as defined by the [hospital inpatient care](#) benefit), along with provider charges, will be covered at the in-network level.

For emergency substance abuse treatment, see the [mental health and chemical dependency treatment](#) benefit.

Please see the [Federal No Surprise Billing Protection](#) section for more information about certain legal protections when you receive emergency services provided by an out-of-network provider.

Hearing care and hardware

Hearing exams and testing

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers one routine hearing examination and one routine hearing test (or screening) per member each calendar year.

Hearing exam services include:

- Examination of the inner ear and exterior of the ear
- Observation and evaluation of hearing, such as whispered voice and tuning fork
- Case history and recommendations
- The use of calibrated equipment

Hearing hardware

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

Limit: up to \$10,000 maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in one or more Premera-administered health plan options

This benefit covers one FDA approved hearing hardware (either an over-the-counter or prescribed hearing aid) up to a maximum benefit of \$10,000 per member in a period of three consecutive calendar years.

Before obtaining a prescribed hearing aid, you must be examined by a licensed physician (M.D. or D.O.) or audiologist (CCC-A or CCC-MSPA).

Benefits cover the following:

- The hearing aid(s) (monaural or binaural) prescribed as a result of an exam or an FDA approved over-the-counter hearing aid(s) (monaural or binaural)
- Ear mold(s)
- Hearing aid rental while the primary unit is being repaired
- The initial batteries, cords, and other necessary ancillary equipment
- A follow-up consultation within 30 days following delivery of the prescribed hearing aid with either

the prescribing physician or audiologist

- Repairs, servicing, and alteration of hearing aid equipment

Additional exclusions and limitations for hearing care and hardware

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Hearing aids purchased before your effective date of coverage under this plan

- A prescription or over-the-counter hearing aid, for any reason, more often than once in a period of three consecutive calendar years during which you are continuously enrolled in one or more Premera-administered health plan options
- Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid
- A prescription hearing aid that exceeds the specifications prescribed for correction of hearing loss
- Expenses incurred after your coverage ends under this plan unless a prescribed hearing aid was ordered before that date and was delivered within 90 days after the date your coverage ended
- Charges in excess of this benefit; these expenses are also not eligible for coverage under other benefits of this plan

Home health care and Nursing care

In-home care, other than Hospice Care and Respite Care (non-hospice), can be broken into two categories for purposes of benefit coverage:

Benefit	Description	Care Duration	Coverage
Home health care	Short-duration, intermittent care to complete specific tasks by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, social worker (MSW) working for home health agency, or a certified respiratory therapist.	The length of home health care visits varies depending on the tasks to be accomplished, but typically these visits last up to 2 hours.	In-network: 90%, deductible applies Out-of-network: 70% of allowable charges, deductible applies
Nursing care	Longer-duration, skilled hourly nursing care in the home by a registered nurse (RN) or licensed practical nurse (LPN).	Generally needed for more than 4 hours per day.	In-network: 90%, deductible applies Out-of-network: 90%, deductible applies

Read below for additional in-home care coverage details.

Home health care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers home visits for short-duration, intermittent care to complete specific tasks by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, social worker (MSW) working for home health agency, or a certified respiratory therapist. The length of home health care visits varies depending on the tasks to be accomplished, but typically these visits last up to 2 hours. The benefit includes the cost of a home health aide when acting under the direct

supervision of one of the before-mentioned therapists and while performing services specifically ordered by the doctor in the treatment plan. The benefit also includes disposable medical supplies and eligible medication prescribed by a physician when provided by the home health care agency.



Intermittent care is care provided due to the medically predictable recurring need for skilled home health care services.

Home health care services provided and billed by a Medicare-approved or state-licensed home health care agency for treatment of an illness or injury are covered. The services must be part of a formal written treatment plan prescribed by your doctor.

One postpartum home health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center will be eligible for coverage.

Additional exclusions and limitations for home health care

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services
- Materials such as handrails and ramps
- Services performed by family members and volunteer workers
- Psychiatric care
- Unnecessary and inappropriate services
- Maintenance or [custodial care](#)
- Diversional therapy
- Services or supplies not included in the written treatment plan
- Over-the-counter drugs, solutions, and nutritional supplements
- Dietary assistance, such as Meals on Wheels
- Services provided to someone other than the ill or injured enrollee

Nursing care

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

This benefit covers longer-duration, skilled hourly nursing care in the home by a registered nurse (RN) or licensed practical nurse (LPN) working under a licensed home health agency. Skilled hourly nursing care is provided in lieu of hospitalization and generally is needed for more than 4 hours per day. The nurse who is providing the care cannot be a permanent resident in the member's home.



Skilled nursing care is provided by a registered nurse (RN), or licensed practical nurse (LPN) and the care must require the technical proficiency, scientific skills, and knowledge of an RN or LPN. The need for skilled

nursing is determined by the condition of the patient, the nature of the services required, and the complexity or technical aspects of the services provided. Nursing care is not skilled simply because an RN or LPN delivers it or because a physician orders it.

Prior authorization

A prior authorization, also referred to as a pre-service review, is strongly recommended for nursing care to determine if coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Hospice care

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

The hospice care benefit allows a terminally ill member to remain at home or to use the services of a hospice center instead of using hospital inpatient services. The plan covers services provided through a state-licensed hospice or other hospice program that meets the standards of the National Hospice and Palliative Care Organization. The services must be part of a written treatment plan prescribed by a licensed physician.

This benefit covers visits for intermittent care by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, a certified respiratory therapist or a Master of Social Work. Also included is the cost of a home health aide who acts under the direct supervision of one of the before-mentioned therapists and who is performing services specifically ordered by the member's doctor in the treatment plan. The benefit also includes disposable medical supplies and medications prescribed by the physician, and the rental of durable medical equipment.

In addition, the hospice care benefit covers care in a hospice, and up to 672 hours of respite care for each six-month period of hospice care. The respite care provision allows family members of the terminally ill patient an opportunity to recover from the emotionally and physically demanding tasks of caring for the patient.



Hospice care is a coordinated program of palliative and supportive care for dying members by an interdisciplinary team of professionals and volunteers centering primarily in the member's home.

Intermittent care is care provided due to the medically predictable recurring need for skilled home health care services.

Respite care is continuing to provide care in the temporary absence of the member's primary caregiver or caregivers.

Additional exclusions and limitations for hospice care

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Bereavement or pastoral counseling
- Financial or legal counseling, including real-estate planning or drafting of a will
- Funeral arrangements
- Diversional therapy

- Services that are not related solely to the member, such as transportation, house cleaning, or sitter services

Hospital inpatient care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers the following inpatient medical and surgical services:

- Room and board, including general duty nursing and special diets
- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment, and oxygen
- Diagnostic and therapeutic services
- Blood, blood derivatives, and their administration

Regardless of network status, after being treated in the emergency department for an emergent condition and admitted to a hospital, inpatient care (as defined by the hospital inpatient care benefit), along with provider charges for that emergent condition, will be covered at the in-network level.

Please see [the Federal No Surprise Billing Protection](#) section for more information about certain legal protections when you receive emergency and non-emergency services provided by an out-of-network provider.

For substance abuse treatment, see the [mental health and chemical dependency treatment](#) benefit.

Additional exclusions and limitations for hospital inpatient care

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Hospital admissions for diagnostic purposes only, unless the services cannot be provided without the use of inpatient hospital facilities, or unless the member's medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay required to treat the member's condition

Hospital outpatient care and ambulatory surgical center care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers operating, procedure, and recovery rooms; plus, services and supplies, such as diagnostic imaging (including X-ray) and laboratory services, X-ray and radium therapy, anesthesia and its administration, surgical dressings and drugs, furnished by and used while at the hospital or ambulatory surgical center.

Please see [the Federal No Surprise Billing Protection](#) section for more information about certain legal protections when you receive emergency and non-emergency services provided by an out-of-network provider.

Infertility

In-network: 90% after deductible for coverage, within the Plan's infertility vendor (Progyny) provider network Out-of-network: not applicable

Limit: Up to two Smart Cycles per household for the duration of your continuous enrollment in one or more Premera-administered health plan options, and one additional Smart Cycle if neither of the first two results in a successful pregnancy, subject to certain restrictions described below



Members must contact their **Progyny Patient Care Advocate** at (888) 203-5066 to confirm eligibility and utilize a Progyny Network Provider to access the benefit.

This benefit covers services to assist in achieving a pregnancy for Woodgrove Financial employees and their enrolled spouse/domestic partner regardless of reason or origin of condition.

The Progyny SMART cycle benefit allows for:

- Two (2) Smart Cycles per household, with an additional Smart Cycle available if the first two do not result in a successful pregnancy, for the duration of your continuous enrollment in one or more Premera-administered health plan options, subject to the restrictions described below for certain members who received infertility benefits of less than \$15,000 under the Health Savings Plan prior to 2018. Coverage is subject to all applicable plan copay, coinsurance, and deductible requirements.
- One (1) Smart Cycle per household, with an additional Smart Cycle available if the first does not result in a successful pregnancy, for the duration of your continuous enrollment in one or more Premera-administered health plan options, for members who (1) have been enrolled continuously in one or more Premera-administered health plan options (such as the Health Savings Plan) since before 2018, and (2) incurred \$15,000 or more in infertility benefits under the Plan during such continuous enrollment period prior to 2018. Coverage is subject to all applicable plan copay, coinsurance, and deductible requirements.

The Progyny SMART cycle benefit may be used to receive full coverage for the following treatments and procedures:

- Two consultations per calendar year
- Diagnostic testing
- Transvaginal ultrasounds
- Intrauterine insemination (also known as artificial insemination)
- In vitro fertilization (IVF)
- Gamete intra-fallopian transplant (GIFT)
- Intracytoplasmic sperm injection (ICSI)
- Pre-implantation genetic screening (PGS)
- Pre-implantation genetic diagnosis (PGD)
- Embryo assessment and transfer
- Services used to preserve fertility such as cryopreservation of eggs, sperm and/or embryos. This includes oncofertility preservation.

- Up to four years of storage (egg, embryo, sperm) with annual renewal and eligibility verification
- Purchase of donor tissue (sperm, eggs) as follows:
 - Previously frozen donor sperm or donor oocytes (eggs) from a donor agency intended for the use and transfer into a covered female member (one egg cohort purchase constitutes one SMART

Cycle, and one donor sperm purchase constitutes $\frac{1}{4}$ SMART Cycle). You will be required to pay for the donor sperm or oocytes out of pocket and submit the eligible charges, with appropriate supporting documentation, to Progyny for reimbursement.

- A fresh donor recipient cycle, whereby the egg donor undergoes an egg retrieval procedure at an in-network Progyny provider to allow for a fresh embryo transfer into a covered female member (one fresh donor recipient cycle constitutes one SMART Cycle). The treatment must occur at an in-network Progyny provider, or else you may be required to pay all expenses up front, out of pocket. If an in-network provider is not contracted for the fresh donor recipient cycle, Progyny will pursue a special case agreement. If a special case agreement request is denied, you will pay for the donor services out of pocket but may submit eligible charges, with appropriate supporting documentation, to Progyny for reimbursement.

Medication prescribed for fertility treatment will be fulfilled by a Progyny Rx specialty pharmacy and delivered next day to ensure accurate timing with treatment. All medications, compounds, ancillary medication and equipment required for treatment are included in the shipment of medications. Progyny Rx coverage also includes the UnPack It Call where a trained pharmacy clinician will explain drug administration and storage guidelines.

Additional exclusions and limitations for infertility

The following exclusions apply to this benefit:

- Fees paid to donors for their participation in any service
- Testing and treatment for potential surrogates that would not otherwise be covered for a member enrolled in the Plan
- Home ovulation prediction kits
- Services and supplies furnished for a dependent child (under age 26) except for oncofertility preservation due to cancer or medical treatments
- Services and supplies furnished by a provider outside the Progyny network, except as otherwise provided
- Fertility Services following a voluntary sterilization procedure

Maternity care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers maternity benefits provided for you, your enrolled spouse/domestic partner, and your eligible dependent children.

For women's preventive care visits during and after pregnancy, see the preventive care benefit. If the physician bills the delivery together with the routine (preventive) prenatal

care, 40% of the allowed amount applies to the preventive prenatal care benefit and 60% of the allowed amount applies to the maternity care benefit.

The home health care benefit covers one postpartum health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center.

Benefits are for maternity care in a hospital, alternative birthing center, or at home, including:

- Prenatal testing when required to diagnose conditions of the unborn child
- Services of a licensed nurse or midwife (non-medical service, such as non-medical services performed by a doula are not covered)
- Miscarriages and terminations of pregnancy
- Hospital nursery care for benefits-eligible infant while the mother is hospitalized and receiving benefits; services are covered under the hospital services benefit
- Male circumcision by a physician or mohel for a benefits-eligible dependent; services are covered under the physician services benefit
- One postpartum home health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center
- Home births include an allowance of up to \$500 for eligible supplies and/or equipment used for home delivery, for example, birthing packs, birthing tubs, monitoring devices, local anesthetics, and comfort aids. Services for the newborn including hospital services and professional services are covered under the hospital services and physician services benefit.

Medical equipment and supplies (durable medical supplies)

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

Covered services

This benefit covers charges for durable medical and surgical equipment and supplies (DME). Benefits cover rental or purchase (including shipping and handling fees) of DME for treatment of an injury, illness, disease, or medical condition. Rental equipment will not be reimbursed above the purchase price of the equipment. The Plan reserves the right to require a period of rental prior to covering the purchase of equipment. Benefits for DME purchases will be reduced by any prior Plan benefits for renting the same equipment, unless (and to the extent that) the Plan required such prior rental.

Allowed charges to repair or replace covered items are also covered due to a change in the injury, illness, disease, or medical condition, the growth of a child, or when worn out by normal use. Replacement is covered only if needed due to a change in the member's physical condition or if it is less costly to replace than to repair existing equipment or to rent similar equipment.

No more than one item of DME per year will be covered for the same or similar purpose, and in order to be covered, the equipment and accessories to operate it must be:

- Made to withstand prolonged use
- Made for and mainly used in the treatment of an injury, illness, disease, or medical condition
- Suited for use in the home

This list of covered DME includes, but is not limited to:

- Braces
- Crutches
- Wheelchairs
- Prostheses
- Cochlear Implants and associated supplies

- Foot orthotics (custom fitted shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses, when prescribed by a physician for the condition of diabetes or for corrective purposes
- Wigs (up to \$2,000 per calendar year for alopecia caused by medical conditions or treatment for diseases)
- You may purchase one over-the-counter breast pump or rent a hospital grade breast pump during a calendar year (one or the other, but not both). The pump must be for your own use. Replacement supplies may be purchased on an as needed basis. In-network purchase/rental for the pump and replacement supplies is covered at 100%. Out of network purchase/rental for the pump and replacement supplies is covered at 100% of allowable charge. Deductible does not apply. Batteries are not covered.
- Continuous glucose monitors and their supplies are covered at 100% of allowable charges. Deductible does not apply.

Vision hardware may be covered under the medical plan for certain medical conditions of the eye, including, but not limited to:

- Corneal ulcer/abrasion
- Bullous keratopathy
- Recurrent erosion of cornea
- Keratoconus
- Tear film insufficiency (dry-eye syndrome)
- Cataract surgery



Certain supplies such as hypodermic needles, test strips and glucose monitors are covered at 100% by the

preventive care benefit

Additional exclusions and limitations for medical equipment and supplies (durable medical supplies)

In addition to the plan's [exclusions and limitations](#), the following durable medical equipment and supplies will not be covered by this plan when they are:

- Normally of use to persons who do not have an injury, illness, disease, or medical condition
- For use in altering air quality or temperature
- For exercise, training and use during participation in sports, recreation, or similar activities
- Equipment, such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, overbed tables, elevators, vision aids, and telephone alert systems
- Special or extra-cost convenience items and/or features
- Structural modifications to your home and/or private vehicle
- Replacement of lost or stolen equipment or supplies
- Blood pressure cuffs or monitors (even if prescribed by a physician), unless otherwise provided in this SPD

Medical Foods

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This plan covers medically necessary medical foods used to supplement or replace a member's diet in order to treat inborn errors of metabolism. An example is phenylketonuria (PKU). Coverage includes medically necessary enteral formula prescribed by a physician or other provider to treat eosinophilic gastrointestinal associated disorder or other severe malabsorption disorder. Benefits are provided for all delivery methods.

Medical foods are formulated to be consumed or administered enterally under strict medical supervision. These foods generally provide most of a person's nutrition. Medical foods are designed to treat a specific problem that can be diagnosed by medical tests.

This benefit does not cover other oral nutrition or supplements not used to treat inborn errors of metabolism, even if a physician prescribes them. This includes specialized infant formulas and lactose-free foods.

Mental health counseling, mental health inpatient and outpatient services, and chemical dependency treatment

Inpatient and Outpatient:

- 100%, up to calendar year short-term counseling session limits through Spring Health, administrator for the employee assistance program
- *In-network: 90%, deductible applies*
- *Out-of-network: 90% of allowable charges, deductible applies*

This benefit covers medically necessary treatment for:

- mental health conditions such as, but not limited to the diagnosis and treatment stress, anxiety, or depression, or other psychiatric disorders, eating disorders, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD)
- chemical dependency such as substance use disorder and alcohol use disorder

To be covered, services must be furnished by an eligible provider.

All mental health and chemical dependency treatment must be medically necessary to be eligible for coverage.

Type of care	You will be covered as follows
Short-term counseling through the Employee Assistance Program (EAP) administered by Spring Health	No deductible applies 100% of 24 sessions per person per year.

Inpatient and Outpatient benefits	In-network: 90%, deductible applies; out-of-network: 90% of allowable charges, deductible applies
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Eligible providers

Eligible providers include:

- A facility licensed as a hospital or community mental health agency to provide mental health and/or substance abuse services
- A physician, psychiatrist, psychologist, or psychiatric nurse practitioner licensed to provide mental health or substance abuse services
- A master's level mental health provider licensed, registered, or certified as legally required to provide mental health services
- Any other provider or facility who is licensed or certified by the state in which the care is rendered and who is providing care within the scope of their license or certification

Prior authorization

A prior authorization, also referred to as a pre-service review, is strongly recommended for inpatient care and residential treatment centers to determine coverage is available before the service occurs. When an emergency admission occurs, notification to Premera within two days is also recommended. Either the member or the provider may contact Premera for a prior authorization.



A **prior authorization** is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and

benefits at the time of service.

The prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Additional exclusions and limitations for mental health and chemical dependency

In addition to the plan's **exclusions and limitations**, the following exclusions and limitations apply to this benefit:

- Testing must be ordered by a physician for the purpose of diagnosing or medical management
- Smoking cessation programs or materials; (Woodgrove Financial provides a separate Smoking Cessation Program. Prescription drugs for smoking cessation are covered under the prescription drug benefit.)
- Services and supplies that are court-ordered, or are related to deferred prosecution, deferred or

suspended sentencing, or driving rights, if those services are not deemed medically necessary

- Educational or recreational therapy or programs; this includes, but is not limited to, boarding schools. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider, provided that educational or recreational therapy or programs, themselves, are not eligible providers for this purpose.

Nutritional therapy

In-network: 100%

Out-of-network: 100% of allowable charges

Limit: first 12 visits per member per calendar year

After 12 visits (in the same calendar year) benefit coverage is reduced to:

- *In-network: 90%, deductible applies*
- *Out-of-network 70% of allowable, deductible applies*

This benefit covers outpatient nutritional therapy visits with a dietitian, nutritional therapist or certified lactation consultant to manage a covered condition, illness or injury.

Illnesses or conditions that would be eligible for this benefit include, but are not limited to:

- Hypertension
- Cardiac problems
- Feeding difficulties
- Gastric reflux disease

Nutritional therapy visits received in connection with a diagnosed eating disorder or diabetes are unlimited and will be covered at 100% of allowable charges.

Onsite Mammography Screening

Woodgrove Financial offers access to an onsite mammography screening in select Woodgrove Financial locations to employees and their spouse/domestic partners enrolled in a Woodgrove Financial Health Plan. The onsite mammography screening provides a multiple-view screening exam. At the discretion of the technologist performing the mammogram, additional views may be necessary to clarify imaging issues for the radiologist.

The onsite mammography screening program includes the onsite preventive screening mammogram exam only. Any additional or follow-up imaging or other services needed are considered diagnostic and will be covered as outlined in the diagnostic services benefit.

An onsite mammogram is not recommended if you have implants, a breast problem, are pregnant, or are breastfeeding. In those cases, you should consult with your doctor about obtaining an exam at an offsite breast center or other health care facility. Such an offsite exam would not be covered by the onsite mammography screening program but may be covered by the Plan's preventive or diagnostic services coverage, as applicable. As the onsite mammogram is a screening exam, the vendor is not able to provide imaging for a breast problem such as a lump. If you have questions about mammogram screenings, talk with your primary care physician.

Who Provides the Mammograms?

In the Puget Sound area of Washington state, Mammograms are provided by Swedish Mobile Mammography Services (operated by Swedish Health Services). The mammography technologists are registered by the American Registry of Radiologic Technology, have advanced credentials in mammography, and are certified by the State of Washington. The interpreting physicians are employed by Radia, are board certified by the American College of Radiology, and specialize in breast imaging.

In other areas, Woodgrove Financial partners with local vendors who specialize in onsite mammography and have the appropriate equipment and licensure. To provide services onsite, there must be sufficient demand to fill a day of appointments and a local vendor who is qualified to provide the services. Onsite mammography events will be advertised for any locations where they are available.

When Do the Screenings Occur?

Periodically each year, usually during

the fall. **Eligibility**

US benefits-eligible employees and their spouse/domestic partner age 35 and over, who are enrolled in

medical coverage under the Plan, are eligible to participate in onsite mammography screenings.

You are eligible to participate in the onsite screening even if you have had a routine mammogram in the past 12 months. However, you should talk with your primary care provider to determine the benefits and risks of having a second mammogram within a 12-month period. If you suspect you have a breast problem, such as a lump, you should see your primary care provider.

Women under the age of 35 are ineligible, unless they have written permission from their physician.



At some locations, women under age 35 will not be allowed to participate, even with written permission from their physician.

Dependent children (regardless of age), agency temporaries/external staff, international based employees, and any individuals who are not enrolled in medical coverage under the Plan are not eligible to participate.

Physician services

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers:

- Medical and surgical services of a physician
- Urgent care visits at an urgent care facility
- Care via online and telephonic methods when medically appropriate:
 - Benefits for telemedicine are subject to standard office visit cost-shares and other provisions as stated in this booklet. Services must be medically necessary to treat a covered illness, injury or condition.
- Biofeedback services for any condition covered by the medical benefit when provided by an eligible provider



An **Urgent care** visit is billed and covered at the same rate as an office visit with your regular physician and is a cost-effective option when you have an urgent need for care. Urgent care is the best option for treatment of a sudden illness, injury or condition that:

Requires prompt medical attention to avoid serious deterioration of the member's health Does not require the level of care provided in the emergency room or a hospital

Cannot be postponed until the member's physician is available

A **Physician** is a state licensed:

Doctor of Medicine and Surgery (M.D.)

Doctor of Osteopathy (D.O.)

In addition, professional services provided by one of the following types of providers will be treated as physician services under this plan to the extent the provider is providing a service that is within the scope of their state license and providing a service for which benefits are specified in this SPD and would be payable if the service were provided by a physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Advanced Registered Nurse Practitioner (A.R.N.P.)
- Nurse (R.N.)
- Naturopathic physician (N.D.)

Plastic and reconstructive surgery

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers services, supplies, and procedures for plastic or reconstructive surgery purposes, along with complications of these services, supplies, or procedures, for the following:

- Repair of a defect that is the direct result of an accidental injury, providing such repair is started within 12 months of the date of the accident
- Treatment for a congenital anomaly of a covered child
- Treatment of visible birth marks of a covered child
- All stages of reconstruction of the involved breast following a mastectomy, and surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Correction of physical functional disorders. Benefits may include, but are not limited to, blepharoplasty or breast reduction.

The treatment plan for any of the above conditions must be prescribed by a physician.



A **congenital anomaly** is a marked difference from the normal structure of a body part that is physically evident from birth.

A **physical functional disorder** is a limitation from normal (or baseline level) of physical functioning that may include, but is not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts or obstruction of an orifice. The physical functional impairment can be due to structure, congenital deformity, pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairment or potential

impairment.

Prescription drugs

In-network: 90%, deductible applies, up to limits provided below

Out-of-network: 90%, deductible applies, up to limits provided below

This benefit covers most FDA-approved, medically necessary prescription drugs, when prescribed for the member's use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also, included in this benefit are injectable supplies.

Certain single-source brand and generic preventive drugs will be covered at 100% under the preventive care benefit and are not subject to the deductible. Brand-name preventive medications with an available generic equivalent will not be covered by the preventive care benefit. Review the [preventive care](#) benefit for more information.

Generic drug substitution

This plan encourages the use of appropriate generic drugs (as defined below). When available and indicated by the prescriber, a generic equivalent drug will be dispensed in place of a brand name drug. If your prescriber indicates that substituting a generic equivalent for the brand name drug is inappropriate, you'll be charged only the brand name cost share (as applicable). However, if the prescriber does not indicate that substituting a generic equivalent drug is inappropriate, and you request the brand name drug anyway, you'll be charged the difference in price between the brand name drug and the generic equivalent along with the applicable brand name cost-share. Note: The difference in price between the brand name drug and the generic equivalent will not apply to your deductible and/or coinsurance maximum. Even if you reach your deductible or coinsurance maximum, you will still be responsible for the full amount of the difference in price between the brand name drug and the generic equivalent.



A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.

Brand-name prescriptions are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.

Generic drugs are equivalent to brand-name drugs but available at a lower cost than brand-name prescriptions because the patent has expired.

Prescription limits

	Retail pharmacy	Home delivery	Specialty pharmacy
Coverage	Up to a 90-day supply for generic maintenance medication; all others are up to a 30-day supply*	Up to 90-day supply* is covered only when using Express Scripts Pharmacy Home Delivery	Up to a 30-day supply* Additional clinical support for members using specialty drugs
In-network pharmacies	Express scripts pharmacies bill the plan on your behalf To find an Express Scripts retail pharmacy, call the Premera customer service team at (800) 676-1411	Express scripts pharmacies bill the plan on your behalf	AllianceRx Walgreens Pharmacy or Accredo Specialty Pharmacy** will bill the plan on your behalf
Out-of-network pharmacies	You will need to submit a prescription reimbursement form, with your receipt, for reimbursement	Not covered	Not covered

* Unless the drug maker's packaging limits the supply in some other way.

** Contact AllianceRx Walgreens Pharmacy at (877) 223-6447 or Accredo Specialty Pharmacy at (800) 689-6592 to get started.

The dispensing limits (or days' supply) for drugs dispensed at retail and specialty pharmacies, and through the mail-order pharmacy benefit, are described in the above chart.

Refills for a medication will be covered only when the member has used 75% of the supply of that medication, based on both of the following:

- The number of units and days' supply dispensed on the last fill or refill, and
- The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill, if applicable



Generic maintenance medications have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year.

Specialty drugs are high-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply.



Premera provides a customer service team dedicated to Woodgrove Financial employees and their dependents. You can use this service by calling (800) 676-1411 with questions regarding:

- Status of mail order prescriptions
- Plan design, including which medications are covered or not covered
- Location of retail pharmacies

Covered drugs

This benefit covers the following FDA-approved items when dispensed by a licensed pharmacy for use outside of a medical facility. Certain drugs may need a prior authorization.

- Prescription drugs (Federal Legend Drugs as prescribed by a licensed provider). This benefit includes coverage for off-label use of FDA-approved drugs as provided under this plan's definition of prescription drug.
- Compounded medications are covered when the main ingredient is a covered prescription drug. Benefits are subject to standard supply limit.
- Inhalation spacer devices and peak flow meters
- Glucagon and allergy emergency kits
- Prescribed injectable medications for self-administration (such as insulin)
- Hypodermic needles, syringes, and alcohol swabs used for self-administered injectable prescription medications
- Disposable diabetic testing supplies, including test strips, testing agents, and lancets
- Prescription contraceptive drugs and devices (for example, oral drugs, diaphragms, and cervical caps)
- Human growth hormone
- Prescription drugs for smoking cessation
- Impotence medications are limited to 15 pills at retail per 30 days: 45 pills at mail-order per 90 days

Benefits for immunization agents and vaccines, including the professional services to administer the medication, are provided under the [preventive care](#) benefit.

Prior authorization

Prior authorization, also referred to as a pre-service review, is **required** to determine if coverage for a certain prescription drug is available before prescription can be filled.

To determine if prior authorization is required for a particular drug, refer to the [formulary drug list](#), or either the member or the provider may contact Premera.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time

of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

In order for certain types of drugs to be covered, information from your doctor must be submitted that identifies the disease being treated and explains the role of the drug in the treatment plan to establish its medical necessity. If that information is made available prior

to the prescription being filled, and it is determined that the drug is medically necessary, the prescription will be covered as described above. If information for a drug in this category is not provided, you may pay for the prescription to be filled and submit the claim for consideration along with the clinical information. If it is determined that you do not meet medical necessity criteria needed for the drug to be eligible, you will not be reimbursed for the cost of the drug.

Benefits for some prescription drugs may be limited to one or more of the following:

- A set number of days’ supply
- A specific drug or drug dose that is appropriate for a normal course of treatment
- A specific diagnosis
- Be under the care of an appropriate medical specialist
- Trying a generic drug or a specified brand name drug first

In making these determinations, Premera takes into consideration clinically evidence-based medical necessity criteria, recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration guidelines, published medical literature and standard reference compendia.



For questions about your pharmacy benefits or quantity limits, contact Premera Customer Service at (800) 676-1411.

The table below provides information on how to submit information for a medical necessity review.

Drug	Information
Certain drugs require a prior authorization. Examples include but are not limited to: rheumatoid arthritis, certain cancer treatment drugs, growth hormones, anti-depressants, corticosteroid nasal sprays, diabetes, migraine therapy, multiple sclerosis, sleeping disorders, weight loss drugs, and compound medications.	<p>Have your provider call (888) 261-1756 to start or update the benefit review process for these or other drugs needing clinical review.</p> <p>If you would like to find out if your drug requires review, refer to the formulary drug list or call Premera Customer Services at (800) 676-1411.</p>



Categories of drugs on this list may be added or deleted from time to time, based on factors including FDA approval status, medical necessity, member safety, and best practices. If you have paid for a prescription of a drug in this category, you may appeal any denial of benefits for that drug through the appeals process.

Drug-usage patterns

The Plan may be provided with information from a variety of sources regarding drug-usage patterns of individual members that merit further investigation. If the conclusion of the

investigation is that the drug- usage patterns are not consistent with generally accepted standards of practice, the Plan may choose to restrict access to the benefit to one prescribing physician for those members. If this action is taken, the member will be notified in advance.

Your 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 drugs are covered under this Plan and what coverage limitations are in your contract.



If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, call the Premera customer service team at (800) 676-1411.

If you have a concern about the pharmacists or pharmacies serving you, call your State Department of Health.

Pharmacy manufacturer coupons and financial assistance

In order to avoid potential adverse tax consequences, enrollees in the Health Savings Plan should not utilize pharmacy manufacturer coupons or other financial assistance for prescription drugs.

Additional exclusions and limitations for prescription drugs

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Drugs and medications not approved by the Food and Drug Administration (FDA) except as defined in the Experimental and Investigational section
- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. These may include but are not limited to: nonprescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines, and nutritional and dietary supplements (for example, infant formulas or protein supplements). This exclusion does not apply to emergency contraceptive methods (such as "Plan B"), aspirin for women and men, folic acid for women and iron supplements.
- Over-the-counter contraceptives, supplies, and devices (except as required by law)
- Drugs for the purpose of cosmetic use (for example, promote or stimulate hair growth, stop hair loss, or prevent wrinkles)
- Growth hormone for the diagnosis of idiopathic short stature (ISS), familial short stature (FSS), or constitutional short stature (CSS)
- Drugs for experimental or investigational use
- Any prescription refilled too soon or in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order
- Replacement of lost or stolen medication
- Devices and appliances, support garments, and non-medical supplies
- This plan does not cover the cost of drugs that are reimbursed under another plan or another portion of your Woodgrove Financial coverage (for example, drugs administered while hospitalized)
- Charges for prescription drugs when obtained through an unauthorized pharmacy or provider when a restriction of the prescription drug benefit is in place
- Shipping and handling charges for prescriptions drugs are not covered.

Preventive care

Preventive services:

In-network: 100%

Out-of-network: 100% of allowable charges

This benefit covers routine exams, immunizations and health screenings, such as:

- Routine physicals for women and men
- Women's preventive care including a gynecological exam, routine pap smear (cervical cancer screening) and routine mammogram (breast cancer screening)
- Contraception management office visits
- Well-child exams, including physical exams, tests, and immunizations, through age 18
- Hearing screening for children through age 18
- Routine prenatal and postnatal care. (If the physician bills the delivery together with the routine prenatal care, 40% of the allowed amount applies to the preventive care benefit and 60% of the allowed amount applies to the [maternity care](#) benefit).
- Routine eye exams
- Flu shots
- Colorectal cancer screening
- Prostate cancer screening
- Lung cancer screening
- Immunizations, which need not be done at the same time as the routine exam

For individuals with known risk factors, such as family history of a disease with known hereditary links, the limits in the recommended guidelines for preventive screenings may not be applicable.

Preventive prescription drugs:

In-network: 100%

Out-of-network: 100%

- This benefit covers certain single-source brand and generic prescriptions to prevent the onset of disease by a person who has risk factors for a particular condition, or those taken to prevent a recurrence of a disease. Covered preventive prescription drugs include drugs for the treatment of high cholesterol with cholesterol-lowering medications to prevent heart disease, or the treatment of recovered heart attack or stroke victims with ACE inhibitor medications to prevent a recurrence. This benefit also covers certain supplies such as hypodermic needles, test strips and glucose monitors.



For a complete list of what is considered preventive care and paid 100% by the plan, see the [Preventive Care Services list](#) and the [Preventive Drug list](#), or contact Premera Customer Service at (800) 676-1411.

For information on how to fill your prescription, see the [prescription drug](#) section.

Rehabilitation

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers physical therapy, functional occupational therapy, and speech therapy services to:

- Restore and improve a bodily or cognitive function that was previously normal but was lost after an

accidental injury or illness

- Treat disorders or delays in the development of language, cognitive, or motor skills

Inpatient services are covered when services cannot be rendered in any other setting (see inpatient benefits). Outpatient services are limited to a maximum of one hour of each specialty (physical therapy, occupational therapy and speech therapy) per day.

Physical therapy, functional occupational therapy, and speech therapy, including cardiac rehabilitation, are covered when rendered by a physician or by a licensed or registered physical or occupational therapist or a certified speech therapist that is licensed or registered as required as such by the state in which they practice, subject to the Plan's review and approval of your treatment plan for physical therapy and functional occupational therapy services. Premera or its designee may review a member's treatment plan for the purpose of verifying that the treatment is clinically safe, effective, and appropriate for the member's condition. Based on a prospective, concurrent or retrospective review, Premera may deny coverage if, in its determination, such services are not medically necessary.

Services rendered by a massage therapist are not covered under the rehabilitation benefit. Refer to the Chiropractic services, acupuncture, and medical massage therapy benefit for coverage.

Respite Care (Non-Hospice)

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

Limit: 672 hours per calendar year

Respite care is for covered members who need assistance with activities of daily living (ADLs) such as bathing and dressing due to a permanent or temporary disabling medical condition, such as a traumatic brain injury, advanced multiple sclerosis, and severe cerebral palsy, where the member needs assistance moving from one place to the other. This benefit covers 672 hours per calendar year in the member's residential home to provide family caregivers an opportunity to recover from the emotionally and physically demanding tasks of caring for the covered member who requires assistance with ADLs.

The respite care application form and a home assessment must be completed prior to accessing this benefit. After the home assessment, Premera will make a determination if the covered member needs assistance with ADLs related to a disabling medical condition and qualifies for respite care coverage, which may be approved for up to a 12-month period. The home assessment is covered under the [Home health care](#) benefit. For the respite care application and more information on this benefit, call Premera Customer Service at (800) 676-1411.

Additional exclusions and limitations for respite care:

In addition to the plan's [exclusions and Limitations](#), the following exclusions and limitations apply to this benefit:

- Respite care provided by a non-certified or non-licensed provider or agency
- Respite care provided by a family member or friend
- Travel expenses, mileage, supplies or any other personal needs of the provider of the respite care
- Instrumental ADLs – examples of instrumental ADLs that are not covered by this benefit include, but are not limited to: shopping, housework, managing finances and using the computer.

Skilled nursing facility

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

Limit: up to 120 days per member per calendar year

This benefit covers inpatient care in a Medicare-approved skilled nursing facility for up to 120 days in each calendar year. Services must be part of a formal written treatment plan prescribed by the doctor. Custodial care is not included in this coverage.



Custodial care is provided primarily for ongoing maintenance of a person's condition or to assist a person in meeting activities of daily living, and not for therapeutic value or requiring the constant attention of trained medical personnel. Review the [glossary](#) for a full definition.

Services and supplies eligible for reimbursement include:

- Room and board, meals, and general nursing care
- Services and supplies furnished and used while you are in the skilled nursing facility, such as:
 - The use of special treatment rooms
 - Routine lab exams
 - Physical
 - Occupational or speech therapy
 - Respiratory and other gas therapy
 - Drugs and biologicals (such as blood products and solutions)
 - Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts

Prior authorization

A prior authorization, also referred to as a pre-service review, is strongly recommended for skilled nursing facilities to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Additional exclusions and limitations for skilled nursing facility

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Custodial care is not provided
- Care that is primarily for neurocognitive disorder, intellectual disability, or the treatment of substance use disorder and alcohol use disorder

Sterilization services

Elective Sterilization – Female

In-network: 100%

Out-of-network: 100% of allowable charges

This benefit covers elective, permanent sterilization procedures, such as tubal ligation. Reversals or attempted reversals of these procedures are not covered.

Elective Sterilization – Male

In-network: 100%, deductible applies

Out-of-network: 100% of allowable charges, deductible applies

This benefit covers elective, permanent sterilization procedures, such as vasectomy. Reversals or attempted reversals of these procedures are not covered.

Surgical weight loss treatment

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

Who is eligible

This benefit covers you, your spouse/domestic partner, or dependent when the criteria listed in the Premera Medical Policy on Bariatric Surgery are met.



Contact Premera at (800) 676-1411 for a copy of the policy.

Examples of qualifying criteria include:

- A Body Mass Index (BMI) greater than 40 Kilograms (kg) per square meter (m²) or BMI greater than 35 Kg per m² in conjunction with severe diabetes, hypertension, or obstructive sleep apnea
- Physician-supervised weight reduction program which includes:

- A program lasting at least three consecutive months within the 12-month period before surgery is considered,
- Evidence of active participation in a program documented in the member's medical records,
- A psychological evaluation and clearance by a licensed mental health provider, to help rule out other psychological disorders, inability to provide informed consent, or inability to comply with pre- and post-surgical requirements.

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Temporomandibular joint (TMJ) dysfunction

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers treatment of temporomandibular joint (TMJ) dysfunction and other related disorders, such as myofascial pain dysfunction (MPD). Services must be rendered by a physician, hospital, licensed or registered physical therapist, or licensed dentist.



While not required by the Plan, pre-service review is strongly recommended for some TMJ services, to ensure that coverage is available. For a list of such services, call (800) 676-1411. Fax pre-service review requests to Dental Review at (425) 918-5956 or mailed to:

Dental Review
MS 173

P.O. Box 91059

TMJ services and supplies for the treatment of TMJ dysfunction and myofascial pain dysfunction include:

- Diagnostic and follow-up examinations
- Diagnostic X-ray services
- Oral surgery
- Physical therapy

- Biofeedback
- Transcutaneous Electrical Nerve Stimulation (TENS)
- TMJ splints or TMJ guards

Transfusions, blood, and blood derivatives

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

This benefit covers transfusions, blood, and blood derivatives that are not replaced by voluntary donors. The cost of donating and storing your own blood for a planned surgery is also covered.

Gender Affirming surgical services

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

This benefit covers medically necessary gender affirming surgical services, including facility and anesthesia charges related to the surgery.

Coverage of prescription drugs and mental health treatment associated with gender reassignment surgery is available under the [prescription drugs](#) and [mental health](#) benefits.

When services are covered

Surgical gender reassignment services will be considered medically necessary and covered if you are diagnosed as having gender dysphoria, and the following criteria are met:

For breast/chest surgery:

- You are at least 13 years old.
- You have one letter of recommendation for surgery from a mental health professional. The recommendation must be based on an assessment conducted within the last 24 months and must verify that your decision is current, well thought out, not impulsive, and not due to any other condition and/or mental disorder.
- The surgery is medically necessary according to the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH).

For genital surgery:

- You are at least 18 years old.
- You have two letters of recommendations for surgery from two separate mental health professionals, at least one of which includes an extensive report. A letter from a master's degree-level professional is acceptable if the second letter is from a psychiatrist or PhD clinical psychologist.
- The recommendation must be based on assessments conducted within the last 24 months and must verify that your decision is current, well thought out, not impulsive, and not due to any other treatable condition and/or disorder.
- The surgery is medically necessary according to the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH).

For other procedures:

- The surgery is medically necessary according to the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH).

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended for coverage to be made available for gender affirming surgical services. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

For gender affirming services, the prior authorization should include:

- The surgical procedure(s) for which coverage is being requested
- The date the procedure will be performed
- Information supporting the criteria listed above has been met, based on the surgery being requested



Your physician can fax this information to (800) 843-1114 or mail it to:

Premera Blue Cross

Attn: Integrated Health Management

P.O. 91059

Transplants

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers solid organ transplants and bone marrow/stem cell reinfusion — procedures cannot be experimental or investigational.



Experimental or investigational services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#) for a full definition.



The transplant benefit doesn't cover cornea transplantation, skin grafts, or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure.

Eligible providers

To be eligible for coverage, the transplant or reinfusion must be furnished in an approved transplant center that has developed expertise in performing solid organ transplants, bone marrow reinfusion, or stem cell reinfusion, and is approved by Premera. Premera has contractual agreements with approved transplant centers and has access to a special network of approved transplant centers, throughout the United States. Whenever medically possible, we will direct you to an approved transplant center with which Premera has a contract. Of course, if neither a Premera-approved transplant center nor a Premera

network transplant center can provide the type of transplant you need, this benefit will cover a transplant center that meets the approval standards that are set by Premera.



Approved transplant center is a hospital or other provider that has developed expertise in performing covered transplant services and has a contractual agreement in place with Premera. Review the [glossary](#) for a full definition.

Donor costs

All donor acquisition costs such as selection (testing and typing), harvesting (removal) transportation of donor organ, bone marrow and stem cells, and storage costs for bone marrow and stem cells for a period of up to 12 months are covered services, including costs incurred by the surgical harvesting teams.

Additional exclusions and limitations for transplants

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Nonhuman or mechanical organs, unless they are not experimental or investigational
- Services and supplies that are payable by any government, foundation, or charitable grant. This includes services performed on potential or actual recipients or donors (living or cadaver).
- Donor costs are not covered if the recipient of the transplant service is not a Woodgrove Financial enrollee. This applies to donor costs for all types of transplant services, solid organ and bone marrow or stem cell reinfusion.
- Donor costs are not covered by Woodgrove Financial if benefits are available under other group or individual coverage
- Donor costs are not covered for transportation for typing or matching

Travel and Lodging Reimbursement Benefit

In-network: 100%, deductible applies (additional IRS limitations below)

Out-of-network: 100%, deductible applies (additional IRS limitations below) Limit:

\$10,000 per member, per calendar year

The following travel and lodging reimbursement benefits are available when travel is necessary to obtain covered services under the Plan that are not available within 100 miles of the member's residence.

Travel Allowances: Travel expenses are reimbursed between the member's residence and the location of the covered treatment for round trip (air, train, or bus) transportation costs. Airfare, or train or bus fare, must be for a regularly scheduled commercial flight, or train or

bus route (coach class only). If traveling by automobile, mileage, parking, and toll costs are reimbursed. Costs for surface transportation (rideshares, taxi, ferry, etc.) are also covered. Mileage reimbursement is based on the current IRS medical mileage reimbursement. Please refer to the IRS website, www.irs.gov, publication 502 Medical and Dental expenses, for current mileage reimbursement rates.

Lodging Allowances: Hotel or motel stays (or similar accommodations) away from the geographic area of the member's residence. Reimbursement of expenses incurred by a member and one companion for hotel or motel lodging away from home, in the geographic area where the covered treatment is performed, is provided at a rate of \$50 per night per person, or up to \$100 per night total for the member

and one companion, if applicable (see below), in accordance with applicable IRS reimbursement requirements.

Overall Maximum: The travel and lodging reimbursement benefit is limited to a total of \$10,000 per member per calendar year.

Companions: The travel and lodging benefit is available for the reimbursement of eligible expenses incurred by the member, as well as a companion, to the extent that a companion is needed to accompany the member for the treatment due to medical necessity or safety concerns.

- Adult member (age 18 or older) – travel and lodging reimbursement for 1 companion is permitted.
- Child member – travel and lodging reimbursement for 1 parent or guardian is permitted

Limits: Eligible travel and lodging expenses under this benefit are reimbursable up to the IRS mileage rate, lodging allowance, or other limits, as applicable, in effect on the date you incurred the expense, which are subject to change. Please visit to the IRS website, **www.irs.gov**, for details. Nothing in this summary of the travel and lodging reimbursement benefit should be considered legal or tax advice.

Please consult with a personal legal or tax advisor for more information.

Non-Covered Expenses:

- Alcohol/tobacco
- Car rental expenses
- Any airfare, train or bus fare, or upgrades, for any ticket other than a regularly scheduled commercial flight or route in coach class
- Baggage fees
- Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
- Expenses for persons other than the patient and an eligible companion
- Lodging at a residence owned by a family member or friend
- Costs for pets or animals, other than service animals
- Meals
- Personal care items (e.g., shampoo, deodorant, toothbrush etc.)
- Souvenirs (e.g., T-shirts, sweatshirts, toys, etc.)
- Telephone calls

Limitations/exclusions:

- The travel and lodging must occur, and the treatment must be provided, within the United States
- The patient must be covered by one of Woodgrove Financial's Premera plans at the time the treatment is provided and the travel and lodging expenses are incurred
- The medical treatment for which the patient is required to travel more than 100 miles from the patient's residence must be a covered benefit under the Plan

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine in advance whether coverage is available for travel and lodging reimbursement.



Prior authorization is an advance determination by Premera that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Virtual Care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

Virtual Care is the delivery of health-related services and information between a member and provider via telecommunications (email, telephone, video, and online) for the purpose of diagnosis, prevention, health advice, disease management and treatment.

Electronic Visits. An electronic visit (“e-visit”) is a structured, secure online consultation between an approved physician and the member. This benefit will cover medically necessary e-visits for an illness or injury. Each approved physician will determine which conditions and circumstances are appropriate for e- visits in their practice.

Telehealth Services. Your plan covers access to care via online and telephonic methods when medically appropriate. Services must be medically necessary to treat a covered illness, injury or condition. Your provider will determine which conditions and circumstances are appropriate for telehealth services.

Services delivered via telehealth methods are subject to standard office visit cost-shares and other provisions as stated in this booklet. Virtual Care with a provider located outside of the United States is not covered.

For information about how the novel coronavirus (COVID-19) pandemic impacts this benefit see [Important information due to the coronavirus pandemic](#).

Vision therapy

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

Limit: up to 32-visit benefit maximum, per member, for the duration of the member’s continuous enrollment

This benefit covers vision training, eye training or eye exercises up to a maximum of 32 treatment visits, for the duration of the member’s continuous enrollment in one or more Premera-administered health plan options, for the following conditions only:

- Amblyopia

- Convergence insufficiency
- Esotropia or exotropia

All other uses of vision therapy are considered investigative and are not covered. Vision therapy is not a covered service under the [Vision plan](#). Costs of equipment and supplies associated with vision therapy are not covered.

Weight Management program

In-network (eligible providers): 80% up to \$6,000 maximum for the duration of your continuous enrollment in one or more Premera-administered health plan options; deductible and coinsurance maximum do not apply

Out-of-network: not applicable

This benefit covers comprehensive and clinically based weight management programs for the treatment of obesity. The 20% coinsurance you pay will not count toward the deductible or coinsurance maximum and will continue after the deductible and coinsurance maximum are met.

Who is eligible

Members are eligible for this benefit if they meet the following criteria:

- Diagnosed as obese (commonly Body Mass Index (BMI) greater than or equal to 30)
- Overweight with a BMI greater than or equal to 27, and diagnosed with two or more of the following conditions:
 - Congestive heart failure
 - Coronary heart disease
 - Depression
 - Diabetes
 - Hyperlipidemia
 - Hypertension

Dependent children are not eligible for this benefit.

Eligible providers

Approved [weight management providers](#) of this benefit must meet eligibility requirements set forth by Woodgrove Financial and Premera and be providing services under a weight management program that is contracted for and approved by Premera for this plan.

Approved weight management programs will be those programs that are comprehensive and clinically based. Approved programs must be based on medical oversight and include treatment from professionals in the areas of nutrition, behavioral therapy, and personal training. An approved program must include an initial minimum 10-week period of frequent sessions with the program's physician, personal trainer, dietitian, and behavioral therapist. This initial period must be followed by a minimum three-month maintenance period, which includes regular follow-up visits with these program professionals.

The Weight Management program must be contracted for and approved by Premera both at the time the participant or covered spouse/domestic partner begins the program and when

they complete the program. If the program is not approved and contracted for until after the participant has started treatment under the program, no part of the cost of the program will be covered under this benefit.



To find an approved provider, review the [Weight Management providers list](#).

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

A [Weight Management Recommendation form](#) or confirmation of your BMI and co-morbid conditions must be submitted to Premera in order to receive reimbursement from Premera. Your physician's recommendation will confirm you meet the contract criteria required for this benefit to be available.

The following are the steps that you are strongly recommended to complete in advance to ensure that your treatment meets the criteria of this benefit:

1. Take the Weight Management Recommendation form to your regular physician
2. An evaluation is performed by your physician to determine if you meet the eligibility requirements set forth above
3. Your physician faxes or mails the Weight Management Recommendation Form to Premera to confirm that you meet the weight management eligibility requirements and your physician's approval



Your physician can fax this information to (800) 676-1477

4. Premera will review the information submitted and verify the coverage through a prior authorization

Claims payment

Final claims payment will be contingent on Premera receiving all biometric reporting information for the participant. Reimbursement for this benefit may occur in one of two ways. The program you attend will select the claims payment method used.

Method 1: Direct reimbursement to member

The provider will bill you directly for services provided. The frequency of billing should be made clear by the provider before you start the program. The weight management provider may collect a deposit from you to initiate your participation in the program.

During the course of the program, you can submit an interim billing member claim form on a monthly or quarterly basis to Premera for reimbursement. Upon completion of the program, you must submit the weight management final billing claim form for your final payment. Final claims payment is contingent on receiving the form with all biometric information completed.

If your coverage terminates during the time you are participating in an approved program, and you do not elect COBRA, only services rendered up to the date of termination of coverage will be reimbursed.

Method 2: Direct reimbursement to provider

Reimbursement will be made directly to the weight management provider on a monthly or quarterly basis. The weight management provider may collect a deposit from you to initiate your participation in the program but will bill Premera on a monthly or quarterly basis for your ongoing participation.

Additional exclusions and limitations for Weight Management program

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Food
- Nutritional supplements (i.e., protein shakes)
- Drugs or surgical procedures to assist in reducing weight or curbing hunger are not covered under the weight management program benefit. Refer to the [Prescription drugs](#) or [Surgical weight loss treatment](#) benefit for coverage.

Exclusions and limitations

- Services or supplies not medically necessary for diagnosis, care, or treatment of a disease, illness, injury, or medical condition, except for the following: (a) newborn nursery care covered under the hospital benefit; (b) male circumcision benefit; (c) sterilization benefit; (d) termination of pregnancy benefit; (e) infertility benefit; (f) hospice care benefit; and (g) well-child care and adult physical exam benefits
- Charges in excess of eligible charges, including out-of-network provider billed amounts over the allowable charges
- Expenses in excess of the applicable annual and lifetime benefit maximums
- Services for which a claim was not received by Premera within 12 months of the date of service. Corrected claims and COB claims need to be submitted within 12 months from the original claim submission date.
- Over-the-counter drugs (unless prescribed); food dietary supplements (for example, infant formulas or protein supplements); and herbal or naturopathic/homeopathic medicine
- Over the counter (OTC) testing and supplies (for example, OTC pregnancy test and ovulation tests)

except as covered under the DME benefit

- Charges for or in connection with services or supplies that are determined to be experimental or investigational
- Benefits that overlap or duplicate benefits for which the member is eligible under any other group benefit plan; Workers' Compensation or similar employee benefit law; Medicare A or B; or government-sponsored program of any type

- Services or supplies that are covered through any type of no-fault coverage or similar type of insurance coverage or contract, including but not limited to Personal Injury Protection (PIP) coverage, motor vehicle medical (MEDPAY), motor vehicle no-fault coverage, any excess insurance coverage, Medical premises coverage for homeowners or commercial (MEDPREM), commercial liability coverage, boat coverage, homeowner policy, or school and/or athletic policies.
 - This exclusion applies when the available or existing contract or insurance is either issued to, or makes benefits available to a Participant/claimant, whether or not the Participant/claimant makes a claim under such coverage.
 - Further, the Participant is responsible for any cost-sharing required by motor vehicle coverage, unless applicable state law requires otherwise.
 - If other insurance is available for medical benefits, the Participant must put such other insurance to use towards those medical bills before coverage under the Plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, Benefits will be provided according to the Plan.
- Work-related Conditions: This exclusion applies whether or not a proper or timely claim for benefits has been made under the following programs. This plan does not cover services or supplies for which you are entitled to receive benefits under:
 - Occupational coverage required of, or voluntarily obtained by, the employer
 - State or federal workers' compensation acts
 - Any legislative act providing compensation for work-related illness or injury
- In the event that you do not comply with the contractual terms of subrogation, the plan will no longer be obligated to provide any benefits. The plan has the right to deduct the amount of benefits paid from any future benefits payable to the enrollee or to any other covered dependent.
- Any services or supplies for which no charge is made, or for which a charge is made because this plan is in effect, or for services or supplies for which the member is legally liable because this plan is in effect
- Services of a social worker except as provided in the hospice care benefit, the home health care benefit, and the mental health and chemical dependency benefit
- Routine or palliative foot care to treat fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other problems that are commonly treated with off-the-shelf, over-the-counter (OTC) therapy. This exclusion does not apply to medically necessary foot care.
- Foot or shoe prosthetics, appliances, orthotics or inserts except as described under the durable medical and surgical equipment and supplies benefit. This does not apply to enrollees who are diabetic.
- Massage therapy that is not medically necessary or is furnished without a prescription
- Any benefits or services not specifically provided for in this SPD
- Liquid diets or fasting programs, memberships in diet programs or health clubs, or wiring of the jaw
- Drugs and medications not approved by the Food and Drug Administration (FDA) except as defined in the Experimental and Investigational section
- Procedures for sterilization reversals
- Hypnotherapy, regardless of provider
- Hippotherapy or other forms of equine or animal-based therapy

- Electronic services and/or consults, except as specifically described under the plan
- Services or supplies furnished by a member to himself or herself or by a provider who is in any way related to the member. This also includes but is not limited to a provider covered dependents under the plan (whether or not living in the household), spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent or spouse of grandchild.
- Services that are illegal, outside the scope of the provider's license or certification, or furnished by a provider that is not licensed or certified by the jurisdiction in which the services or supplies were received
- Separate charges for records or reports, except those Premera requests for utilization review
- Voluntary support or affinity groups such as patient support, diabetic support groups or Alcoholics Anonymous. Additionally, volunteer services or services provided by or through a school, books, and other training aids are also not covered.
- Non-treatment facilities, institutions or programs: Benefits are not provided for institutional care, housing, incarceration, or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, juvenile detention facilities, group homes, foster homes and adult family homes. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider, provided that such non-treatment facilities, institutions, or programs, themselves, are not eligible providers for this purpose.
- Services or supplies for any of the following:
 - Education and training programs including testing or supplies/materials, including vision training supplies
 - Educational or recreational therapy or programs; this includes, but is not limited to, boarding schools. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider, provided that educational or recreational therapy or programs, themselves, are not eligible providers for this purpose.
 - Social, cultural, or vocational rehabilitation or vision training supplies
- Refractive surgery of the eye (surgery to improve vision that can be corrected with glasses or contact lenses) is covered only as specified under the vision plan
- Hospital grade breast pumps are not available for purchase; however, they may be covered for rent for up to 12 months
- Services for individuals not eligible for coverage under the Woodgrove Financial Plan will not be reimbursed except in the following circumstances:
 - Donors for organ or bone marrow/stem cell transplantation for services specific to that procedure
 - Genetic testing of relatives when the information is needed to adequately assess risk in the member; the result of the test will directly impact the treatment to the member; and there is no other coverage available to the relative
- Lodging is covered only as outlined in the Travel and Lodging Reimbursement Benefit
- When Coordinating Benefits (COB) if you fail to follow the rules of the primary plan, this plan would pay nothing for that expense
- Benefits are not provided for services or supplies (1) for which no charge is made, (2) for which no charge would have been made if this plan were not in effect or (3) that were not received by the member while covered by the plan

- Services received in excess of a benefit limit or maximum are not covered. Any network discounts for in network providers do not apply to services received in excess of the benefit limit.

In addition, certain exclusions and limitations apply to the following benefits. CTRL+Click to navigate to the benefit information.

- [Autism/ABA therapy](#)
- [Dental services](#)
- [Hearing care and hardware](#)
- [Home health care](#)
- [Hospice care](#)
- [Hospital inpatient care](#)
- [Infertility](#)
- [Medical equipment and supplies](#)
- [Mental health and chemical dependency treatment](#)
- [Prescription drugs](#)
- [Skilled nursing facility](#)
- [Transplants](#)
- [Weight Management program](#)

How to file a claim

In most cases, when you receive care from an in-network provider, your provider will submit bills directly to Premera, and this submission is your claim for benefits. If your provider does not submit a bill directly to Premera, you will need to submit a claim for benefits.

If possible, you should submit the claim form within 30 days of the service. The plan will not reimburse claims submitted more than 12 months after the date of service.

For information about how the novel coronavirus (COVID-19) pandemic impacts the claims process and timelines, [Important information due to the coronavirus pandemic](#).

To submit a claim online:

From the Benefits Site, select **View My Claims**, which will direct you to the Premera Portal. Or sign in to your account on premera.com. Next, from the top menu bar select **Claims** and then **Submit Claims**.

Follow the steps and upload a copy of the itemized receipt. To submit a claim via mail, fax or email:

1. Download the [Premera Claim Reimbursement Request Form](#). You can also email Premera from your Woodgrove Financial email address (employees) to Woodgrove.Financial@premera.com or through your Secure Messaging center in the Premera portal (all enrollees including dependents)

- and COBRA members) to request a claim form.
2. Complete the claim form, including all of the following information:
 - a. Your name and the member's name
 - b. Identification numbers shown on your identification card (including the 3-digit plan prefix or MSJ)

- c. Provider's name, address, and tax identification number
- d. If you are seeking secondary coverage from the Woodgrove Financial health plan, information about other insurance coverage related to the claim at hand, including a copy of their Explanation of Benefits (EOB), if applicable
- e. If treatment is as a result of an accident: the date, time, location and brief description of the accident
- f. Date of onset of the illness or injury
- g. Date of service
- h. Diagnosis or ICD-10 code (this information can be found on the provider bill)
- i. Procedure codes (CPT-4, HCPCS, ADA, or UB-92) or descriptive English language for each service (this information can be found on the provider bill)
- j. Itemized charges for each service rendered by provider
- 3. Sign the form in the space provided and attach the itemized provider bill
- 4. Submit the completed form to:
Mail: Premera Blue Cross
P.O. Box 91059

Seattle, WA 98111-9159

Fax: (800) 676-1477

Email from Woodgrove Financial email address:

claims.Woodgrove Financial@premera.com Email through the

Secure Messaging center in your Premera portal



COBRA-eligibility claims should be submitted as described in the [Continuation of coverage for health benefits and FSA benefits \(COBRA\)](#) section.

In the following circumstances, you may submit claims according to the [appeals process](#):

If you cannot submit the claim in a timely manner due to circumstances beyond your control If your claim regards plan eligibility for you, your spouse/domestic partner, or dependent child

Claim review and payment

The claim review process begins once Premera receives a claim from you or your provider or other authorized representative. Premera will send you an Explanation of Benefits (EOB) or other communication notifying you of their decision on your claim. In most cases, this communication will be sent to you no more than 30 days after Premera receives the claim, although Premera may extend this 30-day period for up to 15 days if the extension is required due to matters beyond Premera's control.

If your claim relates to an item for which the Plan requires you to obtain approval (or "prior authorization") before it is furnished to you, then Premera generally will send a decision no later than 15 calendar days after receipt of your request. Premera may extend this 15-day

period for up to an additional 15 days if the extension is required due to matters beyond Premera's control.

If Premera needs additional information from you to process your pre- or post-service claim, Premera will notify you in writing, within 30 days after receiving your claim, of the specific information required. You will have at least 45 days to provide the additional information. The determination period to respond to your claim (as provided above) will be suspended as of the date Premera sends the notice and will resume again once you have provided the additional information. If you do not provide the requested information within the specified timeframe, Premera will decide the claim without the requested information.

If your claim is for “urgent care,” meaning the application of the standard time periods for making determinations could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment at issue, then the following special rules apply:

- Premera will send you an EOB or other communication notifying you if they have denied your claim, in writing or electronically, within 72 hours after Premera receives all necessary information for your claim either via phone or in writing, taking into account the seriousness of your condition.
- Premera’s denial notice may be oral, with a written or electronic confirmation to follow within three days.
- If the claim was filed incorrectly, Premera will notify you of the error and how to correct it within 24 hours after the claim was received. If additional information is needed to process the claim, Premera will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information. You will then be notified of Premera’s determination no later than 48 hours after (1) Premera’s receipt of the requested information, or (2) the end of the 48-hour period when you were to provide the additional information if the information is not received in that timeframe.

If your claim is a request to extend an ongoing course of treatment beyond a previously approved period of time or number of treatments, and is considered an urgent care claim, Premera will decide your claim within 24 hours, provided that your claim is submitted at least 24 hours before the end of the approved treatment.



Explanation of benefits (EOB) is the statement you receive from Premera Blue Cross detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

Premera will make a payment to the employee, a dependent (age 13 or older), a provider, or another carrier. Payments are subject to applicable laws and regulations:

- Premera may make payments on behalf of an enrolled child to a non-enrolled parent or state agency to which the plan is required by applicable law to direct such payments
- Payments made will discharge the plan to the extent of the amount paid, so that the plan is not liable to anyone due to its choice of payee

Denied claims notice

If all or part of your claim is denied, Premera will send you an Explanation of Benefits (EOB) or other notice with the following information:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A description of any additional material or information needed from you and the reason it is needed
- An explanation of the appeals procedures and the applicable time limits

- A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request)

- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)
- If the claim is for urgent care (as defined above), a description of the expedited review process applicable to such claims
- If you have filed a claim with Premera relating to plan eligibility, and this claim is denied, Premera will send you a notice explaining your appeal rights
- Notice regarding your right to bring legal action following a denial on appeal

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
- The denial code and its meaning
- A description of the plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal
- Contact information for Premera Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

Appeal for internal review

If you do not agree with the decision made by the plan, you may appeal for an internal review of the decision within 180 days of receiving the Explanation of Benefits (EOB) or adverse decision.

For information about how the novel coronavirus (COVID-19) pandemic impacts the appeal process and timelines, [Important information due to the coronavirus pandemic](#).



An **appeal** is a written request to reconsider a written or official verbal adverse determination to deny, modify, reduce or end payment, coverage or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to and continued stays in a facility. The process also applies to Flexible Spending Account appeals for reimbursement but does not apply to appeals of denied COBRA eligibility claims.



If you fail to file the internal appeal within 180 days of receiving the Explanation of Benefits, you will permanently lose your right to appeal the denied claim.

Submitting an appeal for internal review

You or your authorized representative* must provide the following information as part of your written appeal to the Premera Appeals Department:

- Your name,
- Your Premera member number,
- The name of this plan, and
- A concise statement of why you disagree with the decision, including facts or theories supporting your claim.

Your written request may (but is not required to) include issues, comments, documents, and other records you want considered in the review.



The appeal should be mailed or faxed to Premera:

Appeals Coordinator
Premera Blue Cross

P.O. Box 91102

*You may, at your own expense, have a representative file an appeal on your behalf. Your attorney, family member, your provider, or anyone else who you wish to designate as your authorized representative may also appeal with written authorization. In order to designate an authorized representative for this purpose, you must submit a completed and signed [Woodgrove Financial Member Appeals Form](#), which includes an appeal authorization section.

In the case of an urgent care appeal, you may submit your appeal request orally or in writing and all necessary information may be transmitted between you and the plan by telephone or fax. If your provider believes your situation is urgent as defined under law and so notifies Premera, your appeal will be conducted on an expedited basis. Notification will be furnished to you as soon as possible, but not later than 72 hours after receipt of the expedited appeal. Your appeal should clearly indicate your request for an expedited appeal.

For urgent situations or if you are in an ongoing course of treatment, you may begin an external independent review at the same time as Premera Blue Cross's internal review process. The external review agency is not legally affiliated or controlled by Premera. The external review agency decision is final and is binding upon the Plan.



To file an urgent care appeal request, you may fax a request to (425) 918-5592.



The external review for non-urgent situations is available only after you have properly exhausted the internal appeal as described above.



An urgent care claim or appeal is one where the application of the standard time periods for making determinations could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Internal review and timeframe

All the information you submit will be taken into account on appeal, even if it was not reviewed as part of the initial decision. You may ask to examine or receive free copies of all pertinent plan documents, records, and other information relevant to your claim by asking Premera.

The plan may consult with a health care professional who has experience in the field of medicine involved in the medical judgment to decide your appeal. You may request the identity of medical experts whose

advice was obtained by the plan in connection with your initial claim denial, even if their advice was not relied upon in making the initial decision.

In the event any new or additional information (evidence) is considered, relied on or generated by Premera in connection with your appeal, Premera will provide this information to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Premera, Premera will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that that you will have an opportunity to respond.

Other than urgent care appeals, described above, in most cases Premera will send a decision on your appeal no later than 60 calendar days after receipt of your appeal request. However, if the appeal relates to an item for which the Plan requires you to obtain approval before it is furnished to you, then it will be considered a pre-service appeal, and Premera will send a decision no later than 30 calendar days after receipt of your appeal request.

Denied appeal notice

If your appeal is denied, you will receive a written notice setting forth:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits
- A statement explaining the external review procedures offered by the plan and your right to bring a civil action under ERISA section 502(a)
- A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in denying the claim (a copy of which will be provided free upon request)
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
- The denial code and its meaning
- A description of the Plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal
- Contact information for Premera Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

Appeal for external review

If you are not satisfied with the final internal denial of your claim, you may request an external review by an independent review organization (IRO) if that denial (1) has a retroactive effect and is considered a rescission of coverage under the law, or (2) is based on medical judgment including:

- Requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit

- A determination that a treatment is experimental or investigational



An **independent review organization (IRO)** is an independent organization of medical experts who are qualified to review medical and other relevant information.

The external review for non-urgent situations is available only after you have properly exhausted the internal appeals process as described above. There are no fees or costs imposed on you as part of the external review.

The external review agency decision is final and is binding upon the plan.

Submitting an appeal for external review

To initiate the external review, you must send a written request to Premera at the address below no later than 120 days after the date you receive your internal appeal determination letter, which the plan deems to be seven days after the date on the internal appeal determination letter.



If you fail to submit the written request within this timeframe, you will permanently lose your right to an external review.



Mail or fax the written request to:

Premera Blue Cross

Attn: Woodgrove Financial Member Appeals – IRO Mail Stop 123

P.O. Box 91102

External review and timeframe

If your appeal is eligible for external review, Premera will notify the IRO of your request for an external review and send them all the information included in your internal appeal and other relevant materials within six days of receipt.

The IRO will contact Premera directly if additional information is needed. Premera will provide the IRO with any additional information they request that is reasonably available. The external review request is considered complete when the IRO has all the requested information, and the IRO review begins.



If your provider believes your situation is urgent under law (as defined above under Appeal for internal review), your external review will be conducted on an expedited basis. For expedited external reviews, you and Premera will be notified by phone, e-mail message or fax as soon as possible, but no later than 72 hours after receipt of your external review request. A written determination will follow.

The plan agrees that any statute of limitations (including the one-year contractual limitations period described below) or other defense based on timeliness is on hold during the time that the external review is pending. Your decision whether to file the external review will have no effect on your rights to any other benefits under the plan.

The external review process does not apply to appeals of denied claims for plan eligibility or for other appeals of denied claims that are not based on medical judgment.

Decision on the external review

The plan is bound by the IRO's decision. If the IRO overturned the final internal adverse determination, the plan will implement their decision. The IRO will notify you and Premera in writing of its determination on the external review no later than 45 days after receipt of your complete external review request.

Decisions upon the external review are the final decision under the plan's appeal process, and there are no further appeals available from Premera or Woodgrove Financial or any person administering claims or appeals under the plan. However, you still have the right to file suit under ERISA Section 502(a) as a result of the external review decision.

Limits on your right to judicial review

You must follow the appeals process described above through the decision on the appeal before taking action in any other forum regarding a claim for benefits under the plan. Any legal action initiated under the plan must be brought no later than one year following the adverse determination on the appeal. This one-year limitations period on claims for benefits applies in any forum where you initiate legal action. If a legal action is not filed within this period, your benefit claim is deemed permanently waived and barred. In addition, you must raise all issues and grounds for appealing a decision on a claim for benefits at every stage of the appeal process, or else such issues and grounds will be deemed permanently waived and barred.



If you have questions about understanding a denial of a claim or your appeal rights, you may contact Premera Customer Service for assistance at (800) 676-1411. You may also seek assistance from the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor at (866) 444-EBSA (3272).

Right to recover benefits paid in error

If Premera makes a payment in error on your behalf to you or a provider, and you are not eligible for all or a part of that payment, Premera has the right to recover payment, including deducting the amount paid mistake from future benefits.

Note: Health care providers are not “beneficiaries” of the plan, and although Premera may make direct payment to health care providers for the convenience of participants and their

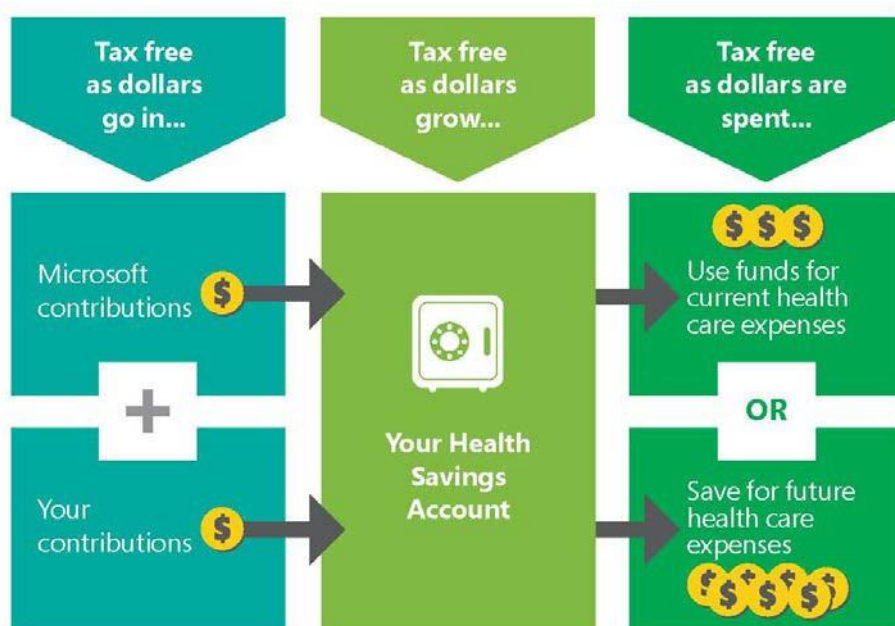
dependents, such payments of services shall not be considered “benefits” available under the plan or confer beneficiary standing upon a health care provider.

Health Savings Account (HSA)

The Health Savings Account is an interest-bearing savings account designed to allow you to pay for medical expenses (both now and in the future) with tax-free dollars. The Health Savings Account is yours—you own, manage, and control the funds in the account. If you do not spend it, you get to keep it, and you can watch it grow over time.

The Health Savings Account is available only to those enrolled in a high-deductible health plan, such as the Health Savings Plan, that meets certain Internal Revenue Service (IRS) criteria.

The Health Savings Account features triple tax savings—tax-free contributions into your account, tax-free earnings on interest and dividends, and tax-free when you withdraw funds to pay for eligible health care expenses.



For more information visit:

Active employees/dependents go here...

[Health Savings Plan](#) on the Benefits site

COBRA enrollees go here...

Premera.com

A Health Savings Account is not an ERISA employee benefit plan established or maintained by Woodgrove Financial. Woodgrove Financial will not: (1) limit your ability to move your funds from one Health Savings Account to another,

(2) impose conditions on utilization of your Health Savings Account funds, (3) make or influence investment decisions with respect to your Health Savings Account funds, or (4) receive any payment or compensation in connection with your Health Savings Account. Your choice whether or not to participate in a Health Savings Account is completely voluntary.

Setting up your account

Woodgrove Financial and Premera work with [Fidelity](#) to administer your Health Savings Account. Once you enroll in the Health Savings Plan, Woodgrove Financial will open a Health Savings Account for you with [Fidelity](#). Woodgrove Financial will pay for the initial account setup fee and monthly access fee while you are covered under the plan as an active employee. You are responsible for paying any additional fees you incur. You may also establish an account at another bank and transfer the funds from the [Fidelity](#) account.

Eligibility to contribute to an HSA

You are eligible for a Health Savings Account if:

- You are enrolled in a Health Savings Account-compatible, high-deductible health plan (such as the Premera Health Savings Plan offered by Woodgrove Financial)
- You are not covered by another health plan (other than another high-deductible health plan), including coverage under your spouse's/domestic partner's health plan or Medicare
- You are not covered by your spouse's Health Care Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA) (except a limited purpose FSA or HRA)
- You cannot be claimed as a dependent on another person's tax return
- You are not enrolled in Medicare (parts A, B, C or D) or TRICARE, and you have not received medical or prescription benefits from the Veteran's Administration (VA) in the preceding three months (other than benefits for preventive care or a service-connected disability, as defined by applicable law). Note: mere eligibility for medical benefits from the Veteran's Administration does not disqualify you from participating in the HSA.



You still have medical coverage under the Health Savings Plan even if you cannot contribute to a Health Savings Account.

If you do not qualify to contribute to a Health Savings Account because you have coverage under another health plan, you or your spouse/domestic partner can take action if you wish to address your eligibility issue.

- If you are covered by your spouse's/domestic partner's health plan, you should have them remove you as a covered dependent and/or withdraw from their health care FSA/HRA
- If you are enrolled in Medicare or TRICARE (medical), or if you have received VA medical/prescription benefits in the past three months (other than for preventive care or a service-connected disability), you are not eligible for the Health Savings Account and typically you cannot take action to address your eligibility issue. In these circumstances, Woodgrove Financial will provide you with an alternative taxable cash contribution, equal to the annual Health Savings Account contribution for your coverage level, via paycheck deposit.

Woodgrove Financial will discontinue all employer contributions to the Health Savings Account when you indicate that you are no longer covered under the plan as an active Woodgrove Financial employee or if you are covered by disqualifying coverage under another health plan.



If you continue medical coverage in the Health Savings Plan through COBRA, you will not continue to receive Woodgrove Financial contributions to your Health Savings Account.

Contributions to your Health Savings Account (HSA)

Woodgrove Financial will make a pre-tax contribution to your Health Savings Account (for active employees only) based upon your role and coverage level, as outlined in the table below. The Woodgrove Financial contribution is deposited in two equal installments in January and July. The amount of your Woodgrove Financial contribution to the Health Savings Account is adjusted based on a prorated calculation of full months of plan enrollment if you or your family members, as applicable, are enrolled in the plan for only part of the year.

Examples

1. Marco (a Woodgrove Financial employee at level 59) enrolls in the Health Savings Plan with employee only coverage during Open Enrollment. His coverage effective date is January 1, 2023. His total Woodgrove Financial HSA contribution for 2023 is \$1,000 and will be contributed to his account as follows:
 - \$500 deposited at the same time as his January 15th paycheck (one half of his total Woodgrove Financial contribution)
 - \$500 deposited at the same time as his July 15th paycheck (one half of his total Woodgrove Financial contribution)
2. Ana (a new Woodgrove Financial employee at level 59) enrolls in the Health Savings Plan with family (employee + 2 or more) coverage. Based on her date of hire, her coverage effective date under the plan is March 7th, 2023. Her total Woodgrove Financial contribution for 2023 is \$1,875 and will be contributed to her account as follows:
 - \$625 will be her first Woodgrove Financial HSA contribution and will occur within 1-2 payrolls following the date she successfully opens her HSA account. This amount represents 3 full months of enrollment under the plan (April, May, and June)
 - \$1,250 deposited at the same time as her July 15th paycheck (one half of the full annual Woodgrove Financial contribution)

You may make additional tax-free contributions to your account. Changes to your employee HSA contributions will take effect as of the first day of the month following the date that you make the election change. If you and your spouse both have an HSA, your combined HSA contributions may not exceed the annual family coverage contribution limit (that is, \$7,750 in 2023). Individuals age 55 or over may make an additional annual catch-up contribution as listed below.

Due to IRS regulations, the annual combined Woodgrove Financial/employee tax-free contribution to the Health Savings Account cannot exceed the maximum annual limits listed in the table below.

Annual tax-free contribution limits for the Health Savings Account				
		Woodgrove Financial	Employee maximum contribution	Maximum annual limit
Level 40-49 and	Employee only	\$1,000	\$2,850	\$3,850
	Employee + 1	\$2,000	\$5,750	\$7,750

59 and above	Employee + 2 or more	\$2,500	\$5,250	\$7,750
Level 30-39 and 50-58	Employee only	\$1,500	\$2,350	\$3,850
	Employee + 1	\$3,000	\$4,750	\$7,750
	Employee + 2 or more	\$3,750	\$4,000	\$7,750
Age 55 or over catch-up contribution		\$0	Maximum contribution plus \$1,000	Maximum contribution plus \$1,000



If you exceed the allowable maximum, excess contributions not removed before your tax filing deadline are subject to an additional 6% excise tax.

If during the year you become eligible to contribute to a health savings account, or are already eligible to contribute to a health saving account but make a mid-year change in your Health Savings Plan coverage level (e.g., from employee-only to employee-plus-one coverage) due to a qualified status change event, then in determining your employee maximum contribution for the year, you may be treated as having been for the entire year eligible to contribute to a health savings account, and enrolled in the coverage that you had as of December 1. This is called the “last month rule.” However, if you use the last month rule and then cease to be eligible to contribute to your health savings account before December 31 of the following year, you may be subject to income and additional taxes on a portion of your previous health savings account contributions.

Woodgrove Financial’s contribution to your health savings account will not be affected by the last month rule, but rather will be adjusted based on a prorated calculation of full months of plan enrollment (and/or twice annual basis, in January and July, as applicable), based upon your role and coverage level at the time of each Woodgrove Financial contribution.

If both you and your spouse/eligible domestic partner are employed by Woodgrove Financial and enroll for coverage in the Health Savings Plan, certain rules apply to your HSA contributions from Woodgrove Financial.

- **If you enroll together under one plan**, the primary subscriber will receive the contribution from Woodgrove Financial to their Health Savings Account for your coverage level. Health care expenses for both you and your spouse/domestic partner will count toward the same deductible and coinsurance maximum.
- **If you enroll separately**, you will each receive the contribution from Woodgrove Financial for your coverage level in your own separate Health Savings Accounts. Health care expenses will count toward separate deductibles and coinsurance maximum amounts. You may keep dependent children with one parent only, or if you have more than one child, you may split them between the two parents.
- **If your Woodgrove Financial-employed domestic partner is not a qualifying tax dependent**, you may find it more beneficial to enroll separately so that he/she can have access to the tax saving benefits of the Health Savings Account. You will pay taxes if you use your Health Savings Account to cover expenses for a dependent who does not qualify as a dependent according to the IRS definition.

Woodgrove Financial will discontinue all employer contributions to the Health Savings Account when you are no longer covered under the Health Savings Plan as an active

Woodgrove Financial employee or if you indicate you are covered by disqualifying coverage under another health plan.

Eligible expenses

The money in your Health Savings Account can be withdrawn on a tax-free basis to pay for qualified medical expenses, as defined by IRC section 223(d)(2) and section 213(d). If the amount withdrawn is used for something other than qualified medical expenses and you are under age 65, then it will be subject to income tax and an additional 20% tax. For more information on tax treatment for Health Savings Accounts, refer to IRS Publication 969.

When you reach age 65, the funds in your Health Savings Account can be used for additional medical expenses, such as insurance premiums (such as Medicare Part A&B, but not Medicare Supplemental plans) and your share of retiree medical insurance premiums.

You are responsible for maintaining records of the medical expenses paid through the Health Savings Account. In the event of an IRS audit, you may need to provide documentation that the Health Savings Account was used for qualified medical expenses.

Health Connect Plan (Premera)

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How the plan works

The Health Connect Plan is built around a select group of providers on the Eastside of the Puget Sound area who share Woodgrove Financial’s vision to deliver a more personalized health care experience and help you achieve improved health outcomes over time. In the Health Connect Plan, you work closely with a Primary Care Provider (PCP). Your PCP gets to know your health care needs and goals and helps coordinate care as needed. You are only eligible for the Health Connect Plan if you live in King or Snohomish County.

Where you can get care

With the Health Connect Plan, you have the flexibility to visit the provider or facility you choose and still have coverage. However, seeing a provider in the Health Connect network means more predictable, lower out of pocket costs. You also have the flexibility to see a provider in the Extended network, which includes providers that are part of the national Blue Cross Blue Shield network. Seeing an Extended network provider may mean your out-of-pocket costs are higher.

If you seek care with an out-of-network provider or facility, your out-of-pocket costs typically will be higher, and you may have to pay the provider and then submit a claim for reimbursement.

Review the [What you pay](#) section for information on coverage levels.

Finding an in-network provider

You can maximize your savings by using providers and facilities in the Health Connect network. You also have the option of seeing a provider in the Extended network. Extended network providers are providers that are within the national Blue Cross Blue Shield network.

Extended network note: We have made an arrangement for you as a Premera Blue Cross member with Anthem Blue Cross in California. In order for you to maximize your in-network savings for services received in California, you will need to choose only Anthem Blue Cross network providers, which are

included in the extended network. All other providers in California are deemed out-of-network, including Blue Shield of California network providers who are not also Anthem Blue Cross network providers.

Outside of Washington and California, you may use any Blue Cross and/or Blue Shield provider throughout the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands under the BlueCard® Program. Your Premera identification card tells contracting providers that you are covered through this inter-plan arrangement. It's important to note that receiving services through BlueCard does not change covered benefits, benefit levels, or any stated residence requirements of this plan.



Visit the online Premera Medical Directory to find an in-network provider in the United States or call Premera Blue Cross at (800) 676-1411.

Active employees go here...

[Premera Medical Directory](#)

Active dependents or COBRA enrollees go here...

[Premera.com](#)

Travel outside the United States

If you are traveling outside the United States, the Commonwealth of Puerto Rico, Jamaica and the British and U.S. Virgin Islands and need care, you may be able to take advantage of Blue Cross Blue Shield Global Core, which provides referrals to doctors and other health care providers.



Call (800) 810-BLUE (2583) for Blue Cross Blue Shield Global Core referrals to health care providers outside the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands.

If you are not using a Blue Cross Blue Shield Global Core provider, you will need to submit claim forms to Premera for reimbursement of services received outside the United States. When you submit a claim, clearly detail the services received, diagnosis (including standard medical procedure and diagnosis code, or English nomenclature), dates of service, and the names and credentials for the attending provider.

Benefits reimbursement will be calculated in U.S. dollars.

Care received outside the United States will be covered as long as the services are:

- Medically necessary
- Provided by a licensed provider performing within the scope of their license and practice
- Not deemed experimental or investigational based on the terms of this plan, or medical standards in the United States

Services received outside the United States that are considered urgent or emergent including services received on a cruise ship will be paid as [emergency care](#), subject to the emergency room \$250 copay (waived if admitted). Non-emergent facility and professional

services are considered under the Extended network and covered at 60% of billed charges. Standard deductible and coinsurance would apply.



Experimental or investigational services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#) for a full definition.



Review the [What you pay](#) section for information on coverage levels.

Filling a prescription

Depending on your needs, you may fill your prescription at a retail pharmacy, pharmacy home delivery, or specialty pharmacy. Review the [prescription drug benefit](#) for more information on what is covered.



Woodgrove Financial reserves the right to change pharmacy networks at any time. Such changes will take effect on the date set by the Company, even if this information has not been revised to show the changes.

	Retail pharmacy	Home delivery	Specialty pharmacy
Coverage	Up to a 90-day supply for generic maintenance medication ; all others are up to a 30-day supply*	Up to 90-day supply* only when using Express Scripts Pharmacy Home Delivery	Up to a 30-day supply* Additional clinical support for members using specialty drugs
In-network pharmacies	Express Scripts pharmacies bill the plan on your behalf To find an Express Scripts retail pharmacy, call (800) 676-1411	Express Scripts pharmacies bill the plan on your behalf	AllianceRX Walgreens Pharmacy or Accredo Specialty Pharmacy** will bill the plan on your behalf
Out-of-network pharmacies	You will need to submit a prescription reimbursement form, with your receipt, for reimbursement	Not covered	Not covered

* Unless the drug maker's packaging limits the supply in some other way.

** Contact AllianceRx Walgreens Pharmacy at (877) 223-6447 or Accredo Specialty Pharmacy at (800) 689-6592 to get started.

The dispensing limits (or days' supply) for drugs dispensed at retail and specialty pharmacies, and through the mail-order pharmacy benefit, are described in the above chart.

Refills for a medication will be covered only when the member has used 75% of the supply of that medication, based on both of the following:

- The number of units and days' supply dispensed on the last fill or refill, and
- The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill, if applicable



A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.

Generic maintenance medications have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year. A generic prescription drug is manufactured and distributed after the brand-name drug patent of the innovator company has expired and is available at a lower cost than brand-name prescriptions. Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration and are considered by the FDA to be therapeutically equivalent to the brand-name product.

Specialty drugs are high-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply.

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended for some services and prescriptions to determine that coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Refer to the specific plan benefit for additional details.

What you pay

You pay nothing for preventive care when you use a Health Connect network or Extended network provider. When you receive care or prescription drugs in other situations, such as for the treatment of illnesses, injuries, and chronic conditions, you pay a portion of the cost up to an annual maximum amount. That annual amount, called your out-of-pocket maximum, includes a deductible, co-pays, and coinsurance. If you use a Health Connect network provider or Extended network provider, you'll receive the lower Premera-negotiated rate, called the allowable charge, and higher coverage levels. Examples of how the plan pays for Health Connect network, Extended network and out-of-network care follow on the next page.

Premera utilizes medical and payment policies in administering coverage under this plan. The medical policies generally are used to further define medical necessity, experimental and investigative status, and other aspects for specific procedures, drugs, biologic agents, devices, and other items and services and levels of care. These medical policies are available at <http://premera.com> or by calling Customer Service. The payment policies are used to define provider billing and payment rules and adjustments that can apply in various different settings and circumstances. These payment policies are available to you by calling Customer Service and to your provider by calling Customer Service or going to <http://premera.com> and logging into Premera's provider portal.

What you pay							
	Copay	+	Deductible	+	Coinsurance	=	Out-of-pocket maximum
			A copay, or copayment, is a fixed amount you pay for a covered health care service, usually when you receive the service. For example, you would pay \$20 for an office visit with your PCP under the Health Connect Plan and \$40 for a specialist office visit.		\$20 PCP office visit / \$40 specialist office visit \$250 emergency room (waived if admitted)		You pay 100% of your eligible expenses for applicable services when using the Extended network or an out-of-network provider for medical care, up to the amount of the deductible.
	Health Connect network				N/A		There is no deductible when you see a Health Connect network provider.
	Extended network		Copays apply to urgent care and emergency room care as well.				

\$0	For some services you will pay coinsurance, which is a percentage of eligible expenses, instead of a copay. For services with an Extended network or out-of-network provider, with some exceptions, the deductible will apply before you begin paying coinsurance.	Your copay, deductible, and coinsurance payments will be applied to your annual out-of-pocket maximum. Once you have reached your out-of-pocket maximum, the plan pays 100% of eligible expenses and you pay nothing for covered services in the Health	\$2,000 Individual
\$1,000 individual		Connect and Extended networks for the rest of the year. You will still be responsible for the difference between the provider's bill and the allowable charge if you seek out-of-network care.	\$6,000 family shared with Extended network and out-of-network
\$3,000 family shared with out-of-network	<p>The coinsurance amount you pay depends on where you seek care:</p> <ul style="list-style-type: none">• Health Connect network, you pay 10%• Extended network, you generally pay 40% after meeting the deductible, unless otherwise specified• Out-of-network, you generally pay 50% of allowable charges after meeting the deductible, unless otherwise specified <p>10% (for services not subject to a copay)</p>		\$2,000 individual

40%

What you pay				
Out-of-network	N/A	\$1,000 individual \$3,000 family shared with Extended network	50% of allowable charge	\$2,000 individual \$6,000 family shared with Health Connect network and Extended network (also, may be responsible for the difference between the provider's bill and out-of-network allowable charge)



The **allowable charge** defined differently for Health Connect and Extended Network providers than for out-of-network providers.

- For Health Connect and Extended Network providers, the allowable charge is the negotiated amount that the provider has agreed to accept as payment in full for a covered service.
- For out-of-network providers, the allowable charge is the lowest of three amounts, as outlined in the definition of "allowable charge" in the Glossary. If you choose to use out-of-network providers, you may be responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges.

Example

Jakob needs to visit his cardiologist. He can choose a provider in the Health Connect network or a provider in the Extended network. Both charge \$200 and the allowable charge is \$150. The Health Connect provider will collect a

\$40 copay at the time of the visit as Jakob's full payment and Premera will pay the balance. The Extended network provider would collect the full \$150 allowed amount since Jakob has not yet met his deductible. The Extended network provider will write off the \$50 difference between the allowed amount and the billed charge. If Jakob sees an out-of-network provider, he will be responsible to pay the full \$200 amount billed since Jakob has not yet met his deductible.

Example

Kunji has an ear infection and is going to an urgent care clinic. The amount billed for the provider visit is \$175 and the allowable charge is \$100. Kunji has met her out-of-pocket maximum, so she'll pay nothing for a visit to a Health Connect or Extended network provider. If she sees an out-of-network provider, and assuming the out-of-network allowable charge is also \$100, she will be responsible to pay the \$75 difference between the allowable charge and the billed charge.

Waiver

If you or a family member needs a service or a provider that is not available in the Health Connect network, your PCP may provide a waiver for you to see a provider in the Extended network at the same cost as if they were in the Health Connect network.

Expenses covered at 100% NOT applied to the deductible, coinsurance, or out-of-pocket maximum

The following services are covered by the plan at 100% and do not count toward the deductible, coinsurance, or out-of-pocket maximum.

- Preventive care
- Care received through the [Spring Health for short-term counseling, resource & referral \(employee assistance program\)](#).

Certain other expenses are your responsibility to pay and do not count toward the annual deductible or out-of-pocket maximum. They include:

- Expenses incurred while the member was not covered under the Plan
- Expenses for services, supplies, settings, or providers that are not covered under the Plan
- Expenses in excess of annual or lifetime benefit maximums that apply to certain plan benefits
- Difference between the allowable charges and the provider's bill for out-of-network care
- Coinsurance for services covered under the [Weight Management program](#)

Additionally, charges for medical services received during business travel that are applied to the deductible or coinsurance are not reimbursable business expenses.

To review information on how to track your deductible and/or coinsurance go to <http://premera.com>.

Extended network and Out-of-network care with Health Connect network coverage

You may seek Extended network and out-of-network care and receive Health Connect network coverage levels in the following situations:

Situation	Benefit coverage	What you need to do
Emergency care	Benefits are provided regardless of network status	Go to the nearest emergency facility
The provider type or service is not available in the Health Connect network	Services from an Extended network provider will be covered at the Health Connect network level with a waiver from your PCP. Services from an out-of-network provider will be covered as outlined elsewhere in this SPD (no waiver is necessary).	Talk with your PCP to see if a waiver for an Extended network provider is appropriate for your situation
Your provider's contract with Premera is ending (continuity of care)	If you are receiving ongoing treatment for certain serious and complex medical conditions or illnesses, or pregnancy, are undergoing institutional or inpatient care, or are scheduled for nonelective surgery, you may be eligible to continue to receive in-network benefits for the current course of treatment, for up to 90 days.	To confirm this continued in-network coverage is available, and the length of the available in-network coverage extension, contact Premera at (800) 676-1411 prior to the end of your provider's contract with Premera

Annual, lifetime, and other benefit maximums

There is no overall annual or lifetime maximum in the Health Connect Plan. However, annual, lifetime, and other benefit maximums apply to certain benefits. Review the [What the plan covers](#) section for details on annual, lifetime, and other benefit maximums.



A **lifetime benefit maximum** is the most a plan will pay toward a benefit for a member. Review the [glossary](#) for a full definition.

An annual or other benefit maximum is the most a plan will pay toward a benefit for a member for services within a specified time period. Review the [glossary](#) for a full definition.

Example

There is a \$6,000 weight management program benefit maximum for the duration of the member’s continuous enrollment in one or more Premera-administered health plan options.

Example

There is a \$10,000 hearing hardware maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in one or more Premera-administered health plan options.

Utilization Management

All benefits under this plan are limited to covered services that are medically necessary and as set forth under Plan Benefits. Premera or its designee may review a member’s medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent, or retrospective review, Premera may deny coverage if, in its determination, such services are not medically necessary or do not meet all criteria specified in this SPD. Such determination shall be based on established clinical criteria as described in Premera’s medical policies. The medical policies are on Premera’s website. You or your provider may review them at [premera.com](#). You or your provider may also request a copy of the criteria used to make a medical necessity decision for a particular condition or procedure. To obtain this information by mail, send your request to Medical Policies Coordinator, 7001 220th Street SW MS 438, Mountlake Terrace, WA 98043-2160. Premera will not deny coverage retroactively for services it has previously authorized and that have already been provided to the member except in the case of fraud or an intentional misrepresentation of a material fact.

What the plan covers

The tables below summarize what the Health Connect Plan covers, including what the plan pays for Health Connect network, Extended network, and out-of-network care.



Services and supplies must be medically necessary and are subject to all benefit exclusions and limitations and the plan's [exclusions and limitations](#).



CTRL+Click on the benefits below to access more information.

Common benefits			
These are the most commonly used benefits in the Health Connect Plan			
Benefit	Health Connect network coverage	Extended network coverage	Out-of-network coverage
Preventive Care Including well-child care through age 18, routine gynecological exams, immunizations and preventive prescription drugs (See the Preventive Care Services list and Preventive Drug list)	Preventive services: 100% Preventive prescription drugs: 100%	Preventive services: 100% Preventive prescription drugs: 100%	Preventive services: 50% of allowable charges, after deductible Preventive prescription drugs: 50% of allowable charges
Prescription drugs Including brand-name preventive with available generic equivalent (see the Health Connect Plan Drug Formulary and preventive care above)	<i>Express Scripts Retail: Generic \$10 copay, Preferred Brand \$30 copay, Non-Preferred Brand \$60 copay</i> <i>Express Scripts Mail Order Pharmacy: Generic \$20 copay, Preferred Brand \$60 copay, Non-Preferred Brand \$120 copay</i>		50% of allowable charges
Physician services – office visit	Primary care provider office visit: \$20 copay Specialist provider office visit: \$40 copay	60%, after deductible	50% of allowable charges, after deductible
Physician services – other Including procedures rendered in the office, hospital, or other medical facility	90%	60%, after deductible	50% of allowable charges, after deductible
Diagnostic services Benefits are provided for diagnostic services (including lab and imaging services) for health conditions or symptoms.	90%	90%	50% of allowable charges, after deductible
Hospital inpatient care Including semi-private room and board, anesthesia, supporting services, testing, supplies, and intensive or coronary care	90%	60%, after deductible	50% of allowable charges, after deductible

Common benefits			
These are the most commonly used benefits in the Health Connect Plan			
Benefit	Health Connect network coverage	Extended network coverage	Out-of-network coverage
Hospital outpatient care/ambulatory surgical care center Including minor surgery, X-ray and radium therapy, anesthesia, and pre-admission testing	90%	60%, after deductible	50% of allowable charges, after deductible
Urgent Care	\$40 office visit copay	60%, after deductible	50% of allowable charges, after deductible
Rehabilitation – Physical, Occupational and Speech Therapies (outpatient)	\$40 copay	\$40 copay	50% of allowable charges, after deductible
Contraception Contraceptive devices and injections administered by a physician. Prescription forms of contraception are covered under preventive care.	100%	100%	50% of allowable charges, after deductible
Maternity care (Other than hospital inpatient or outpatient care)	90%	60%, after deductible	50% of allowable charges, after deductible
Maternity support	Free virtual care and on-demand support (through Maven Clinic) for new and expecting parents.		Not applicable
Maternity care bundle (Routine pregnancy and delivery care received within the Health Connect Network)	\$500 copay	Not applicable	Not applicable
Mental health counseling, mental health inpatient and outpatient services, and chemical dependency treatment *In no event will the outpatient professional copay exceed 40% of the allowed amount.	Outpatient services through Spring Health for short-term counseling (employee assistance program): <ul style="list-style-type: none"> 100% of 24 sessions per calendar year. 		Not applicable
	Outpatient professional: \$20 copay Inpatient and outpatient facility: 90%	Outpatient professional: \$20 copay* Inpatient and outpatient facility: 90%	90% of allowable charges

Other benefits			
The Health Connect Plan also covers these additional benefits			
Benefit	Health Connect network coverage	Extended network coverage	Out-of-network coverage
Ambulance (ground or water)	90%	90%	90%
Air Ambulance	90%	90%	90% of allowable charges
Chiropractic services, acupuncture, and medical massage	\$40 copay	\$40 copay	50% of allowable charges, after deductible
	Combined 24-visit limit per member per calendar year		
Diabetes health education	100%	100%	50% of allowable charges, after deductible
Emergency room care and professional services	\$250 copay (waived if admitted)	\$250 copay (waived if admitted)	\$250 copay (waived if admitted)
Hearing care and hardware	Exams: \$40 copay	Exams: \$40 copay	50% of allowable charges, after deductible
	Hardware: 90%; \$10,000 maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in one or more Premera-administered health plan options		
Home health care	90%	60%, after deductible	50% of allowable charges, after deductible
Hospice care	90%	60%, after deductible	50% after deductible
Medical equipment and supplies	90%	90%	50% of allowable charges, after deductible
Nutritional therapy	100%	100%	50% of allowable charges, after deductible
	First 12 visits per member per calendar year, calendar year visit limit waived for nutritional therapy for a diagnosed eating disorder or diabetes.		
Skilled nursing facility	90%	60%, after deductible	50% of allowable charges, after deductible
	120-day limit per member per calendar year		

Other benefits			
The Health Connect Plan also covers these additional benefits			
Benefit	Health Connect network coverage	Extended network coverage	Out-of-network coverage
Surgical weight loss treatment Covered when criteria listed in the Premera Medical Policy on Surgery for Morbid Obesity are met	90%	60%, after deductible	50% of allowable charges, after deductible
Temporomandibular joint (TMJ) dysfunction	90%	60%, after deductible	50% of allowable charges, after deductible
Transplants	90%	90%	50% of allowable charges, after deductible
Vision therapy	\$40 copay	\$40 copay	50% of allowable charges, after deductible
	32-visit maximum per member, for the duration of the member's continuous enrollment in one or more Premera-administered health plan options		

Specialized benefits			
Woodgrove Financial provides these unique benefits to you through the Health Connect Plan			
Benefit	Health Connect network coverage	Extended network coverage	Out-of-network coverage
Autism/Applied Behavior Analysis (ABA) therapy	90%	90%	50% of allowable charges, after deductible
Infertility	90% for coverage, within the Plan's infertility vendor (Progyny) provider network, of generally two Smart Cycles per household per Plan enrollment lifetime, and one additional Smart Cycle if neither of the first two results in a successful pregnancy	Not applicable	Not applicable

Specialized benefits			
Woodgrove Financial provides these unique benefits to you through the Health Connect Plan			
Benefit	Health Connect network coverage	Extended network coverage	Out-of-network coverage
Gender Affirming services	90%	90%	50% of allowable charges, after deductible If waiver obtained due to inadequate access within Extended network, 90%
Weight Management program Including comprehensive and clinically based weight management programs approved by Premera for the treatment of obesity	80% of charges up to a \$6,000 maximum for the duration of the member's continuous enrollment in one or more Premera-administered health plan options. Out-of-pocket maximum does not apply. The 20% coinsurance you pay will not count toward the out-of-pocket maximum and will continue after the out-of-pocket maximum is met.	Not applicable	Not applicable

Plan benefits



The following pages provide details on what the plan covers. The plan's [exclusions and limitations](#), including the requirement of medical necessity, apply to these benefits.

For information about how the novel coronavirus (COVID) is covered under this plan, see [Important information due to the coronavirus pandemic](#).

24-Hour Nurse Line

The Woodgrove Financial 24-Hour Nurse Line is a confidential health-care information service for you and your dependents. The Nurse Line is available 24 hours a day, seven days a week. It provides useful, easy-to-understand health-care information that will help you to make appropriate health-care decisions.

The 24-Hour Nurse Line cannot diagnose illnesses, prescribe treatment, or give medical advice, but they can do the following:

- Provide information, coaching, and support regarding a wide range of health issues, including:
 - Aches and pains

- Diabetes
- High blood pressure
- Illnesses and infections
- Infant care
- Immunizations
- Provide information about Woodgrove Financial-sponsored health programs such as:
 - Disability leave
 - Ergonomic assistance
 - On-site flu shots
 - On-site mammogram screenings
 - Smoking cessation
 - Weight management
- Offer suggestions about appropriate next steps or available resources.

The average call to the 24-Hour Nurse Line lasts approximately five minutes, so that you can obtain information quickly and can move on to the next step, as advised by the 24-Hour Nurse Line nurse.

The 24-Hour Nurse Line is a service provided by Premera Blue Cross. All Woodgrove Financial covered employees and their dependents can access the 24-Hour Nurse Line.

Accessing the 24-Hour Nurse Line

The toll-free phone number for the 24-Hour Nurse Line is a consolidated phone line. From this one number, Woodgrove Financial covered employees and their dependents can access several health-care services, such as the 24-Hour Nurse Line staff of nurses, a professional counselor with the Woodgrove Financial Counseling, Assistance, Referral and Education Services (CARES) Employee Assistance Program and health-care coverage information. When you call, listen carefully to the entire greeting before you make your selection.



You can reach an experienced, registered nurse 24 hours a day, seven days a week by calling one of the following options:

- (800) 676-1411
- For deaf or hard-of-hearing access (TTY), call (800) 676-1411 then provide the number 711

Ambulance

Ground or Water:

Health Connect network: 90% Extended network: 90%

Out-of-network: 90%

Air:

Health Connect network: 90% Extended network: 90%

Out-of-network: 90% of allowable charges

This benefit covers licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat the condition when any other mode of transportation would endanger the member's health or safety. This benefit is limited to the member that requires transportation.

For air ambulance services, please see Federal No Surprise Billing Protection for special rules that apply to out-of-network air ambulance services.

Autism/Applied Behavior Analysis (ABA) therapy

Health Connect network: 90% Extended network: 90%

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers behavioral interventions based on the principles of Applied Behavioral Analysis (ABA) through eligible providers.

Who is eligible

This benefit is available for members who are diagnosed with Autism Spectrum Disorder (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition / DSM-5*), or with any of the following Pervasive Developmental Disorders (*International Classification of Diseases, 10th Revision, Clinical Modification / ICD-10-CM*):

- Autistic Disorder
- Childhood Disintegrative Disorder
- Asperger's Syndrome
- Rett's Syndrome
- Other Pervasive Development Disorder/Atypical Autism
- Pervasive Developmental Disorder unspecified

Eligible providers

Licensed providers — Medical doctors (MD); doctors of osteopathic medicine (DO); nurse practitioners (NP, ANP, ARNP, etc.); and master's-level or above mental health clinicians and occupational, physical, and speech therapists; provided that they are providing the ABA services within the scope of their practice and licensure.

Board Certified Behavioral Analysts — BCBAs are certified by the Behavior Analyst Certification Board. These providers have master's or doctoral degrees. For ABA services,

typically a BCBA functions as a “Program Manager.” The Program Manager conducts behavioral assessments, including functional analyses, and provides behavior analytic interpretations of the results. The Program Manager also designs and periodically reviews behavior analytic interventions (program development and treatment planning) and may supervise Therapy Assistants. Therapy Assistant services must be billed by the Program Manager.

Covered services

Services must be ordered by the member’s treating physician to be covered. Program Manager benefits are available for time used to evaluate the member and document findings and progress reports, and to

create and update treatment plans; and time used to train and evaluate the work of the Therapy Assistants working directly with the member to implement the treatment plan.

In most cases, Therapy Assistants will provide the implementation portion of the treatment plan. Therapy Assistant time may be covered for face-to-face, in-person or virtual visits with the member to perform the tasks described in the treatment plan and to document outcomes, and for time to meet with the Program Manager for training and to discuss treatment plan issues. Therapy Assistant services that are billed by a Program Manager will be paid at the Therapy Assistant rate.

ABA services are not covered for the following:

- Babysitting or doing household chores
- Time spent under the care of any other professional
- Travel time
- Home schooling in academics or other academic tutoring

Additional exclusions and limitations for autism/ABA therapy

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- This benefit is not provided for rehabilitation services (which apply under the [rehabilitation](#) benefit) or mental health services (which apply under the [mental health and chemical dependency](#) benefit).
- Benefits for services provided by volunteers, childcare providers, family members and benefits paid for by state, local and federal agencies will not be covered. Volunteer services or services provided by a family member of the child receiving the services by or through a school, books and other training aids will also not be covered.
- Other unspecified developmental disorders or delays, or any other delay or disorder in a child's motor, speech, cognitive, or social development, are not covered under this benefit.
- This benefit covers only the allowable fees for eligible services performed by the provider and those providing interventions based on principles of ABA and/or related structured behavioral programs under the supervision of the provider. Other expenses associated with providing the treatment, such as the tuition, program fees, travel, meals, and lodging of the provider, expenses of those working under the provider's supervision, the member, and their family members, will not be covered.

Chemotherapy and Radiation Therapy

Health Connect network: 90%

Extended network: 60%, deductible applies

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers the following services:

- Outpatient chemotherapy and radiation therapy services, including proton beam radiation therapy

when medically necessary

- Supplies, solutions and drugs (See the [Prescription Drugs](#) benefit for oral chemotherapy drugs)

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Childbirth / Maternity Classes

Health Connect network: 100%

Extended network: 60%, deductible applies

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers childbirth and pregnancy educational classes, including pre-pregnancy planning, pregnancy, childbirth and Lamaze, breastfeeding and infant education classes. The benefit is for covered employees and dependents only, although a spouse/domestic partner not covered on the medical plan can attend with the covered employee.

Additional exclusions and limitations for childbirth / maternity classes

In addition to the plan's [exclusions and limitations](#), exercise classes, such as maternity yoga, are excluded from benefit.

Chiropractic services, acupuncture, and medical massage therapy

Health Connect network: \$40 copay

Extended network: \$40 copay

Out-of-network: 50% of allowable charges, deductible applies

Limit: up to 24 visits per member per calendar year chiropractic, acupuncture, and medical massage therapy (combined)

This benefit covers (1) chiropractic services from a licensed chiropractor or other provider licensed to perform chiropractic services, (2) acupuncture services provided, when medically necessary to relieve pain or to treat a covered illness, injury, or condition, from licensed

acupuncturist or other provider licensed to perform acupuncture, and (3) medical massage therapy, from a provider licensed to perform medical massage therapy, with a physician's prescription. To be covered, these services must be rendered to restore or improve a previously normal physical function and delivered within the provider's scope of practice guidelines.

These covered services must be medically necessary and will be covered only when the provider is providing the service within the scope of their state license.

These covered services (chiropractic services, acupuncture, medical massage therapy) provided will accrue cumulatively toward the 24-visit annual maximum. For example, if you visit a chiropractor for covered services 20 times in a calendar year, you will have four visits available for covered medical massage and/or acupuncture services in that calendar year. Covered Massage Therapy services are limited to a maximum of one hour per day.

Clinical Trials

This plan covers the routine costs of a qualified clinical trial. Routine costs are the medically necessary care that is normally covered under this plan for a member who is not enrolled in a clinical trial. The trial must be appropriate for the health condition according to the trial protocol and participating provider or information submitted by the member, and the member must be enrolled in the trial at the time of treatment for which coverage is requested.

Benefits are based on the type of service received. For example, benefits for an office visit are covered under the Professional Visits and Services benefit and lab tests are covered under the Diagnostic Services benefit.

A qualified clinical trial is a phase I, II, III or IV clinical trial that is conducted on the prevention, detection or treatment of cancer or other life-threatening diseases or conditions. The trial must also be funded or approved by a federal body, such as the National Institutes of Health (NIH), the Centers for Disease Control and Prevention; the Agency for Health Care Research and Quality; the Centers for Medicare & Medicaid Services; a cooperative group or center of any of the above entities or the Department of Defense (DOD) or the Department of Veterans Affairs (VA); the VA, DOD, and Department of Energy if peer-reviewed and approved as per the Secretary of HHS; or a qualified private research entity that meets the standards for NIH support grant eligibility.

Routine patient costs in connection with a “clinical trial” does not include expenses for:

- Costs for treatment that are not primarily for the care of the patient (such as lab tests performed solely to collect data for the trial)
- The investigational item, device or service itself
- A service that is clearly not consistent with widely accepted and established standards of care for a particular condition

Those interested in this coverage are encouraged to contact customer service at (800) 676-1411 before enrolling in a clinical trial. Customer service can help the member or provider verify that the clinical trial is a qualified clinical trial.

Contraception

Health Connect network: 100%

Extended network: 100%

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers FDA-approved contraceptive devices and injections for contraceptive purposes when prescribed by a physician. Examples include diaphragms, IUDs, and Depo Provera injections. Removal of contraceptive devices by a physician is also covered. This benefit also covers office visits and consultations related to contraception management.

All FDA-approved single-source brand and generic birth control medications are covered under the preventive care benefit at 100% at an in-network pharmacy (Health Connect or Extended network).

Dental services

Health Connect network: 90%

Extended network: 60%, deductible applies

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers certain services from a dental provider that would otherwise be covered by this plan if performed by a physician, as long as these services are provided within the scope of the dental provider's license.



Review the [Dental plan](#) section for information on your dental benefits.

Covered services

This benefit covers treatment of serious dental issues, such as a fractured jaw, excision of a tumor or cyst of the mouth, and incision or drainage of an abscess or cyst of the mouth, when not part of the dentition (gums, teeth, teeth supporting structure).

Hospital or outpatient facility fees and skilled observation for anesthesia administration related to dental treatments may be covered by the medical benefit when the following criteria are met.

Dental treatment in a hospital or outpatient facility is required because of any of the following:

- A physician has determined that the member's medical condition would place them at undue risk if the dental treatment were performed in a dental office. Some examples, though not all inclusive, are:
 - Cardiac conditions
 - Chronic respiratory disease, such as emphysema
 - Hemophilia or other blood disease
 - History of allergy to local anesthesia
 - Severe anemia
 - Severe hypertension
 - Uncontrolled diabetes
- The severity of the dental condition prevents treatment in the dental office setting.
- General anesthesia in a dental office, hospital or outpatient facility is required because of any of the following:
 - The member has a physical or mental disability and cannot be managed with local anesthesia, intravenous (IV) or non-intravenous conscious sedation.
 - The member has tried and failed other means of patient management (including premedication) in the office setting.

- Other means of patient management are contraindicated for the member.

Orthodontia services may be eligible for payment under the medical plan for dependents born with cleft/lip palate or other severe craniofacial anomalies. To qualify for benefits the condition must meet medically necessary criteria in Premera's medical policy addressing orthodontia for repair of cleft palate and other severe congenital anomalies.

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility before the service is provided. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Additional exclusions and limitations for dental services

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Services or supplies not medically necessary for diagnosis, care, or treatment of a disease, illness, or injury
- Dental care and services of a dentist, except as provided in the dental benefit. Hospital and physician services in support of all other dental care are covered only if the care meets two conditions: (1) adequate dental treatment cannot be rendered without the use of the hospital, and (2) the member has a health problem that makes it medically necessary to do the dental work at the hospital.
- Dental services for accidental injuries to the oral and maxillofacial region are covered only when the needed corrective dental repairs are certified in writing by the dental care provider as dentally necessary and are directly related to the accidental injury. Covered dental services include the repair or replacement of existing crowns, inlays, onlays, bridgework, and dentures. The treatment must be started within one year from the date of the accident.
- Benefits for services or supplies for treatment of temporomandibular joint (TMJ) dysfunction or myofascial pain dysfunction (MPD); benefits may be available under the Woodgrove Financial temporomandibular dysfunction benefit
- The medical plan does not cover any other preventive or restorative dental procedures, regardless of origin of condition

Diabetes

Diabetes health education

Health Connect network: 100%

Extended network: 100%

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers outpatient self-management training and education for diabetes, including medical nutritional therapy by a dietitian or nutritionist with expertise in diabetes.

Livongo Diabetes Management, Diabetes Prevention, and Hypertension Programs

In-network: 100%

Out-of-network: not applicable

The Livongo for Diabetes Management, Diabetes Prevention, and Hypertension Programs provide monitoring and health management support to individuals within the programs. If you qualify and enroll in any of the programs, you will receive the following benefits:

Diabetes Management

For members 13 and older who have Type 1 or Type 2 diabetes. If you qualify and join the program, you will get:

- A blood glucose meter that uses cellular technology to automatically upload blood sugar readings to a personal online account.
- A lancing device and unlimited lancets at no cost to you.
- Unlimited test strips for this meter at no cost to you. You can reorder test strips using the meter or online. The strips will be sent to you directly.
- Real-time feedback and tips based on your blood sugar readings that can help keep your levels within a healthy range.
- Coaching and support via phone, text, e-mail, or the program manager's mobile app.

Diabetes Prevention

For members 18 and older who meet pre-diabetes criteria followed by the Centers for Disease Control. The program's duration is 12 months, with an additional 12 months of access for maintenance. If you qualify and join the program, you will get:

- A cellular-connected scale that uploads readings to a personal online account.
- Real-time tips and personalized feedback on health, nutrition or lifestyle changes to help you learn and improve.
- Unlimited coaching and support via phone, text, e-mail or the mobile app.
- Complete CDC-recognized weight management curriculum based on in-app content and online resources.
- Periodic review of plan, self-monitoring data, and feedback from expert coach.
- Experiential learning missions covering nutrition, activity, motivation, sleep, and stress management.
- A mobile app, and device for tracking weight, steps, and achievement of health goals for food and physical activity.

Hypertension

For members 18 and older who have hypertension. If you qualify and join the program, you will get:

- A cellular-enabled blood pressure cuff that uploads blood pressure readings to a personal online account.
- Real-time tips and personalized feedback based on your blood pressure readings that can help keep your pressure within a healthy range.
- Unlimited coaching and support via phone, text, e-mail, or the mobile app. Access to online information.

These programs are available to you and your eligible dependents who qualify. The full cost of these programs will be covered by the Plan. To learn more, see if you qualify and enroll, go to <https://go.livongo.com/Woodgrove Financial>, or call Premera customer service.

Diagnostic Services

Health Connect network: 90% Extended network: 90%

Out-of-network: 50% of allowable charges, deductible applies

Benefits are provided for diagnostic services (including lab and imaging services) for health conditions or symptoms. Included in the coverage are charges for the test or scan itself and charges to interpret the results. Some examples of what's covered under this benefit are:

- Diagnostic imaging and scans (including x-ray, MRI, PET, CAT and EKGs)
- Services that are medically necessary to diagnose infertility
- Laboratory services
- Pathology tests

Diagnostic surgeries, including scope insertion procedures, can only be covered under the Surgical Services benefit.



Prior authorization is strongly recommended for some diagnostic services. Some examples of these include but are not limited to: Genetic Testing, CAT scan, and MRI. Have your provider contact Premera to see if your service needs this pre-service review.

Emergency room care and professional services

Health Connect network: \$250 copay (waived if admitted)

Extended network: \$250 copay (waived if admitted)

Out-of-network: \$250 copay (waived if admitted)

This benefit covers hospital emergency room and provider charges for an emergent condition—regardless of the network status—including related services and supplies, such as diagnostic imaging (including X-ray) and laboratory services, and surgical dressings and drugs furnished by and used while at the hospital.

Following discharge from the emergency room or hospital, eligible services will be paid based on the contracting status of the provider.

Regardless of network status, after being treated in the emergency department for an emergent condition and admitted to a hospital inpatient care (as defined by the [hospital inpatient care](#) benefit), along with provider charges, will be covered at the in-network level.

For emergency substance abuse treatment, see the [mental health and chemical dependency](#) treatment benefit.

Please see the [Federal No Surprise Billing Protection](#) section for more information about certain legal protections when you receive emergency services provided by an out-of-network provider.

Hearing care and hardware

Hearing exams and testing

Health Connect network: \$40 copay

Extended network: \$40 copay

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers one routine hearing examination and one routine hearing test (or screening) per member each calendar year.

Hearing exam services include:

- Examination of the inner ear and exterior of the ear
- Observation and evaluation of hearing, such as whispered voice and tuning fork
- Case history and recommendations
- The use of calibrated equipment

Hearing hardware

Health Connect network: 90% Extended

network: 90%

Out-of-network: 90%

Limit: up to \$10,000 maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in one or more Premera-administered health plan options

This benefit covers one FDA approved hearing hardware (either an over-the-counter or prescribed hearing aid) up to a maximum benefit of \$10,000 per maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in one or more Premera-administered health plan options.

Before obtaining a prescribed hearing aid, you must be examined by a licensed physician (M.D. or D.O.) or audiologist (CCC-A or CCC-MSPA).

Benefits cover the following:

- The hearing aid(s) (monaural or binaural) prescribed as a result of an exam or an FDA approved over-the-counter hearing aid(s) (monaural or binaural)
- Ear mold(s)
- Hearing aid rental while the primary unit is being repaired
- The initial batteries, cords, and other necessary ancillary equipment
- A follow-up consultation within 30 days following delivery of the prescribed hearing aid with either the prescribing physician or audiologist
- Repairs, servicing, and alteration of hearing aid equipment

Additional exclusions and limitations for hearing care and hardware

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Hearing aids purchased before your effective date of coverage under this plan

- A prescription or over-the-counter hearing aid, for any reason, more often than once in a period of three consecutive calendar years during which you are continuously enrolled in one or more Premera-administered health plan options
- Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid
- A prescription hearing aid that exceeds the specifications prescribed for correction of hearing loss
- Expenses incurred after your coverage ends under this plan unless a prescribed hearing aid was ordered before that date and was delivered within 90 days after the date your coverage ended
- Charges in excess of this benefit; these expenses are also not eligible for coverage under other benefits of this plan

Home health care and Nursing care

In-home care, other than Hospice Care and Respite Care (non-hospice), can be broken into two categories for purposes of benefit coverage:

Benefit	Description	Care Duration	Coverage
Home health care	Short-duration, intermittent care to complete specific tasks by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, social worker (MSW) working for home health agency, or a certified respiratory therapist.	The length of home health care visits varies depending on the tasks to be accomplished, but typically these visits last up to 2 hours.	Health Connect network: 90% Extended network: 60%, deductible applies Out-of-network: 50% of allowable charges, deductible applies
Nursing care	Longer-duration, skilled hourly nursing care in the home by a registered nurse (RN) or licensed practical nurse (LPN).	Generally needed for more than 4 hours per day.	Health Connect network: 90% Extended network: 60% Out-of-network: 50%, deductible applies

Read below for additional in-home care coverage details.

Home health care

Health Connect network: 90%

Extended network: 60%, deductible applies

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers home visits for short-duration, intermittent care to complete specific tasks by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, social worker (MSW) working for home

health agency, or a certified respiratory therapist. The length of home health care visits varies depending on the tasks to be accomplished, but typically these visits last up to 2 hours. The benefit includes the cost of a home health aide when acting under the direct supervision of one of the before-mentioned therapists and while performing services specifically ordered by the doctor in the treatment plan. The benefit also includes disposable medical

supplies and eligible medication prescribed by a physician when provided by the home health care agency.



Intermittent care is care provided due to the medically predictable recurring need for skilled home health care services.

Home health care services provided and billed by a Medicare-approved or state-licensed home health care agency for treatment of an illness or injury are covered. The services must be part of a formal written treatment plan prescribed by your doctor.

One postpartum home health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center will be eligible for coverage.

Additional exclusions and limitations for home health care

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services
- Materials such as handrails and ramps
- Services performed by family members and volunteer workers
- Psychiatric care
- Unnecessary and inappropriate services
- Maintenance or [custodial care](#)
- Diversional therapy
- Services or supplies not included in the written treatment plan
- Over-the-counter drugs, solutions, and nutritional supplements
- Dietary assistance, such as Meals on Wheels
- Services provided to someone other than the ill or injured enrollee

Nursing care

Health Connect network: 90% Extended network: 60%

Out-of-network: 50%, deductible applies

This benefit covers longer-duration, skilled hourly nursing care in the home by a registered nurse (RN) or licensed practical nurse (LPN) working under a licensed home health agency. Skilled hourly nursing care is provided in lieu of hospitalization and generally is needed for

more than 4 hours per day. The nurse who is providing the care cannot be a permanent resident in the member's home.



Skilled nursing care is provided by a registered nurse (RN) or licensed practical nurse (LPN) and the care must require the technical proficiency, scientific skills, and knowledge of an RN or LPN. The need for skilled nursing is determined by the condition of the patient, the nature of the services required, and the complexity or technical aspects of the services provided. Nursing care is not skilled simply because an RN or LPN delivers it or because a physician orders it.

Prior authorization

A prior authorization, also referred to as a pre-service review, is strongly recommended for nursing care to determine if coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Hospice care

Health Connect network: 90%

Extended network: 60%, deductible applies

Out-of-network: 50%, deductible applies

The hospice care benefit allows a terminally ill member to remain at home or to use the services of a hospice center instead of using hospital inpatient services. The plan covers services provided through a state-licensed hospice or other hospice program that meets the standards of the National Hospice and Palliative Care Organization. The services must be part of a written treatment plan prescribed by a licensed physician.

This benefit covers visits for intermittent care by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, a certified respiratory therapist or a Master of Social Work. Also included is the cost of a home health aide who acts under the direct supervision of one of the before-mentioned therapists and who is performing services specifically ordered by the member's doctor in the treatment plan. The benefit also includes disposable medical supplies and medications prescribed by the physician, and the rental of durable medical equipment.

In addition, the hospice care benefit covers care in a hospice, and up to 672 hours of respite care for each six-month period of hospice care. The respite care provision allows family members of the terminally ill patient an opportunity to recover from the emotionally and physically demanding tasks of caring for the patient.



Hospice care is a coordinated program of palliative and supportive care for dying members by an interdisciplinary team of professionals and volunteers centering primarily in the member's home.

Intermittent care is care provided due to the medically predictable recurring need for skilled home health care services.

Respite care is continuing to provide care in the temporary absence of the member's primary caregiver or caregivers.

Additional exclusions and limitations for hospice care

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Bereavement or pastoral counseling
- Financial or legal counseling, including real-estate planning or drafting of a will
- Funeral arrangements
- Diversional therapy
- Services that are not related solely to the member, such as transportation, house cleaning, or sitter services

Hospital inpatient care

Health Connect network: 90%

Extended network: 60%, deductible applies

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers the following inpatient medical and surgical services:

- Room and board, including general duty nursing and special diets
- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment, and oxygen
- Diagnostic and therapeutic services
- Blood, blood derivatives, and their administration

Regardless of network status, after being treated in the emergency department for an emergent condition and admitted to a hospital, inpatient care (as defined by the [hospital inpatient care](#) benefit), along with provider charges for that emergent condition, will be covered at the Health Connect network level.

Please see [the Federal No Surprise Billing Protection](#) section for more information about certain legal protections when you receive emergency and non-emergency services provided by an out-of-network provider.

For substance abuse treatment, see the [mental health and chemical dependency](#) treatment benefit.

Additional exclusions and limitations for hospital inpatient care

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Hospital admissions for diagnostic purposes only, unless the services cannot be provided without the use of inpatient hospital facilities, or unless the member's medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay required to treat the member's condition

Hospital outpatient care and ambulatory surgical center care

Health Connect network: 90%

Extended network: 60%, deductible applies

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers operating, procedure, and recovery rooms; plus, services and supplies, such as diagnostic imaging (including X-ray) and laboratory services, X-ray and radium therapy, anesthesia and its administration, surgical dressings and drugs, furnished by and used while at the hospital or ambulatory surgical center.

Please see [the Federal No Surprise Billing Protection](#) section for more information about certain legal protections when you receive emergency and non-emergency services provided by an out-of-network provider.

Infertility

In-network: 90%, within the Plan's infertility vendor (Progyny) provider network Out-of-network: not applicable

Limit: Up to two Smart Cycles per household for the duration of your continuous enrollment in one or more Premera-administered health plan options, and one additional Smart Cycle if neither of the first two results in a successful pregnancy, subject to certain restrictions described below



Members must contact their **Progyny Patient Care Advocate** at (888) 203-5066 to confirm eligibility and utilize a Progyny Network Provider to access the benefit.

This benefit covers services to assist in achieving a pregnancy for Woodgrove Financial employees and their enrolled spouse/domestic partner regardless of reason or origin of condition.

The Progyny SMART cycle benefit allows for:

- Two (2) Smart Cycles per household, with an additional Smart Cycle available if the first two do not result in a successful pregnancy, for the duration of your continuous enrollment in one or more Premera-administered health plan options, subject to the restrictions described below for certain members who received infertility benefits of less than \$15,000 under the Health Savings Plan prior to 2018. Coverage is subject to all applicable plan copay, coinsurance, and deductible requirements.
- One (1) Smart Cycle per household, with an additional Smart Cycle available if the first does not result in a successful pregnancy, for the duration of your continuous enrollment in one or more Premera-administered health plan options, for members who (1) have been enrolled continuously in one or more Premera-administered health plan options (such as the Health Savings Plan) since before 2018, and (2) incurred \$15,000 or more in infertility benefits under the Plan during such continuous enrollment period prior to 2018. Coverage is subject to all applicable plan copay, coinsurance, and deductible requirements.

The Progyny SMART cycle benefit may be used to receive full coverage for the following treatments and procedures:

- Two consultations per calendar year
- Diagnostic testing
- Transvaginal ultrasounds
- Intrauterine insemination (also known as artificial insemination)

- In vitro fertilization (IVF)
- Gamete intra-fallopian transplant (GIFT)
- Intracytoplasmic sperm injection (ICSI)
- Pre-implantation genetic screening (PGS)
- Pre-implantation genetic diagnosis (PGD)
- Embryo assessment and transfer
- Services used to preserve fertility such as cryopreservation of eggs, sperm and/or embryos. This includes oncofertility preservation.
- Up to four years of storage (egg, embryo, sperm) with annual renewal and eligibility verification
- Purchase of donor tissue (sperm, eggs) as follows:
 - Previously frozen donor sperm or donor oocytes (eggs) from a donor agency intended for the use and transfer into a covered female member (one egg cohort purchase constitutes one SMART Cycle, and one donor sperm purchase constitutes ¼ SMART Cycle). You will be required to pay for the donor sperm or oocytes out of pocket and submit the eligible charges, with appropriate supporting documentation, to Progyny for reimbursement.
 - A fresh donor recipient cycle, whereby the egg donor undergoes an egg retrieval procedure at an in-network Progyny provider to allow for a fresh embryo transfer into a covered female member (one fresh donor recipient cycle constitutes one SMART Cycle). The treatment must occur at an in-network Progyny provider, or else you may be required to pay all expenses up front, out of pocket. If an in-network provider is not contracted for the fresh donor recipient cycle, Progyny will pursue a special case agreement. If a special case agreement request is denied, you will pay for the donor services out of pocket but may submit eligible charges, with appropriate supporting documentation, to Progyny for reimbursement.

Medication prescribed for fertility treatment will be fulfilled by a Progyny Rx specialty pharmacy and delivered next day to ensure accurate timing with treatment. All medications, compounds, ancillary medication and equipment required for treatment are included in the shipment of medications. Progyny Rx coverage also includes the UnPack It Call where a trained pharmacy clinician will explain drug administration and storage guidelines.

Additional exclusions and limitations for infertility

The following exclusions apply to this benefit:

- Fees paid to donors for their participation in any service
- Testing and treatment for potential surrogates that would not otherwise be covered for a member enrolled in the Plan
- Home ovulation prediction kits
- Services and supplies furnished for a dependent child (under age 26), except for oncofertility preservation due to cancer or medical treatments.
- Services and supplies furnished by a provider outside the Progyny network, except as otherwise provided
- Fertility Services following a voluntary sterilization procedure

Maternity care

Health Connect network: 90%

Extended network: 60%, deductible applies

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers maternity benefits provided for you, your enrolled spouse/domestic partner, and your eligible dependent children. If you are delivering at a Health Connect network facility, please see the [Maternity care bundle](#) benefit below.

For women's preventive care visits during and after pregnancy, see the [preventive care](#) benefit. If the physician bills the delivery together with the routine (preventive) prenatal care, 40% of the allowed amount applies to the preventive prenatal care benefit and 60% of the allowed amount applies to the maternity care benefit.

The home health care benefit covers one postpartum health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center.

Benefits are for maternity care in a hospital, alternative birthing center, or at home, including:

- Prenatal testing when required to diagnose conditions of the unborn child
- Services of a licensed nurse or midwife
- Miscarriages and terminations of pregnancy
- Hospital nursery care for benefits-eligible infant while the mother is hospitalized and receiving benefits; services are covered under the hospital services benefit
- Male circumcision by a physician or mohel for a benefits-eligible dependent; services are covered under the physician services benefit
- One postpartum home health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center
- Home births include an allowance of up to \$500 for eligible supplies and/or equipment used for home delivery; for example, birthing packs, birthing tubs, monitoring devices, local anesthetics, and comfort aids. Services for the newborn including hospital services and professional services are covered under the hospital services and physician services benefit.
- Birth doula services up to a maximum benefit of \$1,000 per pregnancy. Before seeking doula services, you must be examined by a licensed physician, registered nurse or midwife and have a confirmed pregnancy.
 - Covered doula services include:
 - In person, phone, and email support throughout the pregnancy and post-partum
 - Birth support
 - Lactation support
 - Doula services are not covered for the following:
 - Babysitting or doing household chores
 - Travel time

- Any other services not listed as covered doula services, above
- Eligible providers: a doula who is state-licensed if the state requires a license. If the state does not require a license, then the doula must have a current certification under a recognized doula

certification organization (examples include DONA International and PALS Doulas).

Eligible doulas do not have to be in the Health Connect Network or Extended Network.

- Exclusions: apprentice doulas

Maternity care bundle

Health Connect network: \$500 copay

Extended network: not applicable Out-

of-network: not applicable

This benefit covers maternity benefits provided for you, your enrolled spouse/domestic partner, and your eligible dependent children within the Health Connect Network. This benefit is intended to cover routine pregnancy and delivery care, any items outside the services listed below will be covered as described in the [Maternity care](#) section above.

- Routine professional prenatal and delivery care, including services of a licensed nurse or midwife (non-medical services are not covered, except for doulas as detailed in the [Maternity care](#) section above).
- Routine prenatal testing (For example, fetal non-stress test, ultrasound, echo, fetal biophysical profile, doppler velocimetry, pregnancy test, diabetes testing, etc.)
- Miscarriages and terminations of pregnancy
- Childbirth and pregnancy educational classes, including pre-pregnancy planning, pregnancy, childbirth and Lamaze, breastfeeding and infant education classes. This benefit is intended for covered employees and dependents only, although a spouse/domestic partner not covered on the medical plan can attend with the covered employee.
- You may either purchase one over the counter breast pump or rent a hospital grade breast pump (but not both) during a calendar year. The pump must be for the member's own use. Replacement supplies are covered on an as needed basis.
- Up to 12 visits with an outpatient lactation consultant
- Outpatient self-management training and education for diabetes, including medical nutritional therapy by a dietitian or nutritionist with expertise in diabetes
- Inpatient facility for delivery
- One postpartum home health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center

Additional exclusions and limitations for maternity benefit bundle (covered as any other service)

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Treatment and visits unrelated to routine maternity
- Care for the baby post delivery

Medical equipment and supplies (durable medical supplies)

Health Connect network: 90% Extended network: 90%

Out-of-network: 50% of allowable charges, deductible applies

Covered services

This benefit covers charges for durable medical and surgical equipment and supplies, (DME). Benefits cover rental or purchase (including shipping and handling fees of DME for treatment of an injury, illness, disease, or medical condition. Rental equipment will not be reimbursed above the purchase price of the equipment. The Plan reserves the right to require a period of rental prior to covering the purchase of equipment. Benefits for DME purchases will be reduced by any prior Plan benefits for renting the same equipment, unless (and to the extent that) the Plan required such prior rental.

Allowed charges to repair or replace covered items are also covered due to a change in the injury, illness, disease, or medical condition, the growth of a child, or when worn out by normal use. Replacement is covered only if needed due to a change in the member's physical condition or if it is less costly to replace than to repair existing equipment or to rent similar equipment.

No more than one item of DME per year will be covered for the same or similar purpose, and in order to be covered, the equipment and accessories to operate it must be:

- Made to withstand prolonged use
- Made for and mainly used in the treatment of an injury, illness, disease, or medical condition
- Suited for use in the home

This list of covered DME includes, but is not limited to:

- Braces
- Crutches
- Wheelchairs
- Prostheses
- Cochlear Implants and associated supplies
- Foot orthotics (custom fitted shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses, when prescribed by a physician for the condition of diabetes or for corrective purposes
- Wigs (up to \$2,000 per calendar year for alopecia caused by medical conditions or treatment for diseases)
- You may purchase one over-the-counter breast pump or rent a hospital grade breast pump during a calendar year (one or the other, but not both). The pump must be for your own use. Replacement supplies may be purchased on an as needed basis. In-network purchase/rental for the pump and

replacement supplies is covered at 100%. Out-of-network purchase/rental for the pump and replacement supplies is covered at 100% of allowable charge. Deductible does not apply. Batteries are not covered.

- Continuous glucose monitors and their supplies purchased from a provider in the Health Connect or Extended network is covered at 100%. If purchased from an out-of-network provider they are covered at 50% of allowable charges, deductible applies.

Vision hardware may be covered under the medical plan for certain medical conditions of the eye, including, but not limited to:

- Corneal ulcer/abrasion
- Bullous keratopathy
- Recurrent erosion of cornea
- Keratoconus
- Tear film insufficiency (dry-eye syndrome)
- Cataract surgery



Certain supplies such as hypodermic needles, test strips and glucose monitors are covered at 100% by the [preventive care](#) benefit.

Additional exclusions and limitations for medical equipment and supplies (durable medical supplies)

In addition to the plan's [exclusions and limitations](#), the following durable medical equipment and supplies will not be covered by this plan when they are:

- Normally of use to persons who do not have an injury, illness, disease, or medical condition
- For use in altering air quality or temperature
- For exercise, training and use during participation in sports, recreation, or similar activities
- Equipment, such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, overbed tables, elevators, vision aids, and telephone alert systems
- Special or extra-cost convenience items and/or features
- Structural modifications to your home and/or private vehicle
- Replacement of lost or stolen equipment or supplies
- Blood pressure cuffs or monitors (even if prescribed by a physician), unless otherwise provided in this SPD

Medical Foods

Health Connect network: 90%

Extended network: 60%, deductible applies

Out-of-network: 50% of allowable charges, deductible applies

This plan covers medically necessary medical foods used to supplement or replace a member's diet in order to treat inborn errors of metabolism. An example is phenylketonuria (PKU). Coverage includes medically necessary enteral formula prescribed by a physician or other provider to treat eosinophilic gastrointestinal associated disorder or other severe malabsorption disorder. Benefits are provided for all delivery methods.

Medical foods are formulated to be consumed or administered enterally under strict medical supervision. These foods generally provide most of a person's nutrition. Medical foods are designed to treat a specific problem that can be diagnosed by medical tests.

This benefit does not cover other oral nutrition or supplements not used to treat inborn errors of metabolism, even if a physician prescribes them. This includes specialized infant formulas and lactose-free foods.

Mental health counseling, mental health inpatient and outpatient services, and chemical dependency treatment

Employee Assistance Program

- 100%, up to calendar year short-term counseling session limits through Spring Health the employee assistance program administrator.

Outpatient Office Visit

- Health Connect network: \$20 copay
- Extended network: \$20 copay (in no event will the outpatient office visit copay exceed 40% of the allowed amount)
- Out-of-network: 90% of allowable charges

Inpatient & Outpatient Facility

- Health Connect network: 90%
- Extended network: 90%
- Out-of-network: 90% of allowable charges

This benefit covers medically necessary treatment for:

- mental health conditions such as, but not limited to the diagnosis and treatment stress, anxiety, or depression, or other psychiatric disorders, eating disorders, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD)
- chemical dependency such as substance use disorder and alcohol use disorder

To be covered, services must be furnished by an eligible provider.

All mental health and chemical dependency treatment must be medically necessary to be eligible for coverage.

Type of care	You will be covered as follows
Short-term counseling (employee assistance program) as administered by Spring Health	No deductible or copay applies 100% of 24 sessions per person per calendar year.
Inpatient and Outpatient facility	Health Connect network: 90% Extended network: 90% Out-of-network: 90% of allowable charges
Office Visit *In no event will the office visit copay exceed 40% of the allowed amount.	Health Connect network: \$20 copay Extended network: \$20 copay* Out-of-network: 90% of allowable charges

Eligible providers

Eligible providers include:

- A facility licensed as a hospital or community mental health agency to provide mental health and/or substance abuse services

- A physician, psychiatrist, psychologist, or psychiatric nurse practitioner licensed to provide mental health or substance abuse services
- A master's level mental health provider licensed, registered, or certified as legally required to provide mental health services
- Any other provider or facility who is licensed or certified by the state in which the care is rendered and who is providing care within the scope of their license or certification

Prior authorization

A prior authorization, also referred to as a pre-service review, is strongly recommended for inpatient care and residential treatment centers to determine whether coverage is available before the service occurs. When an emergency admission occurs, notification to Premera within two days is also recommended.

Either the member or the provider may contact Premera for a prior authorization.



A **prior authorization** is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

The prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Additional exclusions and limitations for mental health and chemical dependency

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Testing must be ordered by a physician for the purpose of diagnosing or medical management
- Smoking cessation programs or materials; (Woodgrove Financial provides a separate Smoking Cessation Program. Prescription drugs for smoking cessation are covered under the prescription drug benefit.)
- Services and supplies that are court-ordered, or are related to deferred prosecution, deferred or suspended sentencing, or driving rights, if those services are not deemed medically necessary
- Educational or recreational therapy or programs; this includes, but is not limited to, boarding schools. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider, provided that educational or recreational therapy or programs, themselves, are not eligible providers for this purpose.

Nutritional therapy

Health Connect network: 100%

Extended network: 100%

Out-of-network: 50% of allowable charges, deductible applies

Limit: first 12 visits per member per calendar year

After 12 visits (in the same calendar year) benefit coverage is reduced to:

- *Health Connect network: \$40 copay*
- *Extended network \$40 copay*
- *Out-of-network: 50% of allowable charges, deductible applies*

This benefit covers outpatient nutritional therapy visits with a dietitian, nutritional therapist or certified lactation consultant to manage a covered condition, illness or injury.

Illnesses or conditions that would be eligible for this benefit include, but are not limited to:

- Hypertension
- Cardiac problems
- Feeding difficulties
- Gastric reflux disease

Nutritional therapy visits received in connection with a diagnosed eating disorder or diabetes is unlimited and will be covered at 100%.

Onsite Mammography Screening

Woodgrove Financial offers access to an onsite mammography screening in select Woodgrove Financial locations to employees and their spouse/domestic partners enrolled in a Woodgrove Financial Health Plan. The onsite mammography screening provides a multiple-view screening exam. At the discretion of the technologist performing the mammogram, additional views may be necessary to clarify imaging issues for the radiologist.

The onsite mammography screening program includes the onsite preventive screening mammogram exam only. Any additional or follow-up imaging or other services needed are considered diagnostic and will be covered as outlined in the diagnostic services benefit.

An onsite mammogram is not recommended if you have implants, a breast problem, are pregnant, or are breastfeeding. In those cases, you should consult with your doctor about obtaining an exam at an offsite breast center or other health care facility. Such an offsite exam would not be covered by the onsite mammography screening program but may be covered by the Plan's preventive or diagnostic services coverage, as applicable. As the onsite mammogram is a screening exam, the vendor is not able to provide imaging for a breast

problem such as a lump. If you have questions about mammogram screenings, talk with your primary care physician.

Who Provides the Mammograms?

In the Puget Sound area of Washington state, Mammograms are provided by Swedish Mobile Mammography Services (operated by Swedish Health Services). The mammography technologists are registered by the American Registry of Radiologic Technology, have advanced credentials in mammography, and are certified by the State of Washington. The interpreting physicians are employed by Radia are board certified by the American College of Radiology and specialize in breast imaging.

In other areas, Woodgrove Financial partners with local vendors who specialize in onsite mammography and have the appropriate equipment and licensure. To provide services onsite, there must be sufficient demand to fill a day of appointments and a local vendor who is qualified to provide the services. Onsite mammography events will be advertised for any locations where they are available.

When Do the Screenings Occur?

Periodically each year, usually during the fall. **Eligibility**

US benefits-eligible employees and their spouse/domestic partner age 35 and over, who are enrolled in

medical coverage under the Plan, are eligible to participate in onsite mammography screenings.

You are eligible to participate in the onsite screening even if you have had a routine mammogram in the past 12 months. However, you should talk with your primary care provider to determine the benefits and risks of having a second mammogram within a 12-month period. If you suspect you have a breast problem, such as a lump, you should see your primary care provider.

Women under the age of 35 are ineligible, unless they have written permission from their physician.



At some locations, women under age 35 will not be allowed to participate, even with written permission from their physician.

Dependent children (regardless of age), agency temporaries/external staff, international based employees, and any individuals who are not enrolled in medical coverage under the Plan are not eligible to participate.

Physician services

Office visits:

- *Health Connect network: \$20 copay PCP, \$40 copay Specialist and Urgent care*
- *Extended network: 60%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

Other services:

- *Health Connect network: 90%*
- *Extended network: 60%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

This benefit covers:

- Medical and surgical services of a physician
- Urgent care visits at an urgent care facility
- Care via online and telephonic methods when medically appropriate:
- Benefits for telemedicine are subject to standard office visit cost-shares and other provisions as stated in this booklet. Services must be medically necessary to treat a covered illness, injury or condition.
- Biofeedback services for any condition covered by the medical benefit when provided by an eligible provider



An **Urgent care** visit is billed and covered at the same rate as an office visit with your regular physician and is a cost-effective option when you have an urgent need for care. Urgent care is the best option for treatment of a sudden illness, injury or condition that:

- Requires prompt medical attention to avoid serious deterioration of the member's health
- Does not require the level of care provided in the emergency room or a hospital
- Cannot be postponed until the member's physician is available

A **Physician** is a state licensed:

- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy (D.O.)

In addition, professional services provided by one of the following types of providers will be treated as physician services under this plan to the extent the provider is providing a service that is within the scope of their state license and providing a service for which benefits are specified in this SPD and would be payable if the service were provided by a physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Advanced Registered Nurse Practitioner (A.R.N.P.)
- Nurse (R.N.)
- Naturopathic physician (N.D.)

Plastic and reconstructive surgery

Health Connect network: 90%

Extended network: 60%, deductible applies

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers services, supplies, and procedures for plastic or reconstructive surgery purposes, along with complications of these services, supplies, or procedures for the following:

- Repair of a defect that is the direct result of an accidental injury, providing such repair is started within 12 months of the date of the accident
- Treatment for a congenital anomaly of a child
- Treatment of visible birth marks of a covered child
- All stages of reconstruction of the involved breast following a mastectomy, and surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Correction of physical functional disorders. Benefits may include, but are not limited to, blepharoplasty or breast reduction.

The treatment plan for any of the above conditions must be prescribed by a physician.



A **congenital anomaly** is a marked difference from the normal structure of a body part that is physically evident from birth.

A **physical functional disorder** is a limitation from normal (or baseline level) of physical functioning that may include, but is not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts or obstruction of an orifice. The physical functional impairment can be due to structure, congenital deformity, pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairment or potential impairment.

Prescription drugs

Express Scripts Retail (up to limits provided below):

- *Generic: \$10 copay*
- *Preferred Brand: \$30 copay*
- *Non-Preferred Brand: \$60 copay*

Express Scripts Mail Order Pharmacy (up to limits provided below):

- *Generic: \$20 copay*
- *Preferred Brand: \$60 copay*
- *Non-Preferred Brand: \$120 copay*

Out-of-network: 50% of allowable charges (as listed below); home delivery not covered

This benefit covers most FDA-approved, medically necessary prescription drugs, when prescribed for the member's use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also, included in this benefit are injectable supplies.

Certain single-source brand and generic preventive drugs will be covered at 100% under the preventive care benefit. Brand-name preventive medications with an available generic equivalent will not be covered by the preventive care benefit. Review the [preventive care](#) benefit for more information.

Generic drug substitution

This plan encourages the use of appropriate generic drugs (as defined below). When available and indicated by the prescriber, a generic equivalent drug will be dispensed in place of a brand name drug. If your prescriber indicates that substituting a generic equivalent for the brand name drug is inappropriate, you'll be charged only the brand name cost share (as applicable). However, if the prescriber does not indicate that substituting a generic equivalent drug is inappropriate, and you request the brand name drug anyway, you'll be charged the difference in price between the brand name drug and the generic equivalent along with the applicable brand name cost-share. Note: The difference in price

between the brand name drug and the generic equivalent will not apply to your deductible and/or coinsurance maximum. Even if you reach your deductible or coinsurance maximum, you will still be responsible for the full amount of the difference in price between the brand name drug and the generic equivalent.



A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.

Brand-name prescriptions are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.

Generic drugs are equivalent to brand-name drugs but available at a lower cost than brand-name prescriptions because the patent has expired.

Prescription limits

	Retail pharmacy	Home delivery	Specialty pharmacy
Coverage	Up to a 90-day supply for generic maintenance medication; all others are up to a 30-day supply*	Up to 90-day supply* is covered only when using Express Scripts Pharmacy Home Delivery	Up to a 30-day supply* Additional clinical support for members using specialty drugs
In-network pharmacies	Express scripts pharmacies bill the plan on your behalf To find an Express Scripts retail pharmacy, call the Premera customer service team at (800) 676-1411	Express scripts pharmacies bill the plan on your behalf	AllianceRX Walgreens Pharmacy or Accredo Specialty Pharmacy** will bill the plan on your behalf
Out-of-network pharmacies	You will need to submit a prescription reimbursement form, with your receipt, for reimbursement	Not covered	Not covered

* Unless the drug maker's packaging limits the supply in some other way.

** Contact AllianceRX Walgreens Pharmacy at (877) 223-6447 or Accredo Specialty Pharmacy at (800) 689-6592 to get started.

The dispensing limits (or days' supply) for drugs dispensed at retail and specialty pharmacies, and through the mail-order pharmacy benefit, are described in the above chart.

Refills for a medication will be covered only when the member has used 75% of the supply of that medication, based on both of the following:

- The number of units and days' supply dispensed on the last fill or refill, and
- The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill, if applicable



Generic maintenance medications have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year.

Specialty drugs are high-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply.



Premera provides a customer service team dedicated to Woodgrove Financial employees and their dependents. You can use this service by calling (800) 676-1411 with questions regarding:

- Status of mail order prescriptions
- Plan design, including which medications are covered or not covered
- Location of retail pharmacies

Covered drugs

This benefit covers the following FDA-approved items when dispensed by a licensed pharmacy for use outside of a medical facility. Certain drugs may need a prior authorization.

- Prescription drugs (Federal Legend Drugs as prescribed by a licensed provider). This benefit includes coverage for off-label use of FDA-approved drugs as provided under this plan's definition of prescription drug.
- Compounded medications are covered when the main ingredient is a covered prescription drug. Benefits are subject to standard supply limit.
- Inhalation spacer devices and peak flow meters
- Glucagon and allergy emergency kits
- Prescribed injectable medications for self-administration (such as insulin)
- Hypodermic needles, syringes, and alcohol swabs used for self-administered injectable prescription medications
- Disposable diabetic testing supplies, including test strips, testing agents, and lancets
- Prescription contraceptive drugs and devices (for example, oral drugs, diaphragms, and cervical caps)
- Human growth hormone
- Prescription drugs for smoking cessation
- Impotence medications are limited to 15 pills at retail per 30 days: 45 pills at mail-order per 90 days

Benefits for immunization agents and vaccines, including the professional services to administer the medication, are provided under the [preventive care](#) benefit.

Prior authorization

Prior authorization, also referred to as a pre-service review, is **required** to determine if coverage for certain prescription drug is available before prescription can be filled.

To determine if prior authorization is required for a particular drug, refer to the [formulary drug list](#), or either the member or the provider may contact Premera.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

In order for certain types of drugs to be covered, information from your doctor must be submitted that identifies the disease being treated and explains the role of the drug in the


treatment plan to establish its medical necessity. If that information is made available prior to the prescription being filled, and it is determined that the drug is medically necessary, the prescription will be covered as described above. If information for a drug in this category is not provided, you may pay for the prescription to be filled and submit the claim for consideration along with the clinical information. If it is determined that you do not

meet medical necessity criteria needed for the drug to be eligible, you will not be reimbursed for the cost of the drug.

Benefits for some prescription drugs may be limited to one or more of the following:

- A set number of days' supply
- A specific drug or drug dose that is appropriate for a normal course of treatment
- A specific diagnosis
- Be under the care of an appropriate medical specialist
- Trying a generic drug or a specified brand name drug first


In making these determinations, Premera takes into consideration clinically evidence-based medical necessity criteria, recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration guidelines, published medical literature and standard reference compendia.



For questions about your pharmacy benefits or quantity limits, contact Premera Customer Service at (800) 676-1411.

The table below provides information on how to submit information for a medical necessity review.

Drug	Information
Certain drugs require prior authorization. Examples include but are not limited to: rheumatoid arthritis, certain cancer treatment drugs, growth hormones, anti-depressants, corticosteroid nasal sprays, diabetes, migraine therapy, multiple sclerosis, sleeping disorders, weight loss drugs, and compound medications.	<p>Have your provider call (888) 261-1756 to start or update the benefit review process for these or other drugs needing clinical review.</p> <p>If you would like to find out if your drug requires review, refer to the formulary drug list or call Premera Customer Services at (800) 676-1411.</p>



Categories of drugs on this list may be added or deleted from time to time, based on factors including FDA approval status, medical necessity, member safety, and best practices. If you have paid for a prescription of a drug in this category, you may appeal any denial of benefits for that drug through the appeals process.

Drug-usage patterns

The Plan may be provided with information from a variety of sources regarding drug-usage patterns of individual members that merit further investigation. If the conclusion of the investigation is that the drug-usage patterns are not consistent with generally accepted standards of practice, the Plan may choose to restrict access to the benefit to one prescribing physician for those members. If this action is taken, the member will be notified in advance.

Your 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 drugs are covered under this Plan and what coverage limitations are in your contract.



If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, call the Premera customer service team at (800) 676-1411.

If you have a concern about the pharmacists or pharmacies serving you, call your State Department of Health.

Additional exclusions and limitations for prescription drugs

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Drugs and medications not approved by the Food and Drug Administration (FDA) except as defined in the Experimental and Investigational section
- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. These may include but are not limited to: nonprescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines, and nutritional and dietary supplements (for example, infant formulas or protein supplements). This exclusion does not apply to emergency contraceptive methods (such as "Plan B"), aspirin for women and men, folic acid for women, and iron supplements.
- Over-the-counter contraceptives, supplies, and devices (except as required by law)
- Drugs for the purpose of cosmetic use (for example, promote or stimulate hair growth, stop hair loss, or prevent wrinkles)
- Growth hormone for the diagnosis of idiopathic short stature (ISS), familial short stature (FSS), or constitutional short stature (CSS)
- Drugs for experimental or investigational use
- Any prescription refilled too soon or in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order
- Replacement of lost or stolen medication
- Devices and appliances, support garments, and non-medical supplies
- This plan does not cover the cost of drugs that are reimbursed under another plan or another portion of your Woodgrove Financial coverage (for example, drugs administered while hospitalized)
- Charges for prescription drugs when obtained through an unauthorized pharmacy or provider when a restriction of the prescription drug benefit is in place
- Shipping and handling charges for prescriptions drugs are not covered.

Preventive care

Preventive services:

- *Health Connect network: 100%*

- *Extended network: 100%*
- *Out-of-network: 50% of allowable charges, deductible applies*

This benefit covers routine exams, immunizations and health screenings, such as:

- Routine physicals for women and men
- Women's preventive care including a gynecological exam, routine pap smear (cervical cancer screening) and routine mammogram (breast cancer screening)
- Contraception management office visits
- Well-child exams, including physical exams, tests, and immunizations, through age 18
- Hearing screening for children through age 18
- Routine prenatal and postnatal care. (If the physician bills the delivery together with the routine prenatal care, 40% of the allowed amount applies to the preventive care benefit and 60% of the allowed amount applies to the maternity care benefit).
- Routine eye exams
- Flu shots
- Colorectal cancer screening
- Prostate cancer screening
- Lung cancer screening
- Immunizations, which need not be done at the same time as the routine exam.

For individuals with known risk factors, such as family history of a disease with known hereditary links, the limits in the recommended guidelines for preventive screenings may not be applicable.

Preventive prescription drugs:

- *Express Scripts Pharmacy: 100%*
- *Out-of-network: 50% of allowable charges*

This benefit covers certain single-source brand and generic prescriptions to prevent the onset of disease by a person who has risk factors for a particular condition, or those taken to prevent a recurrence of a disease. Covered preventive prescription drugs include drugs for the treatment of high cholesterol with cholesterol-lowering medications to prevent heart disease, or the treatment of recovered heart attack or stroke victims with ACE inhibitor medications to prevent a recurrence. This benefit also covers certain supplies such as hypodermic needles, test strips and glucose monitors.



For a complete list of what is considered preventive care and paid 100% by the plan, see the [Preventive Care Services list](#) and the [Preventive Drug list](#), or contact Premera Customer Service at (800) 676-1411.

For information on how to fill your prescription, see the [prescription drug](#) section.

Rehabilitation

Health Connect network: \$40 copay

Extended network: \$40 copay

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers physical therapy, functional occupational therapy, and speech therapy services to:

- Restore and improve a bodily or cognitive function that was previously normal but was lost after an accidental injury or illness
- Treat disorders or delays in the development of language, cognitive, or motor skills

Inpatient services are covered when services cannot be rendered in any other setting (see inpatient benefits). Outpatient services are limited to a maximum of one hour of each specialty (physical therapy, occupational therapy and speech therapy) per day.

Physical therapy, functional occupational therapy, and speech therapy, including cardiac rehabilitation, are covered when rendered by a physician or by a licensed or registered physical or occupational therapist or a certified speech therapist that is licensed or registered as required as such by the state in which they practice, subject to the Plan's review and approval of your treatment plan for physical therapy and functional occupational therapy services. Premera or its designee may review a member's treatment plan for the purpose of verifying that the treatment is clinically safe, effective, and appropriate for the member's condition. Based on a prospective, concurrent or retrospective review, Premera may deny coverage if, in its determination, such services are not medically necessary.

Services rendered by a medical massage therapist are not covered under the rehabilitation benefit. Refer to the [Chiropractic services, acupuncture, and medical massage therapy](#) benefit for coverage.

Respite Care (Non-Hospice)

Health Connect network: 90%

Extended network: 60%, deductible applies

Out-of-network: 50% of allowable charges, deductible applies

Limit: 672 hours per calendar year

Respite care is for covered members who need assistance with activities of daily living (ADLs) such as bathing and dressing due to a permanent or temporary disabling medical condition, such as a traumatic brain injury, advanced multiple sclerosis, and severe cerebral palsy, where the member needs assistance moving from one place to the other. This benefit covers 672 hours per calendar year in the member's residential home to provide family caregivers an opportunity to recover from the emotionally and physically demanding tasks of caring for the covered member who requires assistance with ADLs.

The respite care application form and a home assessment must be completed prior to accessing this benefit. After the home assessment, Premera will make a determination if the covered member needs assistance with ADLs related to a disabling medical condition and qualifies for respite care coverage, which may be approved for up to a 12-month period. The home assessment is covered under the Home health care benefit. For the respite care application and more information on this benefit, call Premera Customer Service at (800) 676-1411.

Additional exclusions and limitations for respite care:

In addition to the plan's [exclusions and Limitations](#), the following exclusions and limitations apply to this benefit:

- Respite care provided by a non-certified or non-licensed provider or agency
- Respite care provided by a family member or friend
- Travel expenses, mileage, supplies or any other personal needs of the provider of the respite care
- Instrumental ADLs – examples of instrumental ADLs that are not covered by this benefit include, but are not limited to: shopping, housework, managing finances and using the computer.

Skilled nursing facility

Health Connect network: 90%

Extended network: 60%, deductible applies

Out-of-network: 50% of allowable charges, deductible applies

Limit: up to 120 days per member per calendar year

This benefit covers inpatient care in a Medicare-approved skilled nursing facility for up to 120 days in each calendar year. Services must be part of a formal written treatment plan prescribed by the doctor. Custodial care is not included in this coverage.



Custodial care is provided primarily for ongoing maintenance of a person's condition or to assist a person in meeting activities of daily living, and not for therapeutic value or requiring the constant attention of trained medical personnel. Review the [glossary](#) for a full definition.

Services and supplies eligible for reimbursement include:

- Room and board, meals, and general nursing care
- Services and supplies furnished and used while you are in the skilled nursing facility, such as:
 - The use of special treatment rooms
 - Routine lab exams
 - Physical
 - Occupational or speech therapy
 - Respiratory and other gas therapy
 - Drugs and biologicals (such as blood products and solutions)
 - Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts

Prior authorization

A prior authorization, also referred to as a pre-service review, is strongly recommended for skilled nursing facilities to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time

of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines.

Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Additional exclusions and limitations for skilled nursing facility

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Custodial care is not provided

- Care that is primarily for neurocognitive disorder, intellectual disability, or the treatment of substance use disorder and alcohol use disorder

Sterilization services

Elective Sterilization – Female

Health Connect network: 100%

Extended network: 100%

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers elective, permanent sterilization procedures, such as tubal ligation. Reversals or attempted reversals of these procedures are not covered.

Elective Sterilization – Male

Health Connect network: 100%

Extended network: 100%

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers elective, permanent sterilization procedures, such as vasectomy. Reversals or attempted reversals of these procedures are not covered.

Surgical weight loss treatment

Health Connect network: 90%

Extended network: 60%, deductible applies

Out-of-network: 50% of allowable charges, deductible applies

Who is eligible

This benefit covers you, your spouse/domestic partner, or dependent when the criteria listed in the Premera Medical Policy on Bariatric Surgery are met.



Contact Premera at (800) 676-1411 for a copy of the policy.

Examples of qualifying criteria include:

- A Body Mass Index (BMI) greater than 40 Kilograms (kg) per square meter (m2) or BMI greater than 35 Kg per m2 in conjunction with severe diabetes, hypertension, or obstructive sleep apnea
- Physician-supervised weight reduction program which includes:
 - A program lasting at least three consecutive months within the 12-month period before surgery is considered,
 - Evidence of active participation in a program documented in the member's medical records,
 - A psychological evaluation and clearance by a licensed mental health provider, to help rule out

other psychological disorders, inability to provide informed consent, or inability to comply with pre- and post-surgical requirements.

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Temporomandibular joint (TMJ) dysfunction

Health Connect network: 90%

Extended network: 60%, deductible applies

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers treatment of temporomandibular joint (TMJ) dysfunction and other related disorders, such as myofascial pain dysfunction (MPD). Services must be rendered by a physician, hospital, licensed or registered physical therapist, or licensed dentist.



While not required by the Plan, pre-service review is strongly recommended for some TMJ services, to ensure that coverage is available. For a list of such services, call (800) 676-1411. Fax pre-service review requests to Dental Review at (425) 918-5956 or mailed to:

Dental Review

MS 173

P.O. Box 91059

TMJ services and supplies for the treatment of TMJ dysfunction and myofascial pain dysfunction include:

- Diagnostic and follow-up examinations
- Diagnostic X-ray services
- Oral surgery
- Physical therapy
- Biofeedback
- Transcutaneous Electrical Nerve Stimulation (TENS)
- TMJ splints or TMJ guards

Transfusions, blood, and blood derivatives

Health Connect network: 90%

Extended network: 60%, deductible applies

Out-of-network: 50%, deductible applies

This benefit covers transfusions, blood, and blood derivatives that are not replaced by voluntary donors. The cost of donating and storing your own blood for a planned surgery is also covered.

Gender Affirming surgical services

Health Connect network: 90% Extended network: 90%

Out-of-network: 50% of allowable charges, after deductible. If waiver obtained (from Health Connect network PCP only) due to inadequate access within Extended network 90%.

This benefit covers medically necessary gender affirming surgical services, including facility and anesthesia charges related to the surgery.

Coverage of prescription drugs and mental health treatment associated with gender reassignment surgery is available under the [prescription drugs](#) and [mental health](#) benefits.

When services are covered

Surgical gender reassignment services will be considered medically necessary and covered if you are diagnosed as having gender dysphoria, and the following criteria are met:

For breast/chest surgery:

- You are at least 13 years old.
- You have one letter of recommendation for surgery from a mental health professional. The recommendation must be based on an assessment conducted within the last 24 months and must verify that your decision is current, well thought out, not impulsive, and not due to any other condition and/or mental disorder.
- The surgery is medically necessary according to the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH).

For genital surgery:

- You are at least 18 years old.
- You have two letters of recommendations for surgery from two separate mental health professionals, at least one of which includes an extensive report. A letter from a master's degree-level professional is acceptable if the second letter is from a psychiatrist or PhD clinical psychologist.
- The recommendation must be based on assessments conducted within the last 24 months and must verify that your decision is current, well thought out, not impulsive, and not due to any other treatable

condition and/or disorder.

- The surgery is medically necessary according to the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH).

For other procedures:

- The surgery is medically necessary according to the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH).

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended for coverage to be made available for gender affirming surgical services. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

For gender affirming services, the prior authorization should include:

- The surgical procedure(s) for which coverage is being requested
- The date the procedure will be performed
- Information supporting the criteria listed above has been met, based on the surgery being requested



Your physician can fax this information to (800) 843-1114 or mail it to:

Premera Blue Cross

Attn: Integrated Health Management

P.O. 91059

Transplants

*Health Connect network: 90% Extended
network: 90%*

Out-of-network: 50% of allowable charges, deductible applies

This benefit covers solid organ transplants and bone marrow/stem cell reinfusion. Procedures cannot be experimental or investigational.



Experimental or investigational services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#) for a full definition.



The transplant benefit doesn't cover cornea transplantation, skin grafts, or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure.

Eligible providers

To be eligible for coverage, the transplant or reinfusion must be furnished in an approved transplant center that has developed expertise in performing solid organ transplants, bone marrow reinfusion, or stem cell reinfusion, and is approved by Premera. Premera has contractual agreements with approved transplant centers and has access to a special network of approved transplant centers, throughout the United States. Whenever medically possible, we will direct you to an approved transplant center with which Premera has a contract. Of course, if neither a Premera-approved transplant center nor a Premera network transplant center can provide the type of transplant you need, this benefit will cover a transplant center that meets the approval standards that are set by Premera.



Approved transplant center is a hospital or other provider that has developed expertise in performing covered transplant services and has a contractual agreement in place with Premera. Review the [glossary](#) for a full definition.

Donor costs

All donor acquisition costs such as selection (testing and typing), harvesting (removal) transportation of donor organ, bone marrow and stem cells, and storage costs for bone marrow and stem cells for a period of up to 12 months are covered services, including costs incurred by the surgical harvesting teams.

Additional exclusions and limitations for transplants

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Nonhuman or mechanical organs, unless they are not experimental or investigational
- Services and supplies that are payable by any government, foundation, or charitable grant. This includes services performed on potential or actual recipients or donors (living or cadaver).
- Donor costs are not covered if the recipient of the transplant service is not a Woodgrove Financial enrollee. This applies to donor costs for all types of transplant services, solid organ and bone marrow or stem cell reinfusion.
- Donor costs are not covered by Woodgrove Financial if benefits are available under other group or individual coverage
- Donor costs are not covered for transportation for typing or matching

Travel and Lodging Reimbursement Benefit

Health Connect Network: 100%, deductible applies (additional IRS limitations below) Extended

Network: 100%, deductible applies (additional IRS limitations below)

Out-of-network: 100%, deductible applies (additional IRS limitations below) Limit:

\$10,000 per member, per calendar year

The following travel and lodging reimbursement benefits are available when travel is necessary to obtain covered services under the Plan that are not available within 100 miles of the member's residence.

Travel Allowances: Travel expenses are reimbursed between the member's residence and the location of the covered treatment for round trip (air, train, or bus) transportation costs. Airfare, or train or bus fare, must be for a regularly scheduled commercial flight, or train or bus route (coach class only). If traveling by automobile, mileage, parking, and toll costs are reimbursed. Costs for surface transportation (rideshares, taxi, ferry, etc.) are also covered. Mileage reimbursement is based on the current IRS medical mileage reimbursement. Please refer to the IRS website, www.irs.gov, publication 502 Medical and Dental expenses, for current mileage reimbursement rates.

Lodging Allowances: Hotel or motel stays (or similar accommodations) away from the geographic area of the member's residence. Reimbursement of expenses incurred by a member and one companion for hotel or motel lodging away from home, in the geographic area where the covered treatment is performed, is provided at a rate of \$50 per night per person, or up to \$100 per night total for the member and one companion, if applicable (see below), in accordance with applicable IRS reimbursement requirements.

Overall Maximum: The travel and lodging reimbursement benefit is limited to a total of \$10,000 per member per calendar year.

Companions: The travel and lodging benefit is available for the reimbursement of eligible expenses incurred by the member, as well as a companion, to the extent that a companion is needed to accompany the member for the treatment due to medical necessity or safety concerns.

- Adult member (age 18 or older) – travel and lodging reimbursement for 1 companion is permitted.
- Child member – travel and lodging reimbursement for 1 parent or guardian is permitted

Limits: Eligible travel and lodging expenses under this benefit are reimbursable up to the IRS mileage rate, lodging allowance, or other limits, as applicable, in effect on the date you incurred the expense, which are subject to change. Please visit to the IRS website, www.irs.gov, for details. Nothing in this summary of the travel and lodging reimbursement benefit should be considered legal or tax advice.

Please consult with a personal legal or tax advisor for more information.

Non-Covered Expenses:

- Alcohol/tobacco
- Car rental expenses
- Any airfare, train or bus fare, or upgrades, for any ticket other than a regularly scheduled commercial flight or route in coach class
- Baggage fees
- Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
- Expenses for persons other than the patient and an eligible companion

- Lodging at a residence owned by a family member or friend
- Costs for pets or animals, other than service animals
- Meals
- Personal care items (e.g., shampoo, deodorant, toothbrush etc.)
- Souvenirs (e.g., T-shirts, sweatshirts, toys, etc.)
- Telephone calls

Limitations/exclusions:

- The travel and lodging must occur, and the treatment must be provided, within the United States
- The patient must be covered by one of Woodgrove Financial's Premera plans at the time the treatment is provided

and the travel and lodging expenses are incurred

- The medical treatment for which the patient is required to travel more than 100 miles from the patient's residence must be a covered benefit under the Plan

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine in advance whether coverage is available for travel and lodging reimbursement.



Prior authorization is an advance determination by Premera that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Virtual Care

Mental health and substance use disorder treatment virtual visits:

Health Connect network: 100%

Extended network: 100%

Out-of-network: 100% of allowable charges Other

virtual care services:

Health Connect network: 100%

Extended network: 60%, deductible applies

Out-of-network: 50% of allowable charges, deductible applies

Virtual Care is the delivery of health-related services and information between a member and provider via telecommunications (email, telephone, video, and online) for the purpose of diagnosis, prevention, health advice, disease management and treatment.

Electronic Visits. An electronic visit (“e-visit”) is a structured, secure online consultation between an approved physician and the member. This benefit will cover medically necessary e-visits for an illness or injury. Each approved physician will determine which conditions and circumstances are appropriate for e- visits in their practice.

Telehealth Services. Your plan covers access to care via online and telephonic methods when medically appropriate. Services must be medically necessary to treat a covered illness, injury or condition. Your provider will determine which conditions and circumstances are appropriate for telehealth services.

Virtual Care with a provider located outside of the United States is not covered.

For information about how the novel coronavirus (COVID-19) pandemic impacts this benefit see [Important information due to the coronavirus pandemic](#).

Vision therapy

Health Connect network: \$40 copay

Extended network: \$40 copay

Out-of-network: 50% of allowable charges, deductible applies

Limit: up to 32-visit benefit maximum, per member, for the duration of the member's continuous enrollment

This benefit covers vision training, eye training or eye exercises up to a maximum of 32 treatment visits, for the duration of the member's continuous enrollment in one or more Premera-administered health plan options, for the following conditions only:

- Amblyopia
- Convergence insufficiency
- Esotropia or exotropia

All other uses of vision therapy are considered investigative and are not covered. Vision therapy is not a covered service under the [Vision plan](#). Costs of equipment and supplies associated with vision therapy are not covered.

Weight Management program

In-network (eligible providers): 80% up to \$6,000 maximum for the duration of your continuous enrollment in one or more Premera-administered health plan options; deductible and out-of-pocket maximum do not apply

Out-of-network: not applicable

This benefit covers comprehensive and clinically based weight management programs for the treatment of obesity. The 20% coinsurance you pay will not count toward the Extended Network deductible (if applicable) or your out-of-pocket maximum and will continue after the Extended Network deductible (if applicable) and your out-of-pocket maximum are met.

Who is eligible

Members are eligible for this benefit if they meet the following criteria:

- Diagnosed as obese (commonly Body Mass Index (BMI) greater than or equal to 30)
- Overweight with a BMI greater than or equal to 27, and diagnosed with two or more of the following conditions:
 - Congestive heart failure
 - Coronary heart disease
 - Depression
 - Diabetes
 - Hyperlipidemia
 - Hypertension

Dependent children are not eligible for this benefit.

Eligible providers

Approved [weight management providers](#) of this benefit must meet eligibility requirements set forth by Woodgrove Financial and Premera and be providing services under a weight management program that is contracted for and approved by Premera for this plan.

Approved weight management programs will be those programs that are comprehensive and clinically based. Approved programs must be based on medical oversight and include treatment from professionals in the areas of nutrition, behavioral therapy, and personal training. An approved program must include an initial minimum 10-week period of frequent sessions with the program's physician, personal trainer, dietitian, and behavioral therapist. This initial period must be followed by a minimum three-month maintenance period, which includes regular follow-up visits with these program professionals.

The Weight Management program must be contracted for and approved by Premera both at the time the participant or covered spouse/domestic partner begins the program and when they complete the program. If the program is not approved and contracted for until after the participant has started treatment under the program, no part of the cost of the program will be covered under this benefit.



To find an approved provider, review the [Weight Management providers list](#).

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

A [Weight Management Recommendation form](#) or confirmation of your BMI and co-morbid conditions must be submitted to Premera in order to receive reimbursement from Premera.

Your physician's recommendation will confirm you meet the contract criteria required for this benefit to be available.

The following are the steps that you are recommended to complete in advance to ensure that your treatment meets the criteria of this benefit:

1. Take the Weight Management Recommendation form to your regular physician
2. An evaluation is performed by your physician to determine if you meet the eligibility requirements set forth above
3. Your physician faxes or mails the Weight Management Recommendation Form to Premera to confirm that you meet the weight management eligibility requirements and your physician's approval



Your physician can fax this information to (800) 676-1477

4. Premera will review the information submitted and verify the coverage through a prior authorization

Claims payment

Final claims payment will be contingent on Premera receiving all biometric reporting information for the participant. Reimbursement for this benefit may occur in one of two ways. The program you attend will select the claims payment method used.

Method 1: Direct reimbursement to member

The provider will bill you directly for services provided. The frequency of billing should be made clear by the provider before you start the program. The weight management provider may collect a deposit from you to initiate your participation in the program.

During the course of the program, you can submit an interim billing member claim form on a monthly or quarterly basis to Premera for reimbursement. Upon completion of the program, you must submit the weight management final billing claim form for your final payment. Final claims payment is contingent on receiving the form with all biometric information completed.

If your coverage terminates during the time you are participating in an approved program, and you do not elect COBRA, only services rendered up to the date of termination of coverage will be reimbursed.

Method 2: Direct reimbursement to provider

Reimbursement will be made directly to the weight management provider on a monthly or quarterly basis. The weight management provider may collect a deposit from you to initiate your participation in the program but will bill Premera on a monthly or quarterly basis for your ongoing participation.

Additional exclusions and limitations for Weight Management program

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Food
- Nutritional supplements (i.e., protein shakes)
- Drugs or surgical procedures to assist in reducing weight or curbing hunger are not covered under the weight management program benefit. Refer to the [Prescription drugs](#) or [Surgical weight loss](#)

treatment benefit for coverage.

Exclusions and limitations

- Services or supplies not medically necessary for diagnosis, care, or treatment of a disease, illness, injury, or medical condition, except for the following: (a) newborn nursery care covered under the hospital benefit; (b) male circumcision benefit; (c) sterilization benefit; (d) termination of pregnancy benefit; (e) infertility benefit; (f) hospice care benefit; and (g) well-child care and adult physical exam benefits
- Charges in excess of eligible charges
- Expenses in excess of the applicable annual and lifetime benefit maximums

- Services for which a claim was not received by Premera within 12 months of the date of service. Corrected claims and COB claims need to be submitted within 12 months from the original claim submission date.
- Over-the-counter drugs (unless prescribed); food dietary supplements (for example, infant formulas or protein supplements); and herbal or naturopathic/homeopathic medicine
- Over the counter (OTC) testing and supplies (for example, OTC pregnancy test and ovulation tests) except as covered under the DME benefit
- Charges for or in connection with services or supplies that are determined to be experimental or investigational
- Benefits that overlap or duplicate benefits for which the member is eligible under any other group benefit plan; Workers' Compensation or similar employee benefit law; Medicare A or B; or government-sponsored program of any type
- Services or supplies that are covered through any type of no-fault coverage or similar type of insurance coverage or contract, including but not limited to Personal Injury Protection (PIP) coverage, motor vehicle medical (MEDPAY), motor vehicle no-fault coverage, any excess insurance coverage, Medical premises coverage for homeowners or commercial (MEDPREM), commercial liability coverage, boat coverage, homeowner policy, or school and/or athletic policies.
 - This exclusion applies when the available or existing contract or insurance is either issued to, or makes benefits available to a Participant/claimant, whether or not the Participant/claimant makes a claim under such coverage.
 - Further, the Participant is responsible for any cost-sharing required by motor vehicle coverage, unless applicable state law requires otherwise.
 - If other insurance is available for medical benefits, the Participant must put such other insurance to use towards those medical bills before coverage under the Plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, Benefits will be provided according to the Plan.
- Work-related Conditions: This exclusion applies whether or not a proper or timely claim for benefits has been made under the following programs. This plan does not cover services or supplies for which you are entitled to receive benefits under:
 - Occupational coverage required of, or voluntarily obtained by, the employer
 - State or federal workers' compensation acts
 - Any legislative act providing compensation for work-related illness or injury
- In the event that you do not comply with the contractual terms of subrogation, the plan will no longer be obligated to provide any benefits under this plan. The plan has the right to deduct the amount of benefits paid from any future benefits payable to the enrollee or to any other covered dependent.
- Any services or supplies for which no charge is made, or for which a charge is made because this plan is in effect, or for services or supplies for which the member is legally liable because this plan is in effect
- Services of a social worker except as provided in the hospice care benefit, the home health care benefit, and the mental health and chemical dependency benefit
- Routine or palliative foot care to treat fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other problems that are commonly treated with off-the-shelf, over-the-counter (OTC) therapy. This exclusion does not apply to medically necessary foot care.

- Foot or shoe prosthetics, appliances, orthotics or inserts except as described under the durable medical and surgical equipment and supplies benefit. This does not apply to enrollees who are diabetic.
- Massage therapy that is not medically necessary, or is furnished without a prescription
- Any benefits or services not specifically provided for in this SPD
- Liquid diets or fasting programs, memberships in diet programs or health clubs, or wiring of the jaw
- Drugs and medications not approved by the Food and Drug Administration (FDA) except as defined in the Experimental and Investigational section
- Procedures for sterilization reversals
- Hypnotherapy, regardless of provider
- Hippotherapy or other forms of equine or animal-based therapy
- Electronic services and/or consults, except as specifically described under the plan
- Services or supplies furnished by a member to himself or herself or by a provider who is in any way related to the member. This also includes but is not limited to a provider covered dependents under the plan (whether or not living in the household), spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent or spouse of grandchild.
- Services that are illegal, outside the scope of the provider's license or certification, or that are furnished by a provider that is not licensed or certified by the jurisdiction in which the services or supplies were received
- Separate charges for records or reports, except those Premera requests for utilization review
- Voluntary support or affinity groups such as patient support, diabetic support groups or Alcoholics Anonymous. Additionally, volunteer services or services provided by or through a school, books, and other training aids are also not covered.
- Non-treatment facilities, institutions or programs: Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, juvenile detention facilities, group homes, foster homes and adult family homes. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider, provided that such non-treatment facilities, institutions, or programs, themselves, are not eligible providers for this purpose.
- Services or supplies for any of the following:
 - Education and training programs including testing or supplies/materials, including vision training supplies
 - Educational or recreational therapy or programs; this includes, but is not limited to, boarding schools. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider, provided that educational or recreational therapy or programs, themselves, are not eligible providers for this purpose.
 - Social, cultural, or vocational rehabilitation or vision training supplies
- Refractive surgery of the eye (surgery to improve vision that can be corrected with glasses or contact lenses) is covered only as specified under the vision plan
- Hospital grade breast pumps are not available for purchase; however, they may be covered for rent for up to 12 months.

- Services for individuals not eligible for coverage under the Woodgrove Financial Plan will not be reimbursed except in the following circumstances:
 - Donors for organ or bone marrow/stem cell transplantation for services specific to that procedure
 - Genetic testing of relatives when the information is needed to adequately assess risk in the member; the result of the test will directly impact the treatment to the member; and there is no other coverage available to the relative
- Lodging is covered only as outlined in the Travel and Lodging Reimbursement Benefit
- When Coordinating Benefits (COB) if you fail to follow the rules of the primary plan, this plan would pay nothing for that expense
- Benefits are not provided for services or supplies (1) for which no charge is made, (2) for which no charge would have been made if this plan were not in effect, or (3) that were not received by the member while covered by the plan
- Services received in excess of a benefit limit or maximum are not covered. Any network discounts for in network providers do not apply to services received in excess of the benefit limit.

In addition, certain exclusions and limitations apply to the following benefits. CTRL+Click to navigate to the benefit information.

- [Autism/ABA therapy](#)
- [Dental services](#)
- [Hearing care and hardware](#)
- [Home health care](#)
- [Hospice care](#)
- [Hospital inpatient care](#)
- [Infertility](#)
- [Medical equipment and supplies](#)
- [Mental health and chemical dependency treatment](#)
- [Prescription drugs](#)
- [Skilled nursing facility](#)
- [Transplants](#)
- [Weight Management program](#)

How to file a claim

In most cases, when you receive care from a Health Connect or Extended Network provider, your provider will submit bills directly to Premera, and this submission is your claim for benefits. If your provider does not submit a bill directly to Premera, you will need to submit a claim for benefits.

If possible, you should submit the claim form within 30 days of the service. The plan will not reimburse claims submitted more than 12 months after the date of service.

For information about how the novel coronavirus (COVID-19) pandemic impacts the claims process and timelines, [Important information due to the coronavirus pandemic](#).

To submit a claim online:

From the Benefits Site, select **View My Claims**, which will direct you to the Premera Portal. Or sign in to your account on premera.com. Next, from the top menu bar select **Claims** and then **Submit Claims**.

Follow the steps and upload a copy of the itemized receipt. To submit a claim via mail, fax or email:

1. Download the [Premera Claim Reimbursement Request Form](#). You can also email Premera from your Woodgrove Financial email address (employees) to Woodgrove.Financial@premera.com or through your Secure Messaging center in the Premera portal (all enrollees including dependents and COBRA members) to request a claim form.
2. Complete the claim form, including all of the following information:
 - a. Your name and the member's name
 - b. Identification numbers shown on your identification card (including the 3-digit plan prefix or YMJ)
 - c. Provider's name, address, and tax identification number
 - d. If you are seeking secondary coverage from the Woodgrove Financial health plan, information about other insurance coverage related to the claim at hand, including a copy of their Explanation of Benefits (EOB), if applicable
 - e. If treatment is as a result of an accident: the date, time, location and brief description of the accident
 - f. Date of onset of the illness or injury
 - g. Date of service
 - h. Diagnosis or ICD-10 code (this information can be found on the provider bill)
 - i. Procedure codes (CPT-4, HCPCS, ADA, or UB-92) or descriptive English language for each service (this information can be found on the provider bill)
 - j. Itemized charges for each service rendered by provider
3. Sign the form in the space provided and attach the itemized provider bill
4. Submit the completed form to:

Mail: Premera Blue Cross
P.O. Box 91059

Seattle, WA 98111-9159

Fax: (800) 676-1477

Email from Woodgrove Financial email address:

claims.Woodgrove.Financial@premera.com Email through

the Secure Messaging center in your Premera portal



COBRA-eligibility claims should be submitted as described in the [Continuation of coverage for health and FSA benefits \(COBRA\)](#) section.

In the following circumstances, you may submit claims according to the [appeals process](#):

- If you cannot submit the claim in a timely manner due to circumstances beyond your control
- If your claim regards plan eligibility for you, your spouse/domestic partner, or dependent child

Claim review and payment

The claim review process begins once Premera receives a claim from you or your provider or other authorized representative. Premera will send you an Explanation of Benefits (EOB) or other communication notifying you of their decision on your claim. In most cases, this communication will be sent to you no more than 30 days after Premera receives the claim, although Premera may extend this 30-day period for up to 15 days if the extension is required due to matters beyond Premera's control.

If your claim relates to an item for which the Plan requires you to obtain approval (or “prior authorization”) before it is furnished to you, then Premera generally will send a decision no later than 15 calendar days after receipt of your request. Premera may extend this 15-day period for up to an additional 15 days if the extension is required due to matters beyond Premera’s control.

If Premera needs additional information from you to process your pre- or post-service claim, Premera will notify you in writing, within 30 days after receiving your claim, of the specific information required. You will have at least 45 days to provide the additional information. The determination prior to respond to your claim (as provided above) will be suspended as of the date Premera sends the notice and will resume again once you have provided the additional information. If you do not provide the requested information within the specified timeframe, Premera will decide the claim without the requested information.

If your claim is for “urgent care,” meaning the application of the standard time periods for making determinations could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment at issue, then the following special rules apply:

- Premera will send you an EOB or other communication notifying you if they have denied your claim, in writing or electronically, within 72 hours after Premera receives all necessary information for your claim either via phone or in writing, taking into account the seriousness of your condition.
- Premera’s denial notice may be oral, with a written or electronic confirmation to follow within three days.
- If the claim was filed incorrectly, Premera will notify you of the error and how to correct it within 24 hours after the claim was received. If additional information is needed to process the claim, Premera will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information. You will then be notified of Premera’s determination no later than 48 hours after (1) Premera’s receipt of the requested information, or (2) the end of the 48-hour period when you were to provide the additional information if the information is not received in that timeframe.

If your claim is a request to extend an ongoing course of treatment beyond a previously approved period of time or number of treatments, and is considered an urgent care claim, Premera will decide your claim within 24 hours, provided that your claim is submitted at least 24 hours before the end of the approved treatment.



Explanation of benefits (EOB) is the statement you receive from Premera Blue Cross detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

Premera will make a payment to the employee, a dependent (age 13 or older), a provider, or another carrier. Payments are subject to applicable law and regulation:

- Premera may make payments on behalf of an enrolled child to a non-enrolled parent or state agency to which the plan is required by applicable law to direct such payments
- Payments made will discharge the plan to the extent of the amount paid, so that the plan is not liable to anyone due to its choice of payee

Denied claims notice

If all or part of your claim is denied, Premera will send you an Explanation of Benefits (EOB) or other notice with the following information:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A description of any additional material or information needed from you and the reason it is needed
- An explanation of the appeals procedures and the applicable time limits
- A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request)
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)
- If the claim is for urgent care (as defined above), a description of the expedited review process applicable to such claims
- If you have filed a claim with Premera relating to plan eligibility, and this claim is denied, Premera will send you a notice explaining your appeal rights
- Notice regarding your right to bring legal action following a denial on appeal

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
- The denial code and its meaning
- A description of the plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal
- Contact information for Premera Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

Appeal for internal review

If you do not agree with the decision made by the Plan, you may appeal for an internal review of the decision within 180 days of receiving the Explanation of Benefits (EOB) or adverse decision.

For information about how the novel coronavirus (COVID-19) pandemic impacts the appeal process and timelines, [Important information due to the coronavirus pandemic](#).



An **appeal** is a written request to reconsider a written or official verbal adverse determination to deny, modify, reduce or end payment, coverage or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to and continued stays in a facility. The process also applies to Flexible Spending Account appeals for reimbursement but does not apply to appeals of denied COBRA eligibility claims.



If you fail to file the internal appeal within 180 days of receiving the Explanation of Benefits, you will permanently lose your right to appeal the denied claim.

Submitting an appeal for internal review

You or your authorized representative* must provide the following information as part of your written appeal to the Premera Appeals Department.

- Your name
- Your Premera member number
- The name of this plan, and
- A concise statement of why you disagree with the decision, including facts or theories supporting your claim

Your written request may (but is not required to) include issues, comments, documents, and other records you want considered in the review.



The appeal should be mailed or faxed to Premera: Appeals

Coordinator

Premera Blue Cross

P.O. Box 91102

Seattle, WA 98111-9202

*You may, at your own expense, have a representative file an appeal on your behalf. Your Attorney, family member, your provider, or anyone else who you wish to designate as your authorized representative may also appeal with written authorization. In order to designate an authorized representative for this purpose, you must, must submit a completed and signed [Woodgrove Financial Member Appeals Form](#), which includes an appeal authorization section.

In the case of an urgent care appeal, you may submit your appeal request orally or in writing and all necessary information may be transmitted between you and the plan by telephone or fax. If your provider believes your situation is urgent as defined under law and so notifies Premera, your appeal will be conducted on an expedited basis. Notification will be furnished to you as soon as possible, but not later than 72 hours after receipt of the expedited appeal. Your appeal should clearly indicate your request for an expedited appeal.



For urgent situations or if you are in an ongoing course of treatment, you may begin an external independent review at the same time as Premera Blue Cross's internal review process. The external review agency is not legally affiliated or controlled by Premera. The external review agency decision is final and is binding upon the Plan.

To file an urgent care appeal request, you may fax a request to (425) 918-5592.

The external review for non-urgent situations is available only after you have properly exhausted the internal appeal as described above.



An urgent care claim or appeal is one where the application of the standard time periods for making determinations could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Internal review and timeframe

All the information you submit will be taken into account on appeal, even if it was not reviewed as part of the initial decision. You may ask to examine or receive free copies of all pertinent plan documents, records, and other information relevant to your claim by asking Premera.

The plan may consult with a health care professional who has experience in the field of medicine involved in the medical judgment to decide your appeal. You may request the identity of medical experts whose advice was obtained by the plan in connection with your initial claim denial, even if their advice was not relied upon in making the initial decision.

In the event any new or additional information (evidence) is considered, relied on or generated by Premera in connection with your appeal, Premera will provide this information to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Premera, Premera will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that that you will have an opportunity to respond.

Other than urgent care appeals, described above, in most cases Premera will send a decision on your appeal no later than 60 calendar days after receipt of your appeal request. However, if the appeal relates to an item for which the Plan requires you to obtain approval before it is furnished to you, then it will be considered a pre-service appeal, and Premera will send a decision no later than 30 calendar days after receipt of your appeal request.

Denied appeal notice

If your appeal is denied, you will receive a written notice setting forth:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits
- A statement explaining the external review procedures offered by the plan and your right to bring a civil action under ERISA section 502(a)
- A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in

denying the claim (a copy of which will be provided free upon request)

- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
- The denial code and its meaning
- A description of the Plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal

- Contact information for Premera Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

Appeal for external review

If you are not satisfied with the final internal denial of your claim, you may request an external review by an independent review organization (IRO) if that denial (1) has a retroactive effect and is considered a rescission of coverage under the law, or (2) is based on medical judgment including:

- Requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit
- A determination that a treatment is experimental or investigational



An **independent review organization (IRO)** is an independent organization of medical experts who are qualified to review medical and other relevant information.

The external review for non-urgent situations is available only after you have properly exhausted the internal appeals process as described above. There are no fees or costs imposed on you as part of the external review.

The external review agency decision is final and is binding upon the plan.

Submitting an appeal for external review

To initiate the external review, you must send a written request to Premera at the address below no later than 120 days after the date you receive your internal appeal determination letter, which the plan deems to be seven days after the date on the internal appeal determination letter.



If you fail to submit the written request within this timeframe, you will permanently lose your right to an external review.



Mail or fax the written request to:

Premera Blue Cross

Attn: Woodgrove Financial Member Appeals – IRO Mail Stop 123

P.O. Box 91102

Seattle, WA 98111-9202

External review and timeframe

If your appeal is eligible for external review, Premera will notify the IRO of your request for an external review and send them all the information included in your internal appeal and other relevant materials within six days of receipt.

The IRO will contact Premera directly if additional information is needed. Premera will provide the IRO with any additional information they request that is reasonably available. The external review request is considered complete when the IRO has all the requested information, and the IRO review begins.



If your provider believes your situation is urgent under law (as defined above under Appeal for internal review), your external review will be conducted on an expedited basis. For expedited external reviews, you and Premera will be notified by phone, e-mail message or fax as soon as possible, but no later than 72 hours after receipt of your external review request. A written determination will follow.

The plan agrees that any statute of limitations (including the one-year contractual limitations period described below) or other defense based on timeliness is on hold during the time that the external review is pending. Your decision whether to file the external review will have no effect on your rights to any other benefits under the plan.

The external review process does not apply to appeals of denied claims for plan eligibility or for other appeals of denied claims that are not based on medical judgment.

Decision on the external review

The plan is bound by the IRO's decision. If the IRO overturned the final internal adverse determination, the plan will implement their decision. The IRO will notify you and Premera in writing of its determination on the external review no later than 45 days after receipt of your complete external review request.

Decisions upon the external review are the final decision under the plan's appeal process, and there are no further appeals available from Premera or Woodgrove Financial or any person administering claims or appeals under the plan. However, you still have the right to file suit under ERISA Section 502(a) as a result of the external review decision.

Limits on your right to judicial review

You must follow the appeals process described above through the decision on the appeal before taking action in any other forum regarding a claim for benefits under the plan. Any legal action initiated under the plan must be brought no later than one year following the adverse determination on the appeal. This one-year limitations period on claims for benefits applies in any forum where you initiate legal action. If a legal action is not filed within this period, your benefit claim is deemed permanently waived and barred. In addition, you must raise all issues and grounds for appealing a decision on a claim for benefits at every stage of the appeal process, or else such issues and grounds will be deemed permanently waived and barred.



If you have questions about understanding a denial of a claim or your appeal rights, you may contact Premera Customer Service for assistance at (800) 676-1411. You may also seek assistance from the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor at (866) 444-EBSA (3272).

Right to recover benefits paid in error

If Premera makes a payment in error on your behalf to you or a provider, and you are not eligible for all or a part of that payment, Premera has the right to recover payment, including deducting the amount paid mistake from future benefits.

Note: Health care providers are not “beneficiaries” of the plan, and although Premera may make direct payment to health care providers for the convenience of participants and their dependents, such payments of services shall not be considered “benefits” available under the plan, or confer beneficiary standing upon a health care provider.

HMO Plan Kaiser Foundation Health Plan of Washington (KFHPWA) – Washington only

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How the plan works

The Kaiser Foundation Health Plan of Washington (KFHPWA) HMO Plan offers the convenience of “one- stop shop” medical care. Your Provider Network is KFHPWA’s Core Network (Network). Members are entitled to Covered Services only at Network Facilities and from Network Providers, except for Emergency services and care pursuant to a Preauthorization. Your providers are all part of the same integrated health care system, so they can quickly share your medical records to help make informed decisions about your care. There is also a pharmacy, laboratory, and X-ray facility at every Kaiser Permanente location, so it is easy and efficient to get the care you need when you need it.

Important notice under Federal Health Care Reform

KFHPWA recommends each member choose a Primary Care Physician. This decision is important since the designated Primary Care Physician provides or arranges for most of the member’s health care. The member has the right to designate any Primary Care Physician who participates in one of the KFHPWA networks and who is available to accept the member or the member’s family members. For information on how to select a Primary Care Physician, and for a list of the participating Primary Care Physicians, call the Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington, (888) 901-4636.

For children, the member may designate a pediatrician as the primary care provider.

The member does not need prior authorization from KFHPWA or from any other person (including a Primary Care Physician) to access obstetrical or gynecological care from a health care professional in the KFHPWA network who specializes in obstetrics or gynecology. The

health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for obtaining prior authorization. For a list of participating health care professionals who specialize in obstetrics or gynecology, call the Kaiser

Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington, (888) 901- 4636.

Federal No Surprise Billing Protection

Out-of-network providers generally have the right to charge you more than the Plan's allowed amount or allowable charge for a covered service. This is called "balance billing." However, Federal law protects you from balance billing for the following types of services:

- Emergency Care from an out-of-network hospital or independent freestanding emergency department.
- Out-of-network air ambulance services
- Any services from an out-of-network provider at an in-network hospital, hospital outpatient department, critical access hospital, or outpatient surgical center, provided that the out-of-network provider may balance bill you if the provider gives you advance notice and you provide your written consent, except for the following services (for which balance billing is never permitted):
 - Surgery
 - Anesthesia
 - Pathology
 - Radiology
 - Laboratory
 - Hospitalist Care

Solely for purposes of determining your cost-sharing obligations for these services, the allowed amount or allowable charge is the lesser of (1) the out-of-network provider's or facility's billed charges, or (2) the Plan's median in-network rate for the same or similar service provided in the same or similar specialty in the same geographic area (or any other amount specified for this purpose under applicable law).

Please Note: These balance billing protections do not apply to any other service from an out-of-network provider or facility. If the service is not listed above, the provider or facility may bill you for, and you may be required to pay, any amounts in excess of the plan's allowed amount for the service (and any amounts that you pay in excess of the allowed amount will not count toward any applicable deductible, coinsurance, or out-of-pocket maximum).

Women's health and cancer rights

If the member is receiving benefits for a covered mastectomy and elects breast reconstruction in connection with the mastectomy, the member will also receive coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.

- Prostheses.
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

These services will be provided in consultation with the member and the attending physician and will be subject to the same cost shares otherwise applicable under the Benefits Booklet.

Statement of rights under the Newborns' and Mothers' Health Protection Act

Carriers offering KFHPWA coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, carriers may not, under federal law, require that a provider obtain authorization from the carrier for prescribing a length of stay not in excess of 48 hours (or 96 hours). Also, under federal law, a carrier may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

For more information

KFHPWA will provide the information regarding the types of plans offered by KFHPWA to members on request. Call the Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington, (888) 901-4636.

Where you can get care

The KFHPWA HMO Plan provides comprehensive medical care with several contracted providers, facilities and pharmacies through the KFHPWA Network in Washington. Kaiser Permanente facilities are treated as part of the KFHPWA Network if you need medical services while outside Washington State as described under receiving care in another Kaiser Foundation Health Plan Service Area, below. Benefits will not be denied for any health care service performed by a registered nurse licensed to practice under Washington regulations (Chapter 18.88 RCW), if the service performed was within the lawful scope of the nurse's license, and this plan would have covered the service if it had been performed by a Doctor of Medicine licensed to practice under Washington regulations (Chapter 18.71 RCW).



In the event of unusual circumstances such as a major disaster, epidemic, military action, civil disorder, labor disputes or similar causes, KFHPWA will not be liable for administering coverage beyond the limitations of available personnel and facilities.

Receiving Care in another Kaiser Foundation Health Plan Service Area

If you are visiting the service area of another Kaiser Permanente region, services may be available from designated providers in that region and treated as within the KFHPWA Network if the services otherwise would have been covered under this SPD. These “visiting member” services are subject to the provisions set forth in this SPD including, but not limited to, preauthorization and cost sharing. For more information about receiving visiting member services in other Kaiser Permanente regional health plan service areas, including provider and facility locations, call Kaiser Permanente Member Services at (206) 630-4636 in the Seattle area, or toll-free in Washington, (888) 901-4636. Information is also available online at <https://wa.kaiserpermanente.org/html/public/services/traveling>.

Receiving Care outside the Kaiser Foundation Health Plan Network

If you choose to receive services from a non-KFHPWA HMO (Core) Network provider or facility, except as otherwise specifically provided in this SPD, those services will not be covered, and you will be responsible for the full price of the services. Any amounts you pay for non-covered services will not count toward your out-of-pocket limit.

Services provided outside the KFHPWA Network may not be covered. The plan covers select services outside of the KFHPWA Network, including:

Covered care outside the KFHPWA Network	
Emergency care	You can obtain emergency care from the closest facility to you. You must call the hospital notification line at (888) 457-9516 within 24 hours of admission to a non-contracted facility, or as soon thereafter as medically possible. Review the emergency benefits for more information.
Urgent care	<p>If you are outside the KFHPWA service area, you may receive urgent care at any medical facility. Urgent care within the KFHPWA service area is covered at KFHPWA facilities. Review the urgent care benefits for more information.</p> <p>For urgent care during office hours, you can call your personal physician’s office first to see if you can get a same-day appointment. If a physician is not available or it is after office hours, you may speak with a licensed care provider anytime at 1-800-297-6877 or (206) 630-2244. You may also check https://wa-doctors.kaiserpermanente.org/ or call Member Services to find the nearest urgent care facility in your network.</p>

Covered care outside the KFHPWA Network	
Out of area benefit	If you are outside the KFHPWA service area, the plan covers services up to a maximum of \$2,000 per member per calendar year. All applicable costs, benefits, limitations and exclusions apply as if services were covered within the KFHPWA service area.
Travel and lodging reimbursement	Travel and lodging reimbursement benefits are available when travel is necessary to obtain covered treatment for a medical condition only when a treatment option is not available within 100 miles of your home. The plan covers services up to \$10,000 per member per calendar year.
Prior authorization	<p>Your primary care physician may refer you to a non-contracted provider outside the KFHPWA Network. Prior authorization must be provided by your primary care physician and approved by KFHPWA. KFHPWA will generally process prior authorization requests and provide notification for benefits within the following timeframes:</p> <ul style="list-style-type: none"> • Standard requests – within 5 calendar days <ul style="list-style-type: none"> ○ If insufficient information has been provided a request for additional information will be made within 5 calendar days. The provider or facility then will have 5 calendar days to provide the necessary information. A decision will be made within 4 calendar days of the later of (1) receipt of the requested information or (2) the deadline for receipt of the requested information. • Expedited requests – within 2 calendar days <ul style="list-style-type: none"> ○ If insufficient information has been provided a request for additional information will be made within 1 calendar day. The provider or facility then will have 2 calendar days to provide the necessary information. A decision will be made within 2 calendar days of the later of (1) receipt of the requested information or (2) the deadline for receipt of the requested information.
Your provider's contract with Kaiser is ending (continuity of care)	If you are receiving ongoing treatment (such as physical therapy) for certain serious and complex medical conditions or illnesses, or pregnancy, are undergoing institutional or inpatient care, or are scheduled for nonelective surgery, you may be eligible to continue to receive in-network benefits for the current course of treatment, for up to 90 days. A specific time period. During any such extension of in-network benefits, you may be required to pay any amounts over the allowable charge.



Urgent care is for the sudden, unexpected onset of a medical condition that is of sufficient severity to require medical treatment within 24 hours of its onset.

Primary care physician

You and your primary care physician coordinate your care with specialists and other members of the KFHPWA care team.

You should select a primary care physician for yourself and your covered dependents when you enroll in the KFHPWA HMO Plan. You may select one physician for your entire family, or a different physician for each member. You can select or change your primary care physician by contacting Kaiser Permanente Member Services at (206) 630-4636 or (888) 901-4636, or by visiting KFHPWA online at <https://wa.kaiserpermanente.org/>. If your selected primary care

physician is accepting patients, the change will be made within 24 hours of the request. If a primary care physician accepting new members is not available in your area, contact Kaiser Permanente Member Services, who will ensure you have access to a primary care physician by contacting a physician's office to request they accept new members.

For your personal physician, choose from these specialties:

- Family medicine
- Adult medicine/internal medicine
- Pediatrics/adolescent medicine (for children up to 18)

If you don't choose a physician when you first become a KFHPWA member, you will be matched with a physician to make sure you have one assigned to you if you get sick or injured. You can change your personal physician at any time, for any reason.

If your primary care physician no longer participates in KFHPWA's network, you can use their services for up to 60 days after you've been sent a written notice about selecting a new physician.



A **Physician** is a state licensed:

- Doctor of Medicine and Surgery (M.D.) or
- Doctor of Osteopathy (D.O.)

In addition, professional services provided by one of the following types of providers may be covered under this plan, but only when the provider is providing a service that is within the scope of their state license and for which benefits are specified in this SPD and would be payable if the service were provided by a physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Nurse (R.N.) licensed in Washington state
- Naturopathic physician (N.D.)



Call (206) 630-4636 or (888) 901-4636 or visit KFHPWA online at <https://wa.kaiserpermanente.org/> for a listing of personal physicians, referral specialists, women's health care providers, Health Care Benefit Managers and KFHPWA-designated specialists. Information available online includes each physician's location, education, credentials, and specialties.

Specialist care

Unless indicated in the table below or the [What the plan covers](#) section, you will need a prior authorization from your primary care physician before the plan will cover care from specialists. To access a KFHPWA-designated specialist, consult your KFHPWA primary care physician. For a list of KFHPWA- designated Specialists, contact Member Services at (206) 630-4636 or (888) 901-4636 or view the Provider Directory located at <https://wa.kaiserpermanente.org/>.

Specialty care that doesn't require a referral	
KFHPWA designated - specialists	Preauthorization is not required for services with most specialists at Kaiser Permanente - owned or -operated medical centers. To obtain or request a complete list of these specialists, contact Member Services at (206) 630-4636 or view the Provider Directory located at https://wa.kaiserpermanente.org/ .
Women's health care direct access providers	<p>Female members may make appointments directly with specialists who are contracted by KFHPWA without a referral for the following care areas:</p> <ul style="list-style-type: none"> • Medically necessary maternity care • Covered reproductive health services • Preventive care (well care) and general examinations • Gynecological care • Follow-up visits with: General and Family Practitioners, Physician's Assistants, Gynecologists, Certified Nurse Midwives, Licensed Midwives, Doctors of Osteopathy, Pediatricians, Obstetricians, or Advanced Registered Nurse Practitioners who are contracted by KFHPWA <p>Care is covered as if your primary care physician has been consulted. However, if your provider diagnoses a condition that requires referral to other specialists or hospitalization, you must obtain prior authorization under KFHPWA requirements.</p>

Second opinions

You can get a second opinion on a medical diagnosis or treatment plan from a KFHPWA provider by visiting a KFHPWA-designated specialist. Second opinions are covered when prior authorization is received or when obtained from a KFHPWA-designated specialist.

Prior authorization for a second opinion does not imply that KFHPWA will authorize you to return to the physician providing the second opinion for additional treatment. Your coverage is determined by your medical plan benefits. Coverage for services, drugs, devices, etc., prescribed or recommended as a result of the consultation is determined by your medical plan benefits.



The KFHPWA medical director will determine the necessity, nature, and extent of treatment to be covered in each individual case, and the judgment will be made in good faith. You may refuse any recommended services to the extent permitted by law. If you obtain care not recommended by KFHPWA, you do so with the full understanding that KFHPWA has no obligation for the cost, or liability for the outcome, of such care. Your coverage decisions may be appealed under the plan benefits.

Process for medical necessity determination

Pre-service, concurrent or post-service reviews may be conducted. Once a service has been reviewed, additional reviews may be conducted. Members will be notified in writing when a determination has been made.

First level review

First level reviews are performed or overseen by appropriate clinical staff using KFHPWA approved clinical review criteria. Data sources for the review include, but are not limited to, referral forms, admission request forms, the member's medical record, and consultation with qualified health professionals and multidisciplinary health care team members. The clinical information used in the review may include treatment summaries, problem lists, specialty evaluations, laboratory and x-ray results, and rehabilitation service documentation. The member or legal surrogate may be contacted for information. Coordination of care interventions are initiated as they are identified. The reviewer consults with the member's health care team when more clarity is needed to make an informed medical necessity decision. The reviewer may consult with a board-certified consultative specialist and such consultations will be documented in the review text. If the requested service appears to be inappropriate based on application of the review criteria, the first level reviewer requests second level review by a physician or designated health care professional.

Second level (practitioner) review

The practitioner reviews the treatment plan and discusses, when appropriate, case circumstances and management options with the attending (or referring) physician. The reviewer consults with the member's health care team when more clarity is needed to make an informed coverage decision. The reviewer may consult with board certified physicians from appropriate specialty areas to assist in making determinations of coverage and/or appropriateness. All such consultations will be documented in the review text. If the reviewer determines that the admission, continued stay or service requested is not a covered service, a notice of non-coverage is issued. Only a physician, behavioral health practitioner (such as a psychiatrist, doctoral-level clinical psychologist, certified addiction medicine specialist), dentist or pharmacist who has the clinical expertise appropriate to the request under review with an unrestricted license may deny coverage based on medical necessity.

Filling a prescription

Depending on your needs, you may fill up to a 30-day supply of your prescription at a KFHPWA- designated pharmacy or up to a 90-day supply from KFHPWA-designated mail

order service. Review the [prescription drugs](#) benefit for more information on what is covered.

What you pay

When you receive care for the treatment of illnesses, injuries, and chronic conditions, you pay a portion of the cost, up to an annual out-of-pocket maximum. For most services such as office visits, outpatient surgery, and prescriptions, you pay a flat copayment at the time you receive care, and the plan pays the remainder of the cost. If you have an inpatient hospital stay, the plan pays 90% of the cost and you are

responsible for 10% up to an annual out-of-pocket maximum. When it comes to preventive care, the plan covers 100% when you use network providers.

What you pay		
Copayments	+	Coinsurance
For office visits, outpatient surgery, and prescriptions, you pay a flat dollar copayment at the time you receive care, and the plan pays the remainder of the charges.	=	Out-of-pocket maximum
If you have an inpatient hospital stay, you pay 10% of the cost, called coinsurance, and the plan pays the rest.		
		If you reach your annual out-of-pocket maximum, the plan pays 100% of eligible expenses from that point forward. The out-of-pocket maximum is \$1,500 per person, up to a \$4,500 maximum for three or more covered family members.



Copayment is a fixed, up-front dollar amount that you're required to pay for certain covered services.

Coinsurance is the percentage amount that you are required to pay for certain covered services.

Out-of-pocket maximum is the most you could pay each plan year for covered services and supplies.

Medical care copayments

Type of visit	Copayment	Coinsurance
Primary Care Physician	\$20	None
Specialist	\$40	None
Emergency (waived if admitted)	\$75	None
Hospital – outpatient	\$100	None
Hospital – inpatient	None	10%

Prescription drug copayments

Type of prescription (30-day supply)	KFHPWA pharmacy copayment	KFHPWA mail order copayment
Value-based	\$0	\$0

Preferred generic	\$10	\$5
Preferred brand	\$25	\$20
Non-preferred generic and brand	\$50 (\$35 maximum for insulin)	\$45 (\$35 maximum for insulin)

(when prescribed by KFHPWA provider)



Value-based drugs are drugs for chronic disease management such as diabetes, hyperlipidemia, heart failure and hypertension that are considered high value and are covered on a lower cost share tier.

Preferred generic drugs are equivalent to brand-name drugs but are available at a lower cost because the patent has expired.

Preferred brand-name drugs are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.

The **Preferred drug list** is the list of brand-name prescription drugs that are covered under the KFHPWA HMO Plan.



Call (206) 630-4636 or (888) 901-4636 or visit [KFHPWA](#) online to review the Preferred drug list.

Out-of-pocket maximum

The annual out-of-pocket maximum is capped at \$1,500 for each covered member—this means that once a member reaches his/her out-of-pocket maximum through copayments and coinsurance, the plan pays 100% for the rest of the year for that individual. Also, if you have three or more covered family members, the most you'll pay for the year is \$4,500. Member payments for the Weight Management program do not count toward the out-of-pocket limit. All cost shares for covered services apply to the out-of-pocket maximum.

Utilization Management

All benefits under this plan are limited to covered services that are medically necessary and as set forth under Plan Benefits. KFHPWA may review a member's medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent or retrospective review, KFHPWA may deny coverage if, in its determination, such services are not medically necessary or do not meet all criteria specific in this SPD. Such determination shall be based on established clinical criteria.

KFHPWA will not deny coverage retroactively for services it has previously authorized and that have already been provided to the member except in the case of an intentional misrepresentation of a material fact by the patient, member, or provider of services, or if coverage was obtained based on inaccurate, false, or misleading information provided on the enrollment application, or for nonpayment of premiums.

What the plan covers

The table below summarizes the benefits of the KFHPWA HMO Plan at Kaiser Permanente facilities. You can refer to the details following this table for more information about benefit limits and cost sharing.

The KFHPWA HMO Plan provides benefits for routine patient costs of qualified individuals in approved clinical trials to the extent benefits for these costs are required by law. Routine patient costs include all

items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Clinical trials require prior authorization.



Services and supplies must be medically necessary and are subject to all benefit exclusions and limitations and the plan’s [exclusions and limitations](#). You have the right to participate in decisions regarding your health care and you may refuse any recommended treatment or diagnostic plan to the extent permitted by law. If you obtain care not recommended by KFHPWA, you do so with the full understanding that KFHPWA has no obligation for the cost, or liability for the outcome, of such care. Your coverage decisions may be appealed under the plan Benefits.



CTRL+Click on the benefits below to access more information.

Common benefits	
These are the most commonly used benefits in the KFHPWA HMO Plan.	
Benefit	Coverage
Preventive care Including well-baby care, well-child care routine gynecological exams, immunizations, female sterilization, FDA-approved contraceptive drugs, devices, including device removal, and counseling, preferred contraceptive drugs as recommended by the USPSTF when obtained with a prescription, and annual routine physical exams (see the Preventive Care List and the Kaiser Drug Formulary)	100%; includes well-baby care, child and adult routine exams, and maintenance medications
Prescription drugs	No copayment preventive; \$10 copayment preferred generic; \$25 copayment preferred brand; \$50 copayment non-preferred. (\$35 maximum for insulin)
Primary care office visit	\$20 copayment
Specialist office visit	\$40 copayment
Hospital care—inpatient Including semi-private room and board, anesthesia, supporting services, testing, supplies, and intensive or coronary care	90%

<p>Hospital care—outpatient Including minor surgery, X-ray and radium therapy, anesthesia, and pre-admission testing</p>	<p>\$100 copayment</p>
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Common benefits	
These are the most commonly used benefits in the KFHPWA HMO Plan.	
Benefit	Coverage
Urgent care	\$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists
Rehabilitation and Habilitative Care – Physical, Occupational, Speech and Massage Therapies	Inpatient: 90%; up to 60 days combined per calendar year Outpatient: \$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists; up to 60 visits combined per calendar year
Maternity and pregnancy care	Inpatient: 90% Outpatient: 100% for routine prenatal and postpartum visits; \$20 copayment for other visits with primary care providers; \$40 copayment visits with specialists
Maternity support	Free virtual care and on-demand support (through Maven Clinic) for new and expecting parents.
Mental health and wellness counseling, mental health and wellness inpatient and outpatient services, and substance use disorder	Inpatient: 90% Outpatient services through Spring Health employee assistance program administrator : 100% of 24 sessions per issue per calendar year. Outpatient services under the KFHPWA HMO Plan: \$20 copayment

Other benefits	
The KFHPWA HMO Plan also covers these additional benefits.	
Benefit	Coverage
Acupuncture	\$20 copayment; up to a maximum of eight visits per member per medical diagnosis per calendar year without prior authorization; additional visits are covered with prior authorization No visit limit for treatment for substance use disorder
Ambulance	90%
Detoxification services for alcoholism and drug abuse	Inpatient: 90% Outpatient: \$75 copayment per visit to any emergency facility (copayment waived if admitted)
Devices, equipment, and supplies	90%
Diabetic needs and supplies	100% for insulin, needles, syringes, test strips and lancets covered under the prescription drug benefit 90% for external insulin pumps, blood glucose monitors, and related supplies under the devices, equipment, and supplies benefit 100% for diabetic retinal screening

Other benefits	
The KFHPWA HMO Plan also covers these additional benefits.	
Benefit	Coverage
Dialysis (home and outpatient)	Outpatient: \$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists; \$100 copayment for outpatient hospital care
Emergency care	\$75 copayment per visit to any emergency facility (copayment waived if admitted)
Hearing care and hardware	\$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists Hardware: 90%; \$10,000 hardware limit per member in a period of 36 consecutive (rolling) months
Home health care	100%
Hospice care	100%
Infusion therapy	Outpatient: \$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists 100% for associated infused medications
Laboratory and radiology	100%
Manipulative therapy	\$20 copayment; up to a maximum of twenty visits per member per calendar year
Naturopathy	\$20 copayment; up to a maximum of three visits per member per medical diagnosis per calendar year without prior authorization. Additional visits are covered with prior authorization.
Neurodevelopmental therapy	Inpatient: 90%; up to 60 days per calendar year Outpatient: \$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists; up to 60 visits per calendar year
Nutritional services	90%
Obesity-related surgery	Inpatient: 90% Outpatient: \$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists
Out-of-area benefit	Prescription drugs and medical services obtained outside the KFHPWA service area are covered up to \$2,000 per member per calendar year
Skilled nursing facility	90%; up to 60 days per member per calendar year at a skilled nursing facility
Substance use disorder	Inpatient: 90% Outpatient: \$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists; \$100 copayment for outpatient hospital care
Temporomandibular joint (TMJ) dysfunction	Inpatient: 90% Outpatient: \$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists

Other benefits	
The KFHPWA HMO Plan also covers these additional benefits.	
Benefit	Coverage
Tobacco cessation	100%
Transplants	Inpatient: 90% Outpatient: \$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists

Specialized benefits	
Woodgrove Financial provides these unique benefits to you through the KFHPWA HMO Plan.	
Benefit	Coverage
Autism/Applied behavior analysis (ABA) therapy	90%
Infertility	90% for coverage, within the Plan's infertility vendor (Progyny) provider network, of generally two Smart Cycles per household per Plan enrollment lifetime, and one additional Smart Cycle if neither of the first two results in a successful pregnancy; see Fertility and Family Building for more information
Gender affirming services	\$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists; \$100 copay for outpatient hospital care
Travel and lodging reimbursement	In-network: 100%, deductible applies (additional IRS limitations) Out-of-network: 100%, deductible applies (additional IRS limitations) Limit: \$10,000 per calendar year
Weight management program	80% up to \$6,000 maximum for the duration of your continuous enrollment in the KFHPWA HMO Plan

Plan benefits



The following pages provide details on the plan's benefits. The plan's [exclusions and limitations](#), including the requirement of medical necessity, apply to these benefits.

For information about how the novel coronavirus (COVID) is covered under this plan, see [Important information due to the coronavirus pandemic](#).

Acupuncture

\$20 copayment; up to eight visits per member per diagnosis per calendar year without prior authorization.

Additional visits are covered when prior authorized. Members may make appointments without prior authorization with KFHPWA-contracted providers. Visit limit does not apply for treatment for substance user disorder.

Related laboratory and radiology services are covered only when obtained through a Kaiser Permanente facility under the [laboratory and radiology](#) benefit.

Additional exclusions and limitations for acupuncture

In addition to the plan's [exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Herbal supplements
- Services not within the scope of the practitioner's licensure

Ambulance

Surface Ambulance (ground or water) - Out-of-network: 90%, deductible applies

Ambulance: Out-of-network: 90% of allowable charges, deductible applies

Coverage includes licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat the member's condition when any other mode of transportation would endanger the member's health or safety. This benefit is limited to the member that requires transportation.

Emergency ambulance services is covered only when:

- Transport is to any facility that can treat your condition
- Any other type of transport would put your health or safety at risk
- The service is from a licensed ambulance.

Emergency air or sea medical transportation is covered only when:

- The above requirements for ambulance service are met, and
- Geographic restraints prevent ground Emergency transportation to the nearest facility that can treat your condition, or ground Emergency transportation would put your health or safety at risk.

Benefits are also provided at 100% for transportation from hospital-to-hospital, as medically necessary for the member's care when approved by KFHPWA.

For ambulance services, please see [Federal No Surprise Billing Protection](#) for special rules that apply to out-of-network air ambulance services.

Autism/Applied Behavior Analysis (ABA) therapy

Plan pays 90%

This benefit covers behavioral interventions based on the principles of Applied Behavioral Analysis (ABA) through eligible providers.

Who is eligible

This benefit will be available to members covered by KFHPWA, whose primary diagnosis is the following (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition / DSM-5*), or with any of the following Pervasive Developmental Disorders (*International Classification of Diseases, 10th Revision, Clinical Modification / ICD-10-CM*):

- Autistic Disorder
- Childhood Disintegrative Disorder
- Asperger's Disorder
- Rett's Disorder and Pervasive Development Disorder Not Otherwise Specified/Atypical Autism
- Pervasive Developmental Disorder



If you need assistance confirming the diagnosis your doctor provides is an eligible diagnosis for the Autism/Applied Behavioral Analysis benefit you may contact Kaiser Permanente Member Services at (206) 630-4636.

Eligible providers

The benefit covers services through providers who have met established qualifications for certification (known as certified providers) and who perform services in consultation with a certified provider (known as therapy assistants).



Call (206) 630-4636 or (888) 901-4636 or visit [KFHPWA](#) online for a list of approved Certified Autism Providers (not including Therapy Assistants) eligible for reimbursement under this benefit, to receive a copy of the certification criteria, or for an application for providers not currently on the list.

For the purpose of this benefit only, services of a certified provider will be covered even if the provider does not meet the plan's requirements as an eligible provider under the [rehabilitative services](#) or [mental health and wellness](#) benefit.

Covered services

Services must be ordered by the member's treating physician to be covered. An approved certified provider acts as the program manager for the member. Benefits are available for time used to evaluate the member and document findings and progress reports, and to create and update treatment plans; and time used to train and evaluate the work of the therapy assistants working directly with the member to implement the treatment plan. Therapy Assistant services that are provided by a Program Manager will be paid at the Therapy Assistant rate.

In most cases, therapy assistants will provide the implementation portion of the treatment plan. Therapy assistant time is eligible for face-to-face time with the member to perform the tasks described in the treatment plan and to document outcomes; and time to meet with

the program manager for training and to discuss treatment plan issues. Therapy Assistant services that are provided by a Program Manager will be paid at the Therapy Assistant rate.

Claims for ABA services should clearly list the level of service (certified provider/program manager; or therapy assistant), the date the service was provided, the time the service started and ended, the hourly charge for the service, and the total charge for that service.

ABA services are not covered for the following:

- Babysitting or doing household chores

- Time spent under the care of any other professional
- Travel time
- Home schooling in academics or other academic tutoring

Benefit coverage above the allowable charge

If you obtain services from a non-KFHPWA provider or at a non-KFHPWA facility that nevertheless are covered under this SPD, you may be billed for charges assessed above the allowable charge. Any amounts you pay for charges in excess of allowable charges will not count towards satisfying any deductible requirements, or out-of-pocket maximums that may apply to other benefits provided through this plan.



An **allowable charge** where expenses incurred from a non-KFHPWA provider or facility are covered under this SPD is the negotiated amount that KFHPWA providers and facilities have agreed to accept as payment in full for those same services. Members shall be responsible for paying any difference between the non- KFHPWA

provider's or facility's charge for the services and the allowable charge.

Prior authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact KFHPWA for prior authorization.



Prior authorization is an advance determination by KFHPWA that the service is medically necessary, and that the members plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. KFHPWA and Woodgrove Financial reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

For ABA/Autism benefits, the prior authorization requires the following documents:

- The treating physician's order for ABA services
- The clinical documentation of the qualifying diagnosis

- The Plan of Treatment created by the approved Program Manager

KFHPWA will issue a prior authorization that will provide services for a six-month period of time.

The prior authorization process and subsequent clinical review includes the following steps:

The following is the process for a prior authorization for the autism/ABA therapy benefit and subsequent clinical review:

1. The treating physician or specialist diagnoses the member with an Autism Spectrum Disorder (Autistic Disorder, Childhood Disintegrative Disorder, Rett's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, and Asperger's Disorder) and refers the child for ABA treatment.

2. An initial evaluation is performed by the approved certified provider to determine if the member is a candidate for an ABA and/or related structured behavioral program. If the member is determined to be a candidate by the evaluating approved certified provider, the approved certified provider would create and submit a treatment plan including type and frequency of services planned for the immediate six-month period. The approved certified provider must send the treatment plan to KFHPWA so that eligibility for services can be determined.
3. Every six months, the approved certified provider who is overseeing the treatment must submit an updated treatment plan to KFHPWA. The approved certified provider must determine that the treatment plan and services being provided are in accordance with ABA guidelines. If any substantial change in the frequency or type of program is necessary during the six-month treatment time, a revised Treatment Plan should be submitted to KFHPWA for notification of the revision of the treatment plan.
4. Progress reports should be created at least monthly by the certified provider to include documentation of the therapy assistant interventions and/or their own interventions with the member and a written summary of the member's progress. If the member has not made progress in the last six months, the updated treatment plan should reflect a change in approach. Progress reports should be available to KFHPWA upon request.

Services for this treatment that do not meet criteria described in the program are subject to retrospective denial of benefits. Claims for these services must be accompanied by a completed Autism/ABA Therapy Services Billing Summary signed by the certified provider and the child's parent if therapy is for a minor dependent.

Additional exclusions and limitations for autism/ABA therapy

In addition to the plan's [exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- This benefit is not provided for rehabilitative services (which apply under the [rehabilitation](#) services benefit) or mental health services (which apply under the Mental health counseling, [mental health and wellness inpatient and outpatient services](#), and [substance use disorder](#) benefit).
- Benefits for services provided by volunteers, childcare providers, or family members, and benefits paid for by state, local, and Federal agencies will not be covered. Volunteer services or services provided by a family member of the child receiving the services by or through a school, books, and other training aids will also not be covered.
- Other unspecified developmental disorders or delays, or any other delay or disorder in a member's motor, speech, cognitive, or social development are not covered under this benefit
- This benefit covers only the allowable fees for eligible services performed by the approved certified provider and those providing interventions based on principles of ABA and/or related structured behavioral programs under the supervision of the approved certified provider. Other expenses associated with providing the treatment, such as the tuition, program fees, travel, meals, and lodging of the approved certified provider and expenses of those working under the approved certified provider's supervision, the member, and their family members will not be covered.

Circumcision

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists; \$100 copayment for outpatient hospital care

Devices, equipment, and supplies (Durable Medical Supplies)

Plan pays 90%

The following services are covered:

- **Orthopedic Appliances:** Orthopedic appliances that are attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration/improvement of its function. Excluded appliances include over-the-counter arch supports, and orthopedic shoes that are not attached to an appliance. Therapeutic shoes, modifications, and shoe inserts for severe diabetic foot disease are not excluded.
- **Durable Medical Equipment:** Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and is used in the member's home. Durable medical equipment includes: hospital beds, wheelchairs, walkers, crutches, canes, glucose monitors, external insulin pumps, oxygen and oxygen equipment.
- **Prosthetic Devices:** Prosthetic devices are items that replace all or part of an external body part, or function thereof
- **Ostomy Supplies:** Ostomy supplies for the removal of bodily secretions or waste through an artificial opening
- **Post-mastectomy bras/forms:** Post-mastectomy bras are limited to two every six months (replacements within this 6-month period are covered when medically necessary due to a change in the member's condition)
- Sales tax for devices, equipment, and supplies
- Custom arch supports and shoe inserts
- Wigs (up to \$2,000 per calendar year for alopecia caused by medical conditions or treatment for diseases)

Prior authorization is required for devices, equipment and supplies including repair, adjustment, or replacement of appliances and equipment.

Additional exclusions and limitations for devices, equipment, and supplies

In addition to the plan's [exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Take-home dressings and supplies following hospitalization
- Other supplies, dressings, appliances and devices not specifically listed as covered above
- Replacement or repair of appliances, devices, and supplies due to loss, theft, breakage from willful damage, neglect, wrongful use, or personal preference
- Structural modifications to a member's home or personal vehicle



KFHPWA will determine if equipment is made available on a rental or purchase basis.

Detoxification services for alcoholism and drug abuse

Inpatient: Plan pays 90%

Outpatient: \$75 copayment for emergency facility (waived if admitted)

Benefits are provided for withdrawal of alcohol and/or drugs from a member for whom consequences of abstinence are so severe that they require medical or nursing assistance in a hospital setting, which is needed immediately to prevent serious impairment to the member's health. Chemical withdrawal (detoxification) is provided without prior authorization.

The member must notify KFHPWA via the notification line at (888) 457-9516 within 24 hours following inpatient admission, or as soon as medically possible. If a member is hospitalized in a non-Kaiser Permanente facility or program, KFHPWA reserves the right to require transfer of the member to a Kaiser Permanente facility or program upon consultation between a KFHPWA provider and the attending physician. If the member refuses transfer to a Kaiser Permanente facility or program, all further costs incurred during the hospitalization are the responsibility of the member.

Diabetic needs and supplies

100% for insulin, needles, syringes, test strips and lancets covered under the [prescription drug](#) benefit.

90% for external insulin pumps, blood glucose monitors, and related supplies covered under the [devices, equipment, and supplies](#) benefit.

100% for diabetic retinal screening.

Dialysis (Home and Outpatient)

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists; \$100 copayment for outpatient hospital care

Dialysis in an outpatient or home setting is covered for members with acute kidney failure or end-stage renal disease (ESRD)

Dialysis requires prior authorization

Emergency care

Kaiser Permanente Facility: \$75 copayment (waived if admitted)

Non-Kaiser Permanente Facility: 90% of allowable charges



An **allowable charge** is the negotiated amount that KFHPWA providers have agreed to accept as payment in full for a covered service. Out-of-network providers may not accept the allowable charge as payment in full. You are responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges.

At non-Kaiser Permanente facilities, the plan covers the allowable charge provided you:

- Pay the emergency services copayment

- Notify KFHPWA at (888) 457-9516 within 24 hours following inpatient admission, or as soon as medically possible

Emergency services include professional services, treatment and supplies, facility costs, outpatient charges for patient observation and medical screening exams required to stabilize a patient.

If the member is admitted to an inpatient facility directly from the emergency room, the emergency services copayment is waived. Inpatient hospital care will be covered at 90%. See the hospital care benefit for more information.

If a member is hospitalized in a non-Kaiser Permanente facility, KFHPWA reserves the right to require transfer of the member to a Kaiser Permanente facility, upon consultation between a KFHPWA provider and the attending physician. If the member refuses to transfer to a Kaiser Permanente facility, all further costs incurred during the hospitalization are the responsibility of the member.

Care that is a direct result of the emergency must be obtained from KFHPWA providers, unless a KFHPWA provider has previously authorized such follow-up care from a non-KFHPWA provider.

Please see the [Federal No Surprise Billing Protection](#) section for more information about certain legal protections when you receive emergency services provided by an out-of-network provider.



Urgent care received at any hospital emergency department is not covered unless prior authorization is received by a KFHPWA provider. See the [urgent care](#) benefit for more information.

Gender health services

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists; \$100 copayment for outpatient hospital care

This benefit covers medically necessary gender reassignment surgical services, including facility and anesthesia charges related to the surgery.

Coverage of prescription drugs and mental health and wellness treatment associated with gender reassignment surgery is available under the prescription drugs and mental health and wellness benefits.

Who is eligible?

Surgical gender reassignment services will be considered medically necessary if all the following criteria are met:

- For all surgical procedures recognized as medically necessary in the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH), other than genital and breast surgery, if you are at least 18 years old and diagnosed as having gender identity disorder
- You have been an active member in a recognized gender identity treatment program and have successfully lived and worked within the desired gender role full time for at least 12 months.
- For breast/chest surgery, have one letter of recommendation for surgery from a mental health professional
- For genital surgery, you have received recommendations for surgery from two separate mental health professionals, at least one of which includes an extensive report. One Master's degree-level professional is acceptable if the second letter is from a psychiatrist or PhD clinical psychologist.

Growth hormone

90% under the [prescription drugs](#) benefit

This benefit covers growth hormones for treatment of growth disorders.

Hearing care and hardware

\$20 copayment for primary care providers; \$40 copayment for specialists

Hearing exams for hearing loss and evaluation and diagnostic testing for cochlear implants are covered only when provided at KFHPWA-approved facilities.

Cochlear implants or Bone Anchored Hearing Aids (BAHA) when KFHPWA criteria is met. Hearing exams for hearing loss and evaluation and diagnostic testing for cochlear implants only when provided at KFHPWA-approved facilities.

Covered for cochlear implants and BAHA including implant surgery, pre-implant testing, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).

Hearing hardware

Plan pays 90% up to a maximum benefit of \$10,000 per member in a period of three consecutive (rolling) calendar years of continuous enrollment.

Home health care

Plan pays 100% with no visit limit

Home health care services are covered when services are received from KFHPWA providers for members who meet the following criteria:

- Except for patients receiving palliative care services, the member must be unable to leave home due to their health problem or illness (unwillingness to travel and/or arrangements for transportation do not constitute inability to leave the home).
- The member requires intermittent skilled home health care services.
- A KFHPWA provider has determined that such services are medically necessary and are most appropriately rendered in the member's home.



Skilled home health care includes reasonable and necessary care for treatment of an illness or injury that requires the skill of a nurse or therapist—based on the complexity of the service and the condition of the member. Services are performed directly by an appropriately licensed professional provider.

Covered services for home health care include the following services on an intermittent basis:

- Nursing care

- Restorative physical therapy
- Restorative occupational therapy, restorative respiratory therapy
- Restorative speech therapy
- Durable medical equipment

- Medical social worker
- Limited home health aide services

Home health care services require prior authorization,

Additional exclusions and limitations for home health care

In addition to the plan's exclusions and limitations, the following services and supplies are excluded from this benefit:

- Private duty nursing
- Housekeeping or meal services
- Any care provided by or for a member of the member's family
- Any other services rendered in the home that do not meet the definition of skilled home health care (such as custodial care) or are not specifically listed as covered under this plan

Hospice care

Plan pays 100%; up to five consecutive days per occurrence

- Hospice care is covered when provided by a licensed hospice care program. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a member and any family members who are caring for the member, 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 the member and their family during the final stages of illness. In order to qualify for hospice care, the member's provider must certify that the member is terminally ill and is eligible for hospice services.



Hospice care means a coordinated program of home and inpatient care, available 24 hours a day.

Respite care means continuing to provide care in the temporary absence of the member's primary caregiver or caregivers.

Inpatient hospice services

Short-term care for inpatient hospice services shall be covered when preauthorized. Respite care is covered for a maximum of five consecutive days per 3-month period of hospice.

Other covered hospice services, when billed by a licensed hospice program, include:

- Inpatient and outpatient services and supplies for injury and illness
- Semi-private room and board, except when a private room is determined to be necessary
- Durable medical equipment when billed by a licensed hospice care program

Hospice care requires prior authorization.

Additional exclusions and limitations for hospice care

In addition to the plan's [exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Private duty nursing
- Financial or legal counseling services

- Meal services
- Any services provided by family members

Hospital care

Inpatient: Plan pays 90% for inpatient medical and surgical services

Outpatient: \$100 copayment for outpatient hospital surgery including ambulatory surgical centers

Inpatient services

Inpatient services include:

- Room and board (including private room when prescribed) and general nursing services
- Hospital services (including use of operating room, anesthesia, oxygen, X-ray, laboratory, and radiotherapy services)
- Drugs and medications administered during confinement
- Medical implants
- Withdrawal management services

Alternative care arrangements may be covered as a cost-effective alternative instead of otherwise covered medically necessary hospitalization or other institutional care with the consent of the member and recommendation from the attending physician or licensed health care provider. Alternative care arrangements must be determined to be appropriate and medically necessary based upon the member's medical condition. Such care is covered to the same extent the replaced hospital care is covered.

Alternative care arrangements also require prior authorization.

Members are required to notify KFHPWA by way of the notification line at (888) 457-9516 within 24 hours following any admission, or as soon as medically possible, upon receiving any of the following non-scheduled services:

- Withdrawal management services
- Emergency psychiatric services
- Labor and delivery
- Inpatient admissions needed for treatment of urgent conditions that cannot reasonably be delayed until prior authorization can be obtained

Non-emergency inpatient hospital services require prior authorization, which will be initiated with KFHPWA by your provider.

Additional exclusions and limitations for hospital care

In addition to the plan's [exclusions and limitations](#), the dressings and supplies following hospitalization are excluded from this benefit, as are internally implanted insulin pumps,

artificial larynx and any other implantable device that has not been approved by KFHPWA's medical director.

Continuation of Inpatient Services

A Member who is receiving covered services in a hospital on the date of termination of coverage shall continue to be eligible for covered services while an inpatient for the condition for which the Member was hospitalized, until one of the following events occurs:

- According to KFHPWA clinical criteria, it is no longer Medically Necessary for the Member to be an inpatient at the facility.
- The remaining benefits available for the hospitalization are exhausted, regardless of whether a new calendar year begins.
- The Member becomes covered under another plan with a group health plan that provides benefits for the hospitalization.
- The Member becomes enrolled under a plan with another carrier that provides benefits for the hospitalization.

Please see the [Federal No Surprise Billing Protection](#) section for more information about certain legal protections when you receive emergency and non-emergent services provided by an out-of-network provider.



Call the notification line at (888) 457-9516 within 24 hours of any admission or nonscheduled services.

Infertility

In-network: 90%, within the Plan's infertility vendor (Progyny) provider network

Out-of-network: not applicable

Limit: Up to two Smart Cycles per household and one additional Smart Cycle if neither of the first two results in a successful pregnancy. Coverage is subject to all applicable plan copay and coinsurance requirements.

This benefit covers services to assist in achieving a pregnancy for Woodgrove Financial employees and their enrolled spouse/domestic partner regardless of reason or origin of condition.

Members must contact their Progyny Patient Care Advocate at (888) 203-5066 to confirm eligibility and utilize a Progyny Network Provider to access the benefit.

The Progyny SMART cycle benefit may be used to receive full coverage for the following treatments and procedures:

- Two consultations per calendar year
- Diagnostic testing
- Transvaginal ultrasounds
- Intrauterine insemination (also known as artificial insemination)
- In vitro fertilization (IVF)
- Gamete intra-fallopian transplant (GIFT)
- Intracytoplasmic sperm injection (ICSI)
- Pre-implantation genetic screening (PGS)
- Pre-implantation genetic diagnosis (PGD)

- Embryo assessment and transfer
- Services used to preserve fertility such as cryopreservation of eggs, sperm and/or embryos. This includes oncofertility preservation.
- Up to four years of storage (egg, embryo, sperm) with annual renewal and eligibility verification
- Purchase of donor tissue (sperm, eggs) as follows:

- Previously frozen donor sperm or donor oocytes (eggs) from a donor agency intended for the use and transfer into a covered female member (one egg cohort purchase constitutes one SMART Cycle, and one donor sperm purchase constitutes $\frac{1}{4}$ SMART Cycle). You will be required to pay for the donor sperm or oocytes out of pocket and submit the eligible charges, with appropriate supporting documentation, to Progyny for reimbursement.
- A fresh donor recipient cycle, whereby the egg donor undergoes an egg retrieval procedure at an in-network Progyny provider to allow for a fresh embryo transfer into a covered female member (one fresh donor recipient cycle constitutes one SMART Cycle). The treatment must occur at an in-network Progyny provider, or else you may be required to pay all expenses up front, out of pocket. If an in-network provider is not contracted for the fresh donor recipient cycle, Progyny will pursue a special case agreement. If a special case agreement request is denied, you will pay for the donor services out of pocket but may submit eligible charges, with appropriate supporting documentation, to Progyny for reimbursement.

Medication prescribed for fertility treatment will be fulfilled by a Progyny Rx specialty pharmacy and delivered next day to ensure accurate timing with treatment. All medications, compounds, ancillary medication and equipment required for treatment are included in the shipment of medications. Progyny Rx coverage also includes the UnPack It Call where a trained pharmacy clinician will explain drug administration and storage guidelines.

Additional exclusions and limitations for infertility

The following exclusions apply to this benefit:

- Fees paid to donors for their participation in any service
- Testing and treatment for potential surrogates that would not otherwise be covered for a member enrolled in the Plan
- Home ovulation prediction kits
- Services and supplies furnished for a dependent child (under age 26) except for oncofertility preservation due to cancer or medical treatments
- Services and supplies furnished by a provider outside the Progyny network, except as otherwise provided
- Fertility Services following a voluntary sterilization procedure
- This benefit is only available to KFHPWA members, not visiting members.

Infusion therapy

\$20 copayment for primary care providers; \$40 copayment for specialists

This benefit covers medically necessary infusion therapy such as antibiotics, hydration, chemotherapy and pain management.

Plan pays 100% for associated infused medications.

Laboratory and radiology

Plan pays 100%

This benefit covers nuclear medicine, radiology, ultrasound and laboratory tests, including high end radiology imaging services such as CAT scan, MRI and PET which are subject to prior authorization except when associated with Emergency services or inpatient.

Services received as part of an emergency visit are covered as Emergency Services.

Preventive laboratory and radiology services are covered in accordance with the well care schedule established by KFHPWA and the Patient Protection and Affordable Care Act of 2010. The well care schedule is available in Kaiser Permanente medical centers, at <https://wa.kaiserpermanente.org>, or upon request from Member Services.

Manipulative (chiropractic) therapy

\$20 copayment; up to twenty visits per member per calendar year

This benefit covers visits for manipulative therapy of the spine and extremities when KFHPWA clinical criteria are met.

Additional exclusions and limitations for manipulative therapy

In addition to the plan's [exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Supportive care primarily to maintain the level of correction already achieved
- Care primarily for the convenience of the member
- Care on a non-acute, asymptomatic basis
- Charges for any other services that do not meet KFHPWA's clinical criteria as medically necessary

Maternity and pregnancy care

Inpatient: Plan pays 90%

Outpatient: Plan pays 100% for routine prenatal and postpartum visits; \$20 copayment for primary care providers; \$40 copayment for specialists for non-routine maternity care, including care for complications or termination of pregnancy.

Coverage includes complications of pregnancy, in-utero treatment for the fetus, prenatal testing for the detection of congenital and heritable disorders when medically necessary and prenatal and postpartum care for all female members including dependent daughters. Preventive services related to preconception, prenatal and postpartum care are covered as Preventive Services when medically necessary, as determined by KFHPWA's medical

director and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy. Home births are considered outpatient services.

Childbirth classes are covered at 100%. As described in the preventive care section, breastfeeding support, supplies, and counseling are covered at 100%.

The member's physician, in consultation with the member, will determine the member's length of inpatient stay following delivery. Treatment for post-partum depression or psychosis is covered only under the [mental health and wellness](#) benefit.

Additional exclusions and limitations for maternity and pregnancy care

In addition to the plan's [exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Birthing tubs
- Genetic testing of non-members
- Fetal ultrasound in the absence of medical indications

Mental health and wellness

Inpatient: Plan pays 90%

Outpatient: 100%, up to calendar year short-term counseling session limits through Spring Health, administrator for the employee assistance program, otherwise \$20 copayment for primary care providers;

\$40 copayment for specialists



To access Spring Health go to [Woodgrove Financial.springhealth.com](https://www.woodgrovefinancial.com/springhealth) to access these benefits. For counseling through Kaiser, you must contact the KFHPWA Behavioral Health Unit at (888) 287-2680 or (206) 630-1680.

Inpatient care

Benefits include coverage for acute treatment and stabilization of psychiatric emergencies, residential treatment, and partial hospitalization programs in KFHPWA-approved hospitals. Coverage for services incurred at non-Kaiser Permanente facilities exclude any charges that would otherwise be excluded for hospitalization within a Kaiser Permanente facility. Substance use disorder services are covered subject to the [substance use disorder](#) services benefit. Preauthorization is required for Residential Treatment and non-Emergency inpatient hospital services provided in out-of-state facilities.

Services provided under involuntary commitment statutes must be provided at facilities approved by KFHPWA. Services for any involuntary court-ordered treatment program can be covered—only if determined to be medically necessary by KFHPWA's medical director.

Coverage for voluntary or involuntary emergency inpatient psychiatric services is subject to the emergency care benefit under [emergency services](#) section, including the 24-hour notification and transfer provisions.

Outpatient care

This benefit covers outpatient care, although not required, you may wish to exhaust the [short-term counseling under Spring Health \(employee assistance program\)](#) before obtaining services from Kaiser under this benefit, because Woodgrove Financial pays the entire cost of EAP benefits.

Type of outpatient care	You will be covered as follows
Short-term counseling employee assistance program (EAP) as administered by Spring Health	Outpatient services through Spring Health employee assistance program: 100% of 24 short-term counseling sessions per calendar year. A visit includes each attendance of the provider to the member, regardless of the type of professional services rendered, and whether it might otherwise be termed consultation, treatment, or described in some other manner. For benefit calculation purposes, a typical mental health visit is considered one hour.
KFHPWA	Inpatient: 90% Outpatient services under the KFHPWA HMO Plan: \$20 copayment

Mental health and wellness services provide the most clinically appropriate and medically necessary level of mental health care intervention as determined by KFHPWA’s medical director. Treatment may use psychiatric, psychological, and/or psychotherapy services to achieve these objectives.

Services rendered to treat mental health conditions are covered. Mental health conditions mean those conditions covered in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, except as otherwise excluded. Mental health and wellness services mean medically necessary outpatient services, residential treatment, partial hospitalization program, and inpatient services provided by a licensed facility or licensed providers, except as otherwise excluded.

Mental health and wellness services including medical management and prescriptions are covered the same as for any other condition. Prescriptions are covered under the [prescription drugs](#) benefit.

Additional exclusions and limitations for mental health and wellness

In addition to the plan’s [exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Covered services are limited to those services authorized by KFHPWA’s medical director for covered clinical conditions for which the reduction or removal of acute clinical symptoms or stabilization can be expected, given the most clinically appropriate level of mental health care intervention
- Academic or career counseling and personal growth or relationship enhancement

- Assessment and treatment services that are primarily vocational and academic
- Court-ordered or forensic treatment not considered medically necessary, including reports and summaries
- Work- or school-ordered assessment and treatment not considered medically necessary
- Counseling for overeating not considered medically necessary
- Specialty treatment programs such as "behavior modification programs" not considered medically necessary
- Relationship counseling or phase-of-life problems (V-code only diagnoses)
- Custodial care not considered medically necessary
- Experimental or investigational therapies.

- Educational or recreational therapy or programs; this includes, but is not limited to, boarding schools.
- All other provisions, exclusions, and limitations under this plan also apply

Naturopathy

\$20 copayment; up to three visits per member per medical diagnosis per calendar year without prior authorization

Additional visits are covered with prior authorization. Related laboratory and radiology services are covered only when obtained through a Kaiser Permanente facility under the [laboratory and radiology](#) benefit.

Additional exclusions and limitations for naturopathy

In addition to the plan's [exclusions and limitations](#), herbal supplements, nutritional supplements, and any services not within the scope of the practitioner's licensure are excluded from this benefit.

Neurodevelopmental therapy

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists Limit: up to 60 days/visits per calendar year (combined with the [rehabilitation benefit](#))

Covered services include: physical therapy, occupational therapy, and speech therapy services for the restoration and improvement of function for neurodevelopmentally disabled members. Coverage also includes maintenance of a covered member in cases where significant deterioration in the member's condition would result without the services.

Additional exclusions and limitations for neurodevelopmental therapy

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- All services must be provided at a Kaiser Permanente facility or a KFHPWA-approved rehabilitation facility and outpatient services require a prescription or order from a physician that reflects a written plan of care to restore function, and must be provided by a rehabilitation team that includes a physician, nurse, physical therapist, occupational therapist, massage therapist, or speech therapist
- Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness, or surgery
- Specialty treatment programs
- Inpatient residential treatment services
- Specialty rehabilitation programs including "behavior modification programs"
- Therapy for degenerative or static conditions when the expected outcome is primarily to maintain the member's level of functioning (except as set forth in this section for treatment of neurodevelopmental conditions)

- Recreational life-enhancing relaxation or palliative therapy
- Implementation of home maintenance programs
- Any services not specifically included as covered in this section
- Any services that are excluded by the plan

Nutritional services

Plan pays 90%

Covered services include parenteral nutritional therapy, enteral therapy when Medically Necessity criteria are met and when given through a PEG, J tube or orally, or for an eosinophilic gastrointestinal disorder, and dietary formula for the treatment of phenylketonuria. Necessary equipment and supplies covered under the [devices, equipment, and supplies benefit](#).

Additional exclusions and limitations for nutritional services

In addition to the plan's [exclusions and limitations](#), this benefit excludes any other of the following:

- Dietary formulas or medical foods
- Oral nutritional supplements that do not meet Medical Necessity criteria or are not related to the treatment of inborn errors of metabolism
- Special diets
- Prepared foods/meals

Obesity-related surgery

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists

Coverage includes bariatric surgery and related hospitalizations when KFHPWA criteria are met. Obesity related services require prior authorization. Services related to obesity screening and counseling are covered as Preventive Services. Weight-loss programs and related physician visits for medication monitoring are not covered, except those covered under the [weight management](#) benefit or as described in the preventive care section.

Additional exclusions and limitations for obesity-related surgery

In addition to the plan's [exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Related weight-loss programs
- Prescribing and monitoring of drugs
- Structured weight-loss and/or exercise programs or memberships
- Specialized nutritional counseling

Onsite Mammography Screening

Woodgrove Financial offers access to an onsite mammography screening in select Woodgrove Financial locations to employees and their spouse/domestic partners enrolled in a Woodgrove Financial Health Plan. The onsite mammography screening provides a multiple-view screening exam. At the discretion of the technologist performing the mammogram, additional views may be necessary to clarify imaging issues for the radiologist.

The onsite mammography screening program includes the onsite preventive screening mammogram exam only. Any additional or follow-up imaging or other services needed are considered diagnostic and will be covered as outlined in the diagnostic services benefit.

An onsite mammogram is not recommended if you have implants, a breast problem, are pregnant, or are breastfeeding. In those cases, you should consult with your doctor about obtaining an exam at an offsite breast center or other health care facility. Such an offsite exam would not be covered by the onsite mammography screening program but may be covered by the Plan's preventive or diagnostic services coverage, as applicable. As the onsite mammogram is a screening exam, the vendor is not able to provide imaging for a breast problem such as a lump. If you have questions about mammogram screenings, talk with your primary care physician.

Who Provides the Mammograms?

In the Puget Sound area of Washington state, Mammograms are provided by Swedish Mobile Mammography Services (operated by Swedish Health Services). The mammography technologists are registered by the American Registry of Radiologic Technology, have advanced credentials in mammography, and are certified by the State of Washington. The interpreting physicians are employed by Radia, are board certified by the American College of Radiology, and specialize in breast imaging.

In other areas, Woodgrove Financial partners with local vendors who specialize in onsite mammography and have the appropriate equipment and licensure. To provide services onsite, there must be sufficient demand to fill a day of appointments and a local vendor who is qualified to provide the services. Onsite mammography events will be advertised for any locations where they are available.

When Do the Screenings Occur?

Periodically each year, usually during

the fall. **Eligibility**

US benefits-eligible employees and their spouse/domestic partner age 35 and over, who are enrolled in

medical coverage under the Plan, are eligible to participate in onsite mammography screenings.

You are eligible to participate in the onsite screening even if you have had a routine mammogram in the past 12 months. However, you should talk with your primary care provider to determine the benefits and risks of having a second mammogram within a 12-month period. If you suspect you have a breast problem, such as a lump, you should see your primary care provider.

Women under the age of 35 are ineligible, unless they have written permission from their physician.



At some locations, women under age 35 will not be allowed to participate, even with written permission from their physician.

Dependent children (regardless of age), agency temporaries/external staff, international based employees, and any individuals who are not enrolled in medical coverage under the Plan are not eligible to participate.


Out-of-area benefit

Plan pays 100%; up to a maximum of \$2,000 per member per calendar year

All applicable cost shares, contract provisions, limitations and exclusions apply the same as if services were covered within KFHPWA's service area.

Members may be asked to pay the provider at the time services are received. If the services are covered under this benefit, you will be reimbursed the reasonable charges for the care up to the maximum amount.

[Submit a claim](#) to KFHPWA for the services for Member Reimbursement. Submit the form with all necessary supporting documentation (i.e., itemized bills and receipts, explanation of the services, and the identification information from your ID card).

 Send claims to:

Kaiser Foundation Health Plan of Washington, Claims Administration

Plastic and reconstructive services

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists; \$100 copayment for outpatient hospital care

Covered services include:

- Correction of a congenital disease or congenital anomaly.
- Correction of a medical condition following an injury or resulting from surgery that has produced a major effect on the member's appearance. The service must, in the opinion of a KFHPWA provider, reasonably correct the condition.
- Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed
- Members will be covered for all stages of reconstruction on the non-diseased breast produce a symmetrical appearance
- Complications of covered mastectomy services, including lymphedemas, are covered

Plastic and reconstructive surgery requires prior authorization.



A **congenital anomaly** is a marked difference from the normal structure of a body part that is physically evident from birth.

Additional exclusions and limitations for plastic and reconstructive services

In addition to the plan's [exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Cosmetic services and surgery
- Treatment for complications resulting from cosmetic surgery
- Complications of non-covered services

Podiatric services

\$20 copayment for primary care providers; \$40 copayment for specialists

Routine foot care is covered when such care is directly related to the treatment of diabetes and, when approved by KFHPWA's medical director, other clinical conditions that affect sensation and circulation to the feet.

Additional exclusions and limitations for podiatric services

In addition to the plan's [exclusions and limitations](#), the following services and supplies are excluded from this benefit: all other routine foot care.

Prescription drugs

This benefit covers all FDA-approved, medically necessary prescription drugs, when prescribed for the member's use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located.

All drugs, supplies, and devices must be obtained at a KFHPWA-designated pharmacy except for drugs dispensed for emergency services. Information regarding KFHPWA-designated pharmacies is reflected in the KFHPWA Provider Directory available at <https://wa.kaiserpermanente.org> or can be obtained by contacting the Kaiser Permanente Member Services Center at (206) 630-4636.

Prescription drug Cost Shares are payable at the time of delivery. Certain brand name insulin drugs are covered at the generic drug Cost Share. Preferred contraceptive drugs as recommended by the U.S. Preventive Services Task Force (USPSTF) are covered as Preventive Services. Contraceptive drugs may be allowed up to a 12-month supply and, when available, picked up in the provider's office.

Members may be eligible to receive an emergency fill for certain prescription drugs filled outside of KFHPWA's business hours or when KFHPWA cannot reach the prescriber for consultation. For emergency fills, members receive and pay the prescription drug cost share for up to 7-day supply or if less, the minimum packaging size available at the time the emergency fill is dispensed. A list of prescription drugs eligible for emergency fills is available on the pharmacy website at www.kp.org/wa/formulary. Members can request an emergency fill by calling (855) 505-8107.

Certain drugs are subject to prior authorization as shown in the [formulary drug list](#). Certain maintenance drugs will be covered at 100% under the [preventive care benefit](#).

Weight loss drugs in accordance with criteria established by KFHPWA are covered subject to a \$50 copayment.

Prescription drug copayments

Type of prescription	KFHPWA	KFHPWA
(see drug list for details)	copayment	copayment

Value-based	\$0	\$0
Preferred Generic	\$10	\$5
Preferred Brand	\$25	\$20
Non-Preferred generic and brand (when prescribed by KFHPWA provider)	\$50 (\$35 maximum for insulin)	\$45 (\$35 maximum for insulin)



A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.

Value-based drugs are drugs for chronic disease management such as diabetes, hyperlipidemia, heart failure and hypertension that are considered high value and are covered on a lower cost share tier.

Preferred generic drugs are equivalent to brand-name drugs but are available at a lower cost because the patent has expired.

Preferred brand-name drugs are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired. The **preferred drug list** is the list of prescription drugs that are covered under the KFHPWA HMO Plan.



Call (206) 630-4636 or (888) 901-4636 or visit [KFHPWA](#) online to review the preferred drug list.



You will be charged, under the benefit, for replacing lost, stolen, or damaged prescription drugs, or devices.

Covered drugs

This benefit covers:

- Prescription drugs, including preferred generic, preferred brand, and non-preferred (if prescribed by a KFHPWA provider)
- Supplies, and devices, including diabetic supplies (insulin, needles, syringes, test strips and lancets)
- Prescription drugs, including medications and injections, for anticipated illness while traveling
- Routine costs for prescription medications provided in a clinical trial. "Routine costs" means items and services delivered to the member that are consistent with and typically covered by the plan or coverage for a member who is not enrolled in a clinical trial.

The KFHPWA Preferred drug list is a list of prescription drugs, supplies, and devices considered to have acceptable efficacy, safety and cost-effectiveness. The Preferred drug list is maintained by a committee consisting of a group of physicians, pharmacists and a consumer representative who review the scientific evidence of these products and determine the Preferred and Non-Preferred status as well as utilization management requirements. Preferred drugs generally have better scientific evidence for safety and effectiveness and are more affordable than Non-Preferred drugs. The preferred drug list is available at www.kp.org/wa/formulary, or upon request from Member Services.

Members may request a coverage determination by contacting Member Services. Coverage determination reviews may include requests to cover non-preferred drugs, obtain prior authorization for a specific drug, or exceptions to other utilization management requirements, such as quantity limits.

Prescription drugs have been approved by the Food and Drug Administration (FDA) and can, under Federal or state law, be dispensed only pursuant to a prescription order. These drugs include off-label use of FDA-approved drugs, provided that such use is:

- Documented to be effective in one of the standard reference compendia
- Shown by a majority of well-designed clinical trials published in peer-reviewed medical literature to provide improved efficacy or safety of the agent in comparison to standard therapies (or over placebo if no standard therapies exist)
- Approved by the Federal Secretary of Health and Human Services

If a member has a new prescription for a chronic condition, the member may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity.

Specialty drugs are high-cost drugs prescribed by a physician that requires close supervision and monitoring for serious and/or complex conditions, such as rheumatoid arthritis, hepatitis or multiple sclerosis. Specialty drugs must be obtained through KFHPWA's preferred specialty pharmacy vendor and/or network of specialty pharmacies. For a list of specialty drugs or more information about KFHPWA's specialty pharmacy network, go to the KFHPWA website at www.kp.org/wa/formulary or contact Member Services at (206) 630-4636 or toll-free at (800) 901-4636.



Standard reference compendia refers to the American Hospital Formulary Service—Drug Information; the American Medical Association Drug Evaluation; 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. "Peer-reviewed medical literature" means scientific studies printed in health care 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.

Medicare Part D coverage

This benefit is equal to or greater than the Medicare Part D prescription drug benefit. Eligible members who are also eligible for Medicare Part D pharmacy benefits can remain covered under the plan and not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D pharmacy plan at a later date; however, the member could be subject to payment of higher Part D premiums if the member subsequently has a break in creditable coverage of 63 continuous days or longer before enrolling in a Part D plan.



For more information about prescription drug policies or benefits, call (206) 630-4636 or (888) 901-4636 or visit KFHPWA online.

Additional exclusions and limitations for prescription drugs

In addition to the plan's [exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Drugs and injectables, except as described in this summary
- Over-the-counter drugs, supplies and devices not requiring a prescription under state law or regulation, including most prescription vitamins, except as recommended by the U.S. Preventive Services Task Force (USPSTF)
- Compounds which include a non-FDA approved drug
- Growth hormones for idiopathic short stature without growth hormone deficiency
- Prescription drugs/products available over the counter or have an over-the-counter alternative that is determined to be therapeutically interchangeable
- Administration of drugs and injectables. This exclusion does not apply to drugs and supplements in accordance with the well care schedule established by KFHPWA and the Patient Protection and Affordable Care Act of 2010.

Preventive care

Plan pays 100% for services detailed in the KFHPWA well-care schedule and preventive (maintenance) medications

Covered services include, but are not limited to:

- Well-baby care
- Well-child care
- Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force (USPSTF)
- Services, tests and screening contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatrics
- Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness services guidelines. Flu vaccines are covered up to the Allowed Amount when provided by a non-network provider.
- Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices
- Female sterilization
- FDA-approved contraceptive drugs, devices, including device removal, and counseling
- Preferred over-the-counter contraceptives and drugs as recommended by the USPSTF when obtained with a prescription
- Routine physical exam
- Mammograms (age appropriate)
- Routine prostate screening
- Colorectal cancer screening for members who are age 50 or older or who are under age 50 and at high risk
- Routine bone density screening
- Obesity screening/counseling; healthy diet; and physical activity counseling (special services are available if the member's BMI is 30 or higher as outlined in USPSTF guidelines).

Additional preventive services for women include:

- Well-woman visits, including preconception, prenatal and postpartum care
- Preferred FDA-approved contraception methods (including sterilization) and counseling
- Breastfeeding supplies
- Human Papillomavirus (HPV) testing
- Screening for gestational diabetes, domestic violence, and sexually transmitted infections
- Breast cancer preventive medications for asymptomatic women who are at increased risk for breast cancer and at low risk for adverse medication effects

Preventive care for chronic disease management includes treatment plans with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, quality of care measurement and results, and education and tools for patient self-management support. In the event that these preventive care

services are not available from a KFHPWA provider, non-network providers may furnish them without cost share when preauthorized.

Value-based (maintenance) medications include prescriptions for chronic conditions and FDA-approved contraception methods in the KFHPWA preferred drug list. All preventive drugs, supplies, and devices must be obtained at a KFHPWA-designated pharmacy.

For a complete list of what is considered preventive care and paid 100% by the plan, see the Preventive Care service list and the Preventive Drug list, or contact KFHPWA at (206) 630-4636 or (888) 901-4636.

Additional exclusions and limitations for preventive care

In addition to the plan's [exclusions and limitations](#), laboratory services that are not in accordance with the KFHPWA well-care schedule will be excluded from this benefit and subject to cost shares.



Review the [Preventive Care Services](#) and [Formulary Drug List](#) for a full list of preventive services.

Radiation therapy

\$40 copayment for oncology, radiation therapy, and chemotherapy specialists

Chemotherapy treats cancer with one or more chemotherapeutic agents (drugs) as part of a standardized regimen. Chemotherapy may also be prescribed to treat other conditions. Oral chemotherapy drugs are covered subject to the Prescription Drug cost share.

Radiation therapy is the medical use of ionizing radiation, generally as part of cancer treatment to control or kill malignant cells. Radiation therapy is synergistic with chemotherapy, and has been used before, during, and after chemotherapy in susceptible cancers.

Respiratory therapy

\$20 copayment for primary care providers; \$40 copayment for specialists.

Respiratory therapy is delivered by a respiratory therapist. Respiratory therapists are specialists and educators in cardiology and pulmonology. Respiratory therapists are also advanced-practice clinicians in airway management; establishing and maintaining the airway during management of trauma, intensive care, and may administer anesthesia for surgery or conscious sedation.

Rehabilitation and Habilitative Care

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists

Limit: up to 60 days/visits, whichever occurs first, per calendar year (combined with the [Neurodevelopmental therapy](#) benefit). Services with mental health diagnoses are covered with no limit. Cardiac rehabilitation is covered for up to a total of 36 visits per cardiac event when clinical criteria are met. Prior authorization is required.

Rehabilitation services restore function following illness, injury or surgery, limited to the following restorative therapies: physical therapy, occupational therapy, massage therapy, and speech therapy.

Habilitative care, includes Medically Necessary services or devices designed to help a Member keep, learn, or improve skills and functioning for daily living. Services may include: occupational therapy, physical therapy, speech therapy is covered when prescribed by a physician.

Inpatient care

Inpatient care includes restorative physical, occupational, and speech therapy services, as well as massage therapy and services for neurodevelopmentally disabled members.

Outpatient care

Outpatient care includes restorative physical, occupational, and speech therapy services, as well as massage therapy and services for neurodevelopmentally disabled members.

Additional exclusions and limitations for rehabilitation services

In addition to the plan's [exclusions and limitations](#), services are subject to all terms, conditions, and limitations of this plan, including the following:

- All services must be provided at a Kaiser Permanente facility or a KFHPWA-approved rehabilitation facility and outpatient services require a prescription or order from a physician that reflects a written plan of care to restore function, and must be provided by a rehabilitation team that includes a physician, nurse, physical therapist, occupational therapist, massage therapist, or speech therapist
- Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness, or surgery
- Specialty treatment programs
- Inpatient Residential Treatment services
- Specialty rehabilitation programs including "behavior modification programs"
- Therapy for degenerative or static conditions when the expected outcome is primarily to maintain the member's level of functioning (except as described for neurodevelopmental therapy)
- Recreational, life-enhancing, relaxation or palliative therapy
- Implementation of home maintenance programs

Reproductive Health

Plan pays 100% for services

Medically Necessary medical and surgical services for reproductive health, including consultations, examinations, procedures and devices, including device insertion and removal.

See [Maternity and pregnancy](#) for termination of pregnancy services.

Reproductive health is the care necessary to support the reproductive system and the ability to reproduce. Reproductive health includes contraception, cancer and disease screenings, termination of pregnancy, maternity, prenatal and postpartum care.

All methods for Medically Necessary FDA-approved (over the counter) contraceptive drugs, devices, and products. Condoms are limited to 120 per 90-day supply.

Contraceptive drugs may be allowed up to a 12-month supply and, when available, picked up in the provider's office.

Skilled nursing facility

Plan pays 90%; up to 60 days per member per calendar year

Skilled nursing care in a skilled nursing facility is covered when full-time skilled nursing care is necessary in the opinion of the attending KFHPWA provider.

Care may include room and board, general nursing care, drugs, biologicals, supplies, and equipment ordinarily provided or arranged by a skilled nursing facility. Short-term restorative physical therapy, occupational therapy, and speech therapy are also included.

Additional exclusions and limitations for skilled nursing facility

In addition to the plan's [exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Personal comfort items such as telephone and television
- Rest cures
- Domiciliary or convalescent care

Sterilization services

Elective Sterilization

Plan pays 100% for FDA-approved sterilization procedures, such as vasectomy, tubal ligation, services, and supplies.

Additional exclusions and limitations for sterilization services

In addition to the plan's [exclusions and limitations](#), procedures and services to reverse sterilization are excluded from this benefit.

Substance use disorder

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists; \$100 copayment for outpatient hospital care

Inpatient services

Residential treatment services are provided in a facility specifically licensed in the state where it practices as a residential treatment center. Preauthorization is required for Residential Treatment and non-Emergency inpatient hospital services provided in out-of-state facilities. The member may receive two days of treatment before being subject to medical necessity review for continued care. The member or facility must notify KFHPWA within 24 hours of admission, or as soon as possible. Members may contact Member Services at (206) 630-4636 or toll-free at (800) 901-4636 to request Preauthorization.



Residential treatment centers or services offer facility-based treatment providing active treatment in a controlled environment. At least weekly physician visits are required, and services must offer treatment by a multi-disciplinary team of licensed professionals.

Outpatient services

All alcoholism and/or drug abuse treatment services must be:

- Provided at a Kaiser Permanente facility or Kaiser Permanente-approved treatment facility
- Deemed medically necessary; the following services are covered on an inpatient or outpatient basis: inpatient residential treatment services, diagnostic evaluation and education, organized individual and group counseling, and/or prescription drugs and medicines
- Court-ordered treatment is covered only if determined to be medically necessary



Substance use disorder means an illness characterized by physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages, and where the member's health is substantially impaired or endangered or their social or economic function is substantially disrupted.

Additional exclusions and limitations for substance use disorder

In addition to the plan's [exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Experimental or investigational therapies such as aversion therapy.
- Educational or recreational therapy or programs; this includes, but is not limited to, boarding schools. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider, provided that educational or recreational therapy or programs, themselves, are not eligible providers for this purpose.
- Facilities and treatment programs which are not certified by the Department of Social Health Services

Telehealth Services

Plan pays 100%

Telemedicine Services provided by the use of real time interactive audio and video communications or store and forward technology between the patient at the originating site and a Network Provider at another location. Store and forward technology means sending a Member's medical information from an originating site to the provider at a distant site for later review. The provider follows up with a medical diagnosis for the Member and helps manage their care. Services must meet the following requirements:

- Be a covered service under this SPD.

- The originating site is qualified to provide the service.
- If the service is provided through store and forward technology, there must be an associated office visit between the Member and the referring provider.
- Is Medically Necessary.
- Online (E-Visits): A Member logs into the secure Member site at www.kp.org/wa and completes a questionnaire. A KFHPWA medical provider reviews the questionnaire and provides a treatment plan for select conditions, including prescriptions. Online visits are not available to Members during in-

person visits at a KFHPWA facility or pharmacy. More information is available at <https://wa.kaiserpermanente.org/html/public/services/evisit>. Exclusions: Fax and e-mail; telehealth services with non-contracted providers; telehealth services in states where prohibited by law; all other services not listed above.

Additional exclusions and limitations for telemedicine

In addition to the plan's [exclusions and limitations](#), fax and email; telehealth services with non-contracted providers; telehealth services in states where prohibited by law; all other services not listed above are excluded.

Temporomandibular Joint (TMJ) services

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists; \$100 copayment for outpatient hospital care

Covered services

- Medical and surgical services related to hospital charges for the treatment of TMJ disorders. TMJ appliances are covered under Devices, Equipment, and Supplies.
- Medically necessary orthognathic (jaw) surgery for the treatment of severe TMJ disorders for which non-surgical interventions have not been successful, radiology services, TMJ specialist services, and fitting/adjustment of splints

Additional exclusions and limitations for Temporomandibular Joint (TMJ) services

In addition to the plan's [exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Treatment for cosmetic purposes
- Bite blocks
- Dental services, including orthodontic therapy and braces for any condition
- Severe obstructive sleep apnea

Any hospitalizations related to these exclusions are also excluded.

Tobacco cessation

Plan pays 100%

This benefit covers:

- Individual and group sessions through KFHPWA-designated tobacco cessation programs
- Tobacco cessation pharmacy products
- Educational materials when provided through KFHPWA

Transplants

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists; \$100 copayment for outpatient hospital care

Transplants include:

- Heart
- Heart-lung
- Single lung
- Double lung
- Kidney
- Pancreas
- Cornea
- Intestinal/multi-visceral
- Bone marrow
- Liver
- Stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high-dose chemotherapy

Covered services are limited to the following:

- Inpatient and outpatient medical expenses
 - Evaluation testing to determine recipient candidacy
 - Donor matching tests
 - Hospital charges
 - Procurement center fees
 - Professional fees
 - Travel costs for a surgical team, and
 - Excision fees
- Donor costs for a covered organ recipient are limited to
 - Procurement center fees
 - Travel costs for a surgical team
 - Excision fees
- Follow-up services for specialty visits
- Re-hospitalization
- Maintenance medications during an inpatient stay

Additional exclusions and limitations for transplants

In addition to the plan's [exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Donor costs to the extent that they are reimbursable by the organ donor's insurance
- Treatment of donor complications
- Living expenses

- Transportation expenses, except as set forth under this plan

Travel and lodging reimbursement

In-network: 100%, deductible applies (additional IRS limitations described below)

Out-of-network: 100%, deductible applies (additional IRS limitations described below) Limit: \$10,000 per calendar year

Travel and lodging reimbursement benefits are available when travel is necessary to obtain covered treatment for a medical condition only when a treatment option is not available within 100 miles of the patient's home.

Travel Allowances: Travel is reimbursed between the patient's home and the location of the covered treatment for round trip (air, train, or bus) transportation costs. Airfare, or train or bus fare, must be for a regularly scheduled commercial flight, or train or bus route (coach class only). If traveling by automobile, mileage, parking, and toll costs are reimbursed. Costs for surface transportation (rideshares, taxi, ferry, etc.) are also covered. Mileage reimbursement is based on the current IRS medical mileage reimbursement. Please refer to the IRS website, www.irs.gov, publication 502 Medical and Dental expenses, for current mileage reimbursement rates.

Lodging Allowances: Hotel or motel stays (or similar accommodations) away from home. Reimbursement of expenses incurred by a patient and companion for hotel or motel lodging away from home, in the geographic area where the covered treatment is performed, is provided at a rate of \$50 per night per person, or up to \$100 per night total for the patient and one companion (see below), in accordance with applicable IRS reimbursement requirements.

Overall Maximum: The travel and lodging reimbursement benefit is limited to a total of \$10,000 per member per plan year.

Companions: The travel and lodging benefit is available for the patient, as well as a companion, to the extent that a companion is needed to accompany the patient for the treatment due to medical necessity or safety concerns.

- Adult Patient (age 18 or older) – 1 companion is permitted.
- Child Patient – 1 parent or guardian is permitted

Limits: Eligible travel and lodging expenses under this benefit are reimbursable up to the IRS limits, if applicable, in effect on the date you incurred the expense, which are subject to change. Please visit the IRS website, www.irs.gov, for details. Nothing in this summary

of the travel and lodging reimbursement benefit should be considered legal or tax advice. Please consult with a personal legal or tax advisor for more information.

Non-Covered Expenses:

- Alcohol/tobacco
- Car rental expenses
- Any airfare, train or bus fare, or upgrades for any ticket other than a regularly scheduled commercial flight in coach class
- Baggage fees
- Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)

- Expenses for persons other than the patient and an eligible covered companion
- Lodging at a residence owned by a family member or friend
- Costs for pets or animals, other than service animals
- Meals
- Personal care items (e.g., shampoo, deodorant, toothbrush etc.)
- Souvenirs (e.g., T-shirts, sweatshirts, toys, etc.)
- Telephone calls

Limitations/exclusions:

- The travel and lodging must occur, and the treatment must be provided, within the United States
- The patient must be currently covered by the Woodgrove Financial provided KFHPWA plan
- The medical treatment for which the patient is required to travel more than 100 miles from the patient's residence must be a covered benefit under the Plan

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine in advance whether coverage is available for travel and lodging reimbursement.



Prior authorization is an advance determination by KFHPWA that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Urgent care

Inside KFHPWA's service area—\$20 copayment for primary care providers; \$40 copayment for specialists

Care for urgent conditions within the KFHPWA service area is not covered at non-Kaiser Permanente facilities except for emergency services. These emergency services will be subject to the applicable emergency care copayment of \$75, plus the difference between the non-Kaiser Permanente facility's charge and the KFHPWA allowable charge.



An **allowable charge** is the negotiated amount that KFHPWA providers have agreed to accept as payment in full for a covered service. Out-of-network providers may not accept the allowable charge as payment in full. You are responsible for paying the difference between the allowable charge and the amount your out-of-network

provider charges.

Weight Management program

*Plan pays 80%; up to \$6,000 maximum for the duration of your continuous enrollment in the KFHPWA HMO Plan
(out-of-pocket maximum does not apply)*

This benefit provides coverage for comprehensive and clinically based weight management programs for the treatment of obesity. This benefit is available to KFHPWA HMO members but is administered by Premera Blue Cross.

Who is eligible

Members are eligible for the Weight Management program benefit if they meet the following criteria:

- Diagnosed as obese (commonly Body Mass Index (BMI) greater than or equal to 30), or
- Overweight with a BMI greater than or equal to 27, and diagnosed with two or more of the following conditions:
 - Congestive heart failure
 - Coronary heart disease
 - Depression
 - Diabetes
 - Hyperlipidemia
 - Hypertension

Dependent children are not eligible for this benefit.

Eligible providers

Approved [weight management providers](#) of this benefit must meet eligibility requirements set forth by Woodgrove Financial and Premera and be providing services under a weight management program that is contracted for and approved by Premera for this plan.

Approved weight management programs will be those programs that are comprehensive and clinically based. Approved programs must be based on medical oversight and include treatment from professionals in the areas of nutrition, behavioral therapy, and personal training. An approved program must include an initial minimum 10-week period of frequent sessions with the program's physician, personal trainer, dietician, and behavioral therapist. This initial period must be followed by a minimum three-month maintenance period, which includes regular follow-up visits with these program professionals.

The Weight Management program must be contracted for and approved by Premera both at the time the member begins the program and when they complete the program. If the program is not approved and contracted for until after the member has started treatment under the program, no part of the cost of the program will be covered under this benefit.



To find an approved provider, review the [Weight Management providers](#).

Prior authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact KFHPWA for prior authorization.



Prior authorization is an advance determination by KFHPWA that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. KFHPWA and Woodgrove Financial reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

A [Weight Management Recommendation form](#) or confirmation of your BMI and co-morbid conditions should be submitted to Premera prior to receiving reimbursement from Premera. Your physician's recommendation will confirm you meet the contract criteria required for this benefit to be available.

The following are the steps that must be completed to ensure that your treatment meets the criteria of this benefit:

1. Take the Weight Management Recommendation form to your regular physician
2. An evaluation is performed by your physician to determine if you meet the eligibility requirements set forth above
3. Your physician faxes or mails the Weight Management Recommendation Form to Premera to confirm that you meet the weight management eligibility requirements and your physician's approval



Your physician can fax this information to 800-676-1477

4. Premera Blue Cross will review the information submitted and verify the coverage through a prior authorization

Participation in the program should begin within six months of the prior authorization being issued or a new prior authorization will need to be requested.

Claims payment

Final claims payment will be contingent on Premera receiving all biometric reporting information for the member. Reimbursement for this benefit may occur in one of two ways. The program you attend will select the claims payment method used.

Method 1: Direct reimbursement to member

The provider will bill you directly for services provided. The frequency of billing should be made clear by the provider before you start the program. The weight management provider may collect a deposit from you to initiate your participation in the program.

During the course of the program, you can submit an interim weight management billing claim form on a monthly or quarterly basis to Premiera for reimbursement. You may also submit a final weight management final billing claim form at the end of the program.

If your coverage terminates during the time you are participating in an approved program, and you do not elect COBRA, only services rendered up to the date of termination of coverage will be reimbursed.

Method 2: Direct reimbursement to provider

Reimbursement will be made directly to the weight management provider on a monthly or quarterly basis. The weight management provider may collect a deposit from you to initiate your participation in the program but will bill Premera on a monthly or quarterly basis for your ongoing participation.

Additional exclusions and limitations for Weight Management program

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Food
- Nutritional supplements (i.e., protein shakes)
- Drugs or surgical procedures to assist in reducing weight or curbing hunger

Exclusions and limitations

General exclusions

In addition to [exclusions associated with specific benefits](#), the following services are not covered:

- Benefits and related services, supplies and drugs that are not medically necessary for the treatment of an illness, injury, or physical disability, that are not specifically listed as covered under the [What the plan covers](#) section, except as required by law
- Follow-up services related to a non-covered service, except as required by federal law
- Complications of non-covered services
- Cosmetic services, including treatment for complications resulting from cosmetic surgery, except as provided under the [What the plan covers](#) section
- Services for which a claim was not received by KFHPWA within 12 months of the date of service. Corrected claims and COB claims need to be submitted within 12 months from the original claim submission date.
- Devices, equipment, and supplies, except as specifically stated under the [devices, equipment, and supplies](#) benefit
- Benefits that overlap or duplicate benefits for which the member is eligible under any other group plan, workers' compensation or similar employee benefit law, Medicare Part A or B, or a government-sponsored program of any type
- Those parts of an examination and associated reports and immunizations required for employment, immigration (except for immigration exams authorized by Woodgrove Financial and provided by designated immigration exam providers), license, travel (except for medications and injections for anticipated illness while traveling), or insurance purposes that are not deemed medically necessary by KFHPWA for early detection of disease, all diagnostic services not specifically stated under Preventive Services
- Cosmetic services related to sexual reassignment surgery including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-covered services; travel

- Services and supplies related to sexual reassignment surgery, such as sex-change operations or transformations and procedures, or treatments designed to alter physical characteristics, unless specifically stated under the Gender affirming service benefit
- Services or supplies not specifically listed as covered under the [What the plan covers](#) section

- The cost of services and supplies resulting from a member's loss of or willful damage to appliances, devices, supplies, and materials covered by KFHPWA for the treatment of disease, injury, or illness
- Orthoptic therapy (eye training)
- Specialty treatment programs such as weight reduction, behavior modification programs and rehabilitation
- Hypnotherapy and all services related to hypnotherapy
- Prognostic (predictive) genetic testing and related services, unless specifically provided in [hospital care](#) benefit. Testing for individuals not enrolled in the plan (for example, surrogate parent).
- Fetal ultrasound in the absence of medical indications
- Liquid diet or fasting programs, membership in diet programs or health clubs, wiring of the jaw, and complications from surgery or fasting programs; however, medically necessary surgery may be covered if specific criteria as determined by KFHPWA is met
- Services or supplies for which no charges are made, or for which a charge would not have been made if the member had no health care coverage or for which the member is not liable; services provided by a member of the member's family or self-care
- Autopsy and associated expenses
- Services provided by government agencies, except as required by federal or state law
- Services covered by the national health plan of any other country the member resides in
- Internally implanted insulin pump, artificial heart, artificial larynx, and any other implantable device that has not been approved by KFHPWA's medical director
- Travel-related vaccinations and medications are usually not covered. Visit <https://healthy.kaiserpermanente.org/washington/get-care/traveling/> for more details.
- Services that are illegal, outside the scope of the provider's license or certification, or furnished by a provider that is not licensed or certified by the jurisdiction in which the services or supplies were received

Dental benefits exclusions

Dentist's or oral surgeon's fees; dental care, surgery, services, and appliances, including: reconstructive surgery to the jaw in preparation for dental implants, dental implants, periodontal surgery, and any other dental services not specifically listed as covered in this summary.

Convalescent care exclusions

Convalescent care is excluded.

Investigational or experimental treatment exclusions



Experimental or investigational services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#) for a full definition.



The transplant benefit doesn't cover cornea transplantation, skin grafts, or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure.

KFHPWA consults with KFHPWA's medical director and then uses the following criteria to decide if a particular service is experimental or investigational:

- A service is considered experimental or investigational for a member's condition if any of the following statements apply to it at the time the service is or will be provided to the member:
 - The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA) and such approval has not been granted
 - The service is the subject of a current new drug or new device application on file with the FDA
 - The service is the trialed agent or for delivery or measurement of the trialed agent provided as part of a qualifying Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial
 - The service is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity, or efficacy as among its objectives
 - The service is under continued scientific testing and research concerning the safety, toxicity, or efficacy of services
 - The service is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity, or efficacy
 - The prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that (1) the use of such service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity, or efficacy of the service
- The following sources of information will be exclusively relied upon to determine whether a service is experimental or investigational:
 - The member's medical records
 - The written protocol(s) or other document(s) pursuant to which the service has been or will be provided
 - Any consent document(s) the member or member's representative has executed or will be asked to execute, to receive the service
 - The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body
 - The published authoritative medical or scientific literature regarding the service, as applied to the member's illness or injury, and
 - Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions

Coverage decisions may be appealed as set forth in the [What the plan covers](#) section.

Vehicle insurance exclusions

- Any services to the extent benefits are "available" to the member as defined herein through vehicle, homeowner's, property, or other insurance policy, except for individual or KFHPWA insurance,

whether the member asserts a claim or not

- Medical coverage, medical "no fault" coverage, personal injury protection coverage, or similar medical coverage in the policy
- Benefits are deemed to be "available" to the member if the member is a named insured, comes within the policy definition of insured, or otherwise has the right to receive first-party benefits under the policy

Additional exclusions and limitations

In addition, certain exclusions and limitations apply to the following benefits. CTRL+Click to navigate to the benefit information.

- [Acupuncture](#)
- [Autism/ABA therapy](#)
- [Devices, equipment, and supplies](#)
- [Home health care](#)
- [Hospice care](#)
- [Hospital care](#)
- [Infertility](#)
- [Manipulative therapy](#)
- [Maternity and pregnancy care](#)
- [Mental health and wellness](#)
- [Naturopathy](#)
- [Neurodevelopmental therapy for children](#)
- [Nutritional services](#)
- [Obesity-related surgery](#)
- [Plastic and reconstructive services](#)
- [Podiatric services](#)
- [Prescription drugs](#)
- [Preventive care](#)
- [Rehabilitation](#)
- [Skilled nursing facility](#)
- [Sterilization](#)
- [TMJ](#)
- [Transplants](#)
- [Travel and lodging reimbursement](#)
- [Weight Management program](#)

How to file a claim

In most cases, when you receive care from a KFHPWA provider or facility, your provider will submit bills directly to KFHPWA, and this submission is your claim for benefits. If your

provider does not submit a bill directly to KFHPWA, you will need to submit a claim for benefits.

If possible, you should submit the claim form within 90 days of the service. The plan will not consider claims submitted more than 12 months after the date of service, except in the absence of legal capacity.

For information about how the novel coronavirus (COVID-19) pandemic impacts the claims process and timelines, [Important information due to the coronavirus pandemic](#).

Claims for benefits may be made before or after services are obtained. For out-of-country claims (Emergency care only) – submit the claim and any associated medical records translated into English at the member's expense, including the type of service, charges in U.S. Dollars, and proof of travel to KFHPWA, P.O. Box 34585, Seattle, WA 98124-1585.

To submit a claim:

1. Download the [KFHPWA Claim Form](#) or call Kaiser Permanente Member Services at (206) 630-4636 or (888) 901-4636 to request a form
2. Complete the form with the necessary information such as an itemization of services received including codes and conditions. Proof of payment is also required if members are seeking reimbursement.
3. Gather copies of your receipts from your covered visit
4. Send your completed form and additional paperwork to:
Claims Reimbursement
PO BOX 34585

Seattle WA 98124-1585



COBRA-eligibility claims should be submitted as described in the [Continuation of coverage for health and FSA benefits \(COBRA\)](#) section.

Claims regarding plan eligibility for you, your spouse/domestic partner, or dependent child can be sent to: Appeals Coordinator

Premiera Blue Cross

P.O. Box 91102

Seattle, WA 98111-9202.

Claim review and payment

KFHPWA will send you an Explanation of Benefits (EOB) or other communication notifying you of their decision on your claim within the following timeframes after KFHPWA receives your claim.

- **Pre-service claims**—KFHPWA will provide notice of a claim approval or denial within 15 days. This 15-day period may be extended for an additional 15 days if the extension is required due to matters beyond KFHPWA's control. You will have at least 45 days to provide any additional information

requested of you by KFHPWA.

- **Urgent care**—KFHPWA will process claims and notify claimants of the decision, in immediate request situations, within 72 hours.
- **Concurrent urgent requests**—KFHPWA will process claims for concurrent urgent requests within 24 hours.
- **Concurrent non-urgent requests**—You will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction so that you will be able to appeal the decision before the coverage is reduced or terminated.

- **Urgent care review requests**—KFHPWA will process claims for urgent care review requests within 48 hours.
- **Non-urgent pre-service review requests**—KFHPWA will process claims for non-urgent pre-service review requests within 15 calendar days. Timeframes for pre-service claims can be extended by KFHPWA for up to an additional 15 days. Members will be notified in writing of such extension prior to the expiration of the initial timeframe.
- **Post-service review requests**—KFHPWA will process claims for post-service review requests within 30 calendar days. Timeframes for post-service claims can be extended by KFHPWA for up to an additional 15 days. Members will be notified in writing of such extension prior to the expiration of the initial timeframe.
- **Claims involving urgently needed care**—If your claim involves urgent care, you or your authorized representative will be notified of KFHPWA's initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event more than 72 hours after receiving the claim. If the claim does not include sufficient information for the Plan Administrator to make a decision, you or your representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. You will have at least 48 hours to respond to this request; KFHPWA then must inform you of its decision within 48 hours of receiving the additional information.
- **Concurrent care claims**—If your claim is one involving concurrent care, KFHPWA will notify you of its decision, whether adverse or not, within 24 hours after receiving the claim. If the claim does not include sufficient information for the Plan Administrator to make a decision, you or your representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. Where urgent care is involved, you will have at least 48 hours to respond to this request. KFHPWA will respond within 24 hours of receipt of the additional information. If the claim does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframes appropriate to the type of claim, (i.e., as a pre-service claim or a post-service claim).
- **Post-service claims**—If you have filed a post-service claim for reimbursement of medical care services that already have been rendered, you will be notified of KFHPWA's decision on your claim if it is denied in whole or in part. This notification will be issued no more than 30 days after KFHPWA receives the claim. KFHPWA may extend this 30-day period for up to 15 days if the extension is required due to matters beyond KFHPWA's control. You will have at least 45 days to provide any additional information requested of you by KFHPWA if the need for the extension is due to KFHPWA's need for additional information from you or your health care providers.



Explanation of benefits (EOB) is the statement you receive from KFHPWA detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

In paying for services, KFHPWA may make payment to the employee, provider or another carrier. KFHPWA may also make payments on behalf of an enrolled child to a non-enrolled parent or state agency to which the plan is required by applicable law to direct such payments. Payments are subject to applicable law and regulation. Payments made will discharge the plan to the extent of the amount paid, so that the plan is not liable to anyone due to its choice of payee.

Denied claims notice

If all or part of your claim is denied, KFHPWA will send you an Explanation of Benefits (EOB) or other notice with the following information:

- The reasons for the denial
- The plan provisions on which the denial is based
- Any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary
- An explanation of the procedure for appeals and the applicable time limits, along with a statement of your right to bring a civil action under ERISA Section 502(a) upon an adverse decision on appeal
- A statement regarding any internal rule, guideline, protocol, or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request)
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)
- If you have filed a claim with KFHPWA relating to plan eligibility, and this claim is denied, KFHPWA will send you a notice explaining your appeal rights
- Notice regarding your right to bring legal action following a denial on appeal

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
- The denial code and its meaning
- A description of the Plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal; and
- Contact information for Kaiser Permanente Member Services or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist members with the internal and external appeals process

Appeal for internal review

Members are entitled to appeal through the appeals process if/when coverage for an item or service is denied due to an adverse determination made by the KFHPWA medical director. Assistance is available to members who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process. If the plan denies your claim, you may appeal for an internal review of the decision within 180 days of receiving the Explanation of Benefits (EOB).

For information about how the novel coronavirus (COVID-19) pandemic impacts the appeal process and timelines, [Important information due to the coronavirus pandemic](#).



An **appeal** is a written request to reconsider a written or official verbal adverse determination to deny, modify, reduce or end payment, coverage or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to and continued stays in a facility. The process also applies to Flexible Spending Account appeals for reimbursement but does not apply to appeals of denied COBRA eligibility claims.



If you fail to file the internal appeal within the timeframe specified above, you will permanently lose your right to appeal the denied claim.

Submitting an appeal for internal review

You must provide the following information as part of your oral or written appeal to KFHPWA's Member Appeals Department:

- Your name
- Your KFHPWA member number
- The name of this plan, and
- A concise statement of why you disagree with the decision, including facts or theories supporting your claim

Your written request may (but is not required to) include issues, comments, documents, and other records you want considered in the review.



The appeal should be submitted to KFHPWA at the following address:

Kaiser Foundation Health Plan of Washington Member
Appeal Department,

You may, at your own expense, have an attorney or other representative act on your behalf. If you want to appoint someone to act for you in the appeals process (including your provider), you must submit a completed and signed [KFHPWA Appointment of Representative form](#) with your written internal appeals request to the address above.

In the case of an urgent care claim, you may submit your appeal request orally or in writing and all necessary information may be transmitted between you and the plan by telephone, facsimile or other similarly expeditious method. If your provider believes your situation is urgent as defined under law and so notifies KFHPWA, your appeal will be conducted on an expedited basis. Notification will be furnished to you as soon as possible, but not later than 72 hours after receipt of the expedited appeal. Your appeal should clearly indicate your request for an expedited appeal.

You may also begin an external review at the same time as the internal appeals process if this is an urgent care situation or you are in an ongoing course of treatment. To request this step, you must call Member Appeals. The external review agency is not legally affiliated or controlled by KFHPWA. The external review agency decision is final and is generally binding upon the Plan.



To file an urgent care appeal request, you may call KFHPWA directly at (866) 458-5479 or you may fax a request to (206) 630-1859.

Internal review and timeframe

All of the information you submit will be taken into account on appeal, even if it was not reviewed as part of the initial decision. You may ask to examine or receive free copies of all pertinent Plan documents, records, and other information relevant to your claim by asking KFHPWA.

The plan may consult with a health care professional who has experience in the field of medicine involved in the medical judgment to decide your appeal. You may request the identity of medical experts whose

advice was obtained by the plan in connection with your initial claim denial, even if their advice was not relied upon in making the initial decision.

In the event any new or additional information (evidence) is considered, relied on or generated by KFHPWA in connection with your appeal, KFHPWA will provide this information to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by KFHPWA, KFHPWA will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that that you will have an opportunity to respond.

If the claim is a post-service claim, you will receive a decision within a reasonable period of time, but not later than 60 days after receipt of your appeal request.

If the claim is a pre-service claim, you will receive a decision within a reasonable period of time, but not later than 30 days after receipt of your appeal request.

Denied appeal notice

If the previous denial is upheld in whole or in part, the notice of the decision on appeal will specify:

- The reasons for the denial
- The Plan provisions on which the denial is based
- A contact point through which the member may review or receive free copies of any documents, records or other information relevant to your claim for benefits
- A statement of your right to bring a civil action under ERISA 502(a) following an adverse benefit determination upon the conclusion of your appeal
- A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request)
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
- The denial code and its meaning
- A description of the Plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal; and
- Contact information for Kaiser Permanente Member Services or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist members with the internal and external appeals process

If KFHPWA fails to grant or reject your request within the applicable required timeframe, you may proceed as if the claim had been rejected.

Appeal for external review

If you are not satisfied with the final internal denial of your claim, you may request an external review by an independent review organization (IRO) if that denial constitutes a rescission of coverage or is based on medical judgment including:

- Requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit
- A determination that a treatment is experimental or investigational



An **independent review organization (IRO)** is an independent organization of medical experts who are qualified to review medical and other relevant information.

The external review is available only after you have properly exhausted the internal appeal as described above. There are no fees or costs imposed on you as part of the external review.

The external review agency decision is final and is generally binding upon the plan.

Submitting an appeal for external review

An [External Review Request Form](#) will be sent with your Internal Appeal determination letter notifying you of your rights to an External Review.

To initiate the External Review, you must complete, sign the External Review Request Form, and send it to KFHPWA at the address below no later than 180 days after the date you receive your Internal Appeal determination letter, which the Plan deems to be 7 days after the date on the Internal Appeal determination letter.



If you fail to submit the completed and signed form within this timeframe, you will permanently lose your right to an External Review.



Mail the External Review Request form to:

Kaiser Foundation Health Plan Washington Member
Appeal Department

External review and timeframe

If your claim is eligible for External Review, KFHPWA will notify the IRO of your request for an External Review and send them all the information included in your Internal Appeal and other relevant materials within six days of receipt.

The IRO will contact you and/or KFHPWA directly if additional information is needed. KFHPWA will provide the IRO with any additional information the IRO requests that is reasonably available. The External Review request is considered complete when the IRO has all the requested information, and the IRO review begins.



If your provider believes your situation is urgent under law (as defined above under Appeal for internal review), your external review will be conducted on an expedited basis. For expedited external reviews, you and KFHPWA will be notified by phone, e-mail message or fax as soon as possible, but no later than 72 hours after receipt of your external review request. A written determination will follow.

The plan agrees that any statute of limitations (including the one-year contractual limitations period described below) or other defense based on timeliness is on hold during the time that the External Review

is pending. Your decision whether to file the External Review will have no effect on your rights to any other benefits under the plan.

The external review process does not apply to appeals of denied claims for plan eligibility or for other appeals of denied claims that are not based on medical judgment.

Decision on the external review

The plan is bound by the IRO's decision. If the IRO overturned the final internal adverse determination, the plan will implement their decision. The IRO will notify you and KFHPWA in writing of its determination on the external review no later than 45 days after receipt of your complete external review request.

Decisions upon the external review are the final decision under the Plan's appeal process, and there are no further appeals available from KFHPWA or Woodgrove Financial or any person administering claims or appeals under the plan. However, you still have the right to file suit under ERISA Section 502(a) as a result of the external review decision.

Limits on your right to judicial review

You must follow the appeals process described above through the decision on the appeal before taking action in any other forum regarding a claim for benefits under the plan. Any legal action initiated under the Plan must be brought no later than one year following the adverse determination on the appeal. This one-year limitations period on claims for benefits applies in any forum where you initiate legal action. If a legal action is not filed within this period, your benefit claim is deemed permanently waived and barred.



If you have questions about understanding a denial of a claim or your appeal rights, you may contact KFHPWA at (206) 630-4636 or (888) 901-4636 or visit [KFHPWA](#) online. You may also seek assistance from the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor at (866) 444-EBSA (3272).

Right to recover benefits paid in error

If KFHPWA makes a payment in error on your behalf to you or a provider, and you are not eligible for all or a part of that payment, KFHPWA has the right to recover payment including deducting the amount paid by mistake from future benefits.

Note: Health care providers are not “beneficiaries” of the plan, and although KFHPWA may make direct payment to health care providers for the convenience of participants and their dependents, such payments of services shall not be considered “benefits” available under the plan or confer beneficiary standing upon a health care provider.

Release of medical information

As part of this plan, physicians, hospitals or other providers may disclose to KFHPWA medical information necessary to administer claims. KFHPWA will keep this information confidential.

HMO Plan (Kaiser Permanente) – California only

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How the plan works

The Kaiser Permanente HMO Plan offers the convenience of “one-stop shop” medical care. Your providers are all part of the same integrated health care system, so they can quickly share your medical records to help make informed decisions about your care. There’s also a pharmacy, laboratory, and X-ray facility at every Kaiser Permanente location, so it’s easy and efficient to get the care you need when you need it.

Where you can get care

The HMO Plan provides comprehensive medical care and prescription drug coverage with contracted providers, facilities, and pharmacies through the Kaiser Permanente network in California and eight other states. Kaiser Foundation Health Plan of Washington facilities are treated as part of the Kaiser Permanente network if you need medical services while in Washington State. Services provided outside the Kaiser Permanente’s service area may not be covered. You may need a referral from your primary care physician before the plan will cover care from specialists.

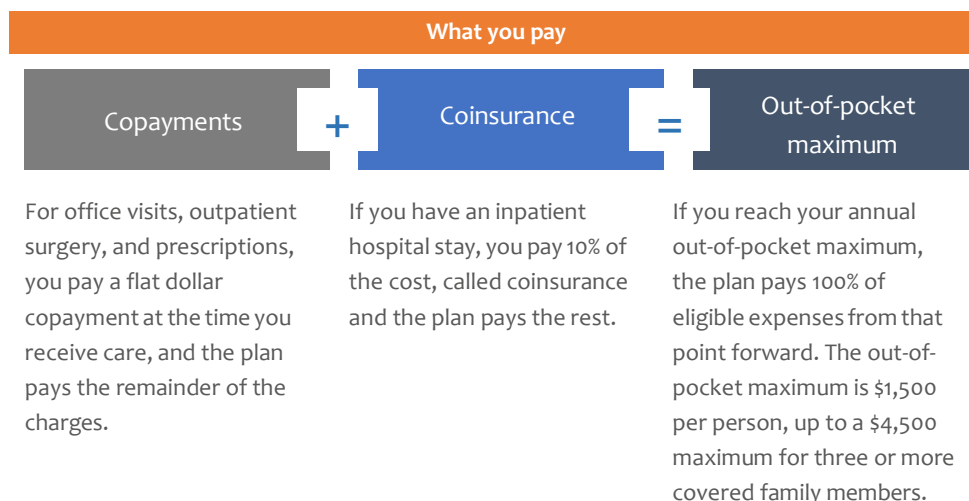


To find an in-network provider of pharmacy, go to www.KP.org or contact the Member Service Contact Center at (800) 464-4000.

What you pay

When you receive care for the treatment of illnesses, injuries, and chronic conditions, you pay a portion of the cost, up to an annual out-of-pocket maximum. For most services such as office visits, outpatient surgery, and prescriptions, you pay a flat copayment at the time you receive care, and the plan pays the remainder of the cost. If you have an inpatient hospital stay, the plan pays 90% of the cost and you are

responsible for 10% up to an annual out-of-pocket maximum. When it comes to preventive care and preventive prescriptions, the plan covers 100% when you use in-network providers.



Copayment is a fixed, up-front dollar amount that you are required to pay for certain covered services in the HMO plans.

Coinsurance is the percentage amount that you are required to pay for certain covered services.

Out-of-pocket maximum is the most you could pay each plan year for covered services and supplies.

Medical care copayments

Type of visit	Copayment	Coinsurance
Primary Care Physician	\$20	None
Specialist	\$40	None
Emergency (waived if admitted)	\$75	None
Hospital – outpatient	\$100	None
Hospital – inpatient	None	10%

Prescription drug copayments

(When prescribed by a Kaiser provider and obtained at a Kaiser pharmacy)	Copayment
Generic	\$10

Brand	\$25
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Generic drugs are equivalent to a brand-name drug but available at a lower cost because the patent has expired.

Brand-name drugs are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.

Out-of-pocket maximum

The annual out-of-pocket maximum is capped at \$1,500 for each covered member—this means that once a member reaches his/her out-of-pocket maximum through copayments and coinsurance, the plan pays 100% for the rest of the year for that individual. Also, if you have three or more covered family members, the most you'll pay for the year is \$4,500. Most copays and coinsurance count toward the annual out-of-pocket maximum, with the exception of prescription drugs and infertility treatment.

What the plan covers

Benefits under this Kaiser Permanente HMO are detailed in the Evidence of Coverage (separate documents for Northern California and Southern California coverage, respectively), which are incorporated by reference in this SPD.

Active employees/dependents go here...	COBRA enrollees go here...
<ul style="list-style-type: none"> • Evidence of Coverage – Northern California • Evidence of Coverage – Southern California 	For more information, go to http://cobra.me.Woodgrove Financial.com > Reference Center > Kaiser CA Evidence of Coverage (EOC) Documents

For information about how the novel coronavirus (COVID) is covered under this plan, see [Important information due to the coronavirus pandemic](#).

Exclusions and limitations

Exclusions and Limitations under this Kaiser Permanente HMO are detailed in the Evidence of Coverage (separate documents for Northern California and Southern California coverage, respectively) which are incorporated by reference in this SPD.

Active employees/dependents go here...	COBRA enrollees go here...
<ul style="list-style-type: none"> • Evidence of Coverage – Northern California • Evidence of Coverage – Southern California 	For more information, go to http://cobra.me.Woodgrove Financial.com > Reference Center > Kaiser CA Evidence of Coverage (EOC) Documents




Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the Benefits and Cost Sharing section in the Evidence of Coverage.

How to file a claim

If you wish to file a claim for benefits, you should follow the claim procedures described in the Evidence of Coverage provided by your Claims Administrator. All questions regarding claims should be directed to the Claims Administrator for the Kaiser Permanente Health Plan.

Active employees/dependents go here...	COBRA enrollees go here...
<ul style="list-style-type: none">Evidence of Coverage – Northern CaliforniaEvidence of Coverage – Southern California	For more information, go to http://cobra.me.Woodgrove Financial.com > Reference Center > Kaiser CA Evidence of Coverage (EOC) Documents

 For more information about filing a claim, contact the Member Services Contact Center at (800) 464-4000.

Hawaii-Only Plan (Premera)

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How the plan works

The Hawaii-Only Plan provides comprehensive medical coverage and the flexibility to see any provider you choose. Preventive care is covered at 100% with in-network providers and facilities and you pay a share of other expenses up to an annual maximum amount.

Where you can get care

With the Hawaii-Only Plan, you have the flexibility to visit the provider or facility you choose and still have coverage. However, providers in the nationwide Premera Blue Cross Blue Shield network feature certain advantages, including:

- Your claims are filed directly with Premera by your provider
- Lower, negotiated rates for care and prescriptions
- The highest coverage levels

If you seek care with an out-of-network provider or facility, your out-of-pocket costs will be higher, and you may have to pay the provider and then submit a claim for reimbursement

Review the [What you pay](#) section for information on coverage levels.

Finding an in-network provider

In Hawaii, you can maximize your savings by using providers and facilities in the Premera network.

Outside of Hawaii, you may use any Blue Cross and/or Blue Shield provider throughout the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin

Islands under the [BlueCard®](#) Program. Your Premera identification card tells contracting providers that you are covered through this inter-plan arrangement. It's important to note that receiving services through BlueCard does not change covered benefits, benefit levels, or any stated residence requirements of this plan.




Visit the online Premera Medical Directory to find an in-network provider in the United States or call Premera Blue Cross at (800) 676-1411.

Active employees go here...	Active dependents or COBRA enrollees go here...
Premera Medical Directory	Premera.com

Travel outside the United States

If you are traveling outside the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands and need care, you may be able to take advantage of [Blue Cross Blue Shield Global Core](#), which provides referrals to doctors and other health care providers.

 Call (800) 810-BLUE (2583) for Blue Cross Blue Shield Global Core referrals to health care providers outside the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands.


If you are not using a Blue Cross Blue Shield Global Core provider, you will need to submit claim forms to Premera for reimbursement of services received outside the United States. When you submit a claim, clearly detail the services received, diagnosis (including standard medical procedure and diagnosis code, or English nomenclature), dates of service, and the names and credentials for the attending provider.


Benefits reimbursement will be calculated in U.S. dollars.

Care received outside the United States will be covered as long as the services are:

- Medically necessary
- Provided by a licensed provider performing within the scope of their license and practice
- Not deemed experimental or investigational based on the terms of this plan, or medical standards in the United States

Services received outside the United States that are considered urgent or emergent including services received on a cruise ship will be paid as [emergency care](#). Non-emergent facility and professional services are considered out-of-network and covered at 70% of billed charges. Standard deductible and coinsurance would apply.

 **Experimental or investigational** services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#) for a full definition.

 Review the [What you pay](#) section for information on coverage levels.

Filling a prescription

Depending on your needs, you may fill your prescription at a retail pharmacy, pharmacy home delivery, or specialty pharmacy. Review the [prescription drug](#) benefit for more information on what is covered.



Woodgrove Financial reserves the right to change pharmacy networks at any time. Such changes will take effect on the date set by the Company, even if this information has not been revised to show the changes.

	Retail pharmacy	Home delivery	Specialty pharmacy
Coverage	Up to a 90-day supply for generic maintenance medication ; all others are up to a 30-day supply*	Up to 90-day supply* only using Express Scripts Pharmacy Home Delivery	Up to a 30-day supply* Additional clinical support for members using specialty drugs
In-network pharmacies	Express Scripts pharmacies bill the plan on your behalf To find an Express Scripts retail pharmacy, call (800) 676-1411	Express Scripts pharmacies bill the plan on your behalf	AllianceRX Walgreens Pharmacy or Accredo Specialty Pharmacy** will bill the plan on your behalf
Out-of-network pharmacies	You will need to submit a prescription reimbursement form, with your receipt, for reimbursement	Not covered	Not covered

* Unless the drug maker's packaging limits the supply in some other way.

** Contact AllianceRx Walgreens Pharmacy at (877) 223-6447 or Accredo Specialty Pharmacy at (800) 689-6592 to get started.

The dispensing limits (or days' supply) for drugs dispensed at retail and specialty pharmacies, and through the mail-order pharmacy benefit, are described in the chart above.

Refills for a medication will be covered only when the member has used 75% of the supply of that medication, based on both of the following:

- The number of units and days' supply dispensed on the last fill or refill, and
- The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill, if applicable



A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.

Generic maintenance medications have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year. A generic prescription drug is manufactured and distributed after the brand-name drug patent of the innovator company has expired and is available at a lower cost than brand-name prescriptions. Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration and are considered by the FDA to be therapeutically equivalent to the brand-name product.

Specialty drugs are high-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply.

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended for some services and prescriptions to determine that coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical

necessity and determine their potential financial responsibility, before service is provided. Services are subject to eligibility and benefits at the time of service.

Refer to the specific plan benefit for additional details.

What you pay

You pay nothing for preventive care when you use in-network providers. When you receive care or prescription drugs in other situations, such as for the treatment of illnesses, injuries, and chronic conditions, you pay a portion of the cost up to an annual maximum amount. That annual amount, called your out-of-pocket maximum, includes a deductible and coinsurance. If you use in-network providers, you’ll receive the lower Premera-negotiated rate, called the allowable charge, and higher coverage levels. Examples of how the plan pays for in- and out-of-network care follow on the next page.

Premera utilizes medical and payment policies in administering coverage under this plan. The medical policies generally are used to further define medical necessity, experimental and investigative status, and other aspects for specific procedures, drugs, biologic agents, devices, and other items and services and levels of care. These medical policies are available at <http://premera.com> or by calling Customer Service. The payment policies are used to define provider billing and payment rules and adjustments that can apply in various different settings and circumstances. These payment policies are available to you by calling Customer Service and to your provider by calling Customer Service or going to <http://premera.com> and logging into Premera’s provider portal.

What you pay

Deductible

+

Coinsurance

=

Out-of-pocket maximum

You pay 100% of your eligible expenses for medical care and prescriptions until you spend up to the amount of the deductible. Only the Premera allowable charge is applied to your deductible if you seek out-of-network care. You pay nothing for in-network preventive care.

\$300 per person, up to \$900 family maximum

If you reach the deductible, then you begin to pay coinsurance up to a capped amount called the coinsurance maximum. That means you pay only a portion of your health care costs and the plan pays the rest. The coinsurance amount you pay depends on where you seek care:

- In-network, you pay 10%
- Out-of-network, you pay 30% of the allowable charge plus the difference between the provider’s bill and the allowable charge; only the allowable

charge is applied to your coinsurance maximum.
\$1,200 per person, up to
\$3,600 family maximum

If you meet your deductible and then you reach your coinsurance maximum, you’ve reached your out- of-pocket maximum. From that point forward, the plan pays 100% of eligible expenses and you pay nothing for in-network health care services for the rest of the year. You will still be responsible for the difference between the allowable charge and the provider’s billed charges if you seek out-of-network care.

\$1,500 per person, up to
\$4,500 family maximum



The **allowable charge** is defined differently for in-network and out-of-network providers.

- For in-network providers, the allowable charge is the negotiated amount that the provider has agreed to accept as payment in full for a covered service.
- For out-of-network providers, the allowable charge is the lowest of three amounts as outlined in the definition of “allowable charge” in the Glossary. If you choose to use out-of-network providers, you may be responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges.

Example

Jakob needs to visit his allergist. He can choose an in-network or an out-of-network provider. Both charge \$115. The in-network provider accepts Premera’s allowable charge of \$100 as full payment. Jakob hasn’t yet met his deductible, so he will pay the allowable charge of \$100 to his in-network provider.

The out-of-network provider does not have the negotiated agreement with Premera, so Jakob would pay the full \$115. If the allowable charge for the out-of-network provider is also \$100, then only that \$100 amount would apply to his

Example

Mimi needs to see her podiatrist. The visit costs \$125. Mimi has met her deductible, so she’ll pay just \$10 for her visit if she uses an in-network provider with a \$100 allowable charge ($\$100 \times 10\%$ coinsurance). If she visits an out-of-network provider for whom the allowable charge is also \$100, she would pay \$55:

30% of the \$100 Premera allowable charge ($\$100 \times 30\%$ coinsurance = \$30)

Example

Kunji has an ear infection. The provider visit costs \$175, and the allowable charge is \$150. Kunji has met her out-of-pocket maximum, so she’ll pay nothing if she visits an in-network provider.

If she visits an out-of-network provider for whom the allowable charge is also \$150, she’ll pay \$25, the difference

Expenses covered at 100% and NOT applied to the deductible or coinsurance maximum

The following services are covered by the plan at 100% with in-network providers and do not count toward the deductible or coinsurance maximum.

- [Preventive care](#)
- Care received through the [Spring Health employee assistance program](#)

Certain other expenses are your responsibility to pay and do not count toward the annual deductible or coinsurance maximum. They include:

- Expenses incurred while the member was not covered under the Plan
- Expenses for services, supplies, settings, or providers that are not covered under the Plan
- Expenses in excess of annual or lifetime benefit maximums that apply to certain plan benefits
- Amounts for out-of-network care in excess of the allowable charge for the service or supply
- Coinsurance for services covered under the [Weight Management program](#)

Additionally, charges for medical services received during business travel that are applied to the deductible or coinsurance are not reimbursable business expenses.


Out-of-network care with in-network coverage

You may seek out-of-network care and receive in-network coverage levels in the following situations:

Situation	Benefit coverage	What you need to do
Emergency care	Benefits are provided regardless of network status	Go to the nearest emergency facility
You cannot find the provider specialty that you need in the Premera network	If the Premera network does not include a provider specialty (such as a speech therapist) anywhere in your state, treatment at out-of-network providers may be paid at the in-network level	To confirm this coverage is available, and the length of available coverage extension, contact Premera at (800) 676-1411
Your provider’s contract with Premera is ending	If you are receiving ongoing treatment for certain serious and complex medical conditions or illnesses, or pregnancy, are undergoing institutional or inpatient care, or are scheduled for nonelective surgery, you may be eligible to continue to receive in-network benefits for the current course of treatment, for up to 90 days.	To confirm this continued in-network coverage is available, and the length of the available in-network coverage extension, contact Premera at (800) 676-1411 prior to the end of your provider’s contract with Premera

Annual, lifetime, and other benefit maximums

There is no overall annual or lifetime maximum in the Hawaii-Only Plan. However, annual, lifetime, and other benefit maximums apply to certain benefits. Review the [What the plan covers](#) section for details on annual, lifetime, and other benefit maximums.



A **lifetime benefit maximum** is the most a plan will pay toward a benefit for a member. Review the [glossary](#) for a full definition.

An annual or other benefit maximum is the most a plan will pay toward a benefit for a member for services within a specified time period. Review the [glossary](#) for a full definition.

Example

Example

There is a \$10,000 hearing hardware maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in one or more Premera-administered health plan.

Utilization Management

All benefits under this plan are limited to covered services that are medically necessary and as set forth under Plan Benefits. Premera or its designee may review a member’s medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent, or retrospective review, Premera may deny coverage if, in its determination, such services are not medically necessary or do not meet all criteria specified in this SPD. Such determination shall be based on established clinical criteria as described in Premera’s medical policies. The medical policies are on Premera’s website. You or your provider may review them at premera.com. You or your provider may also request a copy of the criteria used to make a medical necessity decision for a particular condition or procedure. To obtain this information by mail, send your request to Medical Policies Coordinator, 7001 220th Street SW MS 438, Mountlake Terrace, WA 98043-2160.

Premera will not deny coverage retroactively for services it has previously authorized and that have already been provided to the member except in the case of fraud or an intentional misrepresentation of a material fact.

What the plan covers

The tables below summarize what the Hawaii-Only Plan covers, including what the plan pays for in- network and out-of-network care.



Services and supplies must be medically necessary and are subject to all benefit exclusions and limitations and the plan’s [exclusions and limitations](#).



CTRL+Click on the benefits below to access more information.

Common benefits		
These are the most commonly used benefits in the Hawaii-Only Plan.		
Benefit	In-network coverage	Out-of-network coverage
Preventive Care Including well-child care through age 18, routine gynecological exams, immunizations and preventive prescription drugs (See the Preventive Care Services list and Preventive Drug list)	Preventive services: 100% Preventive prescription drugs: 100%	Preventive services: 70% of allowable charges after deductible; well-child care through age 6 covered at 100% Preventive prescription drugs: 100%

<p>Prescription drugs</p> <p>Including brand-name preventive with available generic equivalent (see the Hawaii-Only Plan Drug Formulary and preventive care above)</p>	90% after deductible	90% after deductible
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Common benefits		
These are the most commonly used benefits in the Hawaii-Only Plan.		
Benefit	In-network coverage	Out-of-network coverage
Physician services Including specialists and second surgical opinions rendered in the office, hospital, or other medical facility	90% after deductible	70% of allowable charges, after deductible
Diagnostic Services Benefits are provided for diagnostic services (including lab and imaging services) for health conditions or symptoms.	90% after deductible	90% of allowable charges, after deductible
Hospital inpatient care Including semi-private room and board, anesthesia, supporting services, testing, supplies, and intensive or coronary care	90% after deductible	70% of allowable charges, after deductible
Hospital outpatient care/ambulatory surgical care center Including minor surgery, X-ray and radium therapy, anesthesia, and pre-admission testing	90% after deductible	70% of allowable charges, after deductible
Urgent care	90% after deductible	70% of allowable charges, after deductible
Rehabilitation – Physical, Occupational and Speech Therapies	90% after deductible	70% of allowable charges, after deductible
Contraception Contraceptive devices and injections administered by a physician and prescription forms of contraception.	100%	100%
Maternity care (Other than hospital inpatient or outpatient care)	90% after deductible	70% of allowable charges, after deductible
Maternity support	Free virtual care and on-demand support (through Maven Clinic) for new and expecting parents.	Not applicable

Common benefits		
These are the most commonly used benefits in the Hawaii-Only Plan.		
Benefit	In-network coverage	Out-of-network coverage
Mental health counseling, mental health inpatient and outpatient services, Attention Deficit Disorder, and chemical dependency treatment	Outpatient services through Spring Health, administrator of the employee assistance program : <ul style="list-style-type: none"> 100% of 24 sessions per calendar year 	Not applicable
	90% after deductible for inpatient and outpatient services	90% of allowable charges, after deductible for inpatient and outpatient services

Other benefits		
The Hawaii-Only Plan also covers these additional benefits.		
Benefit	In-network coverage	Out-of-network coverage
Ambulance (Ground or Water)	90% after deductible	90% after deductible
Air Ambulance	90% after deductible	90% of allowable charges, after deductible
Chiropractic services, acupuncture, and medical massage	90% after deductible	70% of allowable charges, after deductible
	Combined 24-visit limit per member per calendar year	
Diabetes health education	100%	70% of allowable charges, after deductible
Emergency room care and professional services	90% after deductible	90% of allowable charges, after deductible
Hearing care and hardware	Exams: 90% after deductible	Exams: 70% of allowable charges, after deductible
	Hardware: 90% after deductible; \$10,000 maximum, per member, every three consecutive (rolling) calendar years of continuous enrollment in one or more Premera-administered health plan options	
Home health care	90% after deductible	70% of allowable charges, after deductible
Hospice care	90% after deductible	90% after deductible
Medical equipment and supplies	90% after deductible	90% of allowable charges, after deductible
Nutritional therapy	100%	70% of allowable charges, after deductible

First 12 visits per member per calendar year, calendar year visit limit waived for nutritional therapy for a diagnosed eating disorder or diabetes.

Other benefits		
The Hawaii-Only Plan also covers these additional benefits.		
Benefit	In-network coverage	Out-of-network coverage
Skilled nursing facility	90% after deductible	70% of allowable charges, after deductible
	120-day limit per member per calendar year	
Surgical weight loss treatment Covered when criteria listed in the Premera Medical Policy on Surgery for Morbid Obesity are met	90% after deductible	70% of allowable charges, after deductible
Temporomandibular joint (TMJ) dysfunction	90% after deductible	70% of allowable charges, after deductible
Transplants	90% after deductible	70% of allowable charges, after deductible
Vision therapy	90% after deductible	70% of allowable charges, after deductible
	32-visit maximum, per member, for the duration of the member's continuous enrollment in one or more Premera-administered health plan options	

Specialized benefits		
Woodgrove Financial provides these unique benefits to you through the Hawaii-Only Plan.		
Benefit	In-network coverage	Out-of-network coverage
Autism/Applied Behavior Analysis (ABA) therapy	90% after deductible	90% of allowable charges, after deductible
Infertility	90% after deductible for coverage, within the Plan's infertility vendor (Progyny) provider network, of generally two Smart Cycles per household per Plan enrollment lifetime, and one additional Smart Cycle if neither of the first two results in a successful pregnancy	Not applicable
Gender Affirming services	90% after deductible	90% of allowable charges, after deductible

Weight Management program Including comprehensive and clinically based weight management programs approved by Premera for the treatment of obesity	80% of charges up to a \$6,000 maximum for the duration of your continuous enrollment in one or more Premera-administered health plan options Deductible and coinsurance maximum do not apply. The 20% coinsurance you pay will not count toward the deductible or coinsurance maximum and will continue after the deductible and coinsurance are met.	Not applicable
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Plan benefits



The following pages provide details on what the plan covers. The plan's [exclusions and limitations](#), including the requirement of medical necessity, apply to these benefits.

For information about how the novel coronavirus (COVID) is covered under this plan, see [Important information due to the coronavirus pandemic](#).

24-Hour Nurse Line

The Woodgrove Financial 24-Hour Nurse Line is a confidential health-care information service for you and your dependents. The Nurse Line is available 24 hours a day, seven days a week. It provides useful, easy-to-understand health-care information that will help you to make appropriate health-care decisions.

The 24-Hour Nurse Line cannot diagnose illnesses, prescribe treatment, or give medical advice, but they can do the following:

- Provide information, coaching, and support regarding a wide range of health issues, including:
 - Aches and pains
 - Diabetes
 - High blood pressure
 - Illnesses and infections
 - Infant care
 - Immunizations
- Provide information about Woodgrove Financial-sponsored health programs such as:
 - Disability leave
 - Ergonomic assistance
 - On-site flu shots
 - On-site mammogram screenings

- Smoking cessation
- Weight management
- Offer suggestions about appropriate next steps or available resources.

The average call to the 24-Hour Nurse Line lasts approximately five minutes, so that you can obtain information quickly and can move on to the next step, as advised by the 24-Hour Nurse Line nurse.

The 24-Hour Nurse Line is a service provided by Premera Blue Cross. All Woodgrove Financial covered employees and their dependents can access the 24-Hour Nurse Line.

Accessing the 24-Hour Nurse Line

The toll-free phone number for the 24-Hour Nurse Line is a consolidated phone line. From this one number, Woodgrove Financial covered employees and their dependents can access several health-care services, such as the 24-Hour Nurse Line staff of nurses, a professional counselor with the Woodgrove Financial Counseling, Assistance, Referral and Education Services (CARES) Employee Assistance Program and health-care coverage information. When you call, listen carefully to the entire greeting before you make your selection.



You can reach an experienced, registered nurse 24 hours a day, seven days a week by calling one of the following options:

- (800) 676-1411
- For deaf or hard-of-hearing access (TTY), call (800) 676-1411 then provide the number 711

Ambulance

Ground or Water:

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

Air:

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

This benefit covers licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat the condition when any other mode of transportation would endanger the member's health or safety. This benefit is limited to the member that requires transportation.

For air ambulance services, please see [Federal No Surprise Billing Protection](#) (above) for special rules that apply to out-of-network air ambulance services.

Autism/Applied Behavior Analysis (ABA) therapy

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

This benefit covers behavioral interventions based on the principles of Applied Behavioral Analysis (ABA) through eligible providers.

Who is eligible

This benefit is available for members who are diagnosed with Autism Spectrum Disorder (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition / DSM-5*), or with any of the following Pervasive Developmental Disorders (*International Classification of Diseases, 10th Revision, Clinical Modification / ICD- 10-CM*):

- Autistic Disorder
- Childhood Disintegrative Disorder
- Asperger's Syndrome
- Rett's Syndrome
- Other Pervasive Development Disorder/Atypical Autism
- Pervasive Developmental Disorder unspecified

Eligible providers

Licensed providers — Medical doctors (MD); doctors of osteopathic medicine (DO); nurse practitioners (NP, ANP, ARNP, etc.); and master's-level or above mental health clinicians and occupational, physical, and speech therapists; provided that they are providing the ABA services within the scope of their practice and licensure.

Board Certified Behavioral Analysts — BCBAs are certified by the Behavior Analyst Certification Board. These providers have master's or doctoral degrees. For ABA services, typically a BCBA functions as a "Program Manager." The Program Manager conducts behavioral assessments, including functional analyses, and provides behavior analytic interpretations of the results. The Program Manager also designs and periodically reviews behavior analytic interventions (program development and treatment planning) and may supervise Therapy Assistants. Therapy Assistant services must be billed by the Program Manager.

Covered services

Services must be ordered by the member's treating physician to be covered. Program Manager benefits are available for time used to evaluate the member and document findings and progress reports, and to create and update treatment plans; and time used to train and evaluate the work of the Therapy Assistants working directly with the member to implement the treatment plan.

In most cases, Therapy Assistants will provide the implementation portion of the treatment plan. Therapy Assistant time may be covered for face-to-face, in-person or virtual visits with the member to perform the tasks described in the treatment plan and to document outcomes, and for time to meet with the Program Manager for training and to discuss treatment plan issues. Therapy Assistant services that are billed by a Program Manager will be paid at the Therapy Assistant rate.

ABA services are not covered for the following:

- Babysitting or doing household chores
- Time spent under the care of any other professional

- Travel time
- Home schooling in academics or other academic tutoring

Out of network providers

You may be billed for charges assessed above the allowable charges since these providers have not agreed to offer discounts to members covered by this plan. Any amounts you pay for charges in excess of allowable charges, will not count towards satisfying any deductible requirements, or the coinsurance maximum that applies under this plan.



The **allowable charge** is defined differently for in-network and out-of-network providers. For in-network providers, the allowable charge is the negotiated amount that the provider has agreed to accept as payment in full for a covered service. For out-of-network providers, the allowable charge is the lowest of three amounts, as outlined in the definition of “allowable charge” in the Glossary. If you choose to use out-of-network providers, you may be responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges.

Additional exclusions and limitations for autism/ABA therapy

In addition to the plan’s [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- This benefit is not provided for rehabilitation services (which apply under the [rehabilitation](#) benefit) or mental health services (which apply under the [mental health and chemical dependency](#) benefit)
- Benefits for services provided by volunteers, childcare providers, family members and benefits paid for by state, local and Federal agencies will not be covered. Volunteer services or services provided by a family member of the child receiving the services by or through a school, books and other training aids will also not be covered.
- Other unspecified developmental disorders or delays, or any other delay or disorder in a child’s motor, speech, cognitive, or social development are not covered under this benefit
- This benefit covers only the allowable fees for eligible services performed by the provider and those providing interventions based on principles of ABA and/or related structured behavioral programs under the supervision of the provider. Other expenses associated with providing the treatment, such as the tuition, program fees, travel, meals, and lodging of the provider, expenses of those working under the provider’s supervision, the member, and their family members will not be covered.

Chemotherapy and Radiation Therapy

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers the following services:

- Outpatient chemotherapy and radiation therapy services, including proton beam radiation therapy when medically necessary
- Supplies, solutions and drugs (See the [Prescription Drugs](#) benefit for oral chemotherapy drugs)

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member’s plan has benefits available for the service being requested. This determination gives claimants an

opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before service is provided. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Childbirth / Maternity Classes

In-network: 100%

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers childbirth and pregnancy educational classes, including pre-pregnancy planning, pregnancy, childbirth and Lamaze, breastfeeding and infant education classes. The benefit is for covered employees and dependents only, although a spouse/domestic partner not covered on the medical plan can attend with the covered individual.

Additional exclusions and limitations for childbirth / maternity classes

In addition to the plan's [exclusions and limitations](#), exercise classes, such as maternity yoga, are excluded from this benefit.

Chiropractic services, acupuncture, and medical massage therapy

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

Limit: up to 24 visits per member per calendar year chiropractic, acupuncture, and medical massage therapy (combined)

This benefit (1) covers chiropractic service from a licensed chiropractor or other provider licensed to perform chiropractic services, (2) acupuncture services provided when medically necessary to relieve pain or to treat a covered illness, injury, or condition from a licensed acupuncturist or other provider licensed to perform acupuncture, and (3) medical massage therapy from a provider licensed to perform medical massage therapy, with a physician's prescription. To be covered, these services must be rendered to restore or improve a previously normal physical function and delivered within the provider's scope of practice guidelines.

These covered services must be medically necessary and will be covered only when the provider is providing the service within the scope of their state license.

These covered services (chiropractic services, acupuncture, medical massage therapy) will accrue cumulatively toward the 24-visit annual maximum. For example, if you visit a chiropractor for covered services 20 times in a calendar year, you will have four visits

available for covered medical massage and/or acupuncture services in that calendar year. Covered Massage Therapy services are limited to a maximum of one hour per day.

Clinical Trials

This plan covers the routine costs of a qualified clinical trial. Routine costs are the medically necessary care that is normally covered under this plan for a member who is not enrolled in a clinical trial. The trial must be appropriate for the health condition according to the trial protocol and participating provider or information submitted by the member, and the member must be enrolled in the trial at the time of treatment for which coverage is requested.

Benefits are based on the type of service received. For example, benefits for an office visit are covered under the Professional Visits and Services benefit and lab tests are covered under the Diagnostic Services benefit.

A qualified clinical trial is a phase I, II, III or IV clinical trial that is conducted on the prevention, detection or treatment of cancer or other life-threatening diseases or conditions. The trial must also be funded or approved by a federal body, such as the National Institutes of Health (NIH), the Centers for Disease Control and Prevention; the Agency for Health Care Research and Quality; the Centers for Medicare & Medicaid Services; a cooperative group or center of any of the above entities or the Department of Defense (DOD) or the Department of Veterans Affairs (VA); the VA, DOD, and Department of Energy if peer-reviewed and approved as per the Secretary of HHS; or a qualified private research entity that meets the standards for NIH support grant eligibility.

Routine patient costs in connection with a “clinical trial” does not include expenses for:

- Costs for treatment that are not primarily for the care of the patient (such as lab tests performed solely to collect data for the trial)
- The investigational item, device or service itself
- A service that is clearly not consistent with widely accepted and established standards of care for a particular condition

Those interested in this coverage are encouraged to contact customer service at 800-676-1411 before enrolling in a clinical trial. Customer service can help the member or provider verify that the clinical trial is a qualified clinical trial.

Contraception

In-network: 100%

Out-of-network: 100%

This benefit covers FDA-approved contraceptive devices and injections for contraceptive purposes for women when prescribed by a physician. Included are diaphragms, IUDs, and Depo Provera injections. Removal of contraceptive devices by a physician is also covered. This benefit also covers office visits and consultations related to contraception management.

All FDA-approved generic birth control medications are covered under the [prescription drug](#) benefit at 100%.

Dental services

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers certain services from a dental provider that would otherwise be covered by this plan if performed by a physician, as long as these services are provided within the scope of the dental provider's license.



Review the [Dental plan](#) section for information on your dental benefits.

Covered services

This benefit covers treatment of serious dental issues, such as a fractured jaw, excision of a tumor or cyst of the mouth, and incision or drainage of an abscess or cyst of the mouth, when not part of the dentition (gums, teeth, teeth supporting structure).

Hospital or outpatient facility fees and skilled observation for anesthesia administration related to dental treatments may be covered by the medical benefit when the following criteria are met.

Dental treatment in a hospital or outpatient facility is required because of any of the following:

- A physician has determined that the member's medical condition would place them at undue risk if the dental treatment were performed in a dental office. Some examples, though not all inclusive, are:
 - Cardiac conditions
 - Chronic respiratory disease, such as emphysema
 - Hemophilia or other blood disease
 - History of allergy to local anesthesia
 - Severe anemia
 - Severe hypertension
 - Uncontrolled diabetes
- The severity of the dental condition prevents treatment in the dental office setting.
- General anesthesia in a dental office, hospital or outpatient facility is required because of any of the following:
 - The member has a physical or mental disability and cannot be managed with local anesthesia, intravenous (IV) or non-intravenous conscious sedation.
 - The member has tried and failed other means of patient management (including premedication) in the office setting.
 - Other means of patient management are contraindicated for the member.

Orthodontia services may be eligible for payment under the medical plan for dependents born with cleft/lip palate or other severe craniofacial anomalies. To qualify for benefits the condition must meet medically necessary criteria in Premera's medical policy addressing orthodontia for repair of cleft palate and other severe congenital anomalies.

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time

of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Additional exclusions and limitations for dental services

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Services or supplies not medically necessary for diagnosis, care, or treatment of a disease, illness, or injury
- Dental care and services of a dentist, except as provided in the dental benefit. Hospital and physician services in support of all other dental care are covered only if the care meets two conditions: (1) adequate dental treatment cannot be rendered without the use of the hospital, and (2) the member has a health problem that makes it medically necessary to do the dental work at the hospital.
- Dental services for accidental injuries to the oral and maxillofacial region are covered only when the needed corrective dental repairs are certified in writing by the dental care provider as dentally necessary and are directly related to the accidental injury. Covered dental services include the repair or replacement of existing crowns, inlays, onlays, bridgework, and dentures. The treatment must be started within one year from the date of the accident.
- Benefits for services or supplies for treatment of temporomandibular joint (TMJ) dysfunction or myofascial pain dysfunction (MPD); benefits may be available under the Woodgrove Financial temporomandibular dysfunction benefit
- The medical plan does not cover any other preventive or restorative dental procedures, regardless of origin of condition

Diabetes

Diabetes health education

In-network: 100%

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers outpatient self-management training and education for diabetes, including medical nutritional therapy by a dietitian or nutritionist with expertise in diabetes.

Livongo Diabetes Management, Diabetes Prevention, and Hypertension Programs

In-network: 100%

Out-of-network: n/a

The Livongo for Diabetes Management, Diabetes Prevention, and Hypertension Programs provide monitoring and health management support to individuals within the programs. If you qualify and enroll in any of the programs, you will receive the following benefits:

Diabetes Management

For members 13 and older who have Type 1 or Type 2 diabetes. If you qualify and join the program, you will get:

- A blood glucose meter that uses cellular technology to automatically upload blood sugar readings to a personal online account.
- A lancing device and unlimited lancets at no cost to you.
- Unlimited test strips for this meter at no cost to you. You can reorder test strips using the meter or online. The strips will be sent to you directly.
- Real-time feedback and tips based on your blood sugar readings that can help keep your levels within a healthy range.
- Coaching and support via phone, text, e-mail, or the program manager's mobile app.

Diabetes Prevention

For members 18 and older who meet pre-diabetes criteria followed by the Centers for Disease Control. The program's duration is 12 months, with an additional 12 months of access for maintenance. If you qualify and join the program, you will get:

- A cellular-connected scale that uploads readings to a personal online account.
- Real-time tips and personalized feedback on health, nutrition or lifestyle changes to help you learn and improve.
- Unlimited coaching and support via phone, text, e-mail or the mobile app.
- Complete CDC-recognized weight management curriculum based on in-app content and online resources.
- Periodic review of plan, self-monitoring data, and feedback from expert coach.
- Experiential learning missions covering nutrition, activity, motivation, sleep, and stress management.
- A mobile app, and device for tracking weight, steps, and achievement of health goals for food and physical activity.

Hypertension

For members 18 and older who have hypertension. If you qualify and join the program, you will get:

- A cellular-enabled blood pressure cuff that uploads blood pressure readings to a personal online account.
- Real-time tips and personalized feedback based on your blood pressure readings that can help keep your pressure within a healthy range.
- Unlimited coaching and support via phone, text, e-mail, or the mobile app. Access to online information.

These programs are available to you and your eligible dependents who qualify. The full cost of these programs will be covered by the Plan. To learn more, see if you qualify and enroll, go to <https://go.livongo.com/Woodgrove Financial>, or call Premera customer service.

Diagnostic Services

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

Benefits are provided for diagnostic services (including lab and imaging services) for health conditions or symptoms. Included in the coverage are charges for the test or scan itself, and charges to interpret the results. Some examples of what's covered under this benefit are:

- Diagnostic imaging and scans (including x-ray, MRI, PET, CAT and EKGs)
- Services that are medically necessary to diagnose infertility
- Laboratory services
- Pathology tests

Diagnostic surgeries, including scope insertion procedures, can only be covered under the Surgical Services benefit.



Prior authorization is strongly recommended for some diagnostic services. Some examples of these include but are not limited to: Genetic Testing, CAT scan, and MRI. Have your provider contact Premera to see if your service needs this pre-service review.

Emergency room care and professional services

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

This benefit covers hospital emergency room and provider charges for an emergent condition—regardless of the network status—including related services and supplies, such as diagnostic imaging (including X-ray) and laboratory services, and surgical dressings and drugs furnished by and used while at the hospital.

Following discharge from the emergency room or hospital, eligible services will be paid based on the contracting status of the provider.

Regardless of network status, after being treated in the emergency department for an emergent condition and admitted to a hospital inpatient care (as defined by the [hospital inpatient care](#) benefit), along with provider charges, will be covered at the in-network level.

For emergency substance abuse treatment, see the [mental health and chemical dependency](#) benefit. Please see the [Federal No Surprise Billing Protection](#) section for more information about certain legal protections when you receive emergency services provided by an out-of-network provider.

Hearing care and hardware

Hearing exams and testing

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers one routine hearing examination and one routine hearing test (or screening) per member each calendar year.

Hearing exam services include:

- Examination of the inner ear and exterior of the ear
- Observation and evaluation of hearing, such as whispered voice and tuning fork
- Case history and recommendations
- The use of calibrated equipment

Hearing hardware

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

Limit: up to \$10,000 maximum, per member, every three consecutive (rolling calendar) years of continuous enrollment in a Premera-administered health plan option

This benefit covers one FDA approved hearing hardware (either an over-the-counter or prescribed hearing aid) up to a maximum benefit of \$10,000 per member in a period of three consecutive calendar years.

Before obtaining a prescribed hearing aid, you must be examined by a licensed physician (M.D. or D.O.) or audiologist (CCC-A or CCC-MSPA).

Benefits cover the following:

- The hearing aid(s) (monaural or binaural) prescribed as a result of an exam or an FDA approved over-the-counter hearing aid(s) (monaural or binuarl)
- Ear mold(s)
- Hearing aid rental while the primary unit is being repaired
- The initial batteries, cords, and other necessary ancillary equipment
- A follow-up consultation within 30 days following delivery of the prescribed hearing aid with either the prescribing physician or audiologist
- Repairs, servicing, and alteration of hearing aid equipment

Additional exclusions and limitations for hearing care and hardware

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Hearing aids purchased before your effective date of coverage under this plan
- A prescription or over-the-counter hearing aid, for any reason, more often than once in a period of three consecutive calendar years during which you are continuously enrolled in a Premera-administered health plan option
- Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid
- A prescription hearing aid that exceeds the specifications prescribed for correction of hearing loss
- Expenses incurred after your coverage ends under this plan unless a prescribed hearing aid was ordered before that date and was delivered within 90 days after the date your coverage ended
- Charges in excess of this benefit; these expenses are also not eligible for coverage under other benefits of this plan

Home health care and Nursing care

In-home care, other than Hospice Care and Respite Care (non-hospice), can be broken into two categories for purposes of benefit coverage:

Benefit	Description	Care Duration	Coverage
Home health care	Short-duration, intermittent care to complete specific tasks by a registered	The length of home health care visits varies depending	In-network: 90%, deductible applies

Benefit	Description	Care Duration	Coverage
	nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, social worker (MSW) working for home health agency, or a certified respiratory therapist.	on the tasks to be accomplished, but typically these visits last up to 2 hours.	Out-of-network: 70% of allowable charges, deductible applies
Nursing care	Longer-duration, skilled hourly nursing care in the home by a registered nurse (RN) or licensed practical nurse (LPN).	Generally needed for more than 4 hours per day.	In-network: 90%, deductible applies Out-of-network: 90%, deductible applies

Read below for additional in-home care coverage details.

Home health care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers home visits for short-duration, intermittent care to complete specific tasks by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, social worker (MSW) working for home health agency, or a certified respiratory therapist. The length of home health care visits varies depending on the tasks to be accomplished, but typically these visits last up to 2 hours. The benefit includes the cost of a home health aide when acting under the direct supervision of one of the before-mentioned therapists and while performing services specifically ordered by the doctor in the treatment plan. The benefit also includes disposable medical supplies and eligible medication prescribed by a physician when provided by the home health care agency.



Intermittent care is care provided due to the medically predictable recurring need for skilled home health care services.

Home health care services provided and billed by a Medicare-approved or state-licensed home health care agency for treatment of an illness or injury are covered. The services must be part of a formal written treatment plan prescribed by your doctor.

One postpartum home health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center will be eligible for coverage.

Additional exclusions and limitations for home health care

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services
- Materials such as handrails and ramps
- Services performed by family members and volunteer workers

- Psychiatric care
- Unnecessary and inappropriate services
- Maintenance or [custodial care](#)
- Diversional therapy
- Services or supplies not included in the written treatment plan
- Over-the-counter drugs, solutions, and nutritional supplements
- Dietary assistance, such as Meals on Wheels
- Services provided to someone other than the ill or injured enrollee

Nursing care

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

This benefit covers longer-duration, skilled hourly nursing care in the home by a registered nurse (RN) or licensed practical nurse (LPN) working under a licensed home health agency. Skilled hourly nursing care is provided in lieu of hospitalization and generally is needed for more than 4 hours per day. The nurse who is providing the care cannot be a permanent resident in the member's home.



Skilled nursing care is provided by a registered nurse (RN) or licensed practical nurse (LPN) and the care must require the technical proficiency, scientific skills, and knowledge of an RN or LPN. The need for skilled nursing is determined by the condition of the patient, the nature of the services required, and the complexity or technical aspects of the services provided. Nursing care is not skilled simply because an RN or LPN delivers it or because a physician orders it.

Prior authorization

A prior authorization, also referred to as a pre-service review, is strongly recommended for nursing care to determine if coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Hospice care

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

The hospice care benefit allows a terminally ill member to remain at home or to use the services of a hospice center instead of using hospital inpatient services. The plan covers services provided through a state-licensed hospice or other hospice program that meets the standards of the National Hospice and

Palliative Care Organization. The services must be part of a written treatment plan prescribed by a licensed physician.

This benefit covers visits for intermittent care by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, a certified respiratory therapist or a Master of Social Work. Also included is the cost of a home health aide who acts under the direct supervision of one of the before-mentioned therapists and who is performing services specifically ordered by the member's doctor in the treatment plan. The benefit also includes disposable medical supplies and medications prescribed by the physician, and the rental of durable medical equipment.

In addition, the hospice care benefit covers care in a hospice, and up to 672 hours of respite care for each six-month period of hospice care. The respite care provision allows family members of the terminally ill patient an opportunity to recover from the emotionally and physically demanding tasks of caring for the patient.



Hospice care is a coordinated program of palliative and supportive care for dying members by an interdisciplinary team of professionals and volunteers centering primarily in the member's home.

Intermittent care is care provided due to the medically predictable recurring need for skilled home health care services.

Respite care is continuing to provide care in the temporary absence of the member's primary caregiver or caregivers.

Additional exclusions and limitations for hospice care

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Bereavement or pastoral counseling
- Financial or legal counseling, including real-estate planning or drafting of a will
- Funeral arrangements
- Diversional therapy
- Services that are not related solely to the member, such as transportation, house cleaning, or sitter services

Hospital inpatient care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers the following inpatient medical and surgical services:

- Room and board, including general duty nursing and special diets
- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment, and oxygen
- Diagnostic and therapeutic services
- Blood, blood derivatives, and their administration

Regardless of network status, after being treated in the emergency department for an emergent condition and admitted to a hospital, inpatient care (as defined by the hospital inpatient care benefit), along with provider charges for that emergent condition, will be covered at the in-network level.

Please see [the Federal No Surprise Billing Protection](#) section for more information about certain legal protections when you receive emergency and non-emergency services provided by an out-of-network provider.

For substance abuse treatment, see the [mental health and chemical dependency](#) benefit.

Additional exclusions and limitations for hospital inpatient care

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Hospital admissions for diagnostic purposes only, unless the services cannot be provided without the use of inpatient hospital facilities, or unless the member's medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay required to treat the member's condition

Hospital outpatient care and ambulatory surgical center care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers operating, procedure, and recovery rooms; plus, services and supplies, such as diagnostic imaging (including X-ray) and laboratory services, X-ray and radium therapy, anesthesia and its administration, surgical dressings and drugs, furnished by and used while at the hospital or ambulatory surgical center.

Please see [the Federal No Surprise Billing Protection](#) section for more information about certain legal protections when you receive emergency and non-emergency services provided by an out-of-network provider.

Infertility

In-network: 90% after deductible for coverage, within the Plan's infertility vendor (Progyny) provider network Out-of-network: not applicable

Limit: Up to two Smart Cycles per household for the duration of your continuous enrollment in one or more Premera-administered health plan options, and one additional Smart Cycle if neither of the first two results in a successful pregnancy, subject to certain restrictions described below



Members must contact their **Progyny Patient Care Advocate** at (888) 203-5066 to confirm eligibility and utilize a Progyny Network Provider to access the benefit.

This benefit covers services to assist in achieving a pregnancy for Woodgrove Financial employees and their enrolled spouse/domestic partner regardless of reason or origin of condition.

The Progyny SMART cycle benefit allows for:

- Two (2) Smart Cycles per household, with an additional Smart Cycle available if the first two do not result in a successful pregnancy, for the duration of your continuous enrollment in one or more Premera-administered health plan options, subject to the restrictions described below for certain

members who received infertility benefits of less than \$15,000 under the Health Savings Plan prior to 2018. Coverage is subject to all applicable plan copay, coinsurance, and deductible requirements.

- One (1) Smart Cycle per household, with an additional Smart Cycle available if the first does not result in a successful pregnancy, for the duration of your continuous enrollment in one or more Premera-administered health plan options, for members who (1) have been enrolled continuously in one or more Premera-administered health plan options (such as the Health Savings Plan) since before 2018, and (2) incurred \$15,000 or more in infertility benefits under the Plan during such continuous enrollment period prior to 2018. Coverage is subject to all applicable plan copay, coinsurance, and deductible requirements.

The Progyny SMART cycle benefit may be used to receive full coverage for the following treatments and procedures:

- Two consultations per calendar year
- Diagnostic testing
- Transvaginal ultrasounds
- Intrauterine insemination (also known as artificial insemination)
- In vitro fertilization (IVF)
- Gamete intra-fallopian transplant (GIFT)
- Intracytoplasmic sperm injection (ICSI)
- Pre-implantation genetic screening (PGS)
- Pre-implantation genetic diagnosis (PGD)
- Embryo assessment and transfer
- Services used to preserve fertility such as cryopreservation of eggs, sperm and/or embryos. This includes oncofertility preservation.
- Up to four years of storage (egg, embryo, sperm) with annual renewal and eligibility verification
- Purchase of donor tissue (sperm, eggs) as follows:
 - Previously frozen donor sperm or donor oocytes (eggs) from a donor agency intended for the use and transfer into a covered female member (one egg cohort purchase constitutes one SMART Cycle, and one donor sperm purchase constitutes $\frac{1}{4}$ SMART Cycle). You will be required to pay for the donor sperm or oocytes out of pocket and submit the eligible charges, with appropriate supporting documentation, to Progyny for reimbursement.
 - A fresh donor recipient cycle, whereby the egg donor undergoes an egg retrieval procedure at an in-network Progyny provider to allow for a fresh embryo transfer into a covered female member (one fresh donor recipient cycle constitutes one SMART Cycle). The treatment must occur at an in-network Progyny provider, or else you may be required to pay all expenses up front, out of pocket. If an in-network provider is not contracted for the fresh donor recipient cycle, Progyny will pursue a special case agreement. If a special case agreement request is denied, you will pay for the donor services out of pocket but may submit eligible charges, with appropriate supporting documentation, to Progyny for reimbursement.

Medication prescribed for fertility treatment will be fulfilled by a Progyny Rx specialty pharmacy and delivered next day to ensure accurate timing with treatment. All

medications, compounds, ancillary medication and equipment required for treatment are included in the shipment of medications. Progyny Rx coverage also includes the UnPack It Call where a trained pharmacy clinician will explain drug administration and storage guidelines.

Additional exclusions and limitations for infertility

The following exclusions apply to this benefit:

- Fees paid to donors for their participation in any service
- Testing and treatment for potential surrogates that would not otherwise be covered for a member enrolled in the Plan
- Home ovulation prediction kits
- Services and supplies furnished for a dependent child (under age 26), except for oncofertility preservation due to cancer or medical treatments
- Services and supplies furnished by a provider outside the Progyny network, except as otherwise provided
- Fertility Services following a voluntary sterilization procedure

Maternity care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers maternity benefits provided for you, your enrolled spouse/domestic partner, and your eligible dependent children. Benefits are for maternity care in a hospital, alternative birthing center, or at home, including:

- Prenatal testing when required to diagnose conditions of the unborn child
- Normal deliveries and cesarean sections
- Services of a licensed nurse or midwife (non-medical services, such as non-medical services performed by a doula are not covered)
- Miscarriages and terminations of pregnancy
- Hospital nursery care for benefits-eligible infant while the mother is hospitalized and receiving benefits; services are covered under the hospital services benefit
- Male circumcision by a physician or mohel for a benefits-eligible dependent; services are covered under the physician services benefit
- One postpartum home health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center
- Home births include an allowance of up to \$500 for eligible supplies and/or equipment used for home delivery; for example, birthing packs, birthing tubs, monitoring devices, local anesthetics, and comfort aids. Services for the newborn including hospital services and professional services are covered under the hospital services and physician services benefit.

The [home health care](#) benefit covers one postpartum health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center.

Medical equipment and supplies (durable medical supplies)

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

Covered services

This benefit covers charges for durable medical and surgical equipment and supplies, (DME). Benefits cover rental or purchase (including shipping and handling fees) of DME for treatment of an injury, illness, disease, or medical condition. Rental equipment will not be reimbursed above the purchase price of the equipment. The Plan reserves the right to require a period of rental prior to covering the purchase of equipment. Benefits for DME purchases will be reduced by any prior Plan benefits for renting the same equipment, unless (and to the extent that) the Plan required such prior rental.

Allowed charges to repair or replace covered items are also covered due to a change in the injury, illness, disease, or medical condition, the growth of a child, or when worn out by normal use. Replacement is covered only if needed due to a change in the member's physical condition or if it is less costly to replace than to repair existing equipment or to rent similar equipment.

No more than one item of DME per year will be covered for the same or similar purpose, and in order to be covered the equipment and accessories to operate it must be:

- Made to withstand prolonged use
- Made for and mainly used in the treatment of an injury, illness, disease, or medical condition
- Suited for use in the home

This list of covered DME includes, but is not limited to:

- Braces
- Crutches
- Wheelchairs
- Prostheses
- Cochlear Implants and associated supplies
- Foot orthotics (custom fitted shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses, when prescribed by a physician for the condition of diabetes or for corrective purposes

- Wigs (up to \$2,000 per calendar year for alopecia caused by medical conditions or treatment for diseases)
- You may purchase one over-the-counter breast pump or rent a hospital grade breast pump during a calendar year (one or the other, but not both). The pump must be for your own use. Replacement supplies may be purchased on an as needed basis. In-network purchase/rental for the pump and replacement supplies is covered at 100%. Out-of-network purchase/rental for the pump and replacement supplies is covered at 100% of allowable charge. Deductible does not apply. Batteries are not covered.
- Continuous glucose monitors and their supplies are covered at 100% of allowable charges. Deductible does not apply.

Vision hardware may be covered under the medical plan for certain medical conditions of the eye, including, but not limited to:

- Corneal ulcer/abrasion
- Bullous keratopathy
- Recurrent erosion of cornea
- Keratoconus
- Tear film insufficiency (dry-eye syndrome)
- Cataract surgery

Additional exclusions and limitations for medical equipment and supplies (durable medical supplies)

In addition to the plan's [exclusions and limitations](#), the following DME and supplies will not be covered by this plan when they are:

- Normally of use to persons who do not have an injury, illness, disease, or medical condition
- For use in altering air quality or temperature
- For exercise, training and use during participation in sports, recreation, or similar activities
- Equipment, such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, overbed tables, elevators, vision aids, and telephone alert systems
- Special or extra-cost convenience items and/or features
- Structural modifications to your home and/or private vehicle
- Replacement of lost or stolen equipment or supplies
- Blood pressure cuffs or monitors (even if prescribed by a physician), unless otherwise provided in this SPD

Medical Foods

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This plan covers medically necessary medical foods used to supplement or replace a member's diet in order to treat inborn errors of metabolism. An example is phenylketonuria (PKU). Coverage includes medically necessary enteral formula prescribed by a physician or other provider to treat eosinophilic gastrointestinal associated disorder or other severe malabsorption disorder. Benefits are provided for all delivery methods.

Medical foods are formulated to be consumed or administered enterally under strict medical supervision. These foods generally provide most of a person's nutrition. Medical foods are designed to treat a specific problem that can be diagnosed by medical tests.

This benefit does not cover other oral nutrition or supplements not used to treat inborn errors of metabolism, even if a physician prescribes them. This includes specialized infant formulas and lactose-free foods.

Mental health counseling, mental health inpatient and outpatient services, Attention Deficit Disorder, and chemical dependency treatment

Inpatient and Outpatient:

- 100%, up to calendar year short-term counseling limits through Spring Health, administrator of the employee assistance program
- *In-network: 90%, deductible applies*
- *Out-of-network: 90% of allowable charges, deductible applies*

This benefit covers medically necessary treatment for:

- mental health conditions such as, but not limited to the diagnosis and treatment stress, anxiety, or depression, or other psychiatric disorders, eating disorders, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD)
- chemical dependency such as substance use disorder and alcohol use disorder

To be covered, services must be furnished by an eligible provider.

All mental health and chemical dependency treatment must be medically necessary to be eligible for coverage.

Type of care

You will be covered as follows

Short-term counseling employee assistance program (EAP) as administered by Spring Health	No deductible applies 100% of 24 sessions per person per calendar year A visit includes each attendance of the provider to the member, regardless of the type of professional services rendered, and whether it might otherwise be termed consultation, treatment, or described in some other manner. For benefit calculation purposes, a typical mental health visit is considered one hour.
Inpatient and Outpatient benefits	In-network: 90%, deductible applies; out-of-network: 90% of allowable charges, deductible applies

Eligible providers

Eligible providers include:

- A facility licensed as a hospital or community mental health agency to provide mental health and/or substance abuse services
- A physician, psychiatrist, psychologist, or psychiatric nurse practitioner licensed to provide mental health or substance abuse services
- A master's level mental health provider licensed, registered, or certified as legally required to provide mental health services
- Any other provider or facility who is licensed or certified by the state in which the care is rendered and who is providing care within the scope of their license or certification

Prior authorization

A prior authorization, also referred to as a pre-service review, is strongly recommended for inpatient care and residential treatment centers to determine coverage is available before the service occurs. When an emergency admission occurs, notification to Premera within two days is also recommended. Either the member or the provider may contact Premera for a prior authorization.



A **prior authorization** is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time

of service.

The prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Additional exclusions and limitations for mental health and chemical dependency

In addition to the plan's **exclusions and limitations**, the following exclusions and limitations apply to this benefit:

- Testing must be ordered by a physician for the purpose of diagnosing or medical management
- Smoking cessation programs or materials; (Woodgrove Financial provides a separate Smoking Cessation Program. Prescription drugs for smoking cessation are covered under the prescription drug benefit.)
- Services and supplies that are court-ordered, or are related to deferred prosecution, deferred or suspended sentencing, or driving rights, if those services are not deemed medically necessary

- Educational or recreational therapy or programs; this includes, but is not limited to, boarding schools. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider, provided that educational or recreational therapy or programs, themselves, are not eligible providers for this purpose.

Nutritional therapy

In-network: 100%

Out-of-network: 70% of allowable charges, deductible applies

Limit: First 12 visits per member per calendar year

After 12 visits (in the same calendar year) benefit coverage is reduced to:

In-network: 90%, deductible applies

Out-of-network 70% of allowable, deductible applies

This benefit covers outpatient nutritional therapy visits with a dietitian, nutritional therapist or certified lactation consultant to manage a covered condition, illness or injury.

Illnesses or conditions that would be eligible for this benefit include, but are not limited to:

- Hypertension
- Cardiac problems
- Feeding difficulties
- Gastric reflux disease

Nutritional therapy visits received in connection with a diagnosed eating disorder or diabetes is unlimited and will be covered at 100% of allowable charges.

Onsite Mammography Screening

Woodgrove Financial offers access to an onsite mammography screening in select Woodgrove Financial locations to employees and their spouse/domestic partners enrolled in a Woodgrove Financial Health Plan. The onsite mammography screening provides a multiple-view screening exam. At the discretion of the technologist performing the mammogram, additional views may be necessary to clarify imaging issues for the radiologist.

The onsite mammography screening program includes the onsite preventive screening mammogram exam only. Any additional or follow-up imaging or other services needed are considered diagnostic and will be covered as outlined in the diagnostic services benefit.

An onsite mammogram is not recommended if you have implants, a breast problem, are pregnant, or are breastfeeding. In those cases, you should consult with your doctor about obtaining an exam at an offsite breast center or other health care facility. Such an offsite exam would not be covered by the onsite mammography screening program but may be covered by the Plan's preventive or diagnostic services coverage, as applicable. As the onsite mammogram is a screening exam, the vendor is not able to provide imaging for a breast problem such as a lump. If you have questions about mammogram screenings, talk with your primary care physician.

Who Provides the Mammograms?

In the Puget Sound area of Washington state, Mammograms are provided by Swedish Mobile Mammography Services (operated by Swedish Health Services). The mammography technologists are registered by the American Registry of Radiologic Technology, have advanced credentials in mammography, and are certified by the State of Washington. The interpreting physicians are employed by Radia, are board certified by the American College of Radiology, and specialize in breast imaging.

In other areas, Woodgrove Financial partners with local vendors who specialize in onsite mammography and have the appropriate equipment and licensure. To provide services onsite, there must be sufficient demand to fill a day of appointments and a local vendor who is qualified to provide the services. Onsite mammography events will be advertised for any locations where they are available.

When Do the Screenings Occur?

Periodically each year, usually during

the fall. **Eligibility**

US benefits-eligible employees and their spouse/domestic partner age 35 and over, who are enrolled in

medical coverage under the Plan, are eligible to participate in onsite mammography screenings.

You are eligible to participate in the onsite screening even if you have had a routine mammogram in the past 12 months. However, you should talk with your primary care provider to determine the benefits and risks of having a second mammogram within a 12-month period. If you suspect you have a breast problem, such as a lump, you should see your primary care provider.

Women under the age of 35 are ineligible, unless they have written permission from their physician.



At some locations, women under age 35 will not be allowed to participate, even with written permission from their physician.

Dependent children (regardless of age), agency temporaries/external staff, international based employees, and any individuals who are not enrolled in medical coverage under the Plan are not eligible to participate.

Physician services

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers:

- Medical and surgical services of a physician
- Urgent care visits at an urgent care facility
- Care via online and telephonic methods when medically appropriate:
 - Benefits for telemedicine are subject to standard office visit cost-shares and other provisions as stated in this booklet. Services must be medically necessary to treat a covered illness, injury or condition.
 - Coverage for psychiatric conditions is medically appropriate for crisis and emergency evaluations or when the member is temporarily confined to bed for medical reasons only
- Biofeedback services for any condition covered by the medical benefit when provided by an eligible provider



An **Urgent care** visit is billed and covered at the same rate as an office visit with your regular physician and is a cost-effective option when you have an urgent need for care. Urgent care is the best option for treatment of a sudden illness, injury or condition that:

Requires prompt medical attention to avoid serious deterioration of the member's health Does not require the level of care provided in the emergency room or a hospital

Cannot be postponed until the member's physician is available

A **Physician** is a state licensed:

Doctor of Medicine and Surgery (M.D.)

Doctor of Osteopathy (D.O.)

In addition, professional services provided by one of the following types of providers will be treated as physician services under this plan to the extent the provider is providing a service that is within the scope of their state license and providing service for which benefits are specified in this SPD and would be payable if the service were provided by a physician as defined above:

Chiropractor (D.C.)

Dentist (D.D.S. or D.M.D.)

Optometrist (O.D.)

Podiatrist (D.P.M.)

Psychologist (Ph.D.)

Advanced Registered Nurse Practitioner (A.R.N.P.)

Nurse (R.N.)

Naturopathic physician (N.D.)

Plastic and reconstructive surgery

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers services, supplies, and procedures for plastic or reconstructive surgery purposes, along with complications of these services, supplies, or procedures, for the following:

- Repair of a defect that is the direct result of an accidental injury, providing such repair is started within 12 months of the date of the accident
- Treatment for a congenital anomaly of a child
- Treatment of visible birth marks of a covered child
- All stages of reconstruction of the involved breast following a mastectomy, and surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Correction of physical functional disorders. Benefits may include, but are not limited to, blepharoplasty or breast reduction.

The treatment plan for any of the above conditions must be prescribed by a physician.



A **congenital anomaly** is a marked difference from the normal structure of a body part that is physically evident from birth.

A **physical functional disorder** is a limitation from normal (or baseline level) of physical functioning that may include, but is not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts or obstruction of an orifice. The physical functional impairment can be due to structure, congenital deformity, pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairment or potential

impairment.

Prescription drugs

In-network: 90%, deductible applies, up to limits provided below

Out-of-network: 90%, deductible applies, up to limits provided below

This benefit covers most FDA-approved, medically necessary prescription drugs, when prescribed for the member's use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also included in this benefit are injectable supplies.

Certain single-source brand and generic preventive drugs will be covered at 100% under the preventive care benefit and are not subject to the deductible. Brand-name preventive medications with an available generic equivalent will not be covered by the preventive care benefit. Review the preventive care benefit for more information.

Generic drug substitution

This plan encourages the use of appropriate generic drugs (as defined below). When available and indicated by the prescriber, a generic equivalent drug will be dispensed in place of a brand name drug. If your prescriber indicates that substituting a generic equivalent for the brand name drug is inappropriate, you'll be charged only the brand name cost share (as applicable). However, if the prescriber does not indicate that substituting a generic equivalent drug is inappropriate, and you request the brand name drug anyway, you'll be charged the difference in price between the brand name drug and the generic equivalent along with the applicable brand name cost-share. Note: The difference in price between the brand name drug and the generic equivalent will not apply to your deductible and/or coinsurance maximum. Even if you reach your deductible or coinsurance maximum, you will still be responsible for the full amount of the difference in price between the brand name drug and the generic equivalent.



A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.

Brand-name prescriptions are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.

Generic drugs are equivalent to brand-name drugs but available at a lower cost than brand-name prescriptions because the patent has expired.

Prescription limits

	Retail pharmacy	Home delivery	Specialty pharmacy
Coverage	Up to a 90-day supply for generic maintenance medication; all others are up to a 30-day supply*	Up to 90-day supply* only when using Express Scripts Pharmacy Home Delivery	Up to a 30-day supply* Additional clinical support for members using specialty drugs
In-network pharmacies	Express scripts pharmacies bill the plan on your behalf To find an Express Scripts retail pharmacy, call the Premera customer service team at (800) 676-1411	Express scripts pharmacies bill the plan on your behalf	AllianceRx Walgreens Pharmacy or Accredo Specialty Pharmacy** will bill the plan on your behalf
Out-of-network pharmacies	You will need to submit a prescription reimbursement form, with your receipt, for reimbursement	Not covered	Not covered

* Unless the drug maker's packaging limits the supply in some other way.

** Contact AllianceRx Walgreens Pharmacy at (877) 223-6447 or Accredo Specialty Pharmacy at (800) 689-6592 to get started.

The dispensing limits (or days' supply) for drugs dispensed at retail and specialty pharmacies, and through the mail-order pharmacy benefit, are described in the above chart.

Refills for a medication will be covered only when the member has used 75% of the supply of that medication, based on both of the following:

- The number of units and days' supply dispensed on the last fill or refill, and
- The total units or days' supply dispensed for the same medication in the 180 days immediately before the last refill, if applicable



Generic maintenance medications have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year.

Specialty drugs are high-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply.



Premera provides a customer service team dedicated to Woodgrove Financial employees and their dependents. You can use this service by calling (800) 676-1411 with questions regarding:

- Status of mail order prescriptions
- Plan design, including which medications are covered or not covered
- Location of retail pharmacies

Covered drugs

This benefit covers the following FDA-approved items when dispensed by a licensed pharmacy for use outside of a medical facility. Certain drugs may need a prior authorization:

- Prescription drugs (Federal Legend Drugs as prescribed by a licensed provider). This benefit includes coverage for off-label use of FDA-approved drugs as provided under this plan's definition of prescription drug.
- Compounded medications are covered when the main ingredient is a covered prescription drug. Benefits are subject to standard supply limit.
- Inhalation spacer devices and peak flow meters
- Glucagon and allergy emergency kits
- Prescribed injectable medications for self-administration (such as insulin)
- Hypodermic needles, syringes, and alcohol swabs used for self-administered injectable prescription medications
- Disposable diabetic testing supplies, including test strips, testing agents, and lancets
- Prescription contraceptive drugs and devices (for example, oral drugs, diaphragms, and cervical caps)
- Human growth hormone
- Prescription drugs for smoking cessation
- Birth control medications
- Immunization agents and vaccines
- Impotence medications are limited to 15 pills at retail per 30 days: 45 pills at mail-order per 90 days.

Prior authorization

Prior authorization, also referred to as a pre-service review, is **required** to determine if coverage for a certain prescription drug is available before the prescription can be filled.

To determine if prior authorization is required for a particular drug, refer to the [formulary drug list](#), or either the member or the provider may contact Premera.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service provided. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

In order for certain types of drugs to be covered, information from your doctor must be submitted that identifies the disease being treated and explains the role of the drug in the treatment plan to establish its medical necessity. If that information is made available prior

to the prescription being filled, and it is determined that the drug is medically necessary, the prescription will be covered as described above. If information for a drug in this category is not provided, you may pay for the prescription to be filled and submit the claim for consideration along with the clinical information. If it is determined that you do not meet medical necessity criteria needed for the drug to be eligible, you will not be reimbursed for the cost of the drug.

Benefits for some prescription drugs may be limited to one or more of the following:

- A set number of days' supply
- A specific drug or drug dose that is appropriate for a normal course of treatment
- A specific diagnosis
- Be under the care of an appropriate medical specialist
- Trying a generic drug or a specified brand name drug first

In making these determinations, Premera takes into consideration clinically evidence-based medical necessity criteria, recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration guidelines, published medical literature and standard reference compendia.



For questions about your pharmacy benefits or quantity limits, contact Premera Customer Service at (800) 676-1411.

The table below provides information on how to submit information for a medical necessity review.

Drug	Information
Certain drugs require prior authorization. Examples include but are not limited to: rheumatoid arthritis, certain cancer treatment drugs, growth hormones, anti-depressants, corticosteroid nasal sprays, diabetes, migraine therapy, multiple sclerosis, sleeping disorders, weight loss drugs, and compound medications.	<p>Have your provider call (888) 261-1756 to start or update the benefit review process for these or other drugs needing clinical review.</p> <p>If you would like to find out if your drug requires review, refer to the formulary drug list or call Premera Customer Services at (800) 676-1411.</p>



Categories of drugs on this list may be added or deleted from time to time, based on factors including FDA-approval status, medical necessity, member safety, and best practices. If you have paid for a prescription of a drug in this category, you may appeal any denial of benefits for that drug through the appeals process.

Drug-usage patterns

The Plan may be provided with information from a variety of sources regarding drug-usage patterns of individual members that merit further investigation. If the conclusion of the investigation is that the drug-usage patterns are not consistent with generally accepted standards of practice, the Plan may choose to restrict access to the benefit to one

prescribing physician for those members. If this action is taken, the member will be notified in advance.

Your 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 drugs are covered under this Plan and what coverage limitations are in your contract.



If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, call the Premera customer service team at (800) 676-1411.

If you have a concern about the pharmacists or pharmacies serving you, call your State Department of Health.

Additional exclusions and limitations for prescription drugs

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Drugs and medications not approved by the Food and Drug Administration (FDA) except as defined in the Experimental and Investigational section
- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. These may include, but are not limited to, nonprescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines, and nutritional and dietary supplements (for example, infant formulas or protein supplements). This exclusion does not apply to emergency contraceptive methods (such as "Plan B"), aspirin for women and men, folic acid for women and iron supplements.
- Over-the-counter contraceptives, supplies and devices (except as required by law)
- Drugs for the purpose of cosmetic use (for example, promote or stimulate hair growth, stop hair loss, or prevent wrinkles)
- Growth hormone for the diagnosis of idiopathic short stature (ISS), familial short stature (FSS), or constitutional short stature (CSS)
- Drugs for experimental or investigational use
- Any prescription refilled too soon or in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order
- Replacement of lost or stolen medication
- Devices and appliances, support garments, and non-medical supplies
- This plan does not cover the cost of drugs that are reimbursed under another plan or another portion of your Woodgrove Financial coverage (for example, drugs administered while hospitalized)
- Charges for prescription drugs when obtained through an unauthorized pharmacy or provider when a restriction of the prescription drug benefit is in place
- Shipping and handling charges for prescriptions drugs are not covered.

Preventive care

Preventive services:

- *In-network: 100%*
- *Out-of-network: 70% of allowable charges, deductible applies; well-child care through age 6 is covered at 100%*

This benefit covers routine exams, immunizations and health screenings, such as:

- Routine physicals for women and men
- Women's preventive care including a gynecological exam, routine pap smear (cervical cancer screening) and routine mammogram (breast cancer screening)

- Well-child exams, including physical exams, tests, and immunizations, through age 11 and annual physical exams for age 12 through 18
- Hearing screening for children through age 18
- Routine eye exams
- Flu shots
- Colorectal cancer screening
- Prostate cancer screening
- Lung cancer screening
- Immunizations, which need not be done at the same time as the routine exam

For individuals with known risk factors, such as family history of a disease with known hereditary links, the limits in the recommended guidelines for preventive screenings may not be applicable.

Preventive prescription drugs:

- *In-network: 100%*
- *Out-of-network: 100%*

This benefit covers certain single-source brand and generic prescriptions to prevent the onset of disease by a person who has risk factors for a particular condition, or those taken to prevent a recurrence of a disease. Covered preventive prescription drugs include drugs for the treatment of high cholesterol with cholesterol-lowering medications to prevent heart disease, or the treatment of recovered heart attack or stroke victims with ACE inhibitor medications to prevent a recurrence. This benefit also covers certain supplies such as hypodermic needles, test strips and glucose monitors.



For a complete list of what is considered preventive care and paid 100% by the plan, see the [Preventive Care Services list](#) and the [Preventive Drug list](#), or contact Premera Customer Service at (800) 676-1411. For information on how to fill your prescription, see the [prescription drug](#) section.

Rehabilitation

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers physical therapy, functional occupational therapy, and speech therapy services to:

- Restore and improve a bodily or cognitive function that was previously normal but was lost after an accidental injury or illness
- Treat disorders or delays in the development of language, cognitive, or motor skills

Inpatient services are covered when services cannot be rendered in any other setting (see inpatient benefits). Outpatient services are limited to a maximum of one hour of each specialty (physical therapy, occupational therapy and speech therapy) per day.

Physical therapy, functional occupational therapy, and speech therapy, including cardiac rehabilitation, are covered when rendered by a physician or by a licensed or registered physical or occupational therapist or a certified speech therapist that is licensed or registered as required as such by the state in which they practice, subject to the Plan's review and approval of your treatment plan for physical therapy and functional occupational therapy services. Premera or its designee may review a member's treatment plan

for the purpose of verifying that the treatment is clinically safe, effective, and appropriate for the member's condition. Based on a prospective, concurrent or retrospective review, Premera may deny coverage if, in its determination, such services are not medically necessary.

Services rendered by a massage therapist are not covered under the rehabilitation benefit. Refer to the Chiropractic services, acupuncture, and medical massage therapy benefit for coverage.

Respite Care (Non-Hospice)

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

Limit: 672 hours per calendar year

Respite care is for covered members who need assistance with activities of daily living (ADLs) such as bathing and dressing due to a permanent or temporary disabling medical condition, such as a traumatic brain injury, advanced multiple sclerosis, and severe cerebral palsy, where the member needs assistance moving from one place to the other. This benefit covers 672 hours per calendar year in the member's residential home to provide family caregivers an opportunity to recover from the emotionally and physically demanding tasks of caring for the covered member who requires assistance with ADLs.

The respite care application form and a home assessment must be completed prior to accessing this benefit. After the home assessment, Premera will make a determination if the covered member needs assistance with ADLs related to a disabling medical condition and qualifies for respite care coverage, which may be approved for up to a 12-month period. The home assessment is covered under the [Home health care](#) benefit. For the respite care application and more information on this benefit, call Premera Customer Service at (800) 676-1411.

Additional exclusions and limitations for respite care:

In addition to the plan's [exclusions and Limitations](#), the following exclusions and limitations apply to this benefit:

- Respite care provided by a non-certified or non-licensed provider or agency
- Respite care provided by a family member or friend
- Travel expenses, mileage, supplies or any other personal needs of the provider of the respite care
- Instrumental ADLs – examples of instrumental ADLs that are not covered by this benefit include, but are not limited to: shopping, housework, managing finances and using the computer.

Skilled nursing facility

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

Limit: up to 120 days per member per calendar year

This benefit covers inpatient care in a Medicare-approved skilled nursing facility for up to 120 days in each calendar year. Services must be part of a formal written treatment plan prescribed by the doctor. Custodial care is not included in this coverage.



Custodial care is provided primarily for ongoing maintenance of a person's condition or to assist a person in meeting activities of daily living, and not for therapeutic value or requiring the constant attention of trained medical personnel. Review the [glossary](#) for a full definition.

Services and supplies eligible for reimbursement include:

- Room and board, meals, and general nursing care
- Services and supplies furnished and used while you are in the skilled nursing facility, such as:
 - The use of special treatment rooms
 - Routine lab exams
 - Physical
 - Occupational or speech therapy
 - Respiratory and other gas therapy
 - Drugs and biologicals (such as blood products and solutions)
 - Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts

Prior authorization

A prior authorization, also referred to as a pre-service review, is strongly recommended for skilled nursing facilities to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Additional exclusions and limitations for skilled nursing facility

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Custodial care is not provided
- Care that is primarily for neurocognitive disorder, intellectual disability, or the treatment of substance use disorder and alcohol use disorder

Sterilization services

Elective Sterilization – Female

In-network: 100%

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers elective, permanent sterilization procedures, such as tubal ligation. Reversals or attempted reversals of these procedures are not covered.

Elective Sterilization – Male

In-network: 100%

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers elective, permanent sterilization procedures, such as vasectomy. Reversals or attempted reversals of these procedures are not covered.

Surgical weight loss treatment

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

Who is eligible

This benefit covers you, your spouse/domestic partner, or dependent when the criteria listed in the Premera Medical Policy on Bariatric Surgery are met.



Contact Premera at (800) 676-1411 for a copy of the policy.

Examples of qualifying criteria include:

- A Body Mass Index (BMI) greater than 40 Kilograms (kg) per square meter (m²) or BMI greater than 35 Kg per m² in conjunction with severe diabetes, hypertension, or obstructive sleep apnea
- Physician-supervised weight reduction program which includes:
 - A program lasting at least three consecutive months within the 12-month period before surgery is considered,
 - Evidence of active participation in a program documented in the member's medical records,
 - A psychological evaluation and clearance by a licensed mental health provider, to help rule out other psychological disorders, inability to provide informed consent, or inability to comply with pre- and post-surgical requirements.

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time

of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Temporomandibular joint (TMJ) dysfunction

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers treatment of temporomandibular joint (TMJ) dysfunction and other related disorders, such as myofascial pain dysfunction (MPD). Services must be rendered by a physician, hospital, licensed or registered physical therapist, or licensed dentist.



While not required by the Plan, pre-service review is strongly recommended for some TMJ services, to ensure that coverage is available. For a list of such services, call (800) 676-1411. Fax pre-service review requests to Dental Review at (425) 918-5956 or mail to:

Dental Review

MS 173

P.O. Box 91059

TMJ services and supplies for the treatment of TMJ dysfunction and myofascial pain dysfunction include:

- Diagnostic and follow-up examinations
- Diagnostic X-ray services
- Oral surgery
- Physical therapy
- Biofeedback
- Transcutaneous Electrical Nerve Stimulation (TENS)
- TMJ splints or TMJ guards

Transfusions, blood, and blood derivatives

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

This benefit covers transfusions, blood, and blood derivatives that are not replaced by voluntary donors. The cost of donating and storing your own blood for a planned surgery is also covered.

Gender Affirming surgical services

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

This benefit covers medically necessary gender affirming surgical services, including facility and anesthesia charges related to the surgery.

Coverage of prescription drugs and mental health treatment associated with gender reassignment surgery is available under the [prescription drugs](#) and [mental health](#) benefits.

When services are covered

Surgical gender reassignment services will be considered medically necessary and covered if you are diagnosed as having gender dysphoria, and the following criteria are met:

For breast/chest surgery:

- You are at least 13 years old.
- You have one letter of recommendation for surgery from a mental health professional. The recommendation must be based on an assessment conducted within the last 24 months and must verify that your decision is current, well thought out, not impulsive, and not due to any other treatable condition and/or disorder.
- The surgery is medically necessary according to the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH).

For genital surgery:

- You are at least 18 years old.
- You have two letters of recommendations for surgery from two separate mental health professionals, at least one of which includes an extensive report. A letter from a master's degree-level professional is acceptable if the second letter is from a psychiatrist or PhD clinical psychologist.
- The recommendation must be based on assessments conducted within the last 24 months and must verify that your decision is current, well thought out, not impulsive, and not due to any other treatable condition and/or disorder.
- The surgery is medically necessary according to the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH).

For other procedures:

- The surgery is medically necessary according to the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH).

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended for coverage to be made available for gender affirming surgical services. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time

of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

For gender affirming services, the prior authorization should include:

- The surgical procedure(s) for which coverage is being requested
- The date the procedure will be performed
- Information supporting that the criteria listed above have been met, based on the surgery being requested



Your physician can fax this information to (800) 843-1114 or mail it to:

Premera Blue Cross

Attn: Integrated Health Management

P.O. 91059

Transplants

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers solid organ transplants and bone marrow/stem cell reinfusion—procedures cannot be experimental or investigational.



Experimental or investigational services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#) for a full definition.



The transplant benefit doesn't cover cornea transplantation, skin grafts, or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure.

Eligible providers

To be eligible for coverage, the transplant or reinfusion must be furnished in an approved transplant center that has developed expertise in performing solid organ transplants, bone marrow reinfusion, or stem cell reinfusion, and is approved by Premera. Premera has contractual agreements with approved transplant centers and has access to a special

network of approved transplant centers throughout the United States. Whenever medically possible, we will direct you to an approved transplant center with which Premera has a contract. Of course, if neither a Premera-approved transplant center nor a Premera network transplant center can provide the type of transplant you need, this benefit will cover a transplant center that meets the approval standards that are set by Premera.



Approved transplant center is a hospital or other provider that has developed expertise in performing covered transplant services and has a contractual agreement in place with Premera. Review the [glossary](#) for a full definition.

Donor costs

All donor acquisition costs such as selection (testing and typing), harvesting (removal) transportation of donor organ, bone marrow and stem cells, and storage costs for bone marrow and stem cells for a period of up to 12 months are covered services, including costs incurred by the surgical harvesting teams.

Additional exclusions and limitations for transplants

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Nonhuman or mechanical organs, unless they are not experimental or investigational
- Services and supplies that are payable by any government, foundation, or charitable grant. This includes services performed on potential or actual recipients or donors (living or cadaver).
- Donor costs are not covered if the recipient of the transplant service is not a Woodgrove Financial enrollee. This applies to donor costs for all types of transplant services, solid organ and bone marrow or stem cell reinfusion.
- Donor costs are not covered by Woodgrove Financial if benefits are available under other group or individual coverage
- Donor costs are not covered for transportation for typing or matching

Travel and Lodging Reimbursement Benefit

In-network: 100%, deductible applies (additional IRS limitations below)

Out-of-network: 100%, deductible applies (additional IRS limitations below) Limit:

\$10,000 per member, per calendar year

The following travel and lodging reimbursement benefits are available when travel is necessary to obtain covered services under the Plan that are not available within 100 miles of the member's residence.

Travel Allowances: Travel expenses are reimbursed between the member's residence and the location of

the covered treatment for round trip (air, train, or bus) transportation costs. Airfare, or train or bus fare, must be for a regularly scheduled commercial flight, or train or bus route (coach class only). If traveling by automobile, mileage, parking, and toll costs are reimbursed. Costs for surface transportation (rideshares, taxi, ferry, etc.) are also covered. Mileage

reimbursement is based on the current IRS medical mileage reimbursement. Please refer to the IRS website, www.irs.gov, publication 502 Medical and Dental expenses, for current mileage reimbursement rates.

Lodging Allowances: Hotel or motel stays (or similar accommodations) away from the geographic area of the member's residence. Reimbursement of expenses incurred by a member and one companion for hotel or motel lodging away from home, in the geographic area where the covered treatment is performed, is provided at a rate of \$50 per night per person, or up to \$100 per night total for the member and one companion, if applicable (see below), in accordance with applicable IRS reimbursement requirements.

Overall Maximum: The travel and lodging reimbursement benefit is limited to a total of \$10,000 per member per calendar year.

Companions: The travel and lodging benefit is available for the reimbursement of eligible expenses incurred by the member, as well as a companion, to the extent that a companion is needed to accompany the member for the treatment due to medical necessity or safety concerns.

- Adult member (age 18 or older) – travel and lodging reimbursement for 1 companion is permitted.
- Child member – travel and lodging reimbursement for 1 parent or guardian is permitted

Limits: Eligible travel and lodging expenses under this benefit are reimbursable up to the IRS mileage rate, lodging allowance, or other limits, as applicable, in effect on the date you incurred the expense, which are subject to change. Please visit to the IRS website, **www.irs.gov**, for details. Nothing in this summary of the travel and lodging reimbursement benefit should be considered legal or tax advice.

Please consult with a personal legal or tax advisor for more information.

Non-Covered Expenses:

- Alcohol/tobacco
- Car rental expenses
- Any airfare, train or bus fare, or upgrades, for any ticket other than a regularly scheduled commercial flight or route in coach class
- Baggage fees
- Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
- Expenses for persons other than the patient and an eligible companion
- Lodging at a residence owned by a family member or friend
- Costs for pets or animals, other than service animals
- Meals
- Personal care items (e.g., shampoo, deodorant, toothbrush etc.)
- Souvenirs (e.g., T-shirts, sweatshirts, toys, etc.)
- Telephone calls

Limitations/exclusions:

- The travel and lodging must occur, and the treatment must be provided, within the United States
- The patient must be covered by one of Woodgrove Financial's Premera plans at the time the treatment is provided and the travel and lodging expenses are incurred
- The medical treatment for which the patient is required to travel more than 100 miles from the patient's residence must be a covered benefit under the Plan

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine in advance whether coverage is available for travel and lodging reimbursement.



Prior authorization is an advance determination by Premera that the service or prescription is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Virtual Care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

Virtual Care is the delivery of health-related services and information between a member and provider via telecommunications (email, telephone, video, and online) for the purpose of diagnosis, prevention, health advice, disease management and treatment

Electronic Visits. An electronic visit (“e-visit”) is a structured, secure online consultation between an approved physician and the member. This benefit will cover medically necessary e-visits for an illness or injury. Each approved physician will determine which conditions and circumstances are appropriate for e- visits in their practice.

Telehealth Services. Your plan covers access to care via online and telephonic methods when medically appropriate. Services must be medically necessary to treat a covered illness, injury or condition. Your provider will determine which conditions and circumstances are appropriate for telehealth services.

Services delivered via telehealth methods are subject to standard office visit cost-shares and other provisions as stated in this booklet. Virtual Care with a provider located outside of the United States is not covered.

For information about how the novel coronavirus (COVID-19) pandemic impacts this benefit see [Important information due to the coronavirus pandemic](#).

Vision therapy

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

Limit: up to 32-visit benefit maximum, per member, for the duration of the member’s continuous enrollment

This benefit covers vision training, eye training or eye exercises up to a maximum of 32 treatment visits, for the duration of the member’s continuous enrollment in a Premera-administered health plan option, for the following conditions only:

- Amblyopia

- Convergence insufficiency
- Esotropia or exotropia

All other uses of vision therapy are considered investigative and are not covered. Vision therapy is not a covered service under the [Vision plan](#). Costs of equipment and supplies associated with vision therapy are not covered.

Weight Management program

In-network (eligible providers): 80%, up to \$6,000 maximum for the duration of your continuous enrollment in one or more Premera-administered health plan options; deductible and coinsurance maximum does not apply.

Out-of-network: not applicable

This benefit covers comprehensive and clinically based weight management programs for the treatment of obesity. The 20% coinsurance you pay will not count toward the deductible or coinsurance maximum and will continue after the deductible and coinsurance maximum are met.

Who is eligible

Members are eligible for this benefit if they meet the following criteria:

- Diagnosed as obese (commonly Body Mass Index (BMI) greater than or equal to 30)
- Overweight with a BMI greater than or equal to 27, and diagnosed with two or more of the following conditions:
 - Congestive heart failure
 - Coronary heart disease
 - Depression
 - Diabetes
 - Hyperlipidemia
 - Hypertension

Dependent children are not eligible for this benefit.

Eligible providers

Approved [weight management providers](#) of this benefit must meet eligibility requirements set forth by Woodgrove Financial and Premera and be providing services under a weight management program that is contracted for and approved by Premera for this plan.

Approved weight management programs will be those programs that are comprehensive and clinically based. Approved programs must be based on medical oversight and include treatment from professionals in the areas of nutrition, behavioral therapy, and personal training. An approved program must include an initial minimum 10-week period of frequent sessions with the program's physician, personal trainer, dietitian, and behavioral therapist. This initial period must be followed by a minimum three-month maintenance period, which includes regular follow-up visits with these program professionals.

The Weight Management program must be contracted for and approved by Premera both at the time the participant or covered spouse/domestic partner begins the program and when

they complete the program. If the program is not approved and contracted for until after the participant has started treatment under the program, no part of the cost of the program will be covered under this benefit.



To find an approved provider, review the [Weight Management providers list](#).

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

A [Weight Management Recommendation form](#) or confirmation of your BMI and co-morbid conditions must be submitted to Premera in order to receive reimbursement from Premera. Your physician's recommendation will confirm you meet the contract criteria required for this benefit to be available.

The following are the steps that you are recommended to complete in advance to ensure that your treatment meets the criteria of this benefit:

1. Take the Weight Management Recommendation form to your regular physician
2. An evaluation is performed by your physician to determine if you meet the eligibility requirements set forth above
3. Your physician faxes or mails the Weight Management Recommendation Form to Premera to confirm that you meet the weight management eligibility requirements and your physician's approval



Your physician can fax this information to (800) 676-1477

4. Premera will review the information submitted and verify the coverage through a prior authorization

Claims payment

Final claims payment will be contingent on Premera receiving all biometric reporting information for the participant. Reimbursement for this benefit may occur in one of two ways. The program you attend will select the claims payment method used.

Method 1: Direct reimbursement to member

The provider will bill you directly for services provided. The frequency of billing should be made clear by the provider before you start the program. The weight management provider may collect a deposit from you to initiate your participation in the program.

During the course of the program you can submit an interim billing member claim form on a monthly or quarterly basis to Premera for reimbursement. Upon completion of the program you must submit the weight management billing claim form for your final payment. Final claims payment is contingent on receiving the form with all the biometric information completed.

If your coverage terminates during the time you are participating in an approved program, and you do not elect COBRA, only services rendered up to the date of termination of coverage will be reimbursed.

Method 2: Direct reimbursement to provider

Reimbursement will be made directly to the weight management provider on a monthly or quarterly basis. The weight management provider may collect a deposit from you to initiate your participation in the program but will bill Premera on a monthly or quarterly basis for your ongoing participation.

Additional exclusions and limitations for Weight Management program

In addition to the plan's [exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Food
- Nutritional supplements (i.e., protein shakes)
- Drugs or surgical procedures to assist in reducing weight or curbing hunger are not covered under the weight management program benefit. Refer to the [Prescription drugs](#) or [Surgical weight loss treatment](#) benefit for coverage.

Exclusions and limitations

- Services or supplies not medically necessary for diagnosis, care, or treatment of a disease, illness, injury, or medical condition, except for the following: (a) newborn nursery care covered under the hospital benefit; (b) male circumcision benefit; (c) sterilization benefit; (d) termination of pregnancy benefit; (e) infertility benefit; (f) hospice care benefit; and (g) well-child care and adult physical exam benefits
- Charges in excess of eligible charges, including out-of-network provider billed amounts over the allowable charges
- Expenses in excess of the applicable annual and lifetime benefit maximums
- Services for which a claim was not received by Premera within 12 months of the date of service. Corrected claims and COB claims need to be submitted within 12 months from the original claim submission date.
- Over-the-counter drugs (unless prescribed), food dietary supplements (for example, infant formulas or protein supplements), and herbal or naturopathic/homeopathic medicine
- Over the counter (OTC) testing and supplies (for example, OTC pregnancy test and ovulation tests)

except as covered under the DME benefit

- Charges for or in connection with services or supplies that are determined to be experimental or investigational
- Benefits that overlap or duplicate benefits for which the member is eligible under any other group benefit plan; Workers' Compensation or similar employee benefit law; Medicare A or B; or government-sponsored program of any type

- Services or supplies that are covered through any type of no-fault coverage or similar type of insurance coverage or contract, including but not limited to Personal Injury Protection (PIP) coverage, motor vehicle medical (MEDPAY), motor vehicle no-fault coverage, any excess insurance coverage, Medical premises coverage for homeowners or commercial (MEDPREM), commercial liability coverage, boat coverage, homeowner policy, or school and/or athletic policies.
 - This exclusion applies when the available or existing contract or insurance is either issued to, or makes benefits available to a Participant/claimant, whether or not the Participant/claimant makes a claim under such coverage.
 - Further, the Participant is responsible for any cost-sharing required by motor vehicle coverage, unless applicable state law requires otherwise.
 - If other insurance is available for medical benefits, the Participant must put such other insurance to use towards those medical bills before coverage under the Plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, Benefits will be provided according to the Plan.
- Work-related Conditions: This exclusion applies whether or not a proper or timely claim for benefits has been made under the following programs. This plan does not cover services or supplies for which you are entitled to receive benefits under:
 - Occupational coverage required of, or voluntarily obtained by, the employer
 - State or Federal workers' compensation acts
 - Any legislative act providing compensation for work-related illness or injury
- In the event that you do not comply with the contractual terms of subrogation, the plan will no longer be obligated to provide any benefits under this plan. The plan has the right to deduct the amount of benefits paid from any future benefits payable to the enrollee or to any other covered dependent.
- Any services or supplies for which no charge is made, or for which a charge is made because this plan is in effect, or for services or supplies for which the member is legally liable because this plan is in effect
- Services of a social worker except as provided in the hospice care benefit, the home health care benefit and the mental health, substance use disorder, and alcohol use disorder treatment benefit
- Routine or palliative foot care to treat fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other problems that are commonly treated with off-the-shelf, over-the-counter (OTC) therapy. This exclusion does not apply to medically necessary foot care.
- Foot or shoe prosthetics, appliances, orthotics or inserts except as described under the durable medical and surgical equipment and supplies benefit. This does not apply to enrollees who are diabetic.
- Massage therapy that is not medically necessary or is furnished without a prescription
- Any benefits or services not specifically provided for in this SPD
- Liquid diets or fasting programs, memberships in diet programs or health clubs, or wiring of the jaw
- Drugs and medications not approved by the Food and Drug Administration (FDA) except as defined in the Experimental and Investigational section
- Procedures for sterilization reversals
- Hypnotherapy, regardless of provider
- Hippotherapy or other forms of equine or animal-based therapy

- Electronic services and/or consults, except as specifically described under the plan
- Services or supplies furnished by a member to himself or herself or by a provider who is in any way related to the member. This also includes but is not limited to a provider who is a covered dependent under the plan (whether or not living in the household), spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent or spouse of grandchild.
- Services that are illegal, outside the scope of the provider's license or certification, or that are furnished by a provider that is not licensed or certified by the jurisdiction in which the services or supplies were received
- Separate charges for records or reports, except those Premera requests for utilization review
- Voluntary support or affinity groups such as patient support, diabetic support groups or Alcoholics Anonymous. Additionally, volunteer services or services provided by or through a school, books, and other training aids are also not covered.
- Non-treatment facilities, institutions or programs: Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, juvenile detention facilities, group homes, foster homes and adult family homes. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider, provided that such non-treatment facilities, institutions, or programs, themselves, are not eligible providers for this purpose.
- Services or supplies for any of the following:
 - Education and training programs including testing or supplies/materials, including vision training supplies
 - Educational or recreational therapy or programs; this includes, but is not limited to, boarding schools. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider provided that educational or recreational therapy or programs, themselves, are not eligible providers for this purpose.
 - Social, cultural, or vocational rehabilitation or vision training supplies
- Refractive surgery of the eye (surgery to improve vision that can be corrected with glasses or contact lenses) is covered only as specified under the vision plan
- Hospital grade breast pumps are not available for purchase; however, they may be covered for rent for up to 12 months
- Services for individuals not eligible for coverage under the Woodgrove Financial Plan will not be reimbursed except in the following circumstances:
 - Donors for organ or bone marrow/stem cell transplantation for services specific to that procedure
 - Genetic testing of relatives when the information is needed to adequately assess risk in the member; the result of the test will directly impact the treatment to the member; and there is no other coverage available to the relative
- Lodging is covered only as outlined in the Travel and Lodging Reimbursement Benefit
- When Coordinating Benefits (COB) and you fail to follow the rules of the primary plan, this plan would pay nothing for that expense
- Benefits are not provided for services or supplies (1) for which no charge is made, (2) for which no charge would have been made if this plan were not in effect or (3) that were not received by the member while covered by the plan

- Services received in excess of a benefit limit or maximum are not covered. Any network discounts for in-network providers do not apply to services received in excess of the benefit limit.

In addition, certain exclusions and limitations apply to the following benefits. CTRL+Click to navigate to the benefit information.

- [Autism/ABA therapy](#)
- [Dental services](#)
- [Hearing care and hardware](#)
- [Home health care](#)
- [Hospice care](#)
- [Hospital inpatient care](#)
- [Infertility](#)
- [Medical and surgical equipment and supplies](#)
- [Mental health and chemical dependency](#)
- [Prescription drugs](#)
- [Skilled nursing facility](#)
- [Transplants](#)
- [Weight Management program](#)

How to file a claim

In most cases, when you receive care from an in-network provider, your provider will submit bills directly to Premera, and this submission is your claim for benefits. If your provider does not submit a bill directly to Premera, you will need to submit a claim for benefits.

If possible, you should submit the claim form within 30 days of the service. The plan will not reimburse claims submitted more than 12 months after the date of service.

For information about how the novel coronavirus (COVID-19) pandemic impacts the claims process and timelines, [Important information due to the coronavirus pandemic](#).

To submit a claim online:

From the Benefits Site, select **View My Claims**, which will direct you to the Premera Portal. Or sign in to your account on premera.com. Next, from the top menu bar select **Claims** and then **Submit Claims**.

Follow the steps and upload a copy of the itemized receipt. To submit a claim via mail, fax or email:

1. Download the [Premera Claim Reimbursement Request Form](#). You can also email Premera from your Woodgrove Financial email address (employees) to Woodgrove.Financial@premera.com or through your Secure Messaging center in the Premera portal (all enrollees including dependents and COBRA members) to request a claim form.

2. Complete the claim form, including all of the following information:
 - a. Your name and the member's name
 - b. Identification numbers shown on your identification card (including the 3-digit plan prefix or MSJ)
 - c. Provider's name, address, and tax identification number

- d. If you are seeking secondary coverage from the Woodgrove Financial health plan, information about other insurance coverage related to the claim at hand, including a copy of their Explanation of Benefits (EOB), if applicable
- e. If treatment is as a result of an accident: the date, time, location and brief description of the accident
- f. Date of onset of the illness or injury
- g. Date of service
- h. Diagnosis or ICD-10 (this information can be found on the provider bill)
- i. Procedure codes (CPT-4, HCPCS, ADA, or UB-92) or descriptive English language for each service (this information can be found on the provider bill)
- j. Itemized charges for each service rendered by provider
3. Sign the form in the space provided and attach the itemized provider bill
4. Submit the completed form to:

Mail: Premera Blue Cross
P.O. Box 91059

Seattle, WA 98111-9159

Fax (800) 676-1477

Email from Woodgrove Financial email address:

claims.Woodgrove.Financial@premera.com Email through the

Secure Messaging center in your Premera portal



COBRA-eligibility claims should be submitted as described in the [Continuation of coverage for health and FSA benefits \(COBRA\)](#) section.

In the following circumstances, you may submit claims according to the [appeals process](#):

- If you cannot submit the claim in a timely manner due to circumstances beyond your control
- If your claim regards plan eligibility for you, your spouse/domestic partner, or dependent child

Claim review and payment

The claim review process begins once Premera receives a claim from you or your provider or other authorized representative. Premera will send you an Explanation of Benefits (EOB) or other communication notifying you of their decision on your claim. In most cases, this communication will be sent to you no more than 30 days after Premera receives the claim, although Premera may extend this 30-day period for up to 15 days if the extension is required due to matters beyond Premera's control.

If your claim relates to an item for which the Plan requires you to obtain approval (or "prior authorization") before it is furnished to you, then Premera generally will send a decision no later than 15 calendar days after receipt of your request. Premera may extend this 15-day

period for up to an additional 15 days if the extension is required due to matters beyond Premera's control.

If Premera needs additional information from you to process your pre- or post-service claim, Premera will notify you in writing, within 30 days after receiving your claim, of the specific information required. You will have at least 45 days to provide the additional information. The determination period to respond to your claim (as provided above) will be suspended as of the date Premera sends the notice and will resume again once you have provided the additional information. If you do not provide the requested information within the specified timeframe, Premera will decide the claim without the requested information.

If your claim is for "urgent care," meaning the application of the standard time periods for making determinations could seriously jeopardize your life, health, or ability to regain maximum function, or in the

opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment at issue, then the following special rules apply:

- Premera will send you an EOB or other communication notifying you if they have denied your claim, in writing or electronically, within 72 hours after Premera receives all necessary information for your claim either via phone or in writing, taking into account the seriousness of your condition.
- Premera's denial notice may be oral, with a written or electronic confirmation to follow within three days.
- If the claim was filed incorrectly, Premera will notify you of the error and how to correct it within 24 hours after the claim was received. If additional information is needed to process the claim, Premera will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information. You will then be notified of Premera's determination no later than 48 hours after (1) Premera's receipt of the requested information, or (2) the end of the 48-hour period when you were to provide the additional information if the information is not received in that timeframe.

If your claim is a request to extend an ongoing course of treatment beyond a previously approved period of time or number of treatments, and is considered an urgent care claim, Premera will decide your claim within 24 hours, provided that your claim is submitted at least 24 hours before the end of the approved treatment.



Explanation of benefits (EOB) is the statement you receive from Premera Blue Cross detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

Premera will make a payment to the employee, a dependent (age 13 or older), a provider, or another carrier. Payments are subject to applicable law and regulation:

- Premera may make payments on behalf of an enrolled child to a non-enrolled parent or state agency to which the plan is required by applicable law to direct such payments
- Payments made will discharge the plan to the extent of the amount paid, so that the plan is not liable to anyone due to its choice of payee

Denied claims notice

If all or part of your claim is denied, Premera will send you an Explanation of Benefits (EOB) or other notice with the following information:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A description of any additional material or information needed from you and the reason it is needed
- An explanation of the appeals procedures and the applicable time limits
- A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request)

- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)

- If the claim is for urgent care (as defined above), a description of the expedited review process applicable to such claims
- If you have filed a claim with Premera relating to plan eligibility, and this claim is denied, Premera will send you a notice explaining your appeal rights
- Notice regarding your right to bring legal action following a denial on appeal

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
- The denial code and its meaning
- A description of the plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal
- Contact information for Premera Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

Appeal for internal review

If you do not agree with the decision made by the plan you may appeal for an internal review of the decision within 180 days of receiving the Explanation of Benefits (EOB) or adverse decision.

For information about how the novel coronavirus (COVID-19) pandemic impacts the appeal process and timelines, [Important information due to the coronavirus pandemic](#).



An **appeal** is a written request to reconsider a written or official verbal adverse determination to deny, modify, reduce or end payment, coverage or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to and continued stays in a facility. The process also applies to Flexible Spending Account appeals for reimbursement but does not apply to appeals of denied COBRA eligibility claims.



If you fail to file the internal appeal within 180 days of receiving the Explanation of Benefits, you will permanently lose your right to appeal the denied claim.

Submitting an appeal for internal review

You or your authorized representative* must provide the following information as part of your written appeal to the Premera Appeals Department:

- Your name,
- Your Premera member number,
- The name of this plan, and

- A concise statement of why you disagree with the decision, including facts or theories supporting your claim.

Your written request may (but is not required to) include issues, comments, documents, and other records you want considered in the review.



The appeal should be mailed or faxed to Premera:

Appeals Coordinator
Premera Blue Cross

P.O. Box 91102

*You may, at your own expense, have a representative file an appeal on your behalf. Your attorney, family member, your provider, or anyone else who you wish to designate as your authorized representative may also appeal with written authorization. In order to designate an authorized representative for this purpose, you must submit a completed and signed [Woodgrove Financial Member Appeal form](#) which includes an appeal authorization section.

In the case of an urgent care appeal, you may submit your appeal request orally or in writing and all necessary information may be transmitted between you and the plan by telephone or fax. If your provider believes your situation is urgent as defined under law and so notifies Premera, your appeal will be conducted on an expedited basis. Notification will be furnished to you as soon as possible, but not later than 72 hours after receipt of the expedited appeal. Your appeal should clearly indicate your request for an expedited appeal.

For urgent situations or if you are in an ongoing course of treatment you may begin an external independent review at the same time as Premera Blue Cross's internal review process. The external review agency is not legally affiliated or controlled by Premera. The external review agency decision is final and is binding upon the Plan.



To file an urgent care appeal request, you may fax a request to (425) 918-5592.



The external review for non-urgent situations is available only after you have properly exhausted the internal appeal as described above.



An urgent care claim or appeal is one where the application of the standard time periods for making determinations could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Internal review and timeframe

All the information you submit will be taken into account on appeal, even if it was not reviewed as part of the initial decision. You may ask to examine or receive free copies of all

pertinent plan documents, records, and other information relevant to your claim by requesting these from Premera.

The plan may consult with a health care professional who has experience in the field of medicine involved in the medical judgment to decide your appeal. You may request the identity of medical experts whose advice was obtained by the plan in connection with your initial claim denial, even if their advice was not relied upon in making the initial decision.

In the event any new or additional information (evidence) is considered, relied on or generated by Premera in connection with your appeal, Premera will provide this information to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Premera, Premera will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that that you will have an opportunity to respond.

Other than urgent care appeals, described above, in most cases Premera will send a decision on your appeal no later than 60 calendar days after receipt of your appeal request. However, if the appeal relates to an item for which the Plan requires you to obtain approval before it is furnished to you, then it will be considered a pre-service appeal, and Premera will send a decision no later than 30 calendar days after receipt of your appeal request.

Denied appeal notice

If your appeal is denied, you will receive a written notice setting forth:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits
- A statement explaining the external review procedures offered by the plan and your right to bring a civil action under ERISA section 502(a)
- A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in denying the claim (a copy of which will be provided free upon request)
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
- The denial code and its meaning
- A description of the Plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal
- Contact information for Premera Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

Appeal for external review

If you are not satisfied with the final internal denial of your claim, you may request an external review by an independent review organization (IRO) if that denial 1) has a

retroactive effect and is considered a rescission of coverage under the law, or (2) is based on medical judgment including:

- Requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit
- A determination that a treatment is experimental or investigational



An **independent review organization (IRO)** is an independent organization of medical experts who are qualified to review medical and other relevant information.

The external review for non-urgent situations is available only after you have properly exhausted the internal appeals process as described above. There are no fees or costs imposed on you as part of the external review.

The external review agency decision is final and is binding upon the plan.

Submitting an appeal for external review

To initiate the external review, you must send a written request to Premera at the address below no later than 120 days after the date you receive your internal appeal determination letter, which the plan deems to be seven days after the date on the internal appeal determination letter.



If you fail to submit the written request within this timeframe, you will permanently lose your right to an external review.



Mail or fax the written request to:

Premera Blue Cross

Attn: Woodgrove Financial Member Appeals – IRO Mail Stop 123

P.O. Box 91102

External review and timeframe

If your appeal is eligible for external review, Premera will notify the IRO of your request for an external review and send them all the information included in your internal appeal and other relevant materials within six days of receipt.

The IRO will contact Premera directly if additional information is needed. Premera will provide the IRO with any additional information they request that is reasonably available. The external review request is considered complete when the IRO has all the requested information and the IRO review begins.



If your provider believes your situation is urgent under law (as defined above under Appeal for internal review), your external review will be conducted on an expedited basis. For expedited external reviews, you and Premera will be notified by phone, e-mail message or fax as soon as possible, but no later than 72 hours after receipt of your external review request. A written determination will follow.

The plan agrees that any statute of limitations (including the one-year contractual limitations period described below) or other defense based on timeliness is on hold during the time that the external review is pending. Your decision whether to file the external review will have no effect on your rights to any other benefits under the plan.

The external review process does not apply to appeals of denied claims for plan eligibility or for other appeals of denied claims that are not based on medical judgment.

Decision on the external review

The plan is bound by the IRO's decision. If the IRO overturned the final internal adverse determination, the plan will implement their decision. The IRO will notify you and Premera in writing of its determination on the external review no later than 45 days after receipt of your complete external review request.

Decisions upon the external review are the final decision under the plan's appeal process, and there are no further appeals available from Premera or Woodgrove Financial or any person administering claims or appeals under the plan. However, you still have a right to file suit under ERISA Section 502(a) as a result of the external review decision.

Limits on your right to judicial review

You must follow the appeals process described above through the decision on the appeal before taking action in any other forum regarding a claim for benefits under the plan. Any legal action initiated under the plan must be brought no later than one year following the adverse determination on the appeal. This one-year limitations period on claims for benefits applies in any forum where you initiate legal action. If a legal action is not filed within this period, your benefit claim is deemed permanently waived and barred. In addition, you must raise all issues and grounds for appealing a decision on a claim for benefits at every stage of the appeal process, or else such issues and grounds will be deemed permanently waived and barred.



If you have questions about understanding a denial of a claim or your appeal rights, you may contact Premera Customer Service for assistance at (800) 676-1411. You may also seek assistance from the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor at (866) 444-EBSA (3272).

Right to recover benefits paid in error

If Premera makes a payment in error on your behalf to you or a provider, and you are not eligible for all or a part of that payment, Premera has the right to recover payment, including deducting the amount paid mistake from future benefits.

Note: Health care providers are not “beneficiaries” of the plan, and although Premera may make direct payment to health care providers for the convenience of participants and their dependents, such payments of services shall not be considered “benefits” available under the plan, or confer beneficiary standing upon a health care provider.

Section IV: Vision

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✓ COBRA enrollees – the Vision section applies

How the plan works

The vision plan helps pay for routine eye-care expenses when prescribed by a physician or optometrist. The vision coverage you have depends on the medical plan in which you participate and may not pay the total cost of eye-care services and supplies.

All of the benefits for each vision plan are subject to the plan's exclusions and limitations. Each benefit may have additional eligibility criteria and exclusions and limitations. Specific coverage by medical plan is outlined on the following pages.

To be covered under the plans, vision services and supplies must be medically necessary and provided by a licensed vision provider practicing within the scope of their license.



You have a right to apply for continued vision coverage for you or your covered dependents if your coverage ends because you leave Woodgrove Financial or otherwise become ineligible. For more information, see the [Coverage if you leave Woodgrove Financial](#) section.

*Where you can get care***Premera**

If you are in a Premera Blue Cross (Premera) medical plan you may select any licensed eye doctor.

Kaiser Foundation Health Plan of Washington (Washington only)

If you are in the KFHPWA HMO Plan, you must obtain vision services and supplies from a KFHPWA provider or facility. KFHPWA members can also receive refractive eye surgery through TruVision providers.



To locate a KFHPWA vision provider or facility call (206) 901-4636 or (888) 901-4636 or visit [KFHPWA](#) online.
For a list of TruVision Laser Vision providers, contact TruVision at (877) 762-2020.

Kaiser Permanente (California only)

If you are in the Kaiser Permanente HMO Plan, you must obtain vision services and supplies from a Kaiser Permanente provider or facility.



To locate a Kaiser Permanente vision provider, call Member Services Contact Center at (800) 464-4000 or visit <http://www.kp.org>.

What the plan covers



Services and supplies must be medically necessary and are subject to all benefit exclusions and limitations and the plan's exclusions and limitations.

Provider Visits

The coverage for provider visits depends on the medical plan in which you participate.

Premera	Health Savings Plan, Hawaii-Only Plan	
	One routine eye exam per year: <ul style="list-style-type: none"> • In-network: 100% • Out-of-network: 100% of allowable charges Other exams, as medically necessary: <ul style="list-style-type: none"> • In-network: 90%, deductible applies • Out-of-network: 70% of allowable charges, deductible applies 	
	Health Connect Plan	
	One routine eye exam per year: <ul style="list-style-type: none"> • Health Connect Network: 100% • Extended Network: 100% • Out-of-network: 50% of allowable charges, deductible applies Other exams, as medically necessary: <ul style="list-style-type: none"> • Health Connect Network: \$20 copayment Primary Care Provider, \$40 copayment Specialist • Extended Network: 60% of allowable charges, deductible applies • Out-of-network: 50% of allowable charges, deductible applies 	
Kaiser Foundation Health Plan of Washington	One routine eye exam per calendar year from a KFHPWA provider or facility covered at 100%; other exams, including contact lens exams, and eye and contact lens exams for eye pathology, as medically necessary: <ul style="list-style-type: none"> • \$20 copayment for primary care providers • \$40 copayment for specialists Care from non-KFHPWA providers or facilities is not covered.	
Kaiser Permanente	For information on coverage, view the evidence of coverage documents:	
	Active employees/dependents go here... <ul style="list-style-type: none"> • Evidence of Coverage – Northern California • Evidence of Coverage – Southern California 	COBRA enrollees go here... <p>Go to http://cobra.me.WoodgroveFinancial.com > Reference Center > Kaiser CA Evidence of Coverage (EOC) Documents</p>



An **allowable charge** is the negotiated amount that in-network providers contracted with your plan administrator (Premera, KFHPWA, or Kaiser Permanente). They have agreed to accept as payment in full for a covered service. Out-of-network providers may not accept the allowable charge as payment in full. You are responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges.

A **copayment** is a fixed, up-front dollar amount that you're required to pay for certain covered services in the plan.

A **deductible** is the amount of covered medical costs you must pay each calendar year before the plan begins to pay its share of allowable charges. The deductible must be met before the plan begins paying a share of your vision costs.

In-network providers and facilities have contracted with your plan administrator (Premera, KFHPWA, or Kaiser Permanente) to provide services at a negotiated discount rate. Review the [glossary](#) for a full definition. **Out-of-network** providers and facilities have not contracted with your plan administrator (Premera, KFHPWA, or Kaiser Permanente) to provide services at a negotiated discount rate. Review the [glossary](#) for a full definition.

Routine exams may include:

- Visual acuity testing
- Examination of the external parts of the eye, including the lids, conjunctiva, and sclera
- Pupillary reflexes or other testing for neurological integrity, as indicated
- Ophthalmoscopy (intraocular examination)
- Retinoscopy, where indicated
- Refraction at far and near points, as indicated
- Binocular testing at far and near points
- Case history, recommendations, and prescriptions

Hardware

The coverage for hardware depends on the medical plan in which you participate.

Premiera	<p>19 years and older: Glasses (including frames and lenses) and/or contacts including related examinations and fittings, are covered at 100% up to a maximum benefit of \$350 per member per calendar year.</p> <p>Under 19 years old: One pair of glasses (frames/lenses) or one pair of contacts (or one-year supply of disposable contacts) per calendar year and related fittings are covered at 100% of the allowed amount.</p>	
Kaiser Foundation Health Plan of Washington	<p>Glasses (including frames and lenses) and/or contacts including related examinations and fittings, are covered at 100% up to a maximum benefit of \$350 per member per calendar year. For children under 19 one pair of glasses (frames/lenses) or one pair of contacts (or one year of disposable contacts) per calendar year.</p> <p>Contact lenses for eye pathology are covered at 100%. One contact lens per diseased eye in lieu of an intraocular lens is covered following cataract surgery provided the member has been continuously covered by KFHPWA since such surgery. In the event a member's age or medical condition prevents the member from having an intraocular lens or contact lens, framed lenses are available. Replacement of lenses for eye pathology, including following cataract surgery, is covered only once within a 12-month period and only when needed due to a change in the Member's prescription.</p> <p>You must obtain vision supplies from a KFHPWA provider or facility. Supplies from non-KFHPWA providers or facilities are not covered. To locate a KFHPWA vision provider, call (206) 901-4636 or (888) 901-4636 or visit KFHPWA online at www.kp.org.</p>	
Kaiser Permanente	For information on coverage, view the evidence of coverage documents:	
	Active employees/dependents go here...	COBRA enrollees go here...
	<ul style="list-style-type: none"> • Evidence of Coverage – Northern California • Evidence of Coverage – Southern California 	Go to http://cobra.me.WoodgroveFinancial.com > Reference Center > Kaiser CA Evidence of Coverage (EOC) Documents

The following criteria apply for vision hardware coverage:

- They must be prescribed and furnished by a licensed or certified vision care provider
- They must be listed as covered by this benefit
- They must not be excluded from coverage under this plan
- Benefits for hardware are provided in the calendar year when the hardware is paid for, as reflected on the invoice from the provider
- Prescription sunglasses, prescription safety glasses, and special features, such as tinting or coating, may also be covered
- Vision hardware benefits are based on the maximum benefit for services and supplies. Charges that exceed what is covered under this benefit are not covered under this plan.

Eye Surgery

The Premera and KFHPWA vision plans cover refractive eye surgery as described in the table below.

Premera	Covers 100% of allowable charges, up to a maximum benefit of \$1,000 per participant for the duration of their continuous enrollment in one or more Premera-administered health plan options when performed by an in-network provider.
Kaiser Foundation Health Plan of Washington	Covers 100%, up to a maximum benefit of \$1,000 per participant for the duration of their continuous enrollment in the KFHPWA HMO Plan.
Kaiser Permanente	Laser vision surgery is not covered.

Covered services include but are not limited to:

- Pre- and post-operative exams
- LASIK (LASIK, Custom LASIK, Bladeless LASIK)
- Photorefractive Keratectomy (PRK)
- Implantable Collamer Lens (ICL)
- Intraocular Lens Implant (IOL)



Other medically necessary eye surgery may be covered by your medical plan: [Health Savings Plan](#)

[Health Connect Plan](#)

[Kaiser Foundation Health Plan of WA HMO Kaiser Permanente HMO](#)

Exclusions and limitations

Premera

Exclusions

The following are not covered:

- Artificial eyes (covered under the medical plan as prostheses)
- Nonprescription eyeglasses (for example, sunglasses or safety glasses) or contact lenses, or other special-purpose vision aids (such as magnifying attachments)
- Industrial vision equipment

- Sports-related vision equipment (such as scuba, ski or sports goggles), even if prescribed
- Services or supplies required by an employer as a condition of employment
- Services or supplies received from a medical department maintained by an employer, a mutual benefit association, labor union, trustee, or similar type group

- Any additional charges for the repair of glasses or contact lenses, or service charges to cover potential breakage or damage to eyewear
- Supplies used for the maintenance of contact lenses
- Services and supplies (including hardware) received after your coverage under this benefit has ended, except when all of the following requirements are met:
 - You ordered covered contact lenses, eyeglass lenses, and/or frames before the date your coverage under this benefit or plan ended
 - You received the contact lenses, eyeglass lenses, and/or frames within 30 days of the date your coverage under this benefit or plan ended
 - Vision therapy (covered for approved conditions under the medical plan)
 - Prepaid vision policies
- Eyeglasses that can be purchased without a prescription are not covered (for example "readers" regardless if prescribed)

Limitations

Payment will not be made for more than one complete, routine, eye examination in any calendar year. Payment will also not be made for services or supplies received primarily for cosmetic purposes, other than for the selection of prescription contact lenses in place of eyeglasses.

Kaiser Foundation Health Plan of Washington

Exclusions

Vision benefits do not provide the following:

- Industrial and sports-related vision equipment, even if prescribed
- Evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures
- Sunglasses and safety frames and lenses
- Non-prescription lenses
- Services or supplies required as a condition of employment
- Any additional charges for the repair of glasses or contact lenses or service charges to cover potential breakage or damage to eyewear
- Orthoptic therapy. (i.e., eye training)

Kaiser Permanente

For information on exclusions and limitations, view the evidence of coverage documents:

Active employees/dependents go here...	COBRA enrollees go here...
<ul style="list-style-type: none"> • Evidence of Coverage – Northern California • Evidence of Coverage – Southern California 	Go to http://cobra.me.WoodgroveFinancial.com > Reference Center > Kaiser CA Evidence of Coverage (EOC) Documents

How to file a claim

Premera

In most cases, when you receive care from an in-network provider, your provider will submit bills directly to Premera, and this submission is your claim for benefits.

If your provider does not submit a bill directly to Premera you will need to pay for the services and [submit a claim](#) to Premera for reimbursement.



For more information about filing a claim, review the How to file a claim section under your medical plan:
[Health Savings Plan](#)
[Health Connect Plan Hawaii Only Plan](#)

Kaiser Foundation Health Plan of Washington

For all covered vision care except refractive eye surgery, KFHPWA providers will bill the plan directly so there is no need to file a claim.

For refractive eye surgery services through TruVision, you must pay for the services and submit a KFHPWA Claim form to KFHPWA for reimbursement.



For more information about filing a claim, review the [How to file a claim](#) section for the KFHPWA HMO plan.

Kaiser Permanente

For information on how to file a claim, view the evidence of coverage documents:

Active employees/dependents go here...	COBRA enrollees go here...
<ul style="list-style-type: none"> • Evidence of Coverage – Northern California • Evidence of Coverage – Southern California 	Go to http://cobra.me.Woodgrove.Financial.com > Reference Center > Kaiser CA Evidence of Coverage (EOC) Documents

Section V: Dental

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✓ COBRA enrollees – the Dental section applies

How the plan works

The plan allows you to seek services from in-network or out-of-network providers. In-network preventive care is covered at 100% and out-of-network preventive care is covered at 100% of allowable charges. For all other care, you must pay an annual deductible before the plan pays a share of the cost.

All of the dental benefits are subject to the plan's exclusions and limitations. Each benefit may have additional eligibility criteria and exclusions and limitations. Specific coverage is outlined on the following pages.

To be covered under the plans, dental services and supplies must be dentally necessary and provided by a licensed dental provider practicing within the scope of their license. Services may also be provided by a dental hygienist under the supervision of and billed by a licensed dentist.



A **dentally necessary service or supply** meets certain criteria including:

- It is essential to the diagnosis or the treatment of an illness, accidental injury, or condition that is harmful or threatening to the patient's life or health, unless it is provided for preventive services when specified as covered under the plan
- It is appropriate for the dental condition as specified in accordance with authoritative dental or scientific literature and generally accepted standards of dental practice

Review the [glossary](#) for a full definition.



You have a right to apply for continued dental coverage for you or your covered dependents if your coverage ends because you leave Woodgrove Financial or otherwise become ineligible. For more information, see the [Coverage if you leave Woodgrove Financial](#) section.

Where you can get care

You may seek dental care from any licensed dental provider and still have coverage. However, you will receive the lower, negotiated rates and the highest coverage levels by staying within the Premiera network. Review the [What you pay](#) section for information on coverage levels.



Visit the online Premiera Medical Directory to find an in-network provider in the United States or call Premiera Blue Cross at (800) 676-1411.

Active employees go here...

[Premera Medical Directory](#)

Active dependents or COBRA enrollees go here...

[Premera.com](#)

Hospital and physician services

Dental care is covered when provided by a hospital or a physician only if the following two conditions are met:

- When adequate dental treatment cannot be rendered without the use of the hospital
- A health problem makes it medically necessary to perform the dental work at the hospital

Any charges for the hospital facility or ambulatory surgical center facility and anesthesia charges will be considered under the benefits of your medical plan.

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

What you pay

You pay nothing for diagnostic and preventive services (Class I), when you use in-network providers. Amounts that the plan pays for your diagnostic and preventive services do not apply toward the annual limit.



For a full list of covered services, call Premera customer service at (800) 676-1411.

For other care, you pay 100% of your eligible expenses until you spend up to the amount of the deductible, which is \$25 per individual or \$75 combined for all individuals enrolled in family coverage (if applicable). No one family member can account for more than the individual deductible amount toward the combined family deductible. If you reach the deductible, then you begin to pay a percentage of the allowable charges, called coinsurance, and the plan pays the rest. The amount paid by the plan depends on the type of care you seek.

Benefit coverage after you pay deductible (\$25 individual / \$75 family)

Dental Plus

Class I – Diagnostic and preventive services

Plan pays 100% of allowable charges

For a full list of covered services, call Premera customer service at (800) 676-1411.

Class II – Basic services

Basic restorative services, endodontics, periodontics, and oral surgery

Plan pays 85% of allowable charges, after deductible

Class III – Major services

Major restorative services, installation of bridges, and dentures

Plan pays 50% of allowable charges, after deductible

Orthodontia benefits

One-time \$50 deductible per member; \$2,500 lifetime benefit maximum benefit per member

Plan pays 50% of allowable charges, after deductible

If you use in-network providers, you'll receive the lower Premera-negotiated rate, called the allowable charge. If you use out-of-network providers, only the Premera allowable charge is applied to your deductible. You are responsible for the provider charge over the allowable charge. Examples of how the plan pays for in- and out-of-network care follow below.

The plan pays up to a maximum amount of \$2,500 for Dental Plus per member each calendar year. After the plan pays this annual limit, you are responsible for 100% of the cost when you seek care. The Dental Plus plan also includes a \$2,500 lifetime benefit maximum per member for the orthodontia benefit.

Services received in excess of the annual maximums are not covered by this benefit. Any network discounts for in network providers do not apply to services received in excess of the benefit limit.



The **allowable charge** is defined differently for in-network and out-of-network providers. For in-network providers, the allowable charge is the negotiated amount that the provider has agreed to accept as payment in full for a covered service. For out-of-network providers, the allowable charge is the lowest of three amounts, as outlined in the definition of "allowable charge" in the Glossary. If you choose to use out-of-network providers, you may be responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges.

A **deductible** is the amount of covered dental costs you must pay each calendar year before the plan begins to pay its share of allowable charges.

In-network providers and facilities have contracted with your plan administrator to provide services at a negotiated discount rate. Review the [glossary](#) for a full definition.

Out-of-network providers and facilities have not contracted with your plan administrator to provide services at a negotiated discount rate. Review the [glossary](#) for a full definition.

A **lifetime benefit maximum** is the most a plan will pay toward a benefit for a member. Review the [glossary](#) for a full definition.

Example

Pradip needs a crown, which is a Class III service. He can choose an in-network or an out-of-network provider. Both charge \$975, but the in-network provider accepts the lower Premera-negotiated rate of \$700.

Pradip has employee-only coverage in the Dental Plus plan and hasn't met his deductible yet. He chooses an in-network provider and pays:

- The \$25 deductible, plus
- 50% of the remaining charge ($\$675 \times 50\% = \337.50)

If Pradip had chosen an out-of-network provider, for whom the allowable charge was also \$700, he would have paid \$275 more (the difference between the out-of-network provider's bill and the allowable charge (\$975-

Example

Mary's daughter Judith needs a nightguard which is a Class II service. The charge is \$490, but the in-network allowable charge is \$300.

Mary has family coverage in the Dental Plus Plan and takes her daughter to an out-of-network provider, for whom the allowable charge is also \$300. She pays:

- The \$25 deductible
- 15% of the remaining allowable charge ($\$275 \times 15\% = \41.25)
- The difference between the out-of-network provider's bill and the allowable charge ($\$490 - \$300 = \$190$)
- Mary's cost for the visit is \$231.25

Dental pre-determination

When charges for a proposed dental service or a series of dental services are expected to exceed \$350, your dentist should submit the recommended course of treatment and fees to Premera for a pre-determination of what will be paid for the services. This dental pre-determination is only an estimate and not a guarantee of payment.

When the treatment plan is finished, the dentist should resubmit a claim for payment. Premera will pay benefits based on your continued eligibility and remaining balance of your annual maximum.

If this dental pre-determination process is not followed, payment will be determined by Premera, taking into account alternate procedures or services, based on acceptable standards of dental practice.

Emergency treatments, oral examinations, and dental X-rays are considered part of a course of treatment, but these services may be provided before the dental pre-determination is made.

What the plan covers

This section provides details on the major benefits of the dental plan, including coinsurance coverage for in-network and out-of-network care in three categories:

- [Class I services – Diagnostic and preventive services](#)
- [Class II services – Basic restorative, endodontics, periodontics, and oral surgery](#)
- [Class III services – Major restorative services and installation of bridges and dentures](#)



Services and supplies must be dentally necessary and are subject to all benefit exclusions and limitations and the plan's [exclusions and limitations](#).



Prescription drugs prescribed by your dentist are covered under your medical plan. [Health Savings Plan](#)

[Health Connect Plan](#)

[Kaiser Foundation Health Plan of Washington HMO Kaiser Permanente HMO](#)

Class I services—Diagnostic and preventive services

Dental cleaning (Prophylaxis)

In-network: 100%

Out-of-network: 100% of allowable charges

Two prophylaxes are covered in each calendar year. Services include cleaning, removal of plaque, calculus, and stains from the tooth surface (excluding bleaching or whitening).

Dental X-rays

In-network: 100%

Out-of-network: 100% of allowable charges

Covered dental X-rays include:

- Either a full mouth X-ray or panoramic X-ray or Cone Beam Film, once in a 36-month period, except as covered under the [orthodontia](#) benefit
- Bitewing X-rays
- Periapical X-rays
- Occlusal X-rays

The frequency of full mouth X-rays or panoramic X-ray or cone beam file may be allowed when it is for the diagnosis of a specific condition requiring treatment.

Emergency treatment for dental pain relief

In-network: 100%

Out-of-network: 100% of allowable charges

Emergency treatment for dental pain relief, palliative treatment, is covered. Chart notes, office records, and/or a description of the services provided are required from your provider.

Full mouth debridement

In-network: 100%

Out-of-network: 100% of allowable charges

Full mouth debridement (the removal of plaque and tartar that have accumulated on the teeth) to enable a comprehensive evaluation and diagnosis is covered once every three calendar years.

Oral evaluation

In-network: 100%

Out-of-network: 100% of allowable charges

Two preventive oral evaluations, or “checkups,” are covered in each calendar year.

Emergency oral evaluations are covered when a member is in pain or needs immediate care due to a dental emergency, trauma, or acute infections. Emergency oral evaluations will not count toward the preventive oral evaluation limit of two per calendar year.

Oral pathology laboratory

In-network: 100%

Out-of-network: 100% of allowable charges

Oral pathology laboratory procedures are covered. Coverage for the removal of the tissue samples is under the [Class II Services](#) benefit.

Periodontal maintenance

In-network: 100%

Out-of-network: 100% of allowable charges

Periodontal maintenance (a deeper cleaning that may include removal of bacterial plaque and calculus from above and below the gum line) is a covered service.

Prescription Drugs

Dental Plus

- *In-network: 100%**
- *Out-of-network: 100%**

The Plan covers prescription medications and drugs, when dispensed by your dentist for in office use.

*If you receive a written prescription from your dentist and have it filled at a retail pharmacy, your prescription benefits under your medical plan will apply. Refer to your medical plan for additional information regarding prescription drugs filled at a retail pharmacy.

If you are a member of the HMO Plan (Kaiser Foundation Health Plan of Washington or Kaiser Permanente), the pharmacy will not fill prescriptions written by a dentist. However, medications and drugs prescribed by your dentist can be filled at your local pharmacy and you can obtain reimbursement by completing and submitting the [Premera Claim Reimbursement Request Form](#).

Preventive resin restoration

In-network: 100%

Out-of-network: 100% of allowable charges

Preventive resin restorations are covered on permanent teeth.

Professional consultation

In-network: 100%

Out-of-network: 100% of allowable charges

Professional consultations by dental specialists, such as endodontists and periodontists, are covered when requested by the dentist. Consultations by a dental specialist, will not count toward the preventive dental evaluation limit of two per calendar year. Consultations by a general dentist will count towards the preventive dental evaluation limit of two per calendar year.

A professional consultation performed by an orthodontist is not covered under Class I Benefits.

Sealants

In-network: 100%

Out-of-network: 100% of allowable charges

This benefit covers sealants for permanent and primary teeth.

Space maintainers

In-network: 100%

Out-of-network: 100% of allowable charges

Space maintainers are covered when designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth). This benefit is available for members only under the age of 17.

Topical fluoride or fluoride varnish

In-network: 100%

Out-of-network: 100% of allowable charges

Topical fluoride or fluoride varnish treatment is covered twice in each calendar year.

Class II services—Basic restorative, endodontics, periodontics, and oral surgery

Anesthesia provided in a dental provider's office

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

General anesthesia, intravenous conscious sedation/analgesia, and nitrous oxide provided in a dental provider's office are covered when administered in connection with a covered [Class II](#) or [Class III](#) dental service.

Crown, bridge and denture repair

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

This benefit covers repairs to crowns, bridges, and full and partial dentures when services are performed at least six months after the initial placement.

Crown posts and core build-up

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Crown posts and core build-ups are covered.

Endodontic treatment

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Covered services for the treatment of diseases of the tooth pulp and root canal include the following:

- Pulpotomy and endodontic (root canal) therapy
- Direct Pulp Cap
- Endodontic retreatment
- Apexification/recalcification and apicoectomy/periradicular surgery
- Retrograde filling

Fillings (restorations)

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Fillings using amalgam and resin-based composite filling materials are covered to restore decayed, cracked, broken, or fractured teeth.

Nightguards

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Nightguards are covered for treatment of bruxism and other occlusal factors. Adjustments to nightguards are covered in lieu of replacement.

Occlusal adjustments

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Limited and full occlusal adjustments are covered when not part of a primary procedure.

Oral surgery

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Coverage includes customary postoperative treatment furnished in connection with oral surgery, as follows:

- Surgical extraction of one or more teeth
- Surgical removal of erupted or impacted teeth

- Surgical removal of residual tooth roots
- Bone Replacement graft for ridge augmentation, ridge preservation or repair of bony defect
- Alveolectomy, vestibuloplasty, and frenectomy
- Reimplantation of natural tooth or transplantation of a natural tooth
- Incision and drainage of an abscess related to the tooth structure or gingival tissue
- Excision or removal of a tumor or cyst related to the tooth structure or gingival tissue
- Biopsy of soft or hard tissue related to the tooth structure or gingival tissue

Periodontal scaling and root planing

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Scaling and root planing are covered, but not more often than once per quadrant of the mouth twice per calendar year.

Periodontal surgery

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Covered periodontal surgical services include the following services:

- Osseous surgery that includes gingivectomy, gingivoplasty, and gingival flap procedures
- Clinical crown lengthening
- Guided tissue regeneration
- Bone replacement and tissue grafts
- Biological materials to aid in tissue regeneration (approved and indicated for use by the FDA)
- Localized delivery of antimicrobial agents

Pin retention for fillings

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Pin retention services for fillings are covered.

Re-cementing bridges, inlays, onlays, and crowns

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

The re-cementing of bridges, inlays, onlays, and crowns is covered.

Simple extractions (one or more teeth)

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Simple extraction of one or more teeth is covered.

Study models

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Study models are covered no more often than once in any 36-month period.

Study models performed in conjunction with orthodontia are paid under the [orthodontia](#) benefit.

Therapeutic parenteral medication

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

The single or multiple administrations within the dental office by the treating dentist of antibiotics, steroids, and anti-inflammatory drugs and other therapeutic medications are covered.

Class III services—Major restorative services and installation of bridges and dentures

Prosthetic services and supplies

Dental Plus

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

The plan covers the following prosthetic services and supplies:

- Initial gold, porcelain, or ceramic inlays, onlays, crowns, and veneers, but only when the tooth, as a result of extensive cavities or fracture, cannot be restored with an amalgam or composite filling material. Charges for crowns for the purpose of periodontal splinting are not covered.
- Initial placement of full or partial dentures and fixed bridgework
- Replacement of full or partial dentures, inlays, onlays, veneers, crowns, or fixed bridgework that cannot be made serviceable
- Addition of one or more teeth to an existing partial denture
- Relining, rebasing and adjustments of existing dentures, but only if it has been at least one year since the denture was placed, and not more often than once in any two-year period
- Dental implants and implant-related services

Orthodontia

Dental Plus

- *In-network: 50%, deductible applies, \$50 orthodontia deductible applies, up to \$2,500 lifetime benefit maximum*
- *Out-of-network: 50% of allowable charges, deductible applies, \$50 orthodontia deductible applies, up to \$2,500 lifetime benefit maximum*

The dental deductible does not apply to this benefit. However, you must satisfy a separate, one-time \$50 deductible before this benefit is provided. **There is a \$2,500 combined lifetime benefit maximum for both in-network and out-of-network.**

Covered dental charges include services and supplies provided by a licensed dentist or orthodontist in connection with orthodontic treatment (other than for extractions) to correct malposed teeth. The plan covers only services provided while the member has Dental Plus coverage.

If treatment started before joining this plan, the \$2,500 lifetime benefit maximum benefit for orthodontia treatment is limited to continuing monthly adjustments, retention, or any new phase of orthodontia treatment performed while coverage is in effect under this plan.

Orthodontia services may be eligible for payment under the medical plan for dependents born with cleft/lip palate or other severe craniofacial anomalies. To qualify for benefits, the condition must meet medically necessary criteria in Premera's medical policy. Prior

authorization is strongly recommended for members to determine medical benefit eligibility for this service.

Prior authorization

Prior authorization, also referred to as a pre-service review, is strongly recommended to determine whether coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination gives claimants an opportunity to submit medical records in advance, to establish medical necessity and determine their potential financial responsibility, before the service is provided. Services are subject to eligibility and benefits at the time

of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera reserves the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.



Contact Premera at (800) 676-1411 for a copy of Premera's medical policy addressing orthodontia for repair of cleft palate and other severe congenital anomalies.

Dental coverage extended

Dental coverage will be extended for covered services that are ordered before your coverage ends if the covered service is delivered or completed within 30 days. This includes:

- Dentures
- Fixed bridgework
- Crown
- Root canal therapy



To be considered an “ordered service” the following must have been done:

1. Impressions used to form the dentures, crowns, or fixed bridgework have been taken
2. The teeth have been fully prepared for fixed bridgework and crowns

This is also described in the [When benefits coverage ends](#) section.

Exclusions and limitations

Dental exclusions and limitations include:

- Services that are not listed in this dental plan overview as covered or that are directly related to any condition, service, or supply that is not covered under this Dental plan
- Dental services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trustee, or similar person or group
- Occupational accidents
- Appliances or restorations necessary to increase vertical dimensions

- Any charges covered by a medical plan
- Orthodontic services or dental services (such as X-rays) required as a result of orthodontia, except as stated under the Dental Plus orthodontia benefit
- Services performed for cosmetic reasons including but not limited to enamel microabrasion, odontoplasty, internal or external bleaching, dental veneers, and crown lengthening
- Charges to the extent they are billed amounts above the allowable charges
- Any service or supplies for which no charge is made, or for which a charge is made because this plan is in effect, or for services or supplies for which the member is legally liable because this plan is in effect
- Services or supplies considered part of the primary procedure
- Services or supplies prescribed by a member to himself or herself or by a provider who is in any way related to the member. This also includes covered dependents under the plan who are living within the member's household.
- Oral hygiene instruction
- Nutritional or tobacco counseling for the control of and prevention of dental or oral disease, caries, and conditions
- Behavior management
- Services or supplies for which a claim was not made to Premiera Blue Cross within 12 months of the date of service. Corrected claims and COB claims need to be submitted within 12 months from the original claim submission date.
- Charges resulting from changing from one dentist to another while receiving treatment or from receiving care from more than one dentist for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one dentist had performed all the required dental services
- Services or supplies for or related to orthognathic surgery, temporomandibular joint dysfunction (TMJ), myofacial pain dysfunction (MPD), or similar conditions of the jaw joint
- Services that are incomplete, temporary, interim, or provisional (other than provisional splints)
- Expenses in excess of the applicable benefit maximums
- Benefits that overlap or duplicate benefits for which the member is eligible under any other group benefit plan, workers' compensation or similar employee benefit law, Medicare A or B, or government-sponsored program of any type. Also, not covered are expenses that are in any way reimbursable through "no fault" automobile insurance.
- Charges for or in connection with services or supplies that are determined to be experimental or investigational or not generally accepted as a standard of good dental practice
- Extra or replacement items such as extra dentures or other appliances, including replacements due to loss or theft
- Hospital facility or ambulatory surgical center facility fees, benefits may be available under the Medical Plan
- Home visits, or home-use products such as take-home fluoride, toothbrushes, floss, and toothpaste
- Testing and Treatment Services such as genetic or caries susceptibility tests or testing and treatment for mercury sensitivity or that are allergy related
- Services or supplies that are not dentally necessary for diagnosis, care or treatment of a disease, illness, or injury
- Precision attachments and personalization of appliances

- When payment is subject to the plan's Coordination of Benefits (COB) provisions, and you fail to follow the rules of the primary plan, this plan would pay nothing for that expense
- Replacement of lost or stolen prosthesis originally paid for by the plan Prescription, materials, or supplies that are not approved or indicated for use by the FDA
- Fabrication of athletic mouth guards
- Dental treatment simulations utilizing digital or 3-D imaging
- Indirect pulp caps

How to file a claim

In most cases, when you receive care from an in-network provider, your provider will submit bills directly to Premiera, and this submission is your claim for benefits. If your provider does not submit a bill directly to Premiera, you will need to submit a claim for benefits.

If possible, you should submit the claim form within 30 days of the service. The plan will not reimburse claims submitted more than 12 months after the date of service.

For information about how the novel coronavirus (COVID-19) pandemic impacts the claims process and timelines, [Important information due to the coronavirus pandemic](#).

To submit a claim online:

From the Benefits Site, select **View My Claims**, which will direct you to the Premiera Portal. Or sign in to your account on premera.com. Next, from the top menu bar select **Claims** and then **Submit Claims**.

Follow the steps and upload a copy of the itemized receipt. To submit a claim via mail, fax, or email:

1. Download the [Premera Claim Reimbursement Request Form](#). You can also email Premiera from your Woodgrove Financial email address (employees) to Woodgrove.Financial@premera.com or through your Secure Messaging center in the Premiera portal (all enrollees including dependents and COBRA members) to request a claim form.
2. Complete the claim form, including all of the following information:
 - a. Your name and the member's name
 - b. Identification numbers shown on your identification card (including the 3-digit plan prefix or MSJ)
 - c. Provider's name, address, and tax identification number
 - d. If you are seeking secondary coverage from the Woodgrove Financial health plan, information about other insurance coverage related to the claim at hand, including a copy of their Explanation of Benefits (EOB), if applicable
 - e. If treatment is as a result of an accident: the date, time, location and brief description of the accident
 - f. Date of onset of the illness or injury
 - g. Date of service
 - h. Diagnosis or ICD-10 code (this information can be found on the provider's bill)

- i. Procedure codes (CPT-4, HCPCS, ADA, or UB-92) or descriptive English language for each service (this information can be found on the provider's bill)
 - j. Itemized charges for each service rendered by provider
3. Sign the form in the space provided and attach the itemized provider's bill

4. Submit the completed form to:

Mail: Premera Blue Cross

P.O. Box 91059

Seattle, WA 98111-9159

Fax (800) 676-1477

Email from Woodgrove Financial email address:

claims.Woodgrove.Financial@premera.com Email through the

Secure Messaging center in your Premera portal

In making a claim determination, Premera will interpret the relevant Plan provisions in good faith and in the best interest of participants and beneficiaries and will not take into account either the amount of benefits at issue or the financial impact on Woodgrove Financial.



COBRA-eligibility claims should be submitted as described in the [Continuation of coverage for health and FSA benefits \(COBRA\)](#) section.

In the following circumstances, you may submit claims according to the [appeals process](#):

If you cannot submit the claim in a timely manner due to circumstances beyond your control If your claim regards plan eligibility for you, your spouse/domestic partner, or dependent child

Claim review and payment

The claim review process begins once Premera receives a claim from you or your provider or other authorized representative. Premera will send you an Explanation of Benefits (EOB) or other communication notifying you of their decision on your claim. In most cases, this communication will be sent to you no more than 30 days after Premera receives the claim, although Premera may extend this 30-day period for up to 15 days if the extension is required due to matters beyond Premera's control.

If your claim relates to an item for which the Plan requires you to obtain approval (or "prior authorization") before it is furnished to you, then Premera generally will send a decision no later than 15 calendar days after receipt of your request. Premera may extend this 15-day period for up to an additional 15 days if the extension is required due to matters beyond Premera's control.

If Premera needs additional information from you to process your pre- or post-service claim, Premera will notify you in writing, within 30 days after receiving your claim, of the specific information required. You will have at least 45 days to provide the additional information. The determination period to respond to your claim (as provided above) will be suspended as

of the date Premera sends the notice and will resume again once you have provided the additional information. If you do not provide the requested information within the specified timeframe, Premera will decide the claim without the requested information.

If your claim is for “urgent care,” meaning the application of the standard time periods for making determinations could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment at issue, then the following special rules apply:

- Premera will send you an EOB or other communication notifying you if they have denied your claim, in writing or electronically, within 72 hours after Premera receives all necessary information for your claim either via phone or in writing, taking into account the seriousness of your condition.
- Premera’s denial notice may be oral, with a written or electronic confirmation to follow within three days.

- If the claim was filed incorrectly, Premera will notify you of the error and how to correct it within 24 hours after the claim was received. If additional information is needed to process the claim, Premera will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information. You will then be notified of Premera's determination no later than 48 hours after (1) Premera's receipt of the requested information, or (2) the end of the 48-hour period when you were to provide the additional information if the information is not received in that timeframe.

If your claim is a request to extend an ongoing course of treatment beyond a previously approved period of time or number of treatments, and is considered an urgent care claim, Premera will decide your claim within 24 hours, provided that your claim is submitted at least 24 hours before the end of the approved treatment.



Explanation of benefits (EOB) is the statement you receive from Premera Blue Cross detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

Premera will make a payment to the employee, a dependent (age 13 or older), a provider, or another carrier. Payments are subject to applicable law and regulation:

- Premera may make payments on behalf of an enrolled child to a non-enrolled parent or state agency to which the plan is required by applicable law to direct such payments
- Payments made will discharge the plan to the extent of the amount paid, so that the plan is not liable to anyone due to its choice of payee

Denied claims notice

If all or part of your claim is denied, Premera will send you an Explanation of Benefits (EOB) or other notice with the following information:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A description of any additional material or information needed from you and the reason it is needed
- An explanation of the appeals procedures and the applicable time limits
- A statement regarding any internal rule, guideline, protocol, or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request)
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)
- If the claim is for urgent care (as defined above), a description of the expedited review process applicable to such claims
- If you have filed a claim with Premera relating to plan eligibility, and this claim is denied, Premera will send you a notice explaining your appeal rights
- Notice regarding your right to bring legal action following a denial on appeal

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable

- The denial code and its meaning
- A description of the plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal
- Contact information for Premera Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

Appeal for internal review

If you do not agree with the decision made by the plan, you may appeal for an internal review of the decision within 180 days of receiving the Explanation of Benefits (EOB) or adverse decision.

For information about how the novel coronavirus (COVID-19) pandemic impacts the appeal process and timelines, [Important information due to the coronavirus pandemic](#).



An **appeal** is a written request to reconsider a written or official verbal adverse determination to deny, modify, reduce, or end payment, coverage or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to and continued stays in a facility. The process also applies to Flexible Spending Account appeals for reimbursement but does not apply to appeals of denied COBRA eligibility claims.



If you fail to file the internal appeal within 180 days of receiving the Explanation of Benefits, you will permanently lose your right to appeal the denied claim.

Submitting an appeal for internal review

You or your authorized representative* must provide the following information as part of your written appeal to the Premera Appeals Department.

- Your name
- Your Premera member number
- The name of this plan, and
- A concise statement of why you disagree with the decision, including facts or theories supporting your claim

Your written request may (but is not required to) include issues, comments, documents, and other records you want considered in the review.



The appeal should be submitted to Premera at the following address:

Appeals Coordinator
Premera Blue Cross

*You may, at your own expense, have a representative file an appeal on your behalf. Your attorney, family member, your provider, or anyone else who you wish to designate as your authorized representative may also appeal with written authorization. In order to designate an authorized representative for this purpose,

you must submit a completed and signed [Woodgrove Financial Member Appeal form](#) which includes an appeal authorization section.

In the case of an urgent care appeal, you may submit your appeal request orally or in writing and all necessary information may be transmitted between you and the plan by telephone or facsimile. If your provider believes your situation is urgent as defined under law and so notifies Premera, your appeal will be conducted on an expedited basis. Notification will be furnished to you as soon as possible, but not later than 72 hours after receipt of the expedited appeal. Your appeal should clearly indicate your request for an expedited appeal.

You may begin an external independent review at the same time as Premera Blue Cross's internal review process if this is an urgent situation or you are in an ongoing course of treatment. The external review agency is not legally affiliated or controlled by Premera. The external review agency decision is final and is binding upon the Plan.



To file an urgent care appeal request, you may fax a request to (425) 918-5592.



An urgent care claim or appeal is one where the application of the standard time periods for making determinations could seriously jeopardize your life, health, or your ability to regain maximum function, or in the

Internal review and timeframe

All the information you submit will be taken into account on appeal, even if it was not reviewed as part of the initial decision. You may ask to examine or receive free copies of all pertinent plan documents, records, and other information relevant to your claim by requesting these from Premera. If the adverse benefit determination involved dental judgment, the review will be provided by a dental care provider.

In the event any new or additional information (evidence) is considered, relied on, or generated by Premera in connection with your appeal, Premera will provide this information to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Premera, Premera will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that that you will have an opportunity to respond.

Other than urgent care appeals, described above, in most cases Premera will send a decision on your appeal no later than 60 calendar days after receipt of your appeal request.

However, if the appeal relates to an item for which the Plan requires you to obtain approval before it is furnished to you, then it will be considered a pre-service appeal, and Premera will send a decision no later than 30 calendar days after receipt of your appeal request.

Denied appeal notice

If your appeal is denied, you will receive a written notice setting forth:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits

- A statement explaining the external review procedures offered by the plan and your right to bring a civil action under ERISA section 502(a)
- A statement regarding any internal rule, guideline, protocol, or other criterion that was relied upon in denying the claim (a copy of which will be provided free upon request)
- If the denial is based on a dental necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)

Decisions upon the internal review are final under the plan's appeal process, and there are no further appeals available from Premera or Woodgrove Financial or any person administering claims or appeals under the plan. However, you still have a right to file suit under ERISA Section 502(a) as a result of the decision.

Limits on your right to judicial review

You must follow the appeals process described above through the decision on the appeal before taking action in any other forum regarding a claim for benefits under the plan. Any legal action initiated under the plan must be brought no later than one year following the adverse determination on the appeal. This one-year limitations period on claims for benefits applies in any forum where you initiate legal action. If a legal action is not filed within this period, your benefit claim is deemed permanently waived and barred.



If you have questions about understanding a denial of a claim or your appeal rights, you may contact Premera Customer Service for assistance at (800) 676-1411. You may also seek assistance from the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor at (866) 444-EBSA (3272).

Right to recover benefits paid in error

If Premera makes a payment in error on your behalf to you or a provider, and you are not eligible for all or a part of that payment, Premera has the right to recover payment, including deducting the amount paid mistake from future benefits.

Note: Health care providers are not “beneficiaries” of the plan, and although Premera may make direct payment to health care providers for the convenience of participants and their dependents, such payments of services shall not be considered “benefits” available under the plan or confer beneficiary standing upon a health care provider.

Section VI: Flexible spending accounts (FSAs)

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How FSAs work

What is in this section

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Your FSA options



COBRA enrollees – the Your FSA options section applies

Flexible spending accounts (FSAs) can help you reduce your tax bill by letting you set aside pre-tax dollars to pay for eligible health care and dependent care expenses. If you are enrolled in the Health Savings Account, your health care FSA participation is limited to vision and dental expenses (per IRS rules).

Account type	Eligibility	Expenses covered	Maximum contribution per year
Dental & Vision FSA	For employees with a Health Savings Account	Dental and vision only	\$2,850
Health Care FSA	For employees who don't have a Health Savings Account	Medical, prescription, dental, vision	\$2,850
Dependent Care FSA	For employees with eligible dependent care expenses	Child and elder care	\$5,000



If you leave Woodgrove Financial during the year, you will lose any remaining balance in your FSA accounts. However, you can extend the Dental & Vision FSA or Health Care FSA through COBRA coverage. For more information, see the [Coverage if you leave Woodgrove Financial](#) section.

When you enroll



COBRA enrollees – the When you enroll section does not apply

You decide how much you would like to contribute to your FSA for the year, up to the maximum amount. You must reenroll during the open enrollment period each year if you want to continue participating in the next plan year unless you have a carryover from the prior plan year.

The amount you elect will be deducted on a prorated basis each pay period throughout the year to fund your account. The following dental & vision and health care and dependent care FSA sections provide additional information about contributions.



Estimate your expenses carefully. The FSAs generally can reimburse only services that you use or items that you purchase by December 31 of each year. All claims must be received within 90 days of the end of the plan year. However, for 2020 FSAs, the claim submission deadline will be extended by one year (until March 31, 2022), or until 90 days after the end of the Outbreak Period (as described in [Important information due to the coronavirus pandemic](#)), whichever is earlier.

You may carry over up to \$570 in unused Dental & Vision FSA or Health Care FSA funds to the following plan year. Any remaining balance above \$570 is forfeited, pursuant to IRS rules. However, additional flexibility has been implemented for 2020 and 2021 FSAs due to the novel coronavirus (COVID-19) pandemic, which increases the amount eligible for carryover.

For information about how the COVID-19 pandemic impacts the FSAs (and other benefits) see [Important information due to the coronavirus pandemic](#).



To estimate your potential costs and tax savings under the FSAs, use the decision support tools on the [Benefits Enrollment tool](#).

Making changes



COBRA enrollees – the *Making changes* section does not apply

The annual open enrollment period is your only opportunity to make changes to your FSA elections unless you have a qualifying life event.

Changes to add one or more dependents to health care or dental & vision FSA coverage will take effect as of the date of the special enrollment event (marriage, birth, legal adoption, etc.), such that eligible expenses incurred by the newly-added dependent(s) after that date may be reimbursed from the FSA. However, any change in the amount of your FSA election, and resulting payroll contributions, will take effect prospectively only, for pay periods following the date that you make the election change.

Example

Melissa just had her second baby and changed her dependent care election from \$2,500 to \$5,000 on June 1. The plan will not reimburse expenses incurred before June 1 in excess of \$2,500.



For more information, see the [Life event enrollment](#) section.


Using your FSAs



COBRA enrollees – the *Using your FSAs* section applies

To be eligible for reimbursement, expenses must meet IRS criteria and be incurred during the period of coverage. Services prior to your date of hire are not eligible for reimbursement.

You pay for expenses and then seek reimbursement from your FSA. You may receive your reimbursement via direct deposit or check.



Active employees go here...	COBRA enrollees go here...
My Dashboard	Premera

For direct deposit of your reimbursements, complete the direct deposit form.

All required documentation for eligible expenses must be received within 90 days following the end of the year in order to be considered for reimbursement. Note: for 2020 FSAs, the claim submission deadline will be extended by one year (until March 31, 2022), or until 90 days after the end of the Outbreak Period (as described in Important information due to the coronavirus pandemic), whichever is earlier.

The IRS allows you to carry over up to \$570 in unused Dental & Vision FSA or Health Care FSA funds to the following calendar year. Any funds over \$570 remaining in your Dental & Vision FSA or Health Care FSA following 90 days after the end of the plan year will be forfeited, as required by IRS rules.



In accordance with Internal Revenue Service (IRS) regulations, health care or dependent care expenses from your domestic partner or your domestic partner's children are not eligible for reimbursement under this plan, unless they meet the definition of “dependent” under the tax rules.

For information about how the COVID-19 pandemic impacts the FSAs (and other benefits) see [Important information due to the coronavirus pandemic](#).

Review the [dental & vision and health care](#) and [dependent care](#) FSA sections for more information about eligible expenses and the reimbursement process.

If you're on leave of absence



COBRA enrollees – the If you're on leave of absence section does not apply

Payroll deductions for your dental & vision and health care or dependent care FSA will continue while you are on a paid leave of absence. For unpaid leaves of absence, payroll deductions that would have otherwise been taken during that period will be deducted from your first paycheck upon your return to work. If you are returning from unpaid FMLA leave, you can instead resume your participation at a reduced level and resume contributions in effect before the FMLA leave.

You may be reimbursed for eligible health care expenses during a paid or unpaid leave of absence. Your eligibility to be reimbursed for eligible dependent care expenses depends upon your particular leave situation. For more information, refer to IRS Publication 503.

If you change your election amount as part of a qualified life event while you are on leave, the new amount will be deducted from the first paycheck after the effective date of the change. For more information, see the [Life event enrollment](#) section.

If you are on leave for the entire annual open enrollment period, you will receive information in the mail, including an enrollment form. If you wish to continue your FSA participation, you must submit your election on the Benefits Enrollment tool or return the completed enrollment form by the end of the open enrollment period.

Dental & Vision and Health care FSAs

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Contributions



COBRA enrollees – the Contributions section does not apply

For 2023, you may contribute up to \$2,850 to your dental & vision or health care FSA.



Estimate your expenses carefully. You must use all the money in your FSA by December 31 of each year or any remaining balance above the \$570 that the IRS allows you to carry over to the following calendar year is forfeited, as required by IRS rules. You have 90 days from the end of the year to file claims for reimbursement for services received during the plan year. However, for 2020 FSAs, the claim submission deadline will be extended by one year (until March 31, 2022), or 90 days after the end of the Outbreak Period, whichever is earlier.

For information about how the COVID-19 pandemic impacts this benefit see [Important information due to the coronavirus pandemic](#).

Eligible expenses



COBRA enrollees – the Eligible expenses section applies

If you are enrolled in the Health Savings Account, your FSA participation is limited to vision and dental expenses (per IRS rules). All other eligible employees may participate in the health care FSA, even if they are not enrolled in a Woodgrove Financial medical plan.



In accordance with Internal Revenue Service (IRS) regulations, health care expenses from your domestic partner or your domestic partner's children are not eligible for reimbursement under this plan, unless they are filed as dependents on your tax return.

To be eligible for reimbursement, expenses must:

- Meet the eligibility criteria defined under the Internal Revenue Code. Examples of eligible expenses are provided in the following table.
- Be incurred during the FSA period of coverage

- If your contributions begin after January 1 (for example, if you are a new hire), expenses incurred on or after your date of hire or date of your [special enrollment event](#) are eligible for reimbursement
- If your contributions end before December 31 (for example, due to termination of employment), expenses incurred after your last day of participation will not be eligible for reimbursement unless you elect COBRA coverage
- Otherwise, your expenses must be incurred from January 1 to December 31

Account type	Eligibility	Examples of eligible expenses
Dental & Vision FSA	For employees with a Health Savings Account	<ul style="list-style-type: none"> • Dental expenses that are not fully covered by a group dental plan, including orthodontia • Vision care and hardware expenses, such as glasses, that are not fully covered by a medical plan • Medical plan and dental plan deductibles
Health Care FSA	For employees who don't have current year contributions into a Health Savings Account	<ul style="list-style-type: none"> • Coinsurance and copayments • Medical expenses that are not fully covered by a group medical plan (such as private duty nursing) • Dental expenses that are not fully covered by a group dental plan, including orthodontia and temporomandibular joint disorder (TMJ) • Vision or hearing care and hardware, such as glasses or hearing aids, that are not fully covered by a medical plan • Lamaze classes for mother only



For a complete list of eligible expenses, refer to IRS Publication 502. IRS Publication 502 does not mention:

1) that COBRA premiums may not be reimbursed from a Health Care FSA. 2) that certain menstrual care products (like tampons and pads) are eligible to be reimbursed from a Health Care FSA and 3) that certain over-the-counter medications can be reimbursed from a Dental & Vision or Health Care FSA. Contact Premera at (800) 441-1111 for more information.

How to file a claim



COBRA enrollees – the How to file a claim section applies

You may be reimbursed for eligible health care expenses up to the total amount you have elected to contribute for the year, regardless of the amount contributed to the account to date.

If you participate in the Health Savings Plan, Hawaii Only Plan, or the Health Connect Plan your eligible in- network expenses will be submitted automatically for reimbursement from your FSA, with the exception of the following:

- Claims for members with other coverage (COB)
- Claims for domestic partners or your domestic partner's children
- Sensitive claims for dependents (for example, mental health)



To update your account to manual claim submission, visit:

Active employees go here...

COBRA enrollees go here...

Fidelity

Premera

For all other expenses, you have 90 days following the end of the plan year to submit claims and required documentation to your FSA for reimbursement of expenses that were incurred the previous year. Claims that are submitted more than 90 days after the end of the plan year are not eligible for reimbursement. Note: for 2020 FSAs, the claim submission deadline will be extended by one year (until March 31, 2022), or 90 days after the end of the Outbreak Period, whichever is earlier.

Manual reimbursement

For manual reimbursement, you must submit the following to the address on the claim form:

- A completed claim form
 - [Dental and Vision FSA Claim Form](#)
 - [Health Care Flexible Spending Account Claim Form](#)
- Receipts or itemized bills for expenses that you or an eligible dependent incurred
- The explanation of benefits (EOB) that the health care plan provided if a portion of the expense was paid by a medical or dental plan

To submit your claim online, visit:



Active employees go here...

COBRA enrollees go here...

[My Dashboard](#)

[Premera](#)

Reimbursements are issued as either a check mailed to your home or, if you have direct deposit, an electronic funds transfer is initiated to your bank account.

Appeal for internal review

If the plan denies your claim, you may appeal for an internal review of the decision within 180 days of receiving the Explanation of Benefits (EOB).

For information about how the novel coronavirus (COVID-19) pandemic impacts the appeal process and timelines, [Important information due to the coronavirus pandemic](#).



An **appeal** is a written request to reconsider a written or official verbal adverse determination to deny, modify, reduce, or end payment, coverage, or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to and continued stays in a facility. The process also applies to Flexible Spending Account appeals for reimbursement but does not apply to appeals of denied COBRA eligibility claims.



If you fail to file the internal appeal within 180 days of receiving the Explanation of Benefits, you will permanently lose your right to appeal the denied claim (however, see the note and link above for special rules regarding the appeals process and timeline with regard to the COVID-19 emergency period).

Submitting an appeal for internal review

You or your authorized representative* must provide the following information as part of your written appeal to the Premiera Appeals Department:

- Your name,
- Your Premiera member number,
- The name of this plan, and
- A concise statement of why you disagree with the decision, including facts or theories supporting your claim.

Your written request may (but is not required to) include issues, comments, documents, and other records you want considered in the review.



The appeal should be submitted to Premiera at the following address:

Appeals Coordinator
Premiera Blue Cross

*You may, at your own expense, have a representative act on your behalf. If you want to appoint someone to act for you in the appeals process (this may be your attorney or your provider), you must submit a completed and signed [Woodgrove Financial Member Appeal form](#), which includes an appeal authorization section.

Internal review and timeframe

All the information you submit will be taken into account on appeal, even if it was not reviewed as part of the initial decision. You may ask to examine or receive free copies of all pertinent plan documents, records, and other information relevant to your claim by asking Premiera.

In the event any new or additional information (evidence) is considered, relied on, or generated by Premiera in connection with your appeal, Premiera will provide this information to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Premiera,

Premiera will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that that you will have an opportunity to respond.

Other than urgent care appeals, described above, in most cases Premiera will send a decision on your appeal no later than 60 calendar days after receipt of your appeal request. If the appeal relates to an item for which the Plan requires you to obtain approval before it is furnished to you, then it will be considered a pre-service appeal, and Premiera will send a decision no later than 30 calendar days after receipt of your appeal request.

Denied appeal notice

If your appeal is denied, you will receive a written notice setting forth:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits
- A statement explaining the external review procedures offered by the plan and your right to bring a civil action under ERISA section 502(a)
- A statement regarding any internal rule, guideline, protocol, or other criterion that was relied upon in denying the claim (a copy of which will be provided free upon request)

Decisions upon the internal review are the final decision under the plan's appeal process, and there are no further appeals available from Premera or Woodgrove Financial or any person administering claims or appeals under the plan. However, you still have a right to file suit under ERISA Section 502(a) as a result of the decision.

Limits on your right to judicial review

You must follow the appeals process described above through the decision on the appeal before taking action in any other forum regarding a claim for benefits under the plan. Any legal action initiated under the plan must be brought no later than one year following the adverse determination on the appeal. This one-year limitations period on claims for benefits applies in any forum where you initiate legal action. If a legal action is not filed within this period, your benefit claim is deemed permanently waived and barred. In addition, you must raise all issues and grounds for appealing a decision on a claim for benefits at every stage of the appeal process, or else such issues and grounds will be deemed permanently waived and barred.



If you have questions about understanding a denial of a claim or your appeal rights, you may contact Premera Customer Service for assistance at (800) 676-1411. You may also seek assistance from the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor at (866) 444-EBSA (3272).

Right to recover benefits paid in error

If Premera makes a payment in error on your behalf to you or a provider, and you are not eligible for all or a part of that payment, Premera has the right to recover payment, including deducting the amount paid mistake from future benefits.

Note: Health care providers are not “beneficiaries” of the plan, and although Premera may make direct payment to health care providers for the convenience of participants and their dependents, such payments of services shall not be considered “benefits” available under the plan or confer beneficiary standing upon a health care provider.

Dependent care FSA

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COBRA enrollees – the Dependent care FSA section does not apply

Contributions

Your dependent care FSA contribution cannot exceed the least of the following amounts:

- \$5,000 annually per household if you are married, filing jointly, or single and filing as head of household
- \$2,500 annually if you are married and filing separately
- The lesser of your or your spouse's earned income
- \$250 per month for one dependent or \$500 per month for two or more dependents up to the plan maximum (if your spouse is an unemployed, full-time student or incapable of self-care due to disability)



Estimate your expenses carefully. You must use all the money in your FSA by December 31 of each year, or any remaining balance is forfeited, as required by IRA rules. You have 90 days from the end of the plan year to file claims for reimbursement for services received during the plan year. However, for 2020 FSAs, the claim submission deadline will be extended by one year (until March 31, 2022), or 90 days after the end of the Outbreak Period, whichever is earlier.

Under the Consolidated Appropriations Act of 2021 and the American Rescue Plan Act of 2021 (the “Acts”), you can carry over unused dependent care FSA funds from 2020 into 2021 and again from 2021 into 2022. In a typical year, there would be no carryover option allowed under the dependent care FSA. This temporary provision is unlimited in amount. This means that all your unused 2020 FSA dollars will be carried into 2021 automatically, and all your unused 2021 FSA dollars will be carried into 2022 automatically. It is suggested that you plan carefully, as any unused funds left in your dependent care FSA after the temporary carryover relief expires will be subject to forfeiture.

For information about how the COVID-19 pandemic impacts this benefit see [Important information due to the coronavirus pandemic](#).

Expenses reimbursed from your dependent care FSA cannot be used for the child and dependent care tax credit on your personal income tax return at the end of the year. In certain situations, it may be advantageous to use a combination of the tax credit and dependent care account, regardless of your income level. You should seek the opinion of a tax advisor regarding your personal financial situation.

Eligible expenses

Your dependent care expenses are eligible for reimbursement from your dependent care FSA if you and your spouse/domestic partner both work or if your spouse/domestic partner meets one of the following criteria:

- Is a full-time student
- Is physically or mentally incapable of self-care

You may be reimbursed for eligible dependent care expenses for the following dependents:

- Your children age 12 and under that you claim as dependents for income tax purposes
- Certain other dependents, such as parents or your spouse, who are physically or mentally unable to care for themselves, who live with you for more than half a year, and for non-spouses, receive over half of their support from you
- The Consolidated Appropriations Act of 2021 extends reimbursement eligibility to qualifying children who turned or will turn 13 in 2020 or 2021, respectively. If your child turned 13 in 2020, you may be reimbursed for the child's eligible expenses incurred through the end of 2020 (including those incurred after the child's thirteenth birthday). Reimbursement is also available for expenses incurred in 2021 for children who turned 13 in 2020 (until the child's fourteenth birthday), or who turned or will turn 13 in 2021 (through the end of 2021), if and to the extent you have any remaining unused 2020 dependent care FSA funds that carried over into 2021. It is your responsibility to track and confirm your eligibility for this relief.

To be eligible for reimbursement, expenses must:

- Meet the eligibility criteria defined under the Internal Revenue Code
- Be for care inside your home, except for your children age 12 and under (regardless of the number of hours they spend in your home each day) and other dependents who normally spend at least eight hours in your home each day
- Be incurred during the same period in which amounts are credited to your FSA
 - If your contributions begin after January 1 (for example, if you are a new hire), expenses incurred on or after your date of hire or date of your [special enrollment event](#) are eligible for reimbursement
 - If your contributions end before December 31 (for example due to termination of employment), expenses incurred after your last day of participation will not be eligible for reimbursement
 - Otherwise, your expenses must be incurred from January 1 to December 31

Examples of eligible expenses include:

- Childcare or baby-sitting services inside your home or someone else's home to enable both spouses to work
- Expenses for dependent care centers (that is, a center that cares for more than six people at a time and meets all state and local licensing requirements)
- Certain expenses for a full-time, live-in housekeeper to take care of your dependent who is age 12 or under or who is physically or mentally unable to care for themselves
- School-related costs for your children who are not yet in kindergarten
- Expenses for day camps



For a complete list of eligible child and dependent care expenses, refer to IRS Publication 503.

How to file a claim

You may be reimbursed for eligible dependent care expenses up to the total amount you have elected to contribute for the year, regardless of the amount contributed to the account to date.

You have 90 days following the end of the plan year to submit claims and required documentation for reimbursement of expenses that were incurred the previous plan year. Claims that are submitted more than 90 days after the end of the plan year are not eligible for reimbursement and any funds left in the account will be forfeited. Note: for 2020 FSAs, the claim submission deadline will be extended by one year (until March 31, 2022), or until 90 days after the end of the Outbreak Period (as described in Important information due to the coronavirus pandemic), whichever is earlier.

You must submit the following to the address on the claim form:

- A completed [Dependent Care FSA Claim Form](#)
- Receipts or itemized bills for expenses



To submit your claim online, visit [My Dashboard](#) on the Benefits site.

Reimbursements are issued as either a check mailed to your home or, if you have direct deposit, an electronic funds transfer is initiated to your bank account. You will receive an advance e-mail notification of the reimbursement to your Woodgrove Financial e-mail address.

Section VII: Other health & wellness benefits

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Spring Health Short-term Counseling, Resource & Referral. Employee Assistance Program (EAP)

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How the program works

Spring Health is our confidential, free, short-term counseling and work-life resource and referral provider

(employee assistance program).

Eligibility: Employees and their dependents (spouse/partner, children 6-26). Note for children under 6

Spring Health will help with referrals.

Create your online account at aka.ms/SpringHealth to access their services. You may add dependents under 18 to yours, or your spouse/partner's account.

Adult dependents (spouse/partner, *child 18+) can create accounts in one of two ways:

- From your Spring Health account you can send your adult dependent (spouse/partner, child 18+) an invitation to create their own Spring Health account. Login to your account and to your profile and settings to send the invitation.
- Adult dependents (spouse/partner, *child 18+) can create their own accounts by going to [www.Woodgrove Financial.springhealth.com](https://www.WoodgroveFinancial.springhealth.com). They will need your full name and full email with your alias to create an account.
- You will not have access to or know if your adult dependent has created an account, as it's confidential.

***Note:** In some states dependents under 18 may be able to create their own accounts based on local state law regarding parental consent.



Woodgrove Financial respects your right to privacy in your personal and family life. No record of your use of the Spring Health program will be kept or made available to anyone within Woodgrove Financial. This also applies to your health care plans.



To schedule an appointment with a Spring Health counselor, call (855) 629-0554. You can also visit [Spring Health](#).

If you leave Woodgrove Financial or otherwise become ineligible, you will continue to have access to Spring Health, short-term counseling, resource & referral (EAP) benefits if you elect to continue your coverage. For more information, see the [When coverage ends](#) section.

What the plan covers

Spring Health short-term counseling, work-life resources and referrals, access to the Spring Health Platform and services.

Counseling services

The short-term counseling services covered through Spring Health are described below.

Service	Description	Coverage
Individual, couples, or family counseling	Emotional, psychological, social, or work-related stress; brief problem resolution and/or referral for behavioral health treatment. For couples and/or families, issues related to relationship building, conflict resolution, and decision making within the family unit. You can choose in-person or video/virtual-based therapy.	Up to 24 sessions per calendar year.



Additional mental health coverage may be available under your [medical plan](#). The Spring Health EAP is separate from the mental health services covered under Woodgrove Financial's medical plans.

Counseling services include:

Type of counseling	Description
Child counseling	You can get help for a child who needs to adapt more effectively within the family, at school, and with friends. Experienced child counselors lead individual and group sessions.
Domestic violence treatment program	Education and support is available for women or men trying to overcome the cycle of violence and abuse. Classes and group sessions focus on assessing domestic violence issues, changing abusive behaviors, and learning nonviolent relationship skills.
Grief counseling	Counseling is available for adults and children who have experienced the death of a loved one. Support groups and referral sources are also available.
Work-related and onsite resources	Manager Consultation or Critical incident Stress Management support is available for HR and managers who may be dealing with difficult situations in their work environment, including conflict resolution, communicating sensitive messages, and dealing with deaths in the workplace. Call 1(855)629-0554 (option 4)

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- Access to Spring Health includes the following: Access to Spring Health via Web and App (Woodgrove Financial.springhealth.com)
- Personalized care plan: 5-minute mental health assessment creates a customized care plan
- Counseling: 24 free counseling sessions per calendar year (12 sessions in 2022) with a Spring Health provider per year.
- Care Navigator (Concierge) Support: Unlimited appointments with Care Navigators who are licensed clinicians to help you determine the best care options for you
- Mental & Emotional Wellbeing Coaching
- Moments: self-guided exercises for mental wellbeing, covering topics like anxiety, burnout, better sleep, and more in an on-demand library. You have unlimited access to Moments which are wellness exercises for everyone, for your continued overall wellbeing from anywhere at any time.
- Work-life Resources & Referrals: Covers a variety of childcare, eldercare, financial, legal, and daily life topics. Spring Health will do the research for you to find options, including a list of referrals for childcare, eldercare, pet care, and more. Browse thousands of articles, talk/chat with a work-life consultant and connect with subject-matter experts. Use online tools, articles, audio/video information, resources, and skill builders that provide practical tips on parenting, aging, balancing, thriving, working, living, as well as U.S./international immigration/relocation.
- Monthly and on demand webinars based on various mental and emotional wellbeing topics.
- Access to Gottman Institute to attend one of the following (limited to one of the below sessions per member, per year):
 - [Art and Science of Love](#) couples virtual or online relationship workshop (up to USD599 towards 1 virtual weekend workshop, or one online workshop with or without the DVD per employee per calendar year). If you want to attend the Art and Science of Love workshop in person, you may work with the Gottman institute directly to cover the additional cost from your own funds; or
 - [Emotion Coaching](#) online course (up to USD99 online or DVD, per employee, per calendar year), or
 - [Bringing Baby Home workshop/New Parents relationship workshop](#), virtual or in-person, (up to USD400, per employee, per calendar year)
 - To learn more about how to get access to the Gottman Institute options view the options under, "Access Spring Health" [here](#) or ask your Spring Health Care Navigator.



For more information on Spring Health services and resources, or to schedule an appointment, call go to Woodgrove Financial.springhealth.com, or call 1(855)629-0554.

Expert Medical Opinion (Teladoc Medical Experts)

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How the program works

Woodgrove Financial's Expert Medical Opinion Program, administered by Teladoc Medical Experts, an independent third-party vendor, offers expert medical advice when you or a family member is facing an important medical decision. The program is a voluntary and confidential service provided at no additional cost to all Woodgrove Financial U.S. benefits-eligible employees, along with their spouses, domestic partners, children, and extended family members. The Expert Medical Opinion Program is ideally suited to help complex patients with conditions such as cancer, surgical candidates, and those with complicated or sensitive medical questions.

Teladoc Medical Experts is a global health services provider of physician-driven programs offering advocacy and support to employees experiencing medical confusion and/or crisis. The Expert Medical Opinion Program is delivered only by actively practicing, board certified physicians with access to 50,000 leading consulting experts worldwide.

Teladoc Medical Experts will support all medical specialties including but not limited to:

- Orthopedic Surgery
- Oncology
- Psychiatry
- Cardiology
- Internal Medicine
- Radiology
- Obstetrics/Gynecology
- Nephrology
- Urology
- Ophthalmology
- Emergency Medicine
- Pediatrics

- Family Medicine
- Mental Health
- Hematology

- Pulmonology
- Critical Care
- Pathology

To get started

- Contact Teladoc Medical Experts in one of three ways:
 - Call (800) 676-1411 and follow the prompts to speak with a Teladoc Medical Experts representative. Calls are answered by live representatives twenty-four hours a day, seven days a week, 365 days a year. Any non-covered dependents or extended family members will need to provide a Promo Code (Promo Code is **MSFT-Family**) to access this service.
 - Register on the [Teladoc Medical Experts Microsite](#) member portal and receive a response the same day or next business day.
 - Send an email to memberservices@Teladochealth.com and receive a response the same day or next business day.
- A dedicated Teladoc Medical Experts representative will verify your eligibility, collect all necessary authorizations and consents, and open a case to be reviewed.
- Within one business day of verifying your eligibility, a Physician Case Manager will be assigned to you, and they will contact you to:
 - Discuss Teladoc Medical Experts programs
 - Review your medical history including current and previous treating provider's information
 - Clarify and document your questions and concerns
 - Offer treatment decision support as needed
 - Determine gender, language, preferred contact times and other personal preferences
- After the discussions with you, your new Physician Case Manager will develop an initial report based on the information gathered.
- Your Physician Case Manager will then determine whether to initiate an Expert Medical Opinion, Coaching or Physician Navigation services.



Each person's case is unique, and the components of the services provided by Teladoc Medical Experts may vary. The exact service that any eligible employee or family member receives will be determined by a mix of the following: your preferences and objectives, the amount of data available for expert review, and the medical necessity determined by the Medical Directors.

Expert Medical Opinion

When you need a second, medical opinion from an expert regarding a recent, complex diagnosis or treatment plan.

- If determined your case needs an expert medical opinion, a Physician Navigation Associate will initiate the collection of medical records for your entire medical history, from all of your providers. Teladoc Medical Experts will use their best efforts to collect all necessary records for you within three (3) business days. Collected Records will include, but are not limited to:
 - Physician notes
 - Consult reports
 - Imaging, labs, and testing

- Pathology tissue and reports
- Your Physician Case Manager will consolidate and review your records for any gaps in care and significant medical issues to be explored while working with you and the medical expert that is assigned to your case.
- All collected medical records will be uploaded to your Teladoc Medical Experts Microsite member portal for easy access by you.
- Once the Teladoc Medical Experts Clinical Committee has reviewed your medical records, they will evaluate your case, determine the appropriate medical expertise to engage, and assign the appropriate expert(s).
- The expert(s) assigned will then review your case, make their assessment, and create your final report within a few weeks; depending on the complexities of your case.
- Your Physician case manager will call you every week to update you on the progress and status of your case.
- After your final report is created, your Physician Case Manager will call you on your preferred day and time to discuss the results.
- With your consent, your Physician Case Manager will also contact your treating physician(s) to discuss the final report.
 - The expert(s) and Physician Case Manager will not serve as treating physicians, but only serve as a resource for you and your treating physician(s).
- Your Physician Case Manager will follow up with you within six (6) months of the final report review to discuss and initiate activity as needed to support:
 - Implementation of expert recommendations
 - Resolution and/or ongoing nature of medical concerns
 - New symptoms, conditions, testing, or records requiring expert review
 - Interest in pursuing new or additional treating physicians (via Physician Navigation)
 - Anecdotal data about participation satisfaction recorded

Coaching

When you need additional help navigating the medical system or want answers from a specialist physician to basic questions about health conditions and treatment options.

- After an in-depth discussion with you over your current care and treatment, your Physician Case Manager will coach you on how to interact with the medical system and/or discuss other programs available to you.
- Some or all your medical records may be collected depending on the needs and complexities of your case.
- Teladoc Medical Experts will provide direct and unlimited access for you to get questions and answers from your Physician Case Manager by phone, email, video, and chat.
- Your Physician Case Manager will recommend and/or provide articles, books, and medical literature relevant to your reported condition. Such information may be provided through the Microsite, direct email, and mail.

Physician Navigation

When you need additional help finding a leading, recognized physician in your local area network.

- Teladoc Medical Experts will deliver Physician Navigation support upon your request. After collecting your preferences, a Physician Navigation Associate will compile a “Physician Navigation List” of physicians close to you that are best suited for your situation. This list includes the physician’s certifications, patient satisfaction, education, training, practice area, a sanctions/malpractice check, contact information, in-network status, and availability to see new patients.
- Your Physician Navigation Associate will call all identified physicians to confirm the doctor’s specialty, sub-specialty, acceptance of new patients, acceptance of member’s insurance, appointment availability, referral requirements, contact info and the new patient process, including what to bring to the first appointment, and update the Physician Navigation List accordingly.
- The finalized Physician Navigation List, typically including three physicians, will be reviewed by your Physician Case Manager for quality assurance and then provided to you. Your Physician Case Manager will then verbally review the results on the Physician Navigation List with you.
- At your request, the Physician Navigation Associate will provide appointment facilitation by documenting your preferred appointment days and times and setting up an appointment on your behalf with the newly identified treating physician. Upon your request and permission, your Physician Case Manager will communicate with your new treating physician.



Although the Expert Medical Opinion Program is provided at no additional cost to you, any treatment or services obtained in accordance with your Teladoc Medical Experts report will be subject to the terms, conditions, and provisions of your selected medical plan. Prior to receiving any additional treatment or service, review the coverage details of your medical plan or contact Premera at (800) 676-1411, Kaiser Foundation Health Plan of Washington at (888) 901-4636 or Kaiser Permanente at (800) 464-4000.

Eligibility

All U.S. benefits-eligible employees as well as their spouses, domestic partners, and children (regardless of age or eligibility for other coverage under the Plan), and extended family members (who are otherwise ineligible for benefits under the Plan) may participate in the Expert Medical Opinion Program. For this purpose, extended family members include siblings, parents, grandparents, aunts, uncles, nieces, nephews or cousins of a U.S. benefits-eligible employee or the employee’s spouse or domestic partner. Any non-covered dependents or extended family members will need to provide a Promo Code (Promo Code is **MSFT_Family**) to utilize this service.

Participants who are eligible at the initiation of their case will receive full service throughout the program regardless of their eligibility status (i.e., if an eligible employee uses the services but then terminates their employment at Woodgrove Financial before completion of the case, they would still be permitted to use the services until their case is completed).



For more information about the Expert Medical Opinion Program (Teladoc Medical Experts) or if you are unsure if your case can be reviewed by Teladoc Medical Experts, call (800) 676-1411 and follow the prompts to speak with an Teladoc Medical Experts representative.



Teladoc Medical Experts will NOT share your medical records, medical information or the contents of your Teladoc Medical Experts report with anyone, including Woodgrove Financial or your health plan, unless you specifically authorize such disclosure. In addition, Teladoc Medical Experts endeavors to comply with all relevant state, national, and international laws and regulations including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Unless required by law, your specific name and medical information will NOT be shared with anyone, including Woodgrove Financial, without your written consent. Only de-identified and aggregate information will be used for program evaluation and improvement purposes.

Be Well

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How the program works

The Be Well program offers programs, activities and resources that support your physical, mental, and financial wellbeing.

Flu Shots

Woodgrove Financial provides an annual flu shot program where US benefits-eligible employees and their spouses/domestic partners can receive a flu shot, free of charge. Flu shots are offered through a voucher that can be used at a retail location, or through onsite events at various Woodgrove Financial office locations.




Vouchers to obtain a flu shot offsite from a specific provider, at no charge, are also available for the duration of the Flu Shot Program, which occurs in the fall. Dependent children (regardless of age) are not eligible to participate in the Flu Shot Program, either onsite or with a voucher. To obtain a voucher:

Active employees go here...	COBRA enrollees go here...
Be Well or Flu Shot Program	Email benefits@Woodgrove Financial.com

The Flu Shot Program generally runs in the fall and is separate from the medical coverage offered under the plan. As a reminder the medical coverage also covers flu shots (subject to the terms and conditions of the medical coverage).

Biometric Screenings

Woodgrove Financial provides an annual biometric screening program where US benefits-eligible employees and their spouses/domestic partners can receive a biometric screening, free of charge. Biometric screenings are offered through the Be Well program site and employees can choose the option of a home test kit, a voucher, or book an appointment for a biometric screening through an onsite event at on one of the various Woodgrove Financial office locations.



Dependent children (regardless of age) are not eligible to participate in the Biometric Screening Program, either onsite or home test kit.

The Biometric Screening program generally runs in the fall and is separate from the medical coverage offered under the plan, which also covers biometric screenings (subject to the

terms and conditions of the medical coverage) typically through an appointment with your primary care provider.

Other Programs and Activities

The Be Well platform offers physical, mental, and financial wellbeing activities, programs, and resources, as well as Be Well seminars on topics that support your wellbeing. Log into your Be Well to learn more to help you care for your body, nurture your mind, and invest in your future.

Under Be Well employees and adult dependents have access to the following programs:

- Happify – An App offering science-based activities that you would normally get through counseling or a self-help book have been transformed into fun, digital games and activities that you can do anytime, anywhere.
- Rethink at Home – This program and platform provides support to families caring for children with learning or behavior challenges, or developmental disabilities, at no cost. Parents/Caregivers can take advantage of live teleconsultation (6 free one-hour sessions) with master's and PhD-level behavior experts to answer questions and provide guidance. In addition, Rethink provides parents with a variety of resources, training, and support.



The Be Well online platform and programs is available to employees, spouses, domestic partners and children age 18 and over.

Active employees go here...

[Be Well](#)

COBRA enrollees go here...

Email benefits@Woodgrove Financial.com

Maternity Support (Maven)

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How the program works

Woodgrove Financial provides access to Maven to all employees and their dependents who are covered under a Woodgrove Financial U.S. health plan (including all Premiera and Kaiser plans). Maven is a digital health platform to help navigate preconception, pregnancy, postpartum, adoption, surrogacy, and returning to work.

This program provides support from planning to parenthood:

- Meet with a Care Advocate 24/7, who can answer questions about your benefits, recommend the best practitioners on Maven for your needs, and refer you to in-person, in-network doctors.
- Get on-demand support from providers and coaches across more than 20 specialties, including midwives; doulas; mental health providers; nutritionists; reproductive endocrinologists; egg donor consultants; lactation consultants; infant sleep coaches; adoption and surrogacy specialists; and many others.
- Receive clinically informed content tailored to your journey, take classes with Maven experts, and connect with other working parents through supportive community forums.

To enroll:

1. Go to [Maven](#).
2. Set up an account (you will need your Woodgrove Financial employee ID number).
3. Complete a health assessment to create a specialized care team based on you (or your partner's) needs and interests.

Section VIII: Employee and dependent life insurance

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COBRA enrollees – the Employee and dependent life insurance section does not apply

Employee life insurance

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How the plan works

Employee life insurance provides financial security to your beneficiaries in the event of your death. Information about your coverage options through Prudential and what you pay is provided in the table below.

Amount of coverage	What you pay
You may elect life insurance in the amount of one to 10 times your annual base pay, up to a maximum of \$4,000,000, whichever is less. The minimum coverage amount you may elect is \$50,000.	Woodgrove Financial pays for the cost of insurance that is equal to three times your annual base pay. The value of this coverage above \$50,000 is considered taxable income to you. You may purchase additional employee life insurance coverage using post-tax dollars. Coverage rates are provided in the Benefits Enrollment tool and depend on your age and the amount of coverage you elect.



The IRS regulates the taxable value of life insurance coverage above \$50,000. The IRS taxable value will appear as taxable income on your annual W-2 form and will be reflected on your Woodgrove Financial payroll check stubs as W2GRP. How this impacts your Federal Income and Social Security taxes will depend on your age, tax situation, and the amount of Woodgrove Financial paid life insurance over \$50,000 you elect.

Your coverage will be based on your annual base pay as of the first day of the calendar year for coverage elected during the annual open enrollment period. For employees hired during the calendar year, coverage will be based on your annual base pay as of the first day of enrollment. Annual base pay is defined as follows:

Employee type	Definition of annual base pay
Full-time salary employee	Base salary (not including bonus)
Full-time hourly employee	Hourly wage multiplied by 2080
Part-time hourly employee	Hourly wage multiplied by regularly scheduled hours in a year

Certain coverage levels may require evidence of insurability (EOI) before your coverage election takes effect. If you are on a disability leave of absence when your election to increase coverage is to take effect, the coverage effective date for that increased amount

will be delayed until you are actively at work and request to increase coverage upon your return from disability leave (and, if applicable, Prudential has deemed your EOI to be satisfactory). Choose your level of coverage carefully, as you may not make changes to your coverage level outside of the annual open enrollment period. However, your life

insurance coverage amount will automatically change as your pay changes. These changes to your life insurance coverage will be effective the first day of the month following the change of your base pay.



For more information about the benefits covered under the Woodgrove Financial employee and dependent life insurance plans, see the [Employee & Dependent Life Insurance Certificate](#). If you have additional questions, contact Benefits.



All benefits and coverages described in this SPD are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this SPD and the insurance policies, the insurance policies will always govern.



If you leave the company or become otherwise ineligible for coverage, you have the right to apply for continued life insurance coverage. For more information, see the [Coverage if you leave Woodgrove Financial](#) section.

Evidence of Insurability

Prudential may require satisfactory (EOI) if one of the following criteria applies:

- You are a new employee, and you elect coverage exceeding \$750,000
- You increase coverage by more than one times your base pay during annual open enrollment
- You elect more than \$750,000 in coverage during annual open enrollment, unless your election is based on a multiple of your base pay that is not increasing from the previous year
- You request any increase in coverage after having previously provided unsatisfactory EOI to Prudential

The EOI form is accessible via the [Benefits Enrollment tool](#). You will need to complete and return the EOI to Prudential within 30 days of making your election requiring EOI.



If you do not complete and return an EOI form to Prudential within 30 days of making your election, your coverage will be set at the highest available amount that does not require EOI.



To contact Prudential directly, e-mail Woodgrove.Financial@prudential.com or call (800) 778-3827 or TDD (800) 493-

Assignment of your life insurance rights

You may assign your life insurance to another person or entity (such as a trust) as a gift, including any right you have to choose a beneficiary or to convert to another contract of insurance. If you wish to do this, you will need to alert Prudential of this assignment and the contract holder. This assignment is irrevocable.

If you become disabled

Prudential will waive your employee life insurance premiums if you become disabled, provided your disability meets all of the following criteria:

- You became disabled before your sixtieth birthday and while insured for life insurance under this plan
- Your disability results from sickness or injury and occurs while you are insured

- You are not working at any job for wage or profit, and your disability prevents you from performing the material and substantial duties, for wage or profit, of any job for which you are reasonably suited by education, training, or experience

Prudential must receive notice and proof of your disability within 12 months after you have been continuously disabled. Prudential must also receive annual written medical proof that you remain disabled in order for the premium waiver to continue for successive one-year periods. The premium waiver will end after one year unless, before the end of that one-year period, you provide Prudential with written proof that you meet all of the above conditions, and your disability has continued for at least 9 months.

Prudential may, at its own cost, require you to have physical examinations as often as is reasonably required while a claim is pending.

The waiver of life insurance premiums will end on the date that you meet any of the following criteria:

- Are no longer disabled
- Fail to submit the required proof that the disability continues
- Refuse to be examined when required by Prudential
- Reach the age of 65

If your insurance ends due to your employment and (if applicable) waiver of premium ending, and you do not return to active work within 31 days, you may convert your Woodgrove Financial coverage to a self-paid individual life insurance policy.

If you have converted to an individual life insurance policy, and Prudential later approves your waiver of premium claim, Prudential will cancel the conversion policy and refund any conversion policy premiums you have paid and retroactively reinstate your life insurance coverage under the plan.



For more information, see the [Coverage if you leave Woodgrove Financial](#) section.

How the plan pays

In the event of your death, benefits will be paid as a lump sum to your beneficiaries according to the following guidelines:

- If you name two or more beneficiaries, each will receive an equal share of your life insurance benefit payment unless you indicate a different payment allocation in the Benefits Enrollment tool. In addition, if a beneficiary dies before you, that beneficiary's portion of your benefit will be divided equally among the remaining beneficiaries who survive you.
- If a beneficiary is a minor or otherwise incapable of giving a valid release, Prudential will pay the

benefit according to state laws governing payments to such individual

- If there is no living named beneficiary, Prudential will pay the employee's estate or, at Prudential's option, to any one or more of these surviving relatives of the dependent:
 - Your surviving spouse/registered domestic partner
 - Your surviving child (children)
 - Your surviving parents
 - Your surviving siblings



It's important to keep your beneficiary designations up to date. Prudential will make a payment only to the most recently named beneficiary or beneficiaries.



A beneficiary is the person(s) named as the recipient of the plan benefits in the event of your death.



To select or change your beneficiary, use the [Benefits Enrollment tool](#).

Accelerated payment

If you become chronically or terminally ill while insured under the plan, you can request benefit payment before your death. Prudential will pay 75% of the benefit, up to a maximum of \$500,000, in a lump sum or in 24 monthly installments. The amount will be paid to you and remaining benefits will be reduced by this accelerated payment.

Prudential will pay the accelerated benefit only if:

- You complete and submit a claim form provided by Prudential
- Your employee term life insurance has not been assigned
- For a benefit payment due to a chronic illness while insured under the plan, you require Substantial Supervision (defined for this purpose as continual supervision to protect yourself and/or others) or are not able to perform at least 2 Activities of Daily Living

Prudential will pay the accelerated benefit only if:

You provide a doctor's certification indicating that you are either (1) chronically ill or (2) terminally ill with a life expectancy of 24 months or less. For a chronically ill employee, the certification must state that you either require Substantial Supervision or are incapable of performing at least 2 activities of daily living for the rest of your lifetime. If Prudential disagrees with a doctor's certification, you have the right to mediation or binding arbitration conducted by an independent third party.

The Accelerated payment proceeds will be made available to you on a voluntary basis only. You are not eligible if you elect the benefit involuntarily to meet the claims of creditors and others.

Premium contributions must continue for the remaining benefit until the earlier of one of the following:

- The date you are no longer eligible for coverage
- The date that Woodgrove Financial coverage under this policy ends

If it appears to Prudential that a person incurs expenses in connection with your last illness, death, or burial, that person may receive part of your life insurance proceeds. Prudential, at its option, may pay that person up to the greater of: (a) 10% of the amount for which you are insured, and (b) \$1,000. If an amount is so paid, the remaining life insurance proceeds payable by Prudential will be reduced by the amount so paid.



The accelerated benefit may be taxable. You should seek assistance from a personal tax advisor since reporting and consequences are the sole responsibility of the recipient of the benefit funds.



There are state-specific requirements that may change the provisions under the Coverage(s) described in this SPD. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of the plan.

To review these state-specific requirements, visit Prudential's website at www.prudential.com/etonline. You will need to enter your state of residence and Access Code 43994.

Dependent life insurance

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How the plan works

Dependent life insurance helps provide support in the event of a death in your family. Information about your coverage options through Prudential and what you pay are provided

Amount of coverage	What you pay
Spouse/domestic partner life insurance from \$5,000 to \$750,000 (not to exceed 50% of the coverage of your employee life insurance election)	You may purchase optional dependent life insurance coverage using post-tax dollars. Coverage rates are provided in the Benefits Enrollment tool and depend on the amount of coverage you elect and your age.
Dependent child life insurance in the amounts of \$5,000, \$10,000 or \$15,000 (for each child under age 26)	

You have 30 days from the initial date of eligibility to enroll your newly eligible Spouse/Domestic Partner or Dependent child in Dependent Term Life Coverage. Your Spouse/Domestic Partner or Dependent child will be automatically enrolled in default coverage of \$5,000 if you do not make an active enrollment election within those first 30 days, unless and until you subsequently elect a different coverage amount (or no coverage) pursuant to a future qualifying life event or open enrollment period.

If a child is an eligible dependent of more than one Woodgrove Financial employee, only one Woodgrove Financial employee can claim the child for child life insurance. If two or more Woodgrove Financial employees claim the same eligible dependent child, the child will be considered the dependent of:

1. the Woodgrove Financial employee who first enrolled in dependent life insurance coverage under the Plan while the child was a dependent of that employee; and otherwise
2. the Woodgrove Financial employee who has the longest continuous service with Woodgrove Financial, based on our records.

Certain coverage levels may require evidence of insurability before your dependents' coverage elections take effect. You may not make changes to your coverage level outside of the annual open enrollment period unless you experience a qualifying life event. If a dependent is confined for medical care or treatment, any increases in the dependent's life insurance will be delayed until a final medical release from confinement is received. This limitation does not apply to your newborn child.



For a list of qualifying life events, see the [Life event enrollment](#) section.



For more information about the current benefits that are covered under the Woodgrove Financial employee and dependent life insurance plans, see the [Employee & Dependent Life Insurance Certificate](#). For further questions, contact Benefits.



All benefits and coverages described in this plan description are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this summary and the insurance policies, the insurance policies will always govern.



If you leave the company or become otherwise ineligible for coverage, you have the right to apply for continued life insurance coverage for your covered dependent. For more information, see the [Coverage if you leave Woodgrove Financial](#) section.

Evidence of Insurability (EOI)

Depending on the level of coverage you elect, Prudential may require satisfactory evidence of insurability (EOI). The EOI form is accessible via the Benefits Enrollment tool. You will need to complete and return this medical history questionnaire to Prudential within 30 days of making the following elections:

- You elect coverage of more than \$100,000 for your spouse or domestic partner
- You increase coverage during annual open enrollment
- You increase coverage due to a qualifying change in employment or family status



If you do not complete and return an EOI form to Prudential within 30 days of making your elections, your coverage will be set at an amount that does not require EOI.

Assignment of your life insurance rights

You may assign your dependent life insurance to another person or entity (such as a trust) as a gift, including any right you have to choose a beneficiary or to convert to another contract of insurance. If you wish to do this, you will need to alert Prudential of this assignment and the contract holder.

How the plan pays

Benefits are paid to you upon the death (from any cause) of a covered spouse or domestic partner, or dependent child. You may receive the plan payment in a lump sum.

Accelerated payment

If your spouse/domestic partner becomes terminally ill, you may request accelerated payment of your dependent life insurance benefits. Prudential will pay 75% of the benefit, up to a maximum of \$500,000. Benefits will be paid as a lump sum and remaining benefits will be reduced by the accelerated payment.



You or your spouse/domestic partner can only receive the accelerated benefit once. This benefit is not available for child dependents.

Prudential will pay the accelerated benefit only if:

- You complete and submit a claim form provided by Prudential.
- Your spouse or domestic partner benefit is not assigned.
- You provide a certification by a doctor that your spouse or domestic partner's life expectancy is 24 months or less. The doctor will need to complete the Attending Physician's Certification part of the claim form. If Prudential disagrees with a doctor's certification, you have the right to mediation or binding arbitration conducted by an independent third party.
- Terminal illness proceeds will be made available on a voluntary basis only. You are not eligible if you elect the benefit involuntarily to meet the claims of creditors and others.

Premium contributions must continue for the reduced benefit amount until the earliest of the date that:

- You are no longer eligible for spouse or domestic partner coverage
- Woodgrove Financial coverage under this policy ends
- Spouse or domestic partner coverage for an entire class ends
- This policy ends



The accelerated benefit may be taxable. You should seek assistance from a personal tax advisor since reporting and consequences are the sole responsibility of the recipient of the benefit funds.



There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate.

To review these state-specific requirements, visit Prudential's website at www.prudential.com/etonline. You will need to enter your state of residence and Access Code 43994.

Section IX: Accidental death & dismemberment (AD&D)

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COBRA enrollees – the Accidental death & dismemberment (AD&D) section does not apply

How the plan works

Accidental death and dismemberment (AD&D) insurance protects you and your family in the event of an accident-related death or injury that causes the loss of limbs or certain senses. This is an optional benefit provided through Prudential and doesn't require evidence of insurability (proof of good health).

You may purchase coverage for yourself using pre-tax dollars. However, if you enroll one or more eligible dependents, then the full cost of the family AD&D coverage must be purchased with after-tax dollars.

Coverage rates are provided in the Benefits Enrollment tool and depend on the amount of coverage you elect.

Exception: Your spouse, Domestic Partner, or child is not eligible for dependent AD&D coverage while on active duty in the armed forces of any country.

If a child is an eligible dependent of more than one Woodgrove Financial employee, only one Woodgrove Financial employee can claim the child under AD&D insurance. If two or more Woodgrove Financial employees claim the same eligible dependent child, the child will be considered the dependent of:

1. the Woodgrove Financial employee who obtained AD&D coverage for the child, under the Plan, while the child was a dependent of only that employee; and otherwise
2. the Woodgrove Financial employee who has the longest continuous service with Woodgrove Financial, based on our records.

Information about your coverage options is provided in the table below. The amount of coverage you elect for yourself determines the amount that is available to your eligible dependents. Child dependents are covered to age 26.

Beneficiaries	Coverage
You (Woodgrove Financial employee)	One to 10 times your annual base pay, up to a maximum of \$1,500,000, whichever is less.
Spouse/domestic partner only	65% of employee coverage, up to a \$500,000 maximum
Spouse/domestic partner and children	For spouse/domestic partner, 50% of employee coverage amount, up to a \$500,000 maximum For each child, 15% of employee coverage amount, up to \$75,000 maximum
Children only	For each child, 25% of employee coverage amount, up to \$75,000 maximum

Your coverage will be based on your annual base pay as of the first day of the calendar year for coverage elected during the annual open enrollment period. For employees hired during

the calendar year, coverage will be based on your annual base pay as of the first day of enrollment. Annual base pay is defined as follows:

Employee type	Definition of annual base pay
Full-time salary employee	Base salary (not including bonus)
Full-time hourly employee	Hourly wage multiplied by 2080
Part-time hourly employee	Hourly wage multiplied by regularly scheduled hours in a year

Because your AD&D coverage is based on your pay, your coverage will change automatically as your pay changes. These changes to your AD&D insurance coverage will be effective the day your pay changes as long as you are actively at work, or you return to work. You may change your coverage level only during the annual open enrollment period or if you have a qualifying life event.

All AD&D benefits are subject to the plan's [exclusions and limitations](#). Each benefit may have additional eligibility criteria and exclusions and limitations. More information on what is covered is provided on the following pages.



For more information about conditions of coverage and payable benefits, see the [Employee and Dependent AD&D Certificate](#).



All benefits and coverages described in this plan description are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this summary and the insurance policies, the insurance policies will always govern.



You have a right to apply for continued AD&D coverage through the Portability Plan for you or your covered dependents if your coverage ends because you leave Woodgrove Financial or otherwise become ineligible. For more information, see the [Coverage if you leave Woodgrove Financial](#) section.

How the plan pays

Benefits are payable if you—or a covered dependent—die or suffer certain serious injuries as the direct result of a covered accident. Benefits are paid to your designated beneficiary upon your death. If a covered dependent dies, you are the beneficiary.



A beneficiary is the person(s) named as the recipient of the plan benefits in the event of the member's death or injury.



To update your beneficiary information, use the [Benefits Enrollment tool](#).

Benefits will be paid as a lump sum according to the following guidelines:

- If a covered dependent dies, you are the beneficiary of any amounts paid from the plan
- If you die in a covered accident, AD&D benefits are paid to your named beneficiaries. Contingent beneficiaries will receive the plan benefits if the primary beneficiary dies while you are living.

- If you name two or more beneficiaries, each will receive an equal share of your AD&D benefit payment—unless you indicate a different allocation. If a beneficiary dies before you, that portion of your benefit will be divided equally among the beneficiaries who survive you.
- If you do not name a beneficiary or do not have current beneficiary information on file, your AD&D benefit would be payable to the first survivor on the following list:
 - Your spouse/domestic partner
 - Your children, in equal shares
 - Your parents, in equal shares

- Your sisters and brothers, in equal shares
- Your estate

If you are age 70 or older, your benefits will be reduced according to the following schedule:

Reduction schedule	
Age	Coverage
Age 69 or younger	100% of coverage amount
70-74	65% of coverage amount
75-79	45% of coverage amount
80-84	30% of coverage amount
85 and older	15% of coverage amount

What the plan covers

The following table indicates the percentage of your coverage that is payable in the event of your death or injury due to a covered accident. A percentage of these amounts would be payable for similar losses suffered by a covered dependent. Coverage for your dependent depends upon whether you elected family tier coverage and your family structure. See the beneficiary table in the [How the plan works](#) section for more information. Additional benefits, such as counseling and childcare, are provided following the table.



Benefits are not payable for injury or death from certain events described in the plan's [exclusions and limitations](#). Benefits must be claimed within 365 days after the date of the accident.

Loss	Benefit (percentage of coverage purchased)
Life (see additional benefit details below)	100%
Sight in both eyes (total and permanent)	100%
Speech and hearing in both ears (total and permanent)	100%
Both hands	100%
Both feet	100%
One hand and one foot	100%
One hand and sight in one eye	100%
One foot and sight in one eye	100%
Both arms and both legs (Quadriplegia)	100%
Both arms and one leg or both legs and one arm (Triplegia)	75%
Both legs (Paraplegia)	75%
One arm and one leg (Hemiplegia)	66.6%

Sight of one eye (total and permanent)	50%
One arm or one leg (Uniplegia)	50%
Speech (total and permanent)	50%

Loss	Benefit (percentage of coverage purchased)
Hearing in both ears (total and permanent)	50%
One hand	50%
One foot	50%
Thumb and index finger of the same hand	25%
Loss of hearing in one ear (total and permanent)	25%
Coma (see additional criteria below)	1% per month, up to 100 months

Example

Marissa is in a car accident and loses her foot. She has elected coverage of 3 times her salary of \$80,000, which is \$240,000. The AD&D plan pays 50% for the loss of a foot, so she would receive a lump sum payment of \$120,000 (\$240,000 x 50%).



- Total loss of use must be determined by a licensed physician to be permanent, complete, and irreversible
- A benefit is not payable for both loss of thumb and index finger of the same hand and the loss of one hand as the result of any one accident
- In no event will the total of all benefits payable under the above benefits exceed your amount of AD&D coverage

Additional benefits

Bereavement and trauma counseling

The plan pays up to \$50 per visit for up to 50 visits for bereavement and trauma counseling if it is:

- Required because of a loss
- Provided within one year of the loss

Additional counseling benefits may be provided under your [medical plan](#) or the [Spring Health employee assistance program \(EAP\)](#).

Child's injury

If a child who is covered by AD&D insurance suffers a covered loss other than a loss of life, you will receive an additional benefit equal to the lesser of 200% of the amount payable or the one largest amount to which the child is entitled and \$75,000. This benefit is not payable if the child dies within 90 days of the accident.

Childcare

If you or your insured spouse/domestic partner dies in a covered accident, an additional benefit is paid to cover childcare expenses. Eligible children must:

- Be under the age of 13
- Be covered under AD&D insurance
- Be enrolled at a childcare center or become enrolled at a childcare center within 90 days after the covered accident

The benefit is the lesser of \$5,000, the actual cost charged by the childcare center, or five percent of the benefit amount for the member whose loss of life is the basis of the claim. Benefits are payable each year that the child is enrolled in a childcare center until the age of 13 or a maximum of four years of payment.

This benefit is payable only if the childcare center is a facility or individual that operates pursuant to law, if locally required, is not a family member, and that primarily provides care and supervision for children in a group setting on a regular, daily basis.

If no dependent children qualify, a lump sum amount of \$3,000 will be paid to your beneficiary or beneficiaries. The benefit is paid only once, either for the loss of your life or that of your spouse/domestic partner, but not for both.

Coma

If you or your covered eligible dependent lapse into a coma as the result of a covered accident, an amount of up to 100 percent of the full AD&D benefit will be paid in installments of 1 percent per month. To be eligible for this benefit, coma must:

- Occur within one year of a covered accident
- Continue for one month
- Be diagnosed to be total, continuous, and permanent at the end of that 31-day period.

Continuation of medical coverage

If you must take a leave of absence from work or your employment ends as a result of a covered loss, you may receive payments to help you pay for continuation of medical coverage through COBRA for 24 months. Payments will stop if you become covered under another medical plan. Each payment will equal the lesser of 3% of your benefit or \$125. Proof that the payment will be used for continuation of medical coverage will be required. For more information on continuation of medical coverage, review the [Coverage if you leave Woodgrove Financial](#) section.

Felonious assault

If you suffer a loss that is the result of a felonious assault, the benefit amount payable will increase by an amount equal to the lesser of 5% of the benefit or \$5,000. The assault must occur:

- Because of your employment and while you are working for Woodgrove Financial
- On an authorized business trip

Home alteration and vehicle modification

In the event of a loss that requires home alteration or vehicle modification, you may receive an amount equal to the lesser of:

- The actual cost of the alteration or modification
- 5% of your benefit amount
- \$2,000

Loss of life

If you or your covered spouse/domestic partner suffers a loss of life due to a covered accident, an additional benefit equal to 1% for six consecutive months will be paid to the surviving spouse/domestic

partner; if there is no spouse/domestic partner, then the benefit will be paid to the dependent children. No benefit is payable if there is no surviving spouse/domestic partner or child.

If you and your covered spouse/domestic partner both suffer loss of life due to covered injuries by the same accident or separate accidents within 48 hours of each other, the benefit amount payable to your surviving dependent child or children of your spouse/domestic partner will be the lesser of the difference between (1) the amount payable for your loss of life and the amount payable for your spouse/domestic partner's loss of life; and (2) \$500,000. This benefit is available if you elect AD&D coverage for yourself, spouse/domestic partner, and dependent children.

Rehabilitation

If within one year and as a result of a covered accident, a doctor determines that you or your covered eligible dependent require necessary training to help you return to normal activities, a monthly benefit of 1% of your benefit amount, subject to a maximum of \$500 per month, will be paid for up to 24 months while you need rehabilitation. This benefit will cease if you do not furnish proof of the continuing need for the rehabilitation or fail to undergo a doctor's examination requested by Prudential. Additional rehabilitation benefits may be provided under your [medical plan](#).

Safe driving

If you or a dependent dies from an injury while driving or as a passenger in an automobile, your benefit will be increased by the lesser of 10% or \$25,000 if the member was wearing a properly fastened seat belt and/or protected by a side air bag.

This benefit is not paid if the death results from the following:

- Driving or riding in an automobile used in a race or a speed or endurance test, for acrobatic or stunt driving or for any illegal purpose

Tuition benefits

If you or your insured spouse/domestic partner dies in a covered accident, certain dependent children can continue their education. The lesser of 5% of your benefit or \$5,000, or the actual annual tuition fee (excluding room and board) will be paid per year for up to four consecutive years. Eligible dependent children include:

- Your child who wholly depends on you for support and maintenance on the date of death;
- Children below the age of 25 enrolled as a full-time student in a university, college, or trade school; and

- Children in the 12th grade who enroll as a full-time student in a university, college, or trade school within 365 days after the insured individual's death.

If no dependent children qualify, a lump sum benefit of \$3,000 will be paid. The benefit is paid only once, either for the loss of your life or that of your spouse/domestic partner, but not for both.

If you die in a covered accident, your AD&D insured spouse/domestic partner will be paid a tuition reimbursement benefit if they enroll in a professional or trade program within 30 months after the date of death for the purposes of obtaining an independent source of support or enriching their ability to earn a living. The benefit will equal the lesser of 5% of your benefit, \$5,000, or the actual tuition amount and is payable for one year.



For more information about conditions of coverage and payable benefits, see the [Employee and Dependent AD&D Certificate](#).



There are state-specific requirements that may change the provisions under the Coverage(s) described in the Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate.

Prudential has a website that describes these state-specific requirements. You may access the website at <http://www.prudential.com/etonline>. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 43994.

Exclusions and limitations

This plan does not cover any loss caused by or resulting from the following:

- Suicide or attempted suicide while sane or insane
- Intentionally self-inflicted injuries, or any attempt to inflict such injuries
- Sickness, whether the loss results directly or indirectly from the sickness
- Medical or surgical treatment of sickness, whether the loss results directly or indirectly from the treatment
- Any bacterial or viral infection; however, this exclusion does not include a pyogenic infection resulting from an accidental cut or wound or a bacterial infection resulting from accidental ingestion of a contaminated substance
- Taking part in any insurrection
- War or any act of war, except as provided by any War Risk Hazard provision; war refers to declared or undeclared war and includes resistance to armed aggression
- An accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces. However, this does not include Reserve or National Guard active duty for training.
- Travel or flight in any vehicle used for aerial navigation in any of the following cases:
 - The person is riding as a passenger in any aircraft not intended or licensed for the transportation of passengers
 - The person is performing as a pilot or a crew member of any aircraft
 - You are riding as a passenger in an aircraft owned, operated, controlled, or leased by Woodgrove Financial, its subsidiaries, or affiliates. This includes getting in, out, on, or off any such vehicles.
- Commission of or attempt to commit a felony
- While operating an air, land, or water vehicle, being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a doctor

Section X: Long-term disability (LTD)

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COBRA enrollees- the Long-term disability (LTD) section does not apply

How the plan works

The long-term disability (LTD) plan is designed to provide income replacement in the event you experience a prolonged injury or illness. The LTD plan also offers additional benefits to support you and your family. The plan is administered by Prudential.

You can choose one of three coverage levels, as shown in the table below. If you don't elect coverage, your coverage level will default to 60% coverage.

Election	Coverage
40% Coverage	Covers 40% of your monthly earnings, up to a maximum of \$10,000 per month
50% Coverage	Covers 50% of your monthly earnings, up to a maximum of \$12,500 per month
60% Coverage (default if no coverage elected)	Covers 60% of your monthly earnings, up to a maximum of \$15,000 per month



Monthly earnings are your gross monthly income just prior your date of disability. For a complete definition, review the [glossary](#).

Regardless of which coverage level you choose, Woodgrove Financial pays the full cost of your LTD coverage. The monthly premium amount of this coverage is considered taxable income to you. You do not pay taxes on Woodgrove Financial's contribution to your coverage while you are receiving monthly payments. Any long-term disability benefits that you receive under the Plan generally will be federal tax-free.

If you become disabled while covered by this plan, you may receive a monthly payment and other LTD benefits after an elimination period and provided you meet certain eligibility criteria. Your monthly payments may be reduced by other sources of income or if you continue working while you are disabled. Prudential will send you a payment each month up to a maximum period.

All LTD benefits are subject to the plan's [exclusions and limitations](#). Each benefit may have additional eligibility criteria and exclusions and limitations. More information on what is covered is provided on the following pages.



For more information about conditions of coverage and payable benefits, see the [Long-term Disability Insurance Certificate](#).



All benefits and coverages described in this plan description are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this summary and the insurance policies, the insurance policies will always govern.

When LTD benefits begin

Following an elimination period, you will be eligible for monthly payments and other LTD benefits if you meet the criteria described below.

Elimination period

The elimination period is the longer of 182 days, beginning from your injury or onset of your illness, or the date you exhaust short-term disability benefits from Woodgrove Financial. You can satisfy your elimination period while working, provided you meet Prudential's definition of disability including the additional criteria for [eligibility while working](#) described below.



Short-term disability (STD) provides up to 26 weeks of leave for a non-work-related illness or injury. For information about STD leave, visit the [Leave of Absence \(LOA\) tool](#).

You may have one or more periods of recovery during the elimination period without having to restart the elimination period if both of the following occur:

- You become disabled again from the same or a related medical condition
- You complete the 182-day elimination period within one year (365 days) from the date the disability commenced

If you do not satisfy the elimination period within 365 days, any new period of disability from the same or a related medical condition will be treated as a new claim.

Eligibility criteria

You are considered eligible for monthly payments, subject to exhaustion of the elimination period described above, when Prudential determines that, due to your illness or injury, you are:

- Unable to perform the material and substantial duties of your regular occupation, or you have a 20% or more loss in your monthly earnings; and
- Under the regular care of a doctor



Material and substantial duties are those duties normally required as part of your job that cannot be reasonably omitted or modified. If you are required to work on average more than 40 hours per week, you are considered able to meet this duty if you are able to work 40 hours per week.

Regular care of a doctor means you visit a doctor as frequently as is medically required to manage and treat your condition. For a complete definition, review the [glossary](#).

Example

Caitlin earned \$6,000 a month before her disability and continued to work part-time after her disability, earning less than \$4,800 a month. She would be eligible for partial monthly payments as long as she can no longer perform the material and substantial duties of her job and she is under a doctor's care.

Your LTD benefits will continue after 24 months if Prudential determines that, due to the same illness or injury, you are:

- Unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training, or experience that provides income exceeding your monthly payment, if you are not working; or exceeding 80% of your indexed monthly earnings, if you are working, and
- Under the regular care of a doctor



Your **indexed monthly earnings** are your monthly earnings, adjusted by the lesser of 10% or the current annual percentage increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W). Adjustments are made on each July 1, provided you were disabled for all of the 12 months before that date. Your

indexed monthly earnings may increase or remain the same but will never decrease.

Example

After two years, Caitlin's indexed monthly earnings are \$7,260. If Caitlin is working, she will continue to receive partial monthly payments if that income is lower than \$5,808 (80% of \$7,260) and she is unable to perform any occupation that provides a greater income, and she is under a doctor's care.



The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Prudential will assess your ability to work and the extent to which you are able to work by considering the facts and opinions from your doctors. Prudential may require you to be examined as often as it is reasonable by doctors, other medical practitioners, or vocational experts of Prudential's choosing.

Prudential will pay for these exams. Prudential may require you to be interviewed by an authorized Prudential representative. Refusal to be examined or interviewed may result in denial or termination of your claim.



If you are unable to perform at least two daily activities without substantial assistance or have severe cognitive impairment, you may be eligible for additional monthly payments under the [catastrophic disability](#) benefit.

If you are working while disabled

In certain situations, you may be able to work in a different job than you had when you became disabled (or, during the first 24 months of receiving LTD benefits, in a limited capacity in the same job that you had when you became disabled). If you meet the above criteria and are working, you are eligible for monthly payments. However, your monthly

payments may be reduced if your income from working while disabled exceeds 20% of your indexed monthly earnings. If you become covered under any other LTD plan while working, you won't be eligible for payments under this LTD plan.



You must notify Prudential immediately when you return to work in any capacity.

If you get better within 30 days

If, after satisfying the elimination period, you are disabled for less than one month, Prudential will send you 1/30 of your payment for each day of disability.

Example

If you recover from your disability 15 days after of satisfying the elimination period, your monthly payment will be reduced by half to cover the number of days you were disabled.

If your disability recurs

If you return to work full time after receiving monthly payments and your disability occurs again, Prudential will treat your disability as part of your prior claim, and you will not have to complete another elimination period if both of the following is true:

- You were continuously insured under this plan for the period between your prior claim and your current disability
- Your recurrent disability occurs within six months of the end of your prior claim

Your recurrent disability will be subject to the same terms of the plan as your prior claim. Any disability which occurs after six months from the date your prior claim ended will be treated as a new claim.



A **recurrent disability** is an injury or illness that worsens and is due to one or more of the same causes as a prior disability for which Prudential made a monthly payment.

What the plan pays

Your monthly payments are calculated using your gross monthly income from Woodgrove Financial as of your earnings calculation date, which is:

- The date you meet the eligibility requirements above
- The date immediately preceding the beginning of your most recent elimination period, if you have to restart your elimination period as described above
- Your last full day of employment if you become disabled while you are on a covered layoff or an approved leave of absence

Gross monthly income from Woodgrove Financial, for this purpose, includes base salary and the average commissions, bonuses, and overtime pay earned per month from Woodgrove Financial during the 12-month period preceding your date of disability (or, if shorter, your period of employment with Woodgrove Financial). Gross monthly income does not include any other compensation or amounts of any kind, including any amounts received from sources other than Woodgrove Financial.

Monthly payments may be reduced if:

- You have deductible sources of income, such as workers' compensation payments or disability income payments from Social Security or another retirement plan. For a complete list, review

[deductible sources of income](#) later in this section.

- You have disability earnings, which are any income you receive while working and any additional income you could receive if you work to your greatest extent possible, as follows:
 - For the first 24 months, your disability earnings are from your regular occupation.
 - After 24 months, disability earnings are from any available occupation for which you are reasonably fitted by education, training or experience.



If your disability earnings exceed 80% of your **indexed monthly earnings** Prudential will stop sending you payments and your claim will end. If your disability earnings fluctuate, your indexed monthly earnings will be averaged over a period of 3 months to determine continued eligibility for payment.

For the first twelve months of your disability, your monthly payment is calculated as follows:

Step	Calculation	Example
1	Determine your gross monthly payment, which is the lesser of the following: Your coverage level multiplied by your monthly income just prior to your earnings calculation date The maximum monthly payment for your coverage level	Emrah earned \$7,000 a month before his disability, and he elected the 60% coverage level. $\$7,000 \times 60\% = \$4,200$ Since \$4,200 is less than the maximum monthly payment of \$15,000, his gross monthly payment is \$4,200.
2	Subtract any deductible sources of income from your gross monthly payment to calculate your monthly payment.	Emrah has no deductible sources of income, so his monthly payment is \$4,200.
3	If your disability earnings are more than 20% of your monthly earnings, your monthly payment will be reduced as follows: Add your gross monthly payment and your return-to-work earnings Subtract your indexed monthly earnings from the result if you are disabled and working If the result is a positive number, you will continue to receive the full monthly payment If the result is a negative number, that amount will be subtracted from your monthly payment	Emrah's return to work earnings are \$3,000. He's also working while disabled. Adding his gross monthly payment and his monthly return to work earnings, he gets \$7,200 ($\$4,200 + \$3,000$) Subtracting this amount (\$7,200) from his indexed monthly earnings (\$7,000) results in a negative number ($-\$200$) Emrah's adjusted monthly payment is \$4,000 ($\$4,200 - \200). If Emrah works to his full potential and earns \$3,000, his total income would be \$7,000.



The minimum monthly payment is 10% of the gross monthly payment or \$100, whichever is less. If your benefit is subject to offset(s) resulting in a minimum monthly payment while working, you may be eligible to receive a partial minimum monthly payment.

After 12 months, the disability earnings adjustment to your monthly payment will be calculated as follows:

Step	Calculation
1	Calculate your lost earnings by subtracting your disability earnings from your indexed monthly earnings. <div> Indexed monthly earnings (pre-disability) – Disability earnings = Lost earnings </div> Your actual and potential income from working with a disability

2	<div>Calculate your percentage of lost earnings by dividing the result by your indexed monthly earnings</div> <div>Lost earnings / Indexed monthly earnings = Percentage of lost earnings (pre-disability)</div> <div>Income lost due to disability</div>
3	Multiply the result by your unadjusted monthly payment.

Step	Calculation			
	Monthly payment	X	Percentage of lost earnings	= Monthly payment after 12 months
	Gross monthly payment adjusted for deductible sources of income		Percentage of income lost due to disability	

Example

After a year, Emrah's indexed monthly earnings go up to \$7,700. His monthly payment would be calculated as follows:

Subtracting his disability earnings from his indexed monthly earnings, we get lost earnings of \$4,700 (\$7,700 - \$3,000).

Dividing his lost earnings by his indexed monthly earnings, we get a percentage of lost earnings of 61% (\$4,700/\$7,700).

Multiplying this by the monthly payment he would receive if he were not working, we get a monthly payment of \$2,562 (61% x \$4,200).

Emrah's total income from employment and his monthly payment would be \$4,762.

Proof of income

Prudential may require you to send proof of your income from employment while receiving monthly payments, including copies of your IRS federal income tax return, W-2 and 1099 forms.

Income fluctuation

If your income from employment while receiving monthly payments is expected to fluctuate widely from month to month, Prudential may average your disability earnings over the most recent three months to determine if your claim should continue subject to all other terms and conditions in the plan. In this situation, Prudential will terminate your claim if the average of your disability earnings from the last three months exceeds 80% of indexed monthly earnings. Prudential will not pay you for any month during which disability earnings exceed the above amounts.

Deductible sources of income

Prudential will deduct the following sources of income from your gross LTD amount to calculate your monthly payment:

Deductible sources of income

1	<p>The amount you receive or are entitled to receive as loss-of-time benefits under:</p> <ul style="list-style-type: none">• A workers' compensation law• An occupational disease law• Any other act or law with similar intent
2	<p>The amount you receive or are entitled to receive as loss-of-time disability income payments under any:</p> <ul style="list-style-type: none">• State compulsory benefit act or law• Automobile liability insurance policy required by law• Insurance or a health or welfare plan or other group insurance plan where Woodgrove Financial, directly or indirectly, has paid all or part of the cost or has made payroll deductions• Governmental retirement system as the result of your job with Woodgrove Financial

Deductible sources of income	
3	<p>The gross amount that you, your spouse, and children receive or are entitled to receive as loss-of-time disability payments because of your disability under:</p> <ul style="list-style-type: none"> • The United States Social Security Act • The Railroad Retirement Act • The Canada Pension Plan • The Quebec Pension Plan • Any similar plan or act <p>Amounts paid to your former spouse or to your children living with such spouse will not be included.</p>
4	<p>The gross amount that you receive as retirement payments or the gross amount your spouse and children receive as retirement payments because you are receiving payments under:</p> <ul style="list-style-type: none"> • The United States Social Security Act • The Railroad Retirement Act • The Canada Pension Plan • The Quebec Pension Plan • Any similar plan or act <p>Benefits paid to your former spouse or to your children living with such spouse will not be included.</p>
5	<p>The amount that you:</p> <ul style="list-style-type: none"> • Receive as disability payments under the Woodgrove Financial retirement plan if any • Voluntarily elect to receive as retirement or early retirement payments under the Woodgrove Financial retirement plan • Receive as retirement payments when you reach normal retirement age, as defined in the Woodgrove Financial retirement plan. Disability payments under a retirement plan will be those benefits that are paid due to disability and do not reduce the retirement benefits that would have been paid if the disability had not occurred. Retirement payments will be those benefits that are paid based on the amount that Woodgrove Financial contributes to the retirement plan. Disability benefits which reduce the retirement benefits under the Plan will also be considered as a retirement benefit. Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Prudential will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code, including any future amendments which affect the definition.
6	<p>The amount you receive under the maritime doctrine of maintenance, wages, and cure. This includes only the wages part of such benefits.</p>
7	<p>The amount of loss-of-time benefits that you receive or are entitled to receive under any salary continuation or accumulated sick leave that exceed or would exceed 100 % of your monthly earnings. Salary continuation and accumulated sick leave include continued payments to you by Woodgrove Financial of all or part of your monthly earnings, including severance payments, after you become disabled. This continued payment must be part of an established plan maintained by Woodgrove Financial for the benefit of an employee. Salary continuation or accumulated sick leave does not include compensation paid to you by Woodgrove Financial for work you actually perform after your disability begins.</p>
8	<p>The amount that you receive from a partnership, proprietorship, or any similar draws.</p>
9	<p>The amount that you receive or are entitled to receive under any unemployment income act or law due to the end of employment with Woodgrove Financial.</p>

With the exception of retirement payments or amounts that you receive from a partnership, proprietorship, or any similar draws, Prudential will subtract only deductible sources of income which are payable as a result of the same disability.

Prudential will not reduce your payment by your Social Security retirement payments if your disability begins after age 65 and you were already receiving Social Security retirement payments.

If Prudential determines you qualify for benefits under item one, two, or three

If Prudential determines that you may qualify for benefits under item one, two, or three in the list of deductible sources of income above, Prudential will estimate your entitlement to these benefits.

Prudential can reduce your payment by the estimated amount even if such benefits have not been awarded. However, Prudential will not reduce your payment if you do all of the following:

- Apply for the benefits
- Appeal any denial to all administrative levels that Prudential feels are necessary
- Sign Prudential's Reimbursement Agreement form. This form states that you promise to pay Prudential any overpayment caused by an award.



If your payment has been reduced by an estimated amount, your payment will be adjusted when Prudential receives proof of one of the following:

- *The amount awarded*
- *That benefits have been denied and all appeals that Prudential feels are necessary have been completed*

In this case, a lump sum refund of the estimated amount will be made to you.

If Prudential determines you qualify for benefits under item seven or nine

If Prudential determines that you may qualify for benefits under item seven or nine in the list of deductible sources of income above, Prudential will estimate your entitlement to these benefits. Prudential can reduce your payment by the estimated amount if such benefits have not been received.



If you receive a lump sum payment from any deductible source of income, the lump sum will be prorated on a monthly basis over the time period for which the sum was given. If no time period is stated, Prudential will use a reasonable one.

Minimum monthly payment

If subtracting deductible sources of income results in a zero benefit, the minimum monthly payment is the greater of (a) 10% of the gross disability payment otherwise payable, and (b) \$100. Prudential may apply this amount toward an outstanding overpayment.

After Prudential has subtracted any deductible source of income from your gross disability payment, Prudential will not further reduce your payment due to a cost-of-living increase from that source.

Non-deductible sources of income

Prudential will not deduct from your gross disability payment income you receive from, but not limited to, the following sources:

- 401(k) plans
- Profit sharing plans
- Thrift plans
- Tax-sheltered annuities
- Stock ownership plans
- Non-qualified plans of deferred compensation

- Pension plans for partners
- Military pension and disability income plans
- Credit disability insurance
- Franchise disability income plans
- A retirement plan from another employer
- Individual Retirement Accounts (IRAs)

When monthly payments stop

Prudential will stop monthly payments while you are incarcerated as a result of a conviction. Prudential will stop payments and your claim will end on the earliest of the following:

- During the first 24 months of payments, when you are able to work in your regular occupation on a part-time basis and earn 20% or more of your indexed monthly earnings but you choose not to
- After 24 months of payments, when you are able to work in any gainful occupation on a part-time basis and earn 20% or more of your indexed monthly earnings but you choose not to
- The end of the maximum period of payment as described below
- The date you are no longer disabled under the terms of the plan
- The date you fail to submit proof of continuing disability satisfactory to Prudential
- The date your disability earnings exceed the amount allowable under the plan
- The date you decline to participate in a rehabilitation program that Prudential considers appropriate for your situation and that is approved by an independent doctor
- The date you die

Maximum period of payment

Prudential will provide you a monthly payment each month up to the maximum period of payment as shown in the table below:

Your age on date of disability begins	Your maximum period of benefits
Under age 61	To your normal retirement age*, but not less than 60 months
Age 61	To your normal retirement age*, but not less than 48 months
Age 62	To your normal retirement age*, but not less than 42 months
Age 63	To your normal retirement age*, but not less than 36 months
Age 64	To your normal retirement age*, but not less than 30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

* Your normal retirement age is your retirement age under the Social Security Act, where retirement age depends on your year of birth.

The LTD plan limits the maximum pay period to a combined 24 months during your lifetime for the following disabilities:

- Disabilities based on self-reported symptoms, determined by Prudential as manifestations of your condition that are not verifiable using tests, procedures, and clinical examinations standardly accepted in the practice of medicine. Examples of self-reported symptoms include, but are not limited to: headache, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness, and loss of energy.
- Disabilities due in whole or part to mental illness, determined by Prudential as a psychiatric or psychological condition regardless of cause. Mental illness includes but is not limited to schizophrenia, depression, manic depressive or bipolar illness, anxiety, somatization, substance-related disorders, and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine.

The limitation of 24 months for mental illness does not apply if you meet one of the following conditions:

- If you are confined to a hospital or institution for at least eight hours a day at the end of the 24-month period. If you are still disabled when you are discharged, Prudential will send you payments for a recovery period of up to 90 days. If you become reconfined for at least eight hours a day at any time during the recovery period and remain confined for at least 14 days in a row, Prudential will send payments during that additional confinement and for one additional recovery period up to 90 more days.
- If, after the 24-month period, you continue to be disabled and subsequently become confined for at least eight hours a day to a hospital or institution for at least 14 days in a row, Prudential will send payments during the length of the confinement.
- If you have dementia as a result of the following:
 - Stroke
 - Trauma
 - Viral infection
 - Alzheimer's disease
 - Other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine



Prudential will not pay beyond the limited pay period as indicated above, or the maximum period of payment, whichever occurs first.

Other benefits

In addition to the monthly payments, this plan provides the following benefits in the event of your disability.

Survivor benefit

If you should die within 365 days of your disability and are receiving monthly payments from this plan at the time of your death, Prudential will pay a benefit equal to six months of your gross monthly payment to your eligible survivors, which include your spouse/domestic partner, if living; otherwise, your children under age 25. Your survivor will need to provide proof of your death.

If a benefit is payable to a minor or a person incapable of receiving payment, Prudential may pay the amount to any person or institution that appears to have assumed custody and main support of that person. If you have no eligible survivors, payment will be made to your estate.

Survivor benefit prior to death

If you are receiving monthly payments and you become terminally ill, you may elect to receive the survivor benefit prior to your death. Prudential will pay the survivor benefit if:

- You elect this option in writing in a form that satisfies Prudential
- You provide proof that you are a terminally ill employee, including certification by your doctor that your life expectancy is six months or less
- Your long-term disability coverage is not assigned
- You elect this benefit only on a voluntary basis



You are not eligible for this benefit if:

- *You are required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise*
- *You are required by a government agency to use this benefit in order to apply for, get, or keep a government benefit or entitlement*

You may elect the survivor benefit prior to death option only once during your lifetime. If you elect to receive this benefit prior to your death, no survivor benefit will be paid upon your death. However, Prudential will first apply the survivor benefit to any overpayment which may exist on your claim.

Catastrophic disability

You are catastrophically disabled when Prudential determines that, due to the same sickness or injury that caused your disability, the following is true:

- You are unable to perform, without substantial assistance, at least two activities of daily living. For a complete definition, review the [glossary](#).



Substantial assistance includes:

The physical assistance of another person without which one would not be able to perform an activity of daily living; or

The constant presence of another person within arm's reach who is necessary to prevent, by physical intervention, injury while performing an activity of daily living

Cognitive impairment is a loss or deterioration in intellectual capacity that is comparable to and includes Alzheimer's disease and similar forms of irreversible dementia. For a complete definition, review the [glossary](#).

Substantial supervision means continual oversight that may include cueing by verbal prompting, gestures, or other demonstrations by another person, and which is necessary to protect one from threats to their health or safety.

You will receive catastrophic disability payments when Prudential approves your claim, providing:

- You are receiving monthly payments under the plan
- You have had your catastrophic disability for a period of at least 30 consecutive days

Your monthly catastrophic disability payment, which is an additional benefit on top of the regular monthly payment, is equal to 20% of your monthly earnings, but not more than \$5,000. It will not be reduced by any deductible sources of income.

You will stop receiving payments and your catastrophic disability claim will end on the earliest of the following:

- The date you no longer have a catastrophic disability under the terms of the plan
- The date you fail to submit proof of continuing catastrophic disability satisfactory to Prudential
- The date you are no longer receiving monthly payments under the plan

Worksite modification

A worksite modification might allow you to perform the material and substantial duties of your regular job. One of Prudential's designated professionals will work with you to identify a modification to help you remain at work or return to work. This modification must be documented in writing and signed by you, Woodgrove Financial, and Prudential. This modification benefit is available to you one time only.

Prudential will reimburse Woodgrove Financial for the cost of the modification up to the greater of:

- \$1,000
- The equivalent of two months of your gross monthly payment

Social Security advice

Prudential can arrange for expert advice regarding your Social Security disability benefits claim and assist you with your application or appeal if you are disabled under the plan. Receiving Social Security disability benefits may enable the following:

- You to receive Medicare after 24 months of disability payments
- You to protect your retirement benefits
- Your family to be eligible for Social Security benefits

Prudential can assist you in obtaining Social Security disability benefits by:

- Helping you find appropriate legal representation
- Obtaining medical and vocational evidence
- Reimbursing pre-approved case management expenses



If you are enrolled for life insurance when you become disabled, you may be eligible for a waiver of your life insurance premiums. For more information, see the [Employee and Dependent life insurance](#) section.

Continuing health care coverage

Prudential will send you a payment each month for continued health care coverage costs up to the maximum period of continued health care payments while:

- You are receiving long-term disability benefits under the plan
- You are continuing your health care coverage under COBRA or similar state law
- Prudential has written proof of the cost to you of this coverage

The maximum period of continued health care payments is 29 months. Continued health care payments will end on the earliest of the following:

- The end of the maximum period of continued health care payments
- The date you return to work or become eligible for KFHPWA insurance
- The date you are enrolled in Medicare
- The date you no longer receive long term-disability benefits under the Plan
- The date you fail to provide proof of COBRA continuation

The monthly continued health care payment is \$500. But your monthly continued health care payment will not exceed the actual costs to you for continued health care coverage.



Continued health care coverage costs means the actual costs to you for continued health care coverage provided through your employer, and which you elect under COBRA or similar state law.

Rehabilitation services

Prudential may review your file to determine if rehabilitation services might help you return to work. Once the review is completed by our rehabilitation specialists, working along with your doctor and other appropriate specialists, Prudential may pay for a rehabilitation program. If the program is not developed by Prudential's rehabilitation specialists, you must receive written approval from Prudential before beginning the program.

The rehabilitation program may include, but is not limited to:

- Coordination with Woodgrove Financial to assist you to return to work
- Evaluation of adaptive equipment to allow you to work
- Vocational evaluation to determine how your disability may impact your employment options
- Job placement services

- Resume preparation
- Job seeking skills training

- Retraining for a new occupation
- Assistance with relocation that may be part of an approved rehabilitation program

If, at any time, you decline to take part in or cooperate in a rehabilitation evaluation/assessment or program that Prudential feels is appropriate for your disability and that has been approved by your doctor, Prudential will cease your monthly payment.

Prudential will send you a rehabilitation payment each month up to the maximum period of rehabilitation payment while you are doing all of the following:

- Receiving LTD payments under the plan
- Participating in a rehabilitation program that has been approved by Prudential

Your maximum period of rehabilitation payment is six months. The monthly rehabilitation payment is equal to 10% of your monthly LTD payment. But the monthly rehabilitation payment, together with your monthly LTD payment, will not exceed the maximum monthly LTD payment.

Childcare

Prudential will send you a monthly childcare payment for up to six months while you are doing all of the following:

- Receiving LTD payments under the plan
- Participating in a rehabilitation program that has been approved by Prudential

The monthly daycare payment is equal to the amount of your eligible daycare expenses up to the maximum monthly daycare amount of \$500 multiplied by the number of eligible children, which are children age 12 or under who live with you, including your legally adopted children, your stepchildren and foster children.

Eligible daycare expenses are:

- Charged by a childcare provider who is not a member of your immediate family (you, your spouse/domestic partner, or a child, brother, sister, or parent of you or your spouse/domestic partner)
- Documented by receipts from the childcare provider that include the childcare provider's Social Security number or taxpayer identification number
- Specified in the Prudential-approved rehabilitation program as needed in order for you to participate in the program

Spouse/domestic partner and elder care

Prudential will send you a monthly payment for up to six months while you are doing all of the following:

- Receiving LTD payments under the plan
- Participating in a rehabilitation program that has been approved by Prudential

- The monthly spouse/domestic partner and elder care payment is equal to the amount of your eligible spouse/domestic partner and elder care expenses up to the maximum monthly spouse/domestic partner and elder care amount of \$500 multiplied by the number of eligible family members, which include family members who have a chronic illness or disability, including your spouse/domestic partner, parents, your grandparents who live with you, and your spouse/domestic partner's parents and grandparents who live with you.

Eligible spouse/domestic partner and elder care expenses are:

- Charged by a licensed adult care provider who is not a member of your immediate family (you, your spouse/domestic partner, or a child, brother, sister or parent of you or your spouse/domestic partner)
- Documented by receipts from the licensed adult care provider that include the provider's Social Security number or taxpayer identification number
- Specified in the Prudential-approved rehabilitation program as needed in order for you to participate in the program



A **chronic illness** is one of the following:

A loss of the ability to perform, without substantial assistance, at least two activities of daily living for a period of at least 30 consecutive days.

A severe cognitive impairment, which requires substantial supervision to protect the family member from threats to health and safety, for a period of at least 30 consecutive days.



There are state-specific requirements that may change the provisions under the Coverage(s) described in the Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate.

Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 43994.

Exclusions and limitations

The plan does not cover any disabilities caused by, contributed to by, or resulting from the following:

- Intentionally self-inflicted injuries
- Active participation in a riot
- Commission of a crime for which you have been convicted under state or federal law
- The plan does not cover a disability due to a preexisting condition
- The plan does not cover a disability due to war, declared or undeclared, or any act of war



Prudential considers you to have a **preexisting condition** if both are true:

You received medical treatment, consultation, care, or services, including diagnostic measures, or took prescribed drugs or medicines, or followed treatment recommendation in the three months prior to your effective date of coverage or the date an increase in benefits would be available

Your date of disability begins within 12 months of the date your coverage under the plan becomes effective. You do not have a preexisting condition if, after the date your coverage under the plan becomes effective or the date an increase in benefits would otherwise be available, there is a period of six months or more during

which you do not receive the care described above.

How to file a claim

If you are on an approved paid Short-Term Disability (STD) leave and remain out of work for 18 weeks, Prudential will automatically review your case to determine if you are eligible for LTD benefits. You may submit any additional information for Prudential to review. If you are not on a paid Short-Term Disability leave, you must provide Prudential proof of your disability claim no later than 90 days after your

elimination period ends. If it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.



Absence of legal capacity means an individual is no longer able to act on their own behalf. Ultimately, the individual is not able to execute legal documents.

Prudential will review an existing STD claim for medical documentation but may request additional documentation from you and/or your medical provider(s). Your proof of claim, provided at your expense, must show the following:

- That you are under the regular care of a doctor
- The appropriate documentation of your monthly earnings
- The date your disability began
- Appropriate documentation of the disabling disorder
- The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation or an activity of daily living
- The name and address of any hospital or institution where you received treatment, including all attending doctors
- The name and address of any doctor you have seen

Proof of continuing disability

Prudential may request that you send proof of continuing disability, satisfactory to Prudential, indicating that you are under the regular care of a doctor. In some cases, you will be required to give Prudential authorization to obtain additional medical information, and to provide non-medical information (for example, copies of your IRS federal income tax return, W-2 forms and 1099 forms) as part of your proof of claim, or proof of continuing disability. This proof, provided at your expense, must be received within 30 days of a request by Prudential. Prudential will deny your claim or stop sending you payments if the appropriate information is not submitted.



Prudential will not recognize any relative including, but not limited to, you, your spouse/domestic partner, or a child, brother, sister, or parent of you or your spouse/domestic partner as a doctor for a claim that you send to us.

Payments

Prudential will make payments to you. Prudential has the right to recover any overpayments due to the following:

- Fraud
- Any error Prudential makes in processing a claim
- Your receipt of deductible sources of income

You must reimburse Prudential in full. Prudential will determine the method by which the repayment is to be made. Prudential will not recover more money than the amount Prudential paid you.



In some jurisdictions, if you knowingly and with intent defraud Prudential, file an application or a statement of claim containing any materially false information or conceal, for the purpose of misleading, information concerning any fact material thereto, you commit a fraudulent insurance act, which is a crime and subjects you to criminal and civil penalties. These actions will result in denial or termination of your claim, and, where such laws apply, are subject to prosecution and punishment to the full extent under any applicable law. Prudential will pursue all appropriate legal remedies in the event of insurance fraud.

Determination of Benefits

Prudential will notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, will be furnished to you within the initial 45-day period. The claim determination period may be extended for an additional 30 days, beyond the original 30-day extension, if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, will be furnished to you within the first 30-day extension period if an additional extension of time is needed.

If the claim determination period is extended due to your failure to submit information necessary to decide the claim, Prudential's period for making the benefit determination will be tolled (i.e., suspended) from the date the notification of extension is sent to you until the date you respond to the request for additional information.

If your claim for benefits is denied

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will include:

- One or more specific reasons for the denial
- A discussion of the decision, including, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) a disability determination made by the Social Security Administration
- References to the specific plan provisions on which the benefit determination was based
- A description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits
- A description of Prudential's appeals procedures and applicable time limits, including a statement of

your right to bring a civil action under section 502(a) of ERISA following your appeals

- If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request
- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the plan relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards, or other similar criteria of the plan do not exist

Appeals of Adverse Determination

If your claim for benefits is denied, or if you do not receive a response to your appeal within the appropriate timeframe (in which case the appeal is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of your receipt of the written notice of denial, or 180 days from the date the claim is deemed denied, as applicable.

Similarly, if Prudential does not decide your claim within the time described under “Determination of Benefits,” above, you may appeal, although you are not required to do so.

You may submit with your appeal any written comments, documents, records, and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records, and information relevant to your claim free of charge.

Prudential will conduct a full review of the information in the claim file and any new information submitted to support the appeal, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision will be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date the notification of the extension is sent to you until the date you respond to the request for additional information.

Prudential will provide you, free of charge and prior to any adverse decision on appeal, with any new or additional evidence considered, relied upon, or generated in connection with the claim (including evidence that may be the basis for denial as well as any evidence that may support granting the claim), and any new or additional rationale that will form the basis for Prudential’s decision on appeal. Any such evidence or rationale will be provided as soon as possible and sufficiently in advance of the date the notice of the adverse decision on appeal is provided, in order to give you a reasonable opportunity to respond prior to that date.

If your appeal for benefits is denied

If the claim on appeal is denied in whole or in part, you will receive a written notice from Prudential. The notice will include:

- One or more specific reasons for the adverse determination
- A discussion of the decision, including, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) a disability determination made by the Social Security Administration
- References to the specific plan provisions on which the determination was based
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents, and other information relevant to your benefit claim upon request
- A description of Prudential's review procedures and applicable time limits

- If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request
- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the plan relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards, or other similar criteria of the plan do not exist
- A statement describing any voluntary appeals procedures offered by the plan, and your right to bring a civil suit under ERISA

Submitting a second appeal

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate timeframe (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal in writing to Prudential within 180 days of the receipt of the written notice of denial, or 180 days from the date the claim is deemed denied, as applicable. You may submit with your second appeal, any written comments, documents, records, and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records, and information relevant to your claim free of charge.

Prudential will make a decision on your second claim appeal within 45 days of the receipt of your request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require it. Within the initial 45-day period, you will receive a written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision. However, if the time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (*i.e.*, suspended) from the date the notice of the extension is sent to you until the date on which you respond to the request for additional information.

Submitting a benefit dispute

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled (*i.e.*, suspended) during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a notice of the denial from Prudential. The notice will include the same information that was

included in the first adverse determination letter. If a decision on appeal is not furnished to you within the timeframes mentioned above, the claim will be deemed denied on appeal.

Time Limit to File Suit

If your claim for benefits and any required appeals are denied (or not decided within the time periods described above, and therefore deemed denied), you may file suit in federal court. However, no suit or other legal action may be initiated more than three years after proof of your claim was first due, unless otherwise provided under federal law.

Section XI: Legal insurance plan

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COBRA enrollees – the Legal insurance plan section does not apply

How the plan works

The legal insurance plan from ARAG® offers assistance with many routine legal services for you, your spouse/domestic partner, and eligible dependents. The plan pays 100% of network attorneys' fees for most covered (and not excluded) services. Any interactions you have with your attorney are confidential. Woodgrove Financial will have access only to the enrollment information needed to administer your coverage.

If you select this optional coverage, you will pay the monthly premiums with after-tax dollars. The cost of coverage is available in the [Benefits Enrollment tool](#). Once you elect to participate, you may not cancel this coverage except during the annual open enrollment period.



If you have been enrolled in the plan for at least one year and you leave Woodgrove Financial, you may be eligible to purchase a separate plan through ARAG. For more information, visit the [Coverage if you leave Woodgrove Financial](#) section.



To review your Certificate of Insurance, find a network attorney, or get more information about the benefits under this plan, call ARAG at (800) 331-3425, email service@ARAGlegal.com, or log onto the Woodgrove Financial Benefits site and visit the [ARAG website](#).

Where you can get legal help

The legal plan covers services from any attorney. You can also get help by phone and online from ARAG Customer Care.

Although you can receive services from any attorney, you generally pay less when you use an ARAG network attorney.

- If you use a network attorney, the plan pays 100% of the attorney's fees for most covered (and not excluded) services. In addition, you can save money even if your legal situation is not fully covered and not excluded, as you may be eligible to receive a reduced fee of at least 25% off the network attorney's normal hourly rate.
- If you use an out-of-network attorney for covered (and not excluded) services, the plan will reimburse you based on the allowed indemnity benefit amount provided in the [What the plan covers](#) section.



Remember, any interaction you have with your attorney through ARAG is confidential. Woodgrove Financial will have access only to basic enrollment information needed to administer your coverage.

Finding an attorney

To locate a network attorney in your area, members can:

- Log in to the Woodgrove Financial Benefits site and go to the [ARAG website](#)
 - Select **Attorneys** and **Find an Attorney** to search for attorneys in your area
 - View attorney profiles for areas of law in which they practice, contact information, experience, and languages they speak
- Call (800) 331-3425 to contact an ARAG Customer Care specialist, who will provide you with:

- A CaseAssist® confirmation form for you to provide to the network attorney of your choice so they will have the information needed (e.g., your member ID number, benefit coverage details, contact information) to begin your case work
- Educational information including tips about working with attorneys and a checklist of items to bring in preparation of your first meeting

After you select a network attorney from the list, call the attorney's office and indicate you are a member of an ARAG legal plan. The attorney will:

- Verify your case confirmation number, or may assist in providing you with one
- Provide covered legal services
- File a claim on your behalf with ARAG for payment reimbursement of covered legal services rendered



You do not pay the attorney's fees or file a claim for covered (and not excluded) legal services with in-network attorneys. You will be responsible for out-of-pocket expenses such as filing fees, court costs, title work, and photocopies. If a covered matter has an hourly usage cap limitation, you will be responsible for network attorney fees after you reach the maximum benefit.

If you use an out-of-network attorney, you will need to file a claim for indemnity reimbursement. See the [How to file a claim](#) section for more information.

Advice by phone

You may get advice by phone from an ARAG telephone attorney about how the law relates to your personal legal matter and what actions you can take. The plan also covers follow-up correspondence and telephone calls to third parties on your behalf.



To access legal services by phone, call ARAG at (800) 331-3425.

Document preparation and review

You can receive assistance by phone with the preparation/review of these specific documents:

- Special powers of attorney and revocations
- Childcare authorizations
- Challenge to denial of credit
- Bad check notice
- Promissory note and affidavits related to your personal property
- Bills of sale related to your personal property
- Standard will package, including
 - Standard will documents
 - Testamentary support trusts for children

- Durable powers of attorney/health care powers of attorney and revocations
- Living wills/advanced health care directives
- Codicils

Identity Theft Protection

Identity Theft Protection provides you with assistance online and over the phone with the following services:

- Full-service identity restoration with Identity Theft Restoration Specialists who will work on your behalf to restore your identity
- Lost wallet services with Identity Theft Restoration Specialists to assist you in canceling and reissuing personal documents such as credit cards, driver's license, Social Security cards, etc.
- Internet surveillance monitors thousands of websites and millions of online data points to alert you if your personal information is being traded and/or sold
- Single-bureau credit monitoring informs you of changes to your credit file – including loan applications, credit card applications, delinquencies, etc.
- Child identity monitoring provides you with an alert of the names, addresses and aliases found in public records associated with your child's Social Security number. The service also notifies you if there is any evidence that your child's information is being traded or sold online.
- Change of address monitoring sends you an alert if a change of address request has been submitted to the U.S. Postal Service for your address.
- Identity theft insurance provides coverage up to \$1 million for expenses associated with restoring your identity should you become a victim of identity theft. (Note: The Identity Theft Insurance is underwritten and administered by American Bankers Insurance Company of Florida, an Assurant company. Refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions. To view the Identity Theft Plan Summary, go to the [ARAG website](#), see **What Your Plan Covers** and select **Download Plan Document**.)

Services for parents/grandparents

As a member of the plan, your parents and grandparents have access to certain services designed to address caregiving issues and legal needs. These services include:

- **Annual checkup:** Your parents/grandparents can meet with a network attorney at no cost to discuss legal needs and changes in their life that may have legal or financial implications.
- **General legal advice over the phone:** Call a telephone network attorney to get legal advice and consultation on how the law relates to your parents'/grandparents' legal matter — and which actions may be taken.
- **Reduced fee services:** Your parents/grandparents can work directly with a network attorney who will provide reduced fee services of at least 25 percent off their normal rate for most elder law issues including legal advice, document review and representation.
- **Caregiver support services:** Regarding your parents'/grandparents' caregiving needs, you, your parent, or grandparent can speak to a care advocate who will answer elder care-related questions, assess eldercare needs, help develop a care plan and conduct searches for living and care facilities. There are also several helpful resources and databases available on the ElderAnswers website. To access ElderAnswers, go to the [ARAG website](#), see **Tools, Services for Parents and Grandparents**, and select **Access Care Resources**.)

Immigration assistance

If you're faced with an immigration matter, you can call a network attorney who can work with you to address and resolve the situation by offering legal advice and services that include:

- Guidance on immigration processes and guidelines.
- Filing and processing of applications and petitions.
- Interpreting and explaining laws and regulations governing various types of immigration benefits; including asylum, adjustment of status, business visas, and employment authorizations.
- Outlining the deportation and removal proceedings.

The network attorney is also available to help you with:

- Document review of any immigration forms.
- Document preparation of affidavits and powers of attorney.
- Preparation for immigration hearings.

For additional immigration services, network attorneys provide a reduced rate of at least 25% off their normal rates for any representation-based immigration services. In these situations, the network attorney will bill you as the member directly.

Online resources

To help you better manage today's common legal and financial matters, visit the Learning Center on the [ARAG website](#), where you have access to a variety of tools and resources, including:

- **Educational articles, videos, and guidebooks:** Get helpful tips regarding key legal, financial and consumer issues like estate planning, debt collection, identity theft, caregiving and working with an attorney.
- **Personal Information Organizer:** Download this document to help you keep track of all your critical legal, financial, medical, and personal information.
- **Legal Glossary:** Review this comprehensive collection of terms and coverages, with easy-to-understand descriptions and real-life examples to help you learn more about your legal issue.
- **DIY Docs®**, which allow you to create your own legal documents online.

What the plan covers



All benefits are subject to the plan's [exclusions and limitations](#). ARAG will pay the attorney fees of the network attorney for covered (and not excluded) legal services provided to you, as outlined in the following table, resulting from an insured event which occurs after your plan's effective date and while your Certificate of Insurance is in effect for the legal matters listed below.

Note: When using a non-network attorney, ARAG will reimburse the insured for attorney fees paid up to the indemnity amount indicated for the specific coverage.

Family law

Category definition	Network Attorney	Non-Network Attorney
Adoption – Uncontested		
Legal services in an uncontested adoption for you to become adoptive parent(s).	Paid in full	\$400*
In international adoptions, where a foreign attorney is necessary, you are eligible to receive indemnity reimbursement (Non-Network Attorney) in addition to the benefits available in the United States.		
Adoption – Contested		
Legal services in a contested adoption for you to become adoptive parent(s).		
In international adoptions, where a foreign attorney is necessary, you are eligible to receive indemnity reimbursement (Non-Network Attorney) in addition to the benefits available in the United States.		
Legal services prior to trial	Paid in full	\$800*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Divorce		
Legal services for the named insured in a divorce, a legal separation and/or an annulment of marriage.	Uncontested is Paid in full Contested is Paid-in-full up to 25 hours per insured event	Uncontested - \$640* Contested - \$2,000*
Estate Administration and Estate Closing (Probate)		
Legal services for you in administering an estate where you have been named the executor	Paid in full	\$720*
Executor Appointment		
Legal services for you to be appointed executor of an estate, where no valid will exists.	Paid in full	\$720*
Protection of Inheritance Rights – 6 hours		
Legal services for you claiming the right to inherit from or assert a claim against a deceased person's estate.	Paid in full up to 6 hours per insured event	\$480*
Guardianship/Conservatorship – Uncontested		
Legal services in an uncontested Guardianship/Conservatorship for you to appoint or be appointed as a Guardian/Conservator.	Paid in full	\$480*
Guardianship/Conservatorship – Contested		
Legal services in a contested Guardianship/Conservatorship for you to appoint or be appointed as a Guardian/Conservator.		

Category definition	Network Attorney	Non-Network Attorney
Legal services prior to trial	Paid in full	\$720*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Annual Accounting – Guardianship/Conservatorship		
Legal services for you in required annual accounting court proceeding(s) regarding guardianship/conservatorship.	Paid in full	\$160*
Guardianship/Conservatorship Dispute		
Legal services for you in a legal dispute related to your role as a guardian/conservator.		
Legal services prior to trial	Paid in full	\$720*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion.	Paid in full	\$100,000***
Mental Incompetency or Infirmary Proceedings		
Legal services for you in defense of mental incompetency or infirmity proceedings.		
Legal services prior to trial	Paid in full	\$960*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Name Change		
Legal services for you to legally change your name.	Paid in full	\$240*
Child Custody and Child Visitation Modification – 8 hours		
Legal services for you for a motion brought by you to modify a final decree for child custody or child visitation.	Uncontested – Paid in full	Uncontested - \$320*
(Exclusion #3, see Exclusions and limitations section below, as it relates to post judgment matters is not intended to exclude child custody and child visitation matters.)	Contested – Paid-in-full up to 8 hours per insured event	Contested - \$640*
Child Support Enforcement – 8 hours		
Legal services for you for a motion brought by you or against you to enforce a final decree regarding child support.	Uncontested – Paid in full	Uncontested - \$320*
(Exclusion #3, see Exclusions and limitations section below, as it relates to post judgment matters is not intended to exclude child support matters.)	Contested – Paid-in-full up to 8 hours per insured event	Contested - \$640
Alimony, Child Support, Child Custody and Child Visitation Modification Defense – 8 hours		
Legal services for you for a motion brought against you to modify a final decree for child support, child custody, child visitation or alimony.	Uncontested – Paid in full	Uncontested - \$320*

(Exclusion #3, see Exclusions and limitations section below, as it relates to post judgment matters is not intended to exclude child custody, child visitation, child support and alimony matters.)	Contested – Paid-in-full up	Contested - \$640*
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Category definition	Network Attorney	Non-Network Attorney
	to 8 hours per insured event	
Alimony, Child Custody and Child Visitation Enforcement – 8 hours		
Legal services for you for a motion brought by or against you to enforce a final decree regarding child custody, child visitation or alimony.	Uncontested – Paid in full	Uncontested - \$320*
(Exclusion #3, see Exclusions and limitations section below, as it relates to post judgment matters is not intended to exclude child custody, child visitation, and alimony matters.)	Contested – Paid in full up to 8 hours per insured event	Contested - \$640*
Alimony and Child Support Modification – 8 hours		
Legal services for you for a motion brought by you to modify a final decree for child support or alimony.	Uncontested – Paid in full	Uncontested – \$320*
(Exclusion #3, see Exclusions and limitations section below, as it relates to post judgment matters is not intended to exclude child support and alimony matters.	Contested – Paid in full up to 8 hours per insured event	Contested – \$640*
Child Custody/Child Support Agreement – 8 hours		
Legal services for you for the creation of an initial child custody, child support, or child visitation agreements. This benefit does not include the modification of current agreements.	Uncontested – Paid in full	Uncontested - \$320*
	Contested – Paid in full up to 8 hours per insured event	Contested - \$640*
Prenuptial Agreements		
Legal services for the preparation of premarital or antenuptial agreement.	Paid in full	\$320*
Postnuptial Agreements		
Legal services for the preparation of a postnuptial agreement.	Paid in full	\$320*
Protection from Domestic Violence – Named Insured		
Legal services for the named insured (the person who enrolled in the plan) to obtain a protective order related to domestic violence.	Paid in full	\$320*
Protection from Domestic Violence – Insured		
Legal services for an insured eligible dependent under the plan to obtain a protective order related to domestic violence when the opposing party is not an insured under the same Certificate.	Paid in full	\$320*
Restraining/Protective Order – Named Insured		

Legal services for the named insured (the person who enrolled in the plan) to obtain a restraining/protective order.	Paid in full	\$320*
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Category definition	Network Attorney	Non-Network Attorney
Restraining/Protective Order - Insured		
Legal services for an insured eligible dependent under the plan to obtain a restraining/protective order when the opposing party is not an insured under the same Certificate.	Paid in full	\$320*
School Administrative Hearing		
Legal services for you in an administrative public or private formal school proceeding regarding disabilities, special education, and student policy violations.		
Legal services prior to trial	Paid in full	\$480*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Elder Law – Member Support		
Initial advice for you on the impact of your parent's/grandparent's personal legal matter on you.	Paid in full	\$25*
Legal services for you for the preparation and review of a deed granted by a parent/grandparent where you are the grantee.	Paid in full	\$40 per document
Legal services for you for the preparation and review of a promissory note where your parent/grandparent is the payor, and you are the payee.	Paid in full	\$40 per document
Legal services for you for the review of your parents/grandparents' personal legal documents, including estate planning documents where you have been named as an agent or executor/personal representative.	Paid in full	\$40 per document
Surrogacy Agreements		
Legal services for you for the preparation of a surrogacy agreement.	Paid in full	\$300*
Domestic Partnership Agreements		
Legal services for an insured for the preparation of a domestic partnership agreement.	Paid in full	\$320*
Egg/Sperm/Embryo Donation Agreement		
Legal services for an insured for the preparation of an egg, sperm, or embryo donation agreement.	Paid in full	\$320*
Funeral Directive		
Legal services for an insured for the preparation of a funeral directive.	Paid in full	\$40 per document
Gender Identifier Change		
Legal services for an insured to change your gender identifier on government issued documents.	Paid in full	\$240*

Hospital Visitation Authorization

Legal services for an insured for the preparation of a hospital visitation authorization.	Paid in full	\$40 per document
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Pre-Birth/Post-Birth Parentage Order

Category definition	Network Attorney	Non-Network Attorney
Legal services for an insured for the preparation of a pre-birth and post-birth parentage order.	Paid in full	\$320*
Paternity – Defendant		
Legal services for an insured in the defense of establishment of paternity in a motion brought against you. This does not include legal services related to child support, child custody or visitation rights.		
Legal services prior to trial	Paid in full	\$800*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Paternity – Establishment		
Legal services for an insured in establishing paternity of a child in a motion brought by you, including amendment and reissuance of a birth certificate. This does not include legal services related to child support, child custody or visitation rights.		
Legal services prior to trial	Paid in full	\$800*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

Estate planning law

Category definition	Network Attorney	Non-Network Attorney
Wills and Durable Powers of Attorney		
Individual will or spousal will(s). Does not include any tax planning services done in connection with the will.	Paid in full	\$320 single document \$400 spousal documents
Codicil – amendment to a will	Paid in full	\$40 single document \$80 spousal documents
Living Will/Health Care Directive	Paid in full	\$40 single document \$80 spousal documents
Power of Attorney/Financial Power of Attorney	Paid in full	\$40 single document \$80 spousal documents
Trusts - Irrevocable		
Legal services for you for the preparation of a stand-alone irrevocable trust.	Paid in full	\$320* single document \$400* spousal

		documents
Trusts - Revocable		

Category definition	Network Attorney	Non-Network Attorney
Legal services for you for the preparation of a stand-alone revocable living trust.	Paid in full	\$320* single document \$400* spousal documents

Debt-related law

Category definition	Network Attorney	Non-Network Attorney
Bankruptcy		
Legal services for an insured up to and including filing of a Chapter 7 bankruptcy final report.		
Legal services for an insured up to and including confirmation of a Chapter 13 bankruptcy. This benefit does not include the ongoing maintenance of a Chapter 13 repayment plan.		
Legal services for an insured to file an amendment/modification to a Chapter 7 post-discharge or a Chapter 13 post-confirmation bankruptcy.		
Chapter 7	Paid in full	\$880*
Chapter 13	Paid in full	\$1,200*
Amendment/Modification	Paid in full	\$240*
Credit Record Correction		
Legal services for you related to correcting inaccuracies or misrepresentations on your credit record.		
	Paid in full	\$160*
Defense of Consumer Debt		
Legal services for you as the defendant in a legal dispute related to consumer goods or services (excluding foreclosure, garnishment, mechanic's lien, and student loan debt collection).		
Legal services prior to trial	Paid in full	\$480*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Foreclosure		
Legal services for you regarding written notice of foreclosure related to your primary residence.		
Legal services prior to trial	Paid in full	\$480*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Foreclosure – Secondary Residence		
Legal services for you regarding written notice of foreclosure related to your secondary residence.		

Legal services prior to trial	Paid in full	\$480*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

Garnishment – Exclusion #3, see [Exclusions and limitations](#) section below, as it relates to post judgment is waived for this benefit.

Legal services for you in a legal dispute for a garnishment against you to collect a judgment related to goods or services.

Category definition	Network Attorney	Non-Network Attorney
Legal services prior to trial	Paid in full	\$480*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

Mechanic's Lien

Legal services for you to remove a mechanic's lien.

Legal services prior to trial	Paid in full	\$480*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

Student Loan Debt Collection

Legal services for you as the defendant in a legal dispute related to your student loan.

Legal services prior to trial	Paid in full	\$480*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

Tax law

Category definition	Network Attorney	Non-Network Attorney
IRS Audit Protection		
Legal services for you involving Internal Revenue Service (IRS) audits related to your personal tax return where the initial written notice is received after your effective date. This benefit does not include audits related to your failure to file a personal tax return or your failure to pay taxes that you owed.		
Legal services prior to trial	Paid in full	\$480*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

IRS Collection Defense

Legal services for you in the defense against collection actions by the Internal Revenue Service (IRS) related to errors on your personal tax return where the initial written notice is received after your effective date. This benefit does not include collection actions related to your failure to file a personal tax return or your failure to pay taxes that you owed.

Legal services prior to trial	Paid in full	\$480*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

Consumer protection

Category definition	Network Attorney	Non-Network Attorney
Good and Services		

Legal services for you as a plaintiff or defendant regarding written, verbal, or implied contracts or warranties relating to consumer goods or services and/or residential contractor disputes (excluding insurance disputes).

Category definition	Network Attorney	Non-Network Attorney
Legal services prior to trial	Paid in full	\$800*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Document Preparation		
Legal services for you for the preparation of Deeds, Mortgages, Promissory Notes, Affidavits, Lease Contracts, Demand Letters, Installment Contracts, Bill of Sale, HIPPA Authorization and Certificate of Trust.	Paid in full	\$40 per document

Insurance disputes

Category definition	Network Attorney	Non-Network Attorney
Legal services for you as a plaintiff or defendant relating to disputes with your insurance carrier.		
Legal services prior to trial	Paid in full	\$800*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

Real estate law

Category definition	Network Attorney	Non-Network Attorney
Building Codes		
Legal services for you in an administrative action for permit or code violations relating to the renovation and/or improvement of you existing primary residence.		
Legal services prior to trial	Paid in full	\$400*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Building Codes – Secondary Residence		
Legal services for you in an administrative action for permit or code violations relating to the renovation and/or improvement of your existing secondary residence.		
Legal services prior to trial	Paid in full	\$400*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

Easement

Legal services for you in an administrative action regarding an easement on your primary residence.

Legal services prior to trial	Paid in full	\$400*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

Easement – Secondary Residence

Legal services for you in an administrative action regarding an easement on your secondary residence.

Category definition	Network Attorney	Non-Network Attorney
Legal services prior to trial	Paid in full	\$400*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Home Equity Loan – Primary Residence		
Legal services for you for the preparation and review of home equity loans for your primary residence.	Paid in full	\$160*
Home Equity Loan – Secondary Residence		
Legal services for you for the preparation and review of home equity loans for your primary residence.	Paid in full	\$160*
Neighbor Disputes – Primary Residence		
Legal services for you with a neighbor as a plaintiff or defendant in a dispute related to your primary residence, including boundary or property title disputes.		
Legal services prior to trial	Paid in full	\$720*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Neighbor Disputes - Secondary Residence		
Legal services for you with a neighbor as a plaintiff or defendant in a dispute related to your secondary residence, including boundary or property title disputes.		
Legal services prior to trial	Paid in full	\$720*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Personal Property Protection		
Legal services for you as a plaintiff or defendant regarding contracts or obligations for the transfer of your personal property or your personal property rights.		
Legal services prior to trial	Paid in full	\$320*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Property Tax – Primary Residence		
Legal services for you in an administrative action brought by you to reduce the property tax assessment on your primary residence.		
Legal services prior to trial	Paid in full	\$400*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Property Tax – Secondary Residence		

Legal services for you in an administrative action brought by you to reduce the property tax assessment on your secondary residence

Legal services prior to trial	Paid in full	\$400*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

Purchase/sale of Real Estate – Primary Residence

Category definition	Network Attorney	Non-Network Attorney
Legal services for a member for the purchase or sale of your primary residence for the review and preparation of documents including contract for purchase and attendance at closing.	Paid in full	\$320*
Purchase/sale of Real Estate – Secondary Residence		
Legal services for you for the purchase or sale of your secondary residence for the review and preparation of documents including the contract for purchase or sale and attendance at closing.	Paid in full	\$320*
Real Estate Disputes – Primary Residence		
Legal services for you as a plaintiff or defendant in a dispute regarding contracts or obligations for the construction, purchase, or sale of your primary residence.		
Legal services prior to trial	Paid in full	\$1,200*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Real Estate Disputes - Secondary Residence		
Legal services for you as a plaintiff or defendant in a dispute regarding contracts or obligations for the construction, purchase, or sale of your secondary residence.		
Legal services prior to trial	Paid in full	\$1,200*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Refinancing - Primary Residence		
Advice and review of relevant documents regarding refinancing of your primary residence.	Paid in full	\$160*
Refinancing - Secondary Residence		
Advice and review of relevant documents regarding refinancing of your primary residence.	Paid in full	\$160*
Tenant Matters		
Legal services for you as a plaintiff or defendant with your landlord as a tenant of your primary residence, including but not limited to, eviction and security deposit disputes.		
Legal services prior to trial	Paid in full	\$320*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Rental Property Dispute		
Legal services for you as a plaintiff or defendant with your tenant as landlord of your insured rental property including but not limited to, eviction and security deposit disputes. Coverage is limited to a single insured rental property that is registered with us for the current certificate year.		

(Exclusion #2, see [Exclusions and limitations](#) section below, as it relates specifically to investment interest, under exclusions and limitations, does not apply to this benefit.)

Legal services prior to trial	Paid in full	\$320*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

Landlord Rental Property Lease Review and Preparation

Category definition	Network Attorney	Non-Network Attorney
<p>Legal services for you for the review and preparation of Lease Contracts for your insured rental property. Coverage is limited to a single insured rental property that is registered with us for the current certificate year.</p> <p>(Exclusion #2, see Exclusions and limitations section below, as it relates specifically to investment interests does not apply to this benefit.)</p>	Paid in full	\$40 per document
Purchase of Real Estate – Rental		
<p>Legal services for you for the purchase of your insured rental property for the review and preparation of documents including contract for purchase and attendance at closing. This benefit is limited to one usage per family per certificate year.</p> <p>(Exclusion #2, see Exclusions and limitations section below, as it relates specifically to investment interests does not apply to this benefit.)</p>	Paid in full	\$320*
Sale of Real Estate – Rental		
<p>Legal services for you for the sale of your insured rental property for the review and preparation of documents including contract for sale and attendance at closing. This benefit is limited to one usage per family per certificate year.</p> <p>(Exclusion #2, see Exclusions and limitations section below, as it relates specifically to investment interests does not apply to this benefit.)</p>	Paid in full	\$320*
Neighbor Disputes – Rental		
<p>Legal services for you with a neighbor as a plaintiff or defendant in a dispute related to your insured rental property, including boundary or property title disputes. Coverage is limited to a single insured rental property that is registered with us for the current certificate year.</p> <p>(Exclusion #2, see Exclusions and limitations section below, as it relates specifically to investment interests does not apply to this benefit.)</p>		
Legal services prior to trial	Paid in full	\$720*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Real Estate Disputes – Rental		
<p>Legal services for you as a plaintiff or defendant in a dispute regarding contracts or obligations for the construction, purchase, or sale of your insured rental property. Coverage is limited to a single insured rental property that is registered with us for the current certificate year.</p>		

(Exclusion #2, see [Exclusions and limitations](#) section below, as it relates specifically to investment interests does not apply to this benefit.)

Legal services prior to trial	Paid in full	\$1200*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

Zoning and Variances

Category definition	Network Attorney	Non-Network Attorney
Legal services for a member in an administrative action related to a zoning change, variance or an eminent domain proceeding involving your primary residence.		
Legal services prior to trial	Paid in full	\$400*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Zoning and Variances – Secondary Residence		
Legal services for you in an administrative action related to a zoning change, variance, or an eminent domain proceeding involving your secondary residence.		
Legal services prior to trial	Paid in full	\$400*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Construction Loan – Primary Residence		
Legal services for you for the preparation and review of a construction loan related to building your primary residence.	Paid in full	\$420*
Construction Loan – Secondary Residence		
Legal services for you for the preparation and review of a construction loan related to building your secondary residence.	Paid in full	\$420*
Land Purchase – Primary Residence		
Legal services for you for the purchase of land on which you intend to build your primary residence, for the review and preparation of documents including the contract for sale and attendance at closing.	Paid in full	\$320*

Civil damage defense law

Category definition	Network Attorney	Non-Network Attorney
Legal services for you in the defense against civil damage(s) claims, except claims involving the ownership or use of a motorized vehicle or claims that are covered by other insurance or claims related to a felony.		
Legal services prior to trial	Paid in full	\$800*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

Criminal law

Category definition	Network Attorney	Non-Network Attorney
Criminal Misdemeanor Defense		

Legal services for you in the defense against criminal misdemeanor charge, except those involving motorized vehicles and domestic violence charges. If the charge is escalated to a felony, coverage will cease as of the date of the escalation. If a felony charge is reduced or pled down to a misdemeanor no coverage applies.

Legal services prior to trial	Paid in full	\$720*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

Category definition	Network Attorney	Non-Network Attorney
Expungement		
Legal services for you for the expungement of your criminal record.		
Legal services prior to trial	Paid in full	\$240*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Habeas Corpus		
Legal services for you in habeas corpus proceedings.		
Legal services prior to trial	Paid in full	\$480*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Juvenile Court Proceedings involving an insured child		
Legal services for your child charged with a crime (except those involving traffic matters or felony charges) when the court proceedings are held in juvenile court. If the matter is removed from juvenile court, coverage under this benefit will cease as the date of the removal.		
Legal services prior to trial	Paid in full	\$480*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Parental Responsibilities		
Legal services for you in juvenile court proceedings (except those involving traffic matters) where a state has brought an action regarding your parental responsibilities for an insured child.		
Legal services prior to trial	Paid in full	\$480*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

Traffic law

Category definition	Network Attorney	Non-Network Attorney
Driving Privilege Protection		
Legal services for you in the defense of a traffic offense where conviction of the offense will directly result in the suspension or revocation of your driving privileges.		
Legal services prior to trial	Paid in full	\$480*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***
Driving Privilege Restoration		

Legal services for you in an administrative proceeding for the restoration of suspended or revoked driving privileges of you.	Paid in full	\$240*
Minor Traffic Offenses excluding DWI-related		
Legal services for you in the defense of a traffic offense, the conviction of which would not result in the suspension or revocation of your	Paid in full	\$240*

Category definition	Network Attorney	Non-Network Attorney
driving privileges. This does not include driving while impaired or under the influence of drugs or alcohol, or any non-moving offense.		

Government benefits law

Category definition	Network Attorney	Non-Network Attorney
Social Security/Veterans/Medicare		
Legal services for you in an administrative legal dispute arising out of Social Security, Veterans, Medicare or Medicaid benefits.		
(Exclusion #2, see Exclusions and limitations section below, as it relates to employment matters for Veterans benefits is waived for this benefit.)		
Legal services prior to trial	Paid in full	\$400*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

Small claims court law

Category definition	Network Attorney	Non-Network Attorney
Legal services for you to bring a claim in Small Claims Court (or similar court of limited civil jurisdiction).	Paid in full	\$320*
Legal services for you to defend an action in Small Claims Court (or similar court of limited civil jurisdiction) including representation in court where allowed by law.	Paid in full	\$400*
(Exclusion #4, see Exclusions and limitations section below, as it relates specifically to plaintiff matters does not apply to this benefit.)		

Other coverage

Category definition	Network Attorney	Non-Network Attorney
General In-Office Services		
Legal advice, negotiation, document preparation and review (except those related to matters which are specifically excluded). (THIS BENEFIT IS LIMITED TO FOUR HOURS PER FAMILY PER CALENDAR YEAR)		
Legal services in office with the attorney	Paid in full Up to 4 hours	\$320*
Document Review		
Legal services for you for the review of your personal legal documents.	Paid in full	\$40 per document

Post Judgment Enforcement

Category definition	Network Attorney	Non-Network Attorney
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Legal services for you for an action brought by you to enforce a final judgment, including, but not limited to, a settlement agreement signed by all parties, a final binding arbitration or a final judgment issued by a court. This does not include legal services related to child support, child custody or visitation rights.

Exclusion #3, see [Exclusions and limitations](#) section below, as it relates to post judgment is waived for this benefit.

Legal services prior to trial	Paid in full	\$800*
Trial for three (3) days or less	Paid in full	\$1,800**
Trial starting on day four (4) until completion	Paid in full	\$100,000***

* Non-Network Attorney Indemnity Benefits are up to the stated amount

** Trial Indemnity Benefits are (\$300 per half day of trial time) up to the stated amount

*** Trial Indemnity Benefits are (\$400 per half day of trial time) up to the stated amount

Services for parents/grandparents in-office legal coverage

Category definition	Network Attorney	Non-Network Attorney
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Annual Legal Check-Up or Parents and Grandparents

Legal services for your parent/grandparent to meet with an attorney on an annual basis. This annual meeting is to discuss the legal needs of your parent/grandparent and discuss any changes to their situation and potential legal implications. THIS SERVICE IS LIMITED TO ONE USE PER FAMILY PER CERTIFICATE YEAR (ANNUAL).	Paid in full	\$80
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Services for parents/grandparents

Category definition

You will have access to ARAG network attorneys and Eldercare Advocates who can advise and offer assistance to protect and care for your parents and grandparents.

Access to the ElderAnswers Website which provides you online access to quality-of-care ratings and reports, direct access to the provider database and a wide range of eldercare information. To access ElderAnswers, go to the ARAG website , see Tools, Caregiving , and select Access Care Resources .)	Paid in full
Caregiving Guidebook - access to a "go-to" guidebook provides you with the tools and resources to take a pro-active approach in your caregiving role.	Paid in full
Telephone access to obtain legal advice and consultation on how the law relates to your parents/grandparents' legal matters and which actions may be taken.	Paid in full

Caregiver Support Services You have toll-free access to a Care Advocate who will: <ul style="list-style-type: none">• Answer your eldercare-related questions, assess elder care needs and help develop care plan• Send you a customized information guide that contains lists of assisted living facilities, nursing homes or healthcare agencies, including comparative quality-of-care ratings and reports on thousands of facilities and agencies – along with helpful eldercare information.	Paid in full
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Category definition

- Give you access to the nation's most comprehensive eldercare database with more than 90,000 long term care providers.
- Conduct searches to determine availability and rates of assisted living facilities, nursing homes, home healthcare agencies and adult day care providers. Advocate will also negotiate discounts when available.

Identity Theft Protection**Category definition**

Toll-free legal advice from a Telephone network attorney to assist with legal-related problems that the theft of your identity may have caused	Paid in full
Identity Theft Materials , including: <ul style="list-style-type: none"> • An Identity Theft Prevention Kit to help protect yourself from becoming a victim of identity theft in the first place, • An Identity Theft Victim Action Kit to help speed your recovery should you become an identity theft victim, • A tracking document to help you keep track of phone calls, e-mails and letters for attorneys, • An Identity Theft Affidavit to help you report your identity theft to necessary parties. 	Paid in full
Identity Theft Case Specialists who will help you determine appropriate steps to begin recovery and help you monitor the progress of your recovery.	Paid in full
Full-Service Identity Restoration Restoration Specialists provide full-service identity restoration services, including specialized limited Power of Attorney to work on your behalf to restore your identity.	Paid in full
Lost Wallet Services Restoration Specialists assist you in canceling and reissuing personal documents such as credit cards, driver's license, Social Security cards, etc. - due to lost or stolen wallet or identity documents.	Paid in full
Change of Address Monitoring Sends you an alert if a change of address request has been submitted to the U.S. Postal Service for your address	Paid in full
Identity Theft Insurance Should you become a victim of identity theft, Identity Theft Insurance provides coverage up to \$1 million for expenses associated with restoring your identity. (Note: The Identity Theft Insurance is underwritten and administered by American Bankers Insurance Company of Florida, an Assurant company. Refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions. To view the Identity Theft Plan Summary, go to the ARAG website , go to See What Your Plan Covers and select Download Plan Document .	Paid in full
Single-Bureau Credit Monitoring Services designated to track and immediately inform you of any activities or changes to your credit - including loan applications, credit card activations, purchases, etc.	Paid in full
Internet Surveillance Services that monitor thousands of websites and millions of online data points and will alert you if your personal information is being traded and/or sold.	Paid in full

Category definition	
Child Identity Monitoring Services that enable parents or guardians to protect minor's information from identity theft by registering and tracking their data. This service also provides you with an alert of the names, addresses and aliases found in public records associated with your child's Social Security number.	Paid in full

Toll-free legal advice from a Telephone network attorney to assist with legal-related problems that the theft of your identity may have caused.

Paid in full

Immigration

Category definition	
A service that gives you toll-free access to Telephone network attorneys for legal advice and consultation on: <ul style="list-style-type: none"> • Guidance on immigration processes and guidelines. • Filing and processing of applications and petitions. • Interpreting and explaining laws and regulations governing various types of immigration benefits; including asylum, adjustment of status, business visas, and employment authorizations. • Outlining the deportation and removal proceedings. The network attorney is also available to help you with: <ul style="list-style-type: none"> • Document review of any immigration forms. • Document preparation of affidavits and powers of attorney. • Preparation for immigration hearings. 	Paid in full
For additional immigration services, network attorneys provide a reduced rate of at least 25% off their normal rates for any representation-based immigration services. Network attorneys will bill the member directly.	At least 25% discount off normal hourly rates.

Telephone legal services

Category definition

<p>ARAG will pay the attorney fees of a Telephone Legal Access Law Firm as defined below for Telephone Legal Access Services provided by a Telephone Legal Access Law Firm while your Certificate is in effect.</p> <p>"Telephone Legal Access Law Firm" - means an independent law firm that has entered into a written agreement with us to provide Telephone Legal Access Services to you within the territory of the United States.</p> <p>"Telephone Legal Access Services" - means the type of legal services which, within applicable standard of professional care and conduct, may be rendered by the Telephone Legal Access Law Firm in one or more telephone conversations with a client and which may be connected with other legal services based on telecommunication which are specifically listed below.</p>	Paid in full
<p>You will receive:</p> <ul style="list-style-type: none">• Toll-free telephone advice on how the law relates to your personal legal matter and which action may be taken.	Paid in full

Category definition

- Follow-up correspondence and telephone calls to third parties related to your personal legal matter.
- Specific document preparation and document review.
- You will receive legal assistance from the Telephone Legal Access Law Firm for the preparation or review of a Standard Will or Codicils. Standard Will means a will document without trust provisions other than a support trust for dependent children limited to appointing a guardian and placing assets for dependent children until they reach their age of majority.

Reduced fee legal services**Category definition**

If your legal matter is not fully covered under your insurance policy and is not listed under the "Exclusions" in your Service Plan, you are eligible to work with a network attorney and receive a reduced fee that will be at least 25% off the attorney's normal hourly rate. The initial consultation for each legal matter will be provided at no cost. If you retained the services of a network attorney prior to the effective date of your legal insurance membership, the reduced fee benefit is not available. Payment of attorney fees is handled directly between the plan member and the network attorney. Access to a network attorney is subject to availability. You are encouraged to contact ARAG to determine proximity to a network attorney within legal practice areas.

For matters that include a cap on the number of hours ARAG will pay a network attorney, and where your legal matter will exceed the cap set, the network attorney will bill you directly at reduced rates of at least 25% off their normal hourly rates for the remaining hours. You pay the attorney directly.

For Telephone Advice, if your matter cannot be resolved over the phone and is not fully covered under your insurance policy and not excluded under the "Exclusions" in your Service Plan, you are eligible to work with a network attorney and receive a reduced fee that will be at least 25% off the attorney's normal hourly rate. Payment of attorney fees is handled directly between the plan member and the network attorney.

At least 25% discount off normal hourly rates

DIY Docs®**Category definition**

DIY Docs® offer online access to a variety of valid documents allowing you to create state-specific documents. These documents can assist you with everyday life, including issues involving:

- Automobiles
- Real Estate
- Estate Administration
- Finances

Paid in full

Easy-to-Use Interactive Document Assembly Tool: Helps you efficiently create your own documents by asking simple questions.

Paid in full

My Documents: Online document storage and 24/7 access to create, update, retrieve and print your documents.

Paid in full

Category definition	
Legacy Planning: Create essential legal documents yourself with the help of DIY Docs, including: <ul style="list-style-type: none"> • Durable Power of Attorney • Living Will • Health Care Power of Attorney • Standard Will 	Paid in full

Exclusions and limitations

ARAG does not provide coverage for:

1. Matters against ARAG, the policyholder or an insured against the interests of the named insured under the same Certificate.
2. Legal services arising out of a business interest, investment interests, employment matters, employee benefits, your role as an officer or director of an organization, and patents or copyrights.
3. Legal services in class actions, punitive damages, personal injury, malpractice, court appeals or post judgments (settlement agreement signed by all parties, final binding arbitration, judgment issued by a court).
4. Legal services deemed by us to be frivolous or lacking merit, or in actions where you are the plaintiff and the amount we pay for your legal services exceeds the amount in dispute, or in our reasonable belief you are not actively and reasonably pursuing resolution in your case.

The plan services do not include:

1. Matters against ARAG, the named plan member or the plan sponsor.
2. Matters arising out of a business interest, investment interests, employment matters, employee benefits, your role as an officer or director of an organization, and patents or copyrights.
3. Matters deemed by ARAG to be frivolous or lacking merit.
4. Matters outside the jurisdiction of the United States of America.

Waiver of premium

Upon the death of the named insured, coverage for the surviving spouse or domestic partner and the insured dependents continues under the policy for one year, and ARAG waives further premium payments during this time. Coverage terminates prior to the end of that one-year period if the policyholder cancels the policy during that time frame, and in such case, coverage shall cease as of the date the policyholder cancels the policy.

Deployment Waiver of premium

Should a named insured be deployed for a period of more than 30 consecutive days for the purposes of military service or of responding to a declared national emergency, coverage for the spouse and the insured dependents will continue, with the payment of premium waived

for the length of the named insured's absence and for so long as the named insured remains eligible for benefits through the policyholder.

Reduced fee legal services

If your legal matter is not fully covered under your insurance policy and is not listed under the “Exclusions” in your Service Plan, you are eligible to work with a network attorney and receive a reduced fee that will be at least 25% off the attorney’s normal hourly rate. The initial consultation for each legal matter will be provided at no cost. If you retained the services of a network attorney prior to the effective date of your legal insurance membership, the reduced fee benefit is not available. Payment of attorney fees is handled directly between the plan member and the network attorney. Access to a network attorney is subject to availability. You are encouraged to contact ARAG to determine proximity to a network attorney within legal practice areas.

For matters that include a cap on the number of hours ARAG will pay a network attorney, and where your legal matter will exceed the cap set, the network attorney will bill you directly at reduced rates of at least 25% off their normal hourly rates for the remaining hours. You pay the attorney directly.

For telephone advice, if your matter cannot be resolved over the phone and is not fully covered under your insurance policy and not excluded under the “Exclusions” in your Plan, you are eligible to work with a network attorney and receive a reduced fee that will be at least 25% off the attorney’s normal hourly rate. Payment of attorney fees is handled directly between the plan member and the network attorney.

Reduced contingency fees

This service provides you access to a network attorney for a legal matter the network attorney deems to be appropriately handled through the use of a contingency fee. The network attorney will represent you under a contingent fee arrangement where the contingent fee will not exceed 25% of the net recovery if successfully resolved before trial or will not exceed 33% of the net recovery if successfully resolved after trial or will not exceed 40% of the net recovery if successfully resolved on or after an appeal. The initial consultation for each legal matter will be provided at no cost. If you retained the services of a network attorney prior to the effective date of your legal insurance membership, the reduced fee benefit is not available.



For a complete list of covered services and exclusions and limitations, call ARAG at (800) 331-3425.

How to file a claim

Benefits provided by in-network attorneys will be paid directly by ARAG on your behalf and you do not need to submit a claim.

If you use an out-of-network attorney, follow these steps to file an indemnity claim and be reimbursed, up to the allowed benefit amount, for covered benefits from the plan:

- Notify ARAG by calling (800) 331-3425 within 60 days of consulting the attorney
- Pay the attorney for the services you receive
- Contact ARAG and ask for the Non-Network Attorney Claim Form
- Submit the completed claim form, proof of payment, and an itemized billing statement from the attorney.

ARAG must receive your form within 180 days after the legal services have been completed of the legal expense for you to get reimbursed. The plan will reimburse you according to the indemnity fee schedule provided in the [What the plan covers](#) section.

If ARAG denies a claim, the plan member/attorney has an opportunity to provide additional information to support why they feel a denied claim should be covered. The plan member/attorney has 60 days in which to send in an appeal and additional supporting documentation. If the claim is still denied, the plan member/attorney receives a detailed description of why the matter was not covered.

You are entitled to a full and fair review of a denied claim. To request review of a denied claim, you must submit a written request for review within 180 days of the date of notice.

Your request should include:

- Date of request
- Printed name and address (and name and address of authorized representative if you have designated one)
- Date of service in question
- Description of claim denied (claim number, if available)

ARAG will provide a written response within 60 days of receipt of your request.



Submit your written request for review to:

ARAG Claims Center

500 Grand Ave. Suite 100 Des

SectionXII:Legalinsurance survivor support

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COBRA enrollees – the Legal insurance survivor support section does not apply

How the plan works

This customized legal program administered by ARAG® provides assistance when an employee or dependent is faced with end-of-life decisions or immediately following the death of an employee or dependent. Eligibility includes employees, their spouses/domestic partners, or dependents in addition to non-Plan participants who are acting as the official executor of the estate of an employee, spouse/domestic partner, or dependent who is covered under this Plan (the “Eligibles”).

ARAG network attorneys are available to provide services to Eligibles. The fees for ARAG network attorneys are fully paid and unless otherwise stated, the Eligible will be responsible for payment of associated costs, such as filing fees, court costs or postage.

If an Eligible chooses not to use a network attorney for the stated benefits, the Eligible may be eligible for an indemnity benefit as shown in the schedule below.

Eligibles are able to use the following services for a one-year time period from the date that Woodgrove Financial indicates member eligibility in the Woodgrove Financial Survivor Support Legal Program. A dedicated ARAG team member is available to provide assistance to Eligibles.

What the plan covers

Legal issue	Available service	Network attorney	Indemnity benefit
Will preparation	Includes preparation of the following: Individual will or wife and husband will(s). (Does not include any tax planning services done in connection with the will.)	Paid in full	\$150
Codicil	Change or amendment to an existing will.	Paid in full	\$40 single document \$60 spousal documents (2)
Living will	Legal services to create a living will for you and/or your spouse/domestic partner. A living will is a written document that contains a person's wishes regarding the use of extraordinary life-support or other life-sustaining medical treatment.	Paid in full	\$35 single document \$50 spousal documents (2)

Healthcare power of attorney	Legal services to create a healthcare power of attorney for you and/or your spouse/domestic partner. A healthcare power of attorney is a legal document you can create to grant someone permission to make medical decisions for you if you are unable to make those decisions yourself.	Paid in full	\$35 single document \$50 spousal documents (2)
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Legal issue	Available service	Network attorney	Indemnity benefit
Financial power of attorney	Legal services to create a financial power of attorney for you and/or your spouse/domestic partner. A financial power of attorney is a legal document you can create to grant someone permission to make financial decisions for you if you are unable to make those decisions yourself.	Paid in full	\$40 single document \$60 spousal documents (2)
Sale of primary residence	Legal services including review of documents, preparation of final contract for sale and attendance at closing of your primary residence.	Paid in full	\$360*
Uncontested guardianship	Attorney's fees for representation for you in uncontested court proceedings for appointing or being appointed a guardian or conservator. This coverage does not include annual guardianship or conservatorship review.	Paid in full	\$300*
Estate administration	Legal services in administering an estate where you have been named the executor.	Paid in full	\$540*
General in-office services	General in-office legal services from an attorney for any legal issue that is not otherwise covered or excluded under this plan. Limited to 4 hours per year. If an eligible employee or dependent exceeds 4 hours of general in-office services, Network Attorneys will reduce their hourly rate by at least 25% for additional hours required to resolve the legal issue.	4 hours**	\$240*
Telephone legal advice	Toll-free telephone advice on how the law relates to your personal legal matter and which action may be taken.	Paid in full	NA

*Indemnity benefit/reimbursement amounts are paid at \$60 per hour up to the stated amounts unless stated as paid per document.

**For general in-office services that exceed 4 hours, network attorneys will take at least 25 percent off their regular hourly rate for any remaining hours required to resolve the legal issue.

Exclusions and limitations

The legal insurance survivor support benefit does not cover services for the following:

- Legal services for matters against ARAG, the plan sponsor, and/or your employer.
- Legal services arising out of your profession, business interests, investment interests, occupation, employment, workers or unemployment compensation, relocation required by an employer, patents or copyrights.
- Legal representation deemed by the attorney to be lacking merit or representation that is, in the

judgment of the providing attorney, in violation of attorney ethics rules.

Telephone legal advice and consultation services are excluded for:

- Matters which require, in your and/or the telephone network attorney's opinion, your personal presence in attorney's office or your direct and personal representation by another attorney specialist (including an accountant).
- Matters outside the jurisdiction of the United States of America.



For a complete list of covered services and exclusions and limitations, call ARAG at (800) 247-4184 x269.

SectionXIII:Coverageifyou leave Woodgrove Financial

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When benefit coverage ends

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COBRA enrollees – the When benefit coverage ends section does not apply



Woodgrove Financial reserves the right to [terminate](#) or [amend](#) these plans at any time and for any reason.

Medical, vision and prescription drugs

For employees

Your benefit coverage ends when any one of the following occurs:

- The date this plan is terminated
- The date you no longer qualify as an eligible employee
- The first day following the maximum length of an applicable leave of absence, should you not return to work

For dependents

Coverage for dependents will end on the earliest of the following dates:

- The date your coverage ends
- The date the plan is terminated
- The date your dependent no longer meets the definition of an eligible dependent, including the following situations:
 - Divorce, legal separation, or annulment (for spouses)
 - The dissolution of a domestic partnership

- The end of the month in which a child no longer meets the age requirement for dependent status
- The date coverage for all dependents under the plan is cancelled



If your coverage terminates as a result of your death, your dependent's coverage will continue through the end of the month you die if you die before the 15th of that month, or through the 15th of the next month if you die on or after the 15th of the month. If your coverage terminates as a result of your death Woodgrove Financial will provide your covered dependents, who elect COBRA, a subsidy for 365 days from the date of their medical or dental coverage ends.

You may be eligible to continue your medical, vision, and dental coverage after you leave Woodgrove Financial. See the [Continuation of coverage for health and FSA benefits \(COBRA\)](#) section for more information.

If you live in Hawaii

If your principal residence is in Hawaii and you would otherwise lose medical coverage under the Hawaii Only Plan (Premera) while hospitalized or otherwise prevented by sickness from working, your medical coverage will not be terminated before whichever occurs later:

- The end of the third month following the month in which you first became unable to work due to hospitalization or sickness
- The date Woodgrove Financial ceases to pay you regular wages in such a case

During such period of continued coverage, Woodgrove Financial will contribute the same amount per month toward your cost of medical coverage that it contributed per month for you before you became sick.

Proof of coverage

Following the end of your employment from Woodgrove Financial, you will receive proof of your health coverage under the Woodgrove Financial plan in the mail. If you enroll in another health plan that has an exclusion period for preexisting conditions, you may need this proof of coverage to reduce the exclusion period. Your new plan will let you know if your new plan's exclusion period can be shortened and, if so, by how much.

Dental

Dental coverage will be extended for covered services that are ordered before your coverage ends if the covered service is delivered or completed within 30 days. This includes:

- Dentures
- Fixed bridgework
- Crown
- Root canal therapy



To be considered an “ordered service” the following must have been done:

1. Impressions used to form the dentures, crowns, or fixed bridgework have been taken
 2. The teeth have been fully prepared for fixed bridgework and crowns
-

For employees

Your benefit coverage ends when any one of the following occurs:

- The date this plan is terminated

- The date you no longer qualify as an eligible employee
- The first day following the maximum length of an applicable leave of absence, should you not return to work

For dependents

Coverage for dependents will end on the earliest of the following dates:

- The date your coverage ends
- The date the plan is terminated
- The date your dependent no longer meets the definition of an eligible dependent, including the following situations:
 - Divorce, legal separation, or annulment (for spouses)
 - The dissolution of a domestic partnership
 - The end of the month in which a child no longer meets the age requirement for dependent status
- The date coverage for all dependents under the plan is cancelled



If your coverage terminates as a result of your death, your dependent's coverage will continue through the end of the month you die if you die before the 15th of that month, or through the 15th of the next month if you die on or after the 15th of the month. If your coverage terminates as a result of your death Woodgrove Financial will provide your covered dependents, who elect COBRA a subsidy for 365 days from date their medical or dental coverage ends.

You may be eligible to continue your dental coverage after you leave Woodgrove Financial. See the [Continuation of coverage for health and FSA benefits \(COBRA\)](#) section for more information.

Flexible spending accounts

Your coverage ends on the earliest of:

- The date this plan is terminated
- The date you no longer qualify as an eligible employee

You can claim eligible expenses that were incurred through your coverage end date for up to 90 days following the end of the plan year. Claims submitted more than 90 days after the end of the plan year are not eligible for reimbursement, and any money left in the account will be forfeited. However, claims incurred in 2019 were allowed to be submitted by March 31, 2022, and claims incurred in 2020 may be submitted by March 31, 2022, or 90 days after the end of the Outbreak Period, whichever is earlier.

You may be eligible to continue participation in the health FSA after you leave Woodgrove Financial. See the [Continuation of coverage for health and FSA benefits \(COBRA\)](#) section for more information.

Employee or dependent life insurance



All benefits and coverages are subject to the terms of the [insurance certificates](#) under which the benefits are provided. If there is any conflict between the insurance certificates and this SPD, the certificate will always govern.

For employees

Your coverage ends on the earliest of:

- The date this plan is terminated
- The date you no longer qualify as an eligible employee
- The date the coverage or policy ends
- The date your employment ends
- The date you fail to make a required premium contribution

If your life insurance premium is waived because you become disabled, your coverage will not end solely because of either of the following:

- Your employer's coverage under the Group Contract ends
- The Employee Term Life coverage ends

For dependents

Your dependent's coverage will end on the earliest of the following dates:

- The date your coverage ends
- The date your dependent fails to meet this plan's definition of an eligible dependent

You may be eligible to continue coverage after you leave Woodgrove Financial. See the [Continuation of coverage for other benefits](#) section for more information.

Accidental death & dismemberment (AD&D)

A covered loss that started before the termination of coverage date will not be affected by the termination date.



All benefits and coverages are subject to the terms of the [insurance certificate](#) under which the benefits are provided. If there is any conflict between the insurance certificates and this SPD, the certificate will always govern.

For employees

Your coverage ends on the earliest of:

- The date this policy is terminated
- The end of the grace period if you do not pay the required premium
- The premium due date that falls on or follows the date you are no longer eligible for coverage

For dependents

Your child's coverage will continue as long as your coverage remains in effect and the child remains a dependent child incapable of self-sustaining employment.

Your dependent's coverage will end on the earliest of the following dates:

- The date your coverage ends
- The premium due date that falls on or follows the date your dependent is no longer eligible for coverage

If your child is no longer eligible for AD&D coverage, your dependent child can continue coverage if:

- On the date your child's coverage would otherwise terminate due to age, the child is then mentally or physically incapable of earning a living
- Proof of incapacity is provided within 31 days after the normal termination date
- Your coverage remains in effect.

You may be eligible to continue coverage after you leave Woodgrove Financial. See the [Continuation of coverage for other benefits](#) section for more information.

Long-term disability (LTD)

Your coverage ends on the earliest of:

- The date this plan is terminated
- The date you no longer qualify as an eligible employee

You may be eligible to continue coverage after you leave Woodgrove Financial. See the [Continuation of coverage for other benefits](#) section for more information.

Legal insurance

Coverage will continue for legal matters that began while the plan was still in effect until each covered matter is resolved, regardless of the length of time it takes to reach a resolution.

Your coverage ends on the earliest of:

- The date this plan is terminated
- The last day of the month in which you leave Woodgrove Financial
- The last day of the month in which you no longer qualify as an eligible employee



If you are a participant in the plan and you die, your spouse and dependents remain covered under the plan for one year from the date of death.

If you have been enrolled in the Legal Insurance plan for at least one year, and your coverage ends, you may be eligible to purchase a separate legal insurance plan through ARAG. See the [Continuation of other coverage for other benefits](#) section for more information.

Other health & wellness benefits

Your benefit coverage for other health and wellness benefits (the Spring Health Employee Assistance Program (EAP), Expert Medical Opinion service, onsite Flu Shot and/or biometric Programs, and Be Well) ends when any one of the following occurs:

- The date this plan is terminated
- The date you no longer qualify as an employee eligible for the benefit
- The first day following the maximum length of an applicable leave of absence, should you not return to work

For dependents

Coverage for dependents, if applicable, will end on the earliest of the following dates:

- The date your coverage ends
- The date the plan is terminated
- The date your dependent no longer meets the definition of an eligible dependent, including the following situations:
 - Divorce, legal separation, or annulment (for spouses)
 - The dissolution of a domestic partnership
- The date coverage for all dependents under the plan is cancelled



If your coverage terminates as a result of your death, your dependent's coverage will continue through the end of the month you die if you die before the 15th of that month, or through the 15th of the next month if you die on or after the 15th of the month.

You may be eligible to continue your other health & wellness benefits coverage after you leave Woodgrove Financial. See the [Continuation of coverage for health and FSA benefits \(COBRA\)](#) section for more information.

Continuation of coverage for health and FSA benefits (COBRA)

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COBRA enrollees – the Continuation of coverage for health and FSA benefits (COBRA) applies



Certain individuals may be eligible for temporary premium assistance under the American Rescue Plan Act of 2021 (ARP). For more information regarding the temporary premium assistance see [Important information due to the coronavirus pandemic](#).

How COBRA works

If you are no longer eligible for benefits under the Plan, you may be able to continue coverage of the following benefits on a self-pay basis under COBRA:

- Medical, vision, and prescription drugs
 - Dental
 - Employee Assistance Program (EAP)
 - Wellness; Expert Medical Opinion (Teladoc Medical Experts) and Be Well
 - In some cases, a health care or dental & vision flexible spending account (FSA)
- Note: You may also have other health coverage options available to you through the Health Insurance Marketplace. Visit www.healthcare.gov for further information.

You can continue coverage under COBRA for up to 18 months, or, for dependents who are eligible for COBRA other than due to an employee's termination of employment, up to 36 months. In some cases, you may have the option to extend COBRA coverage.

With regard to benefits, COBRA enrollees have the same rights as employees. COBRA coverage is administered by the Woodgrove Financial COBRA Service Center.



Your rights to COBRA coverage may change as further amendments to COBRA are made by Congress or as interpretations of COBRA are made by the courts and by federal regulatory agencies.

Who is eligible

COBRA coverage is available for you (and your dependents, if applicable) **if**:

- You (and your dependents, if applicable) were covered by Plan benefits on the day before a qualifying event occurs (or, for dependents in particular, you removed your dependents from coverage at Open Enrollment in anticipation of a future qualifying event), or
- A child is born to you or adopted by you, while you are covered under COBRA

And a qualifying event (described above) occurs which results in the loss of benefit coverage for you or for your dependents under the Plan. The qualifying events include:

- The end of your employment with Woodgrove Financial (not including transfers to US Woodgrove Financial subsidiaries) for any reason other than gross misconduct
- Additional qualifying events for dependents only:
 - Your death (if your coverage terminates as a result of your death Woodgrove Financial will provide your covered dependents who elect COBRA a subsidy for 365 days from date their medical or dental coverage ends)
 - Your divorce, legal separation, or annulment
 - The legal dissolution of your domestic partnership
 - The fact that the dependent is no longer an eligible dependent as defined by the Plan

You are eligible for COBRA continuation of coverage for the dental & vision or health care flexible spending account (FSA) if you have a positive balance in your FSA at the time of the qualifying event. At the end of the plan year, you may carryover any unused balance up to \$570 to the next plan year, and you do not have to pay COBRA premiums in the next plan year. Any unused amounts over \$570 are forfeited at the end of the plan year. If you do not have a balance at the end of the plan year, you may not continue FSA coverage for the next plan year.

You may elect separate COBRA coverage for you and each of your eligible dependents. If elected, separate coverage will apply to all of your COBRA benefits and separate premiums will apply to each member. If you are interested in this alternative, contact the [Woodgrove Financial COBRA Service Center](#) at (833) 253- 4929 for more information.



If you elect COBRA medical coverage because you take a leave of absence from work or your employment ends as a result of an injury or illness covered by the accidental death & dismemberment (AD&D) benefit, you may receive up to 24 equal monthly payments to help you pay for COBRA continuation of medical coverage. Payments will stop if you become covered under another group medical plan. Each payment will equal the lesser of 3% of your benefit or \$125. Proof that the payment will be used for continuation of medical coverage will be required.



For active employees, removing a dependent during Open Enrollment is not a COBRA qualifying event so COBRA coverage will not be made available to the removed dependent when they lose coverage on January 1st. However, if you remove a dependent from coverage during Open Enrollment in anticipation of a future qualifying event (such as a divorce, legal separation, annulment, or dissolution of domestic partnership), the dependent will be **deemed** to have been enrolled in Woodgrove Financial benefits coverage on the day before the qualifying event, and therefore may become eligible for COBRA coverage after the qualifying event.

How to start COBRA coverage

If your employment with Woodgrove Financial is ending and you or your dependents are eligible for COBRA coverage, the Woodgrove Financial COBRA Service Center will send you or your dependent a notice about your right to COBRA coverage as well as an election form and instructions to elect COBRA coverage. This notice and form will be mailed to your last known address or the last known address of your dependent within 44 days of your last day of employment (or the notification of your death, if applicable).

If coverage for you or your dependents is ending due to any other qualifying event (including divorce, legal separation, dissolution of a domestic partnership, or dependent becoming ineligible), or your dependent was removed from coverage at Open Enrollment in anticipation of a future qualifying event, you or your dependent must inform Woodgrove Financial no more than 60 days* after the latest of any one of the following events:

- The date of the qualifying event
- The date that benefits would be terminated as a result of the qualifying event
- The date you or your dependent is informed, through the SPD, the general COBRA notice, or otherwise, of the obligation to provide this notice to Woodgrove Financial and the procedures for providing such notice (stated below)



To notify Woodgrove Financial of a qualifying event contact Benefits at (833) 253-4929 or go to the [Woodgrove Financial COBRA Service Center](#).

If you report a qualifying event to Woodgrove Financial, but COBRA coverage is not made available at that time, either due to late reporting by you or your termination of employment due to gross misconduct, the Woodgrove Financial COBRA Service Center will send you a notice of unavailability of COBRA coverage within 14 days of receiving your notice of the event (or your termination of employment, as applicable).

You must enroll for COBRA coverage within 60 days* of the date your benefits end with Woodgrove Financial, or the date you are mailed your COBRA notification and enrollment form, whichever date is later. Through COBRA, you can continue coverage for yourself and any eligible dependent in your current COBRA-eligible plan(s). You do not have to cover the same dependents as you had as an active employee.



If you do not notify Woodgrove Financial within the 60-day period, you and your covered dependents will lose your right to elect COBRA coverage. If you do not choose COBRA coverage or do not pay for COBRA coverage within the time limits set by COBRA, you may not be eligible for COBRA coverage in the future for the same qualifying event.

Cost of COBRA coverage

If you enroll for COBRA coverage, you must pay the full cost of the coverage plus an administrative fee. Generally, this cost is 102% of the cost of coverage for similarly situated active full-time employees and/or dependents. The cost is actuarially determined based on the level of coverage. Separate rates are established for:

- A single employee or single spouse/domestic partner, or a child who enrolls in COBRA after “aging out” of coverage at age 26

- An employee and spouse/domestic partner
- An employee and children
- An employee, spouse/domestic partner, and children
- A child only (other than a child who enrolls in COBRA after aging out of coverage at age 26)

If the cost of active employee coverage changes after your COBRA coverage starts, the cost of COBRA coverage may also change.

If you are disabled and qualify for an additional 11 months of coverage, the cost for those extra 11 months of coverage is 150% (instead of 102%) of the cost of coverage for similarly situated active full- time employees and/or dependents.

You must send your first COBRA payment to the Woodgrove Financial COBRA Service Center postmarked within 45 days* following the date you elect COBRA coverage.



After you have elected and paid your initial COBRA premium payment, your subsequent monthly COBRA payments must be postmarked no more than 30 days following the due date. If your payments are late, your COBRA coverage will be terminated retroactive to the last payment date.*

In the event of your death, Woodgrove Financial will provide your covered dependents a COBRA subsidy for medical and dental coverage (but not premiums for flexible spending account coverage) for up to the first 365 days from the date that they lose such coverage. Your dependents must elect COBRA continuation coverage under a Woodgrove Financial health care plan in order to avail of this benefit.



For more information about COBRA rates, contact Benefits at (833) 253-4929 or go to the [Woodgrove Financial COBRA Service Center](#).

The following table summarizes the monthly COBRA rates for 2023. These rates are subject to change. (All currency amounts are expressed in U.S. dollars.)

2023 COBRA Rates							
Type of coverage	Employee or spouse / domestic partner	Employee and spouse / domestic partner	Employee and children	Employee and spouse / domestic partner and children	Spouse Only	Children Only	Family Only
Medical, vision and prescription drugs							
Health Savings Plan (Premera)	\$605.88	\$1,211.76	\$908.82	\$1,757.46	\$605.88	\$302.94	\$908.82
Hawaii Only Plan (Premera)	\$650.76	\$1,301.52	\$976.14	\$1,887.00	\$650.76	\$325.38	\$976.14
Health Connect Plan (Premera)	\$671.16	\$1,342.32	\$1,006.74	\$1,946.16	\$671.16	\$335.58	\$1,006.74
HMO Plan (Kaiser Foundation Health Plan of Washington)	\$541.62	\$1,083.24	\$812.94	\$1,570.80	\$541.62	\$271.32	\$812.94
HMO Plan (Kaiser Permanente CA)	\$611.34	\$1,222.67	\$917.00	\$1,528.34	\$611.34	\$305.66	\$917.00
Dental							
Dental Plus	\$65.28	\$130.56	\$97.92	\$189.72	\$65.28	\$32.64	\$97.92
EAP & WELLNESS							
Employee Assistance Program	\$13.74	\$13.74	\$13.74	\$13.74	\$13.74	\$13.74	\$13.74
Wellness	\$7.32	\$7.32	\$7.32	\$7.32	\$7.32	\$7.32	\$7.32

Benefit coverage is subject to the terms and conditions set forth by Woodgrove Financial corporate policies, benefit plan documents, and summary plan descriptions.

Filing an appeal for COBRA coverage

If you believe your right to enroll in COBRA coverage should not have been denied, you may file an appeal as follows:

1. Write an appeal in which you explain why you believe your right to COBRA coverage was improperly denied. Include your name, address, and the names of other covered individuals you wish to include in your appeal, along with any additional information you wish to be reviewed.

2. Send your written appeal within 30 days of your receipt of the declination to:

Woodgrove Financial (c/o
Businessolver, Inc.) ATTN:
COBRA Administration

P.O. Box 310512

Des Moines IA 50331-0512

(833) 253-4929

The Woodgrove Financial COBRA Service Center will respond within 30 days after the receipt of your written appeal. This is the exclusive process for appeals of COBRA rights declinations. Appeals for COBRA coverage are not subject to the general plan and ERISA rules for benefit claims and appeals. The Woodgrove Financial COBRA Service Center's determination is final. You cannot appeal further.

Extending COBRA coverage

If a second qualifying event occurs during the 18-month COBRA period that results from the loss of coverage due to your termination of employment (other than for gross misconduct), your covered dependents may continue their coverage for a maximum of 36 months from the date of your termination of employment (i.e., first qualifying event). Your dependents must notify Woodgrove Financial of this change within 60 days* of the second qualifying event.

If the initial qualifying event is your termination of employment and you or a covered dependent become disabled during the first 60 days of your 18-month COBRA period, COBRA coverage may be extended for up to 29 months total for you and your dependents if you or a covered dependent receive a determination of disability from the Social Security Administration within this timeframe. You must send this Social Security Administration notice indicating the disability onset date to the Woodgrove Financial COBRA Service Center no more than 60 days after the latest of any one of the following events:

- The date of the notice from the Social Security Administration
- The date of the qualifying event
- The date benefits are terminated
- The date you are informed, through the SPD or the general COBRA notice, of the obligation to provide this notice, and the procedures for providing such notice
- Note: If you become entitled to Medicare less than 18 months before a qualifying event due to termination of employment, your eligible dependents can elect COBRA for a period of not more than 36 months from the date you became entitled to Medicare.

In addition, individuals enrolled in the Kaiser Permanente HMO Plan for California employees may be eligible for an extended COBRA coverage period, in accordance with California state law (“Cal-COBRA”). For more information, see:

Active employees/dependents go here...	COBRA enrollees go here...
<ul style="list-style-type: none"> • Evidence of Coverage – Northern California • Evidence of Coverage – Southern California 	Go to http://cobra.me.Woodgrove Financial.com > Reference Center > Kaiser CA Evidence of Coverage (EOC) Documents

When COBRA coverage ends

COBRA coverage ends on the date of the earliest of the following events:

- The date the maximum COBRA coverage period ends, as described above
- The last date for which premiums were paid, in the event that you fail to make the next required premium payment either in full or within the grace period required by COBRA
- The date you become covered under another group plan or the effective date of your enrollment under Medicare Part A or B, after the date of your COBRA election
- The date Woodgrove Financial ceases to offer the plan in which you are enrolled. However, COBRA coverage may be available under other Woodgrove Financial plans. If all Woodgrove Financial plans are terminated, all COBRA coverage is also terminated
- If you add dependents to your coverage while on COBRA, their coverage ends when your coverage ends



If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, they must notify the Woodgrove Financial COBRA Service Center of that fact within 30 days after the Social Security Administration's determination. All other rules still apply. COBRA qualified beneficiaries will be notified of their COBRA termination date.



If the qualified beneficiary becomes covered under another group health plan or covered by Medicare Parts A or B, they must notify the Woodgrove Financial COBRA Service Center of that fact within 30 days of being so enrolled. All other rules still apply. COBRA qualified beneficiaries will be notified of their COBRA termination date.



**Certain dates and deadlines generally applicable under this section have been extended during the COVID-19 emergency period. See [Important information due to the coronavirus pandemic](#) for more information.*

Continuation of coverage for other benefits

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COBRA enrollees – the Continuation of coverage for other benefits section does not apply

You may be able to extend the following benefits if your coverage ends with Woodgrove Financial for reasons other than gross misconduct.

Employee or dependent life insurance

If your coverage under the Woodgrove Financial plan ends, you may convert your Woodgrove Financial insurance (a group policy) to an individual policy or apply for similar coverage under the portability plan. You may not choose both options. You and your qualified dependents must have been covered under the Woodgrove Financial life insurance plan when your coverage ends.

Conversion to individual policy

Your coverage may be converted to an individual policy if your employment ends. Dependent coverage may be converted to an individual policy if your employment ends, you die, or you divorce. Evidence of Insurability (EOI) is not required, but you must apply and pay for your converted coverage within 31 days after your employment ends.

The maximum amount you can convert to an individual life policy is the face amount of your employee or dependent term life insurance coverage when your group insurance coverage ends. Rates are based on your age and your class of risk. Dependent rates are based on your dependent's age and class of risk.



For more information about converting to an individual policy, contact Prudential (800) 778-3827.

Continuation of coverage through the portability plan

You may be eligible to continue coverage through the portability plan if your coverage ends because you leave Woodgrove Financial, or you otherwise become ineligible for continuing coverage. This coverage is not available if you fail to make contributions for the coverage, or the Prudential AD&D policy is replaced for all employees with a new policy for which you become eligible within 31 days.

You must be age 79 or younger to continue employee life insurance. You may continue dependent life insurance coverage only if you elect to continue your employee life insurance. If you die or divorce, your spouse or domestic partner will have the right to apply for continued life insurance coverage under the portability plan.

Portability is not available for the following dependents:

- Spouses or domestic partners age 80 or over
- Dependent children older than age 19, or 23 if enrolled as a full-time student in a school and wholly dependent on you for support and maintenance
- Dependents who are confined for medical care or treatment

The amount of insurance coverage that you can continue is:

- For employee coverage: from \$20,000 to \$1,000,000
- For dependent coverage: from \$20,000 to \$500,000

To continue coverage, submit your request in writing to Prudential within 31 days of when your coverage under the Woodgrove Financial plan ends. If you elect to continue your life insurance, coverage is effective at the end of the election period. You do not have to provide EOI to qualify for this continued insurance coverage; however, if you do provide EOI, you may pay lower premium rates.



For more information about the portability plan, contact Prudential (800) 778-3827.

Accidental death & dismemberment (AD&D)

You may be eligible to continue AD&D coverage under the portability plan if your insurance ends because you leave Woodgrove Financial, or you otherwise become ineligible for continuing coverage. This coverage is not available if you fail to make contributions for the coverage, your employment ends because you retire, or the Prudential AD&D policy is replaced for all employees with a new policy for which you become eligible within 31 days.

Portability is not available for the following dependents:

- Spouses/domestic partners age of 80 or older
- Dependent children older than age 19, or 23 if wholly dependent on you for support and maintenance
- Dependents who are confined for medical care or treatment

The amount of insurance coverage that you can continue is:

- For employee coverage: from \$20,000 to five times your base pay or \$1,000,000, whichever is less
- For dependent coverage: from \$20,000 to \$500,000 or the coverage the dependent had when coverage with Woodgrove Financial ends, whichever is less

To continue coverage, submit your request in writing to Prudential within 31 days of when your coverage under the Woodgrove Financial plan ends.

If you elect to continue your life insurance, coverage is effective as of the date your coverage under the Woodgrove Financial Plan ends.



For more information about the portability plan, contact Prudential (800) 778-3827.

Long-term disability (LTD)

If your coverage under the Woodgrove Financial plan ends, you may purchase LTD coverage under Prudential's group conversion plan. You must have been covered under the Woodgrove Financial LTD plan for at least 12 consecutive months when your coverage ends.

You are not eligible to apply for coverage under Prudential's group conversion policy if:

- You are or become insured under another group long-term disability plan within 60 days after your employment ends
- You are disabled under the terms of the plan
- You are age 70 or more when your employment ends
- Your coverage under the plan ends for any of the following reasons:
 - The plan is canceled
 - You retire (applies when retirement is self-reported to Prudential)
 - The plan is changed to exclude the group of employees to which you belong
 - You are no longer in an eligible group
 - You fail to pay the required premium under this plan

You must apply for insurance under the conversion policy and pay the first premium to Prudential within 60 days after the date your employment ends. Evidence of insurability will be required for certain levels of coverage.

Your coverage under the conversion plan will not be more than your coverage under the Woodgrove Financial LTD plan, but it may be lower. The benefits will comply with any state laws or regulations that may apply.

Your rates for the conversion plan will be based on the form and amount of insurance provided, the period and your age at the time of conversion. Your premiums will not be due less often than quarterly unless you agree to another frequency.



For more information about the conversion plan, contact Prudential (800) 778-3827.

Legal insurance

If you have been enrolled in the Legal Insurance plan for at least one year, and your coverage ends, you may be eligible to purchase a new legal insurance plan through ARAG. You will be responsible for payment of premiums from your previous policy's end date through your enrollment date in the new plan. Your premium for coverage will be deducted from your checking or savings account or charged to your credit card each month.



To enroll contact ARAG Customer Care at (800) 331-3425 or go to ARAGlegal.com/MyChoice within 90 days of your last day of employment.



Following the death of an insured employee, spouse and dependents are covered under the plan for one year from when the death occurred.

SectionXIV:Additional resources

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✓ COBRA enrollees – the Additional resources section applies

Glossary

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General terms

Activities of daily living—

- Bathing—Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower
- Continence—The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel and bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag)
- Dressing—Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs
- Eating—Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously
- Toileting—Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene
- Transferring—Sufficient mobility to move into or out of a bed, chair, or wheelchair or to move from place to place, either by walking, using a wheelchair, or by other means
- You have a severe cognitive impairment, which requires substantial supervision to protect you from threats to health and safety

Eligible employee—For purposes of determining eligibility to participate in the plan under this SPD, an eligible employee is an employee who is in an approved headcount regular employment position with Woodgrove Financial, is on the Woodgrove Financial U.S. payroll and is not a Woodgrove Financial retail store employee.

An approved headcount regular employment position is one that is:

- Authorized in writing during the Woodgrove Financial annual or out-of-cycle budgeting process as a regular employment position and is approved by an officer of Woodgrove Financial (or by a regional director for positions in subsidiaries of Woodgrove Financial) and
- Reflected in the official Human Resources (HR) database of Woodgrove Financial or one of its subsidiaries as a regular employment position (for example, as hourly regular or salaried regular)

You are on the Woodgrove Financial U.S. payroll if you are paid from the Woodgrove Financial payroll department located in the United States, and Woodgrove Financial

withholds and pays U.S. employment taxes on your payroll amounts. For purposes of eligible employee status, the term Woodgrove Financial includes those subsidiaries and affiliates of the Woodgrove Financial Corporation that participate in the Plan. The current participating employers are listed in the

[Administrative Information](#) section of this Summary Plan Description. Contact Benefits if you would like a current list of the Woodgrove Financial subsidiaries and affiliates that participate in the Plan.

Notwithstanding the above, the following persons are not eligible employees and are not eligible to participate as employees in the plan under this SPD, even if they meet the definition of a regular employee of Woodgrove Financial:

- Interns and visiting researchers
- Cooperatives
- Apprentices
- Nonresident aliens receiving no U.S. source income from Woodgrove Financial
- Employees covered by a collective bargaining agreement resulting from negotiations with Woodgrove Financial in which retirement benefits were the subject of good faith bargaining and participation in this plan was not provided for
- Persons providing services to Woodgrove Financial pursuant to an agreement between Woodgrove Financial and any other individual or entity, such as a staff leasing organization (leased employees)
- Temporary workers engaged through or employed by temporary or leasing agencies
- Temporary employees of Woodgrove Financial. For purposes of the plan, a temporary employee of Woodgrove Financial is one who is hired by Woodgrove Financial as an employee to work on a specific project or series of projects that in the aggregate is not expected to exceed six months.
- Workers who hold themselves out to Woodgrove Financial as being independent contractors or as being employed by or engaged through another company while providing services to Woodgrove Financial
- Project-based employees. For purposes of the plan, a project-based employee is one who is hired to work on a project or series of projects, is employed for a limited term, and has signed a Project-Based Employment Agreement.
- All other workers who Woodgrove Financial does not classify as being either a full-time or part-time employee on the Woodgrove Financial U.S. payroll, even if that classification is later determined to be incorrect or is retroactively revised.

Dependent children under age 26—Includes your:

- Biological child and/or your spouse's/domestic partner's biological child
- Child for whom you or your spouse/domestic partner has been named legal guardian as appointed by the courts (or recognized as guardian by the state of residence)
- Legally adopted child, or child who has been placed with you for adoption, but not a foster child
- A child's eligibility as a dependent does not rely on the child's financial dependency (on you or any other person), residency with you or with any other person, student status, employment, eligibility for other health plan coverage, or any combination of these factors.

Incapacitated dependent children age 26 or over—An incapacitated dependent is unable to sustain employment due to a developmental or physical disability that existed before the child reached age 26. The individual is chiefly dependent on the member for support.

Spouse—You must be married (whether same or opposite sex) under the laws of any state, possession, or territory of the U.S. in which the marriage is entered into, regardless of domicile, and not legally separated

Domestic Partner—You and your domestic partner (either of the same or opposite sex) must meet all of the following requirements:

- You are each other's sole domestic partner and intend to remain so indefinitely

- Neither of you is legally married
- You are both at least 18 years of age and are mentally competent to consent to contract
- You are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which you legally reside
- You reside together in the same residence and intend to do so indefinitely (excepting a temporary residence change of not more than 90 days during which you and your domestic partner reside in separate homes)
- You are mutually responsible (financially and legally) for each other's common welfare

For life and accidental death & dismemberment (AD&D), a domestic partner includes any person who satisfies the requirements for being a domestic partner, registered domestic partner, or civil union partner of an eligible employee under the law of your jurisdiction of residence.

Health plan terms

Medical Care

Approved transplant center—A hospital or other provider that has developed expertise in performing solid organ transplants, bone marrow reinfusion, or stem cell reinfusion, and is approved by your insurance plan. Your plan has contractual agreements with approved transplant centers and has access to a special network of approved transplant centers, throughout the United States. Whenever medically possible, they will direct you to an approved transplant center with which they have a contract. Of course, if neither a plan-approved transplant center nor a network transplant center can provide the type of transplant you need, this benefit will cover a transplant center that meets the approval standards that are set by the plan.

Bluecard - BlueCard® Program and other inter-plan arrangements

Premiera Blue Cross has relationships with other Blue Cross and/or Blue Shield Licensees generally called "Inter-Plan Arrangements." They include "the BlueCard Program," negotiated National Account arrangements, and arrangements for payments to non-network providers. Whenever you obtain healthcare services outside Washington and Alaska or in Clark County, Washington, the claims are processed through one of these arrangements. You can take advantage of these Inter-Plan Arrangements when you receive covered services from hospitals, doctors, and other providers that are in the network of the local Blue Cross and/or Blue Shield Licensee, called the "Host Blue" in this section. At times, you may also obtain care from non-network providers. Our payment calculation practices in both instances are described below.

It's important to note that receiving services through these Inter-Plan Arrangements does not change covered benefits, benefit levels, or any stated residence requirements of this plan.

Network Providers

When you receive care from a Host Blue's network provider, you will receive many of the conveniences you're used to from Premera Blue Cross. In most cases, there are no claim forms to submit because network providers will do that for you. In addition, your out-of-pocket costs may be less, as explained below.

BlueCard in California

We have made an arrangement for you as a Premera Blue Cross member with Anthem Blue Cross. In

order for you to maximize your in-network savings under the BlueCard Program, you will need to choose only Anthem Blue Cross network providers for services received in California. **Note:** Blue Shield of California network providers are not considered in-network for purposes of the Health Savings Plan, unless (and to the extent) that they are also Anthem Blue Cross network providers.

Negotiated National Account Arrangement in Arizona

Members' claims for covered healthcare services in Arizona are processed through an Inter-Plan Program called a negotiated National Account arrangement with the Host Blue in Arizona. Our responsibilities and those of the Arizona Host Blue and its network providers under this arrangement are the same as under the BlueCard Program.

Allowable charge calculations under the negotiated National Account arrangement are the same as described above in the "Network Providers" section for the BlueCard Program.

Non-Network Providers

The allowable charge for Washington or Alaska providers that don't have a contract with us is the least of the three amounts shown below. The allowable charge for providers outside Washington or Alaska that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the three amounts shown below:

- An amount that is no less than the lowest amount we pay for the same or similar service from a comparable provider that has a contracting agreement with us
- 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
- The provider's billed charges

Notwithstanding any provision of the plan to the contrary, the plan will pay any amounts required by applicable law.

Exceptions Required by Law

In some cases, federal law or the laws in a small number of states may require the Host Blue to include a surcharge as part of the liability for your covered services. If either federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then use the surcharge and/or other amount that the Host Blue instructs us to use in accordance with those laws as a basis for determining the plan's benefits and any amounts for which you are responsible.

Blue Cross Blue Shield Global Core

If you're outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, you may be able to take advantage of Blue Cross Blue Shield Global Core when

accessing covered health services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands in certain ways. For instance, although Blue Cross Blue Shield Global Core provides a network of contracting inpatient hospitals, it offers only referrals to doctors and other outpatient providers. Also, when you receive care from doctors and other outpatient providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you'll typically have to submit the claims yourself to obtain reimbursement for these services.

Further Questions?

If you have questions or need more information about Inter-Plan Arrangements, including the BlueCard Program, call our Customer Service Department. To locate a provider in another Blue Cross and/or Blue Shield Licensee service area, go to our Web site or call the toll-free BlueCard number; both are shown on the back cover of your booklet. You can also get Blue Cross Blue Shield Global Core information by calling

the toll-free phone number.

Brand-name prescription drug—A prescription drug that is sold under a trademark name.

An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.

Brand formulary—The brand-name prescription drugs that are covered under the KFHPWA HMO Plan.

Chemical dependency—This is an illness characterized by a physiological or psychological (or both) dependency on a controlled substance and/or on alcoholic beverages, and where the member's health is substantially impaired or endangered or their social or economic function is substantially disrupted.

Congenital anomaly—A marked difference from the normal structure of a body part that is physically evident from birth

Continuous care—Skilled nursing care provided in the home during a period of crisis in order to maintain the terminally ill member at home

Custodial care—Any service, procedure or supply that is provided primarily:

- For ongoing maintenance of a person's condition, not for therapeutic value, in the treatment of an illness or injury
- To assist a person in meeting activities of daily living for example, assistance in walking, bathing, dressing, eating and preparation of special diets and supervision over self-administration of medication not requiring the constant attention of trained medical personnel

Such services and supplies are regarded as custodial without regard to the following:

- Who prescribes the service and supplies
- Who recommends the service and supplies
- Who performs the service or the method in which such services are performed

Dentally necessary—A service or supply that meets all of the following Premera requirements. It is essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a disease, accidental injury, or condition harmful or threatening to the enrollee's dental health, unless provided for preventive services when specified as covered under this plan

- It is appropriate and consistent with authoritative dental or scientific literature
- It is not primarily for the convenience of the enrollee, the enrollee's family, the enrollee's dental care provider or another provider
- It is not primarily for research or data accumulation

The fact that the covered services are furnished, prescribed, or approved by a dental care provider does not in itself mean that the services are dentally necessary.

Eligible provider—A health care practitioner or facility that is in a licensed or certified provider category regulated by the state in which the practitioner or facility provides care, and that practices within the scope of such licensure or certification. Also included is an employee or agent of such practitioner or facility, acting in the course of and within the scope of his or her employment.

Health care facilities that are owned and operated by an agency of the U.S. government are included as required by federal law. Health care facilities owned by the political subdivision or instrumentality of a state are also covered.

For more information on eligible providers, refer to the section of this SPD describing the specific benefit and plan at issue.

Experimental or investigational—Such services include a treatment, procedure, equipment, drug, drug usage, medical device, or supply that meets one or more of the following criteria as determined by Premiera or KFHPWA (for Kaiser related information refer to the Kaiser EOC):

- There is insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved.
- A drug or device that cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA) and has not been granted such approval on the date that the service is provided
- The service is subject to oversight by an Institutional Review Board.
- No credible scientific evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management, or treatment of the condition.
- Evaluation of credible scientific evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Credible scientific evidence includes, but is not limited to, reports and articles published in authoritative peer-reviewed medical and scientific literature, generally recognized by the relevant medical community and assessments and coverage recommendations published by the Blue Cross and Blue Shield Association Technical Evaluation Center.

However, exclusions for experimental or investigational treatment will not apply with respect to services or supplies (other than drugs) that are received in connection with the treatment of a disease, if Premiera or KFHPWA determines the following:

- The disease can be expected to cause death within one year, in the absence of effective treatment, and
- As demonstrated by scientific data, the care or treatment is effective or shows promise of being effective for the treatment of the disease

In making this determination, Premiera or KFHPWA will take into account the results of a review by a panel of independent medical professionals. Panel members will be selected by Premiera or KFHPWA. The panel will include professionals who treat the type of disease involved.

Also, exclusions for experimental or investigational treatment will not apply with respect to the drugs that meet any one of the following criteria:

- The drug or drugs have been granted the status of "treatment investigational new drug" or "group treatment investigational new drug"
- The drug or drugs are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute
- Premiera determines that available scientific evidence demonstrates that the drug or drugs are

effective or show promise of being effective in the treatment of the disease

Generic maintenance medications have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year. A generic prescription drug is manufactured and distributed after the brand-name drug patent of the innovator company has expired and is available at a lower cost than brand-name prescriptions.

Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration and are considered by the FDA to be therapeutically equivalent to the brand-name product.

Generic drugs are equivalent to brand-name drugs but are available at a lower cost because the patent has expired.

Hospice care—A coordinated program of palliative and supportive care for dying members by an interdisciplinary team of professionals and volunteers centering primarily in the member's home.

Intermittent care—Care provided due to the medically predictable recurring need for skilled home health care services.

Out-of-network—Physicians, hospitals and other providers who have not contracted with Premiera or KFHPWA. If you receive services from an out-of-network provider or facility, then you will typically have a higher coinsurance and you are responsible for the difference between the provider's billed charge and the allowable charge.

Physical functional disorder—A limitation from normal (or baseline level) of physical functioning that may include, but is not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts or obstruction of an orifice. The physical functional impairment can be due to structure, congenital deformity, pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairment or potential impairment.

Physician—A state-licensed:

- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy (D.O.)

In addition, professional services provided by one of the following types of providers will be treated as physician services under this plan to the extent the provider is providing a service that is within the scope of their state license and providing a service for which benefits are specified in this SPD and would be payable if the service were provided by a physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Advanced Registered Nurse Practitioner (A.R.N.P.)
- Nurse (R.N.)
- Naturopathic physician (N.D.)

Preventive Care—This plan covers preventive care as described below. “Preventive care” is as specific set of evidence-based services expected to prevent future illness. These services are based on guidelines established by government agencies and professional medical societies as required under the Affordable Care Act.

Preventive services have limits on how often you should get them and many of these limits are specific to gender, age or your personal risk factors for disease or condition. These limits are based on your age and gender. Some of the services you get as part of a routine exam may not meet preventive guidelines and would be covered as part of medical benefits.

The plan covers the following as preventive services:

- Covered preventive services include those with a Services with an “A” or “B” rating by the United States Preventive Task Force (USPTF);
- immunizations recommended by the Centers for Disease Control and Prevention and as required by state law; and
- preventive care and screening recommended by the Health Resources and Services Administration (HRSA).

Prescription drug—Any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.

Respite care—Continuing to provide care in the temporary absence of the member’s primary caregiver or caregivers.

Skilled home health care—Home skilled nursing is reasonable and necessary care for treatment of an illness or injury that requires the skill of a nurse or therapist—based on the complexity of the service and the condition of the member. Services are performed directly by an appropriately licensed professional provider.

Skilled nursing care—Provided by a registered nurse (RN) or licensed practical nurse (LPN) and the care must require the technical proficiency, scientific skills, and knowledge of an RN or LPN. The need for skilled nursing is determined by the condition of the patient, the nature of the services required, and the complexity or technical aspects of the services provided. Nursing care is not skilled simply because an RN or LPN delivers it or because a physician orders it.

Specialty drugs—High-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply.

Urgent care—

- In the Premera health plans, a visit that is billed and covered at the same rate as an office visit with your regular physician and is a cost-effective option when you have an urgent need for care. Urgent care is the best option for treatment of a sudden illness, injury, or condition that:
 - Requires prompt medical attention to avoid serious deterioration of the member’s health
 - Does not require the level of care provided in the emergency room or a hospital
 - Cannot be postponed until the member’s physician is available
- In the KFHPWA HMO plan, the sudden, unexpected onset of a medical condition that is of sufficient severity to require medical treatment within 24 hours of its onset.

Value-based drugs—Drugs for chronic disease management such as diabetes, hyperlipidemia, heart failure and hypertension that are considered high value and are covered on a lower cost share tier.

Plan Management

Allowable charge or allowed amount—

- In the Premera health plans, the negotiated amount that in-network providers have agreed to accept as payment in full for a covered service. The allowable charge for Washington or Alaska providers that don't have a contract with us is the least of the three amounts shown below. The allowable charge for providers outside Washington or Alaska that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the three amounts shown below:

- An amount that is no less than the lowest amount we pay for the same or similar service from a comparable provider that has a contracting agreement with us
- 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
- The provider's billed charges

Notwithstanding any provision of the plan to the contrary, the plan will pay any amounts required by applicable law. Out-of-network providers may not accept the allowable charge as payment in full. You are generally responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges, unless otherwise provided under the [Federal No Surprise Billing Protection](#). In the Premera medical and dental plans, only the allowable charge will be applied to your deductible, coinsurance maximum, and out-of-pocket maximum, as applicable.

- In the KFHPWA HMO plan, where expenses incurred from a non-KFHPWA provider or facility are covered under this SPD and the EOC, the negotiated amount that KFHPWA providers and facilities have agreed to accept as payment in full for those same services. The charges must be consistent with those normally charged to others by the provider or organization for the same services or supplies, and within the general range of charges made by other providers in the same geographical area for the same services or supplies. Members generally are responsible to pay any difference between the non-KFHPWA provider's or facility's charge for the services and the allowed amount, unless otherwise provided under the [Federal No Surprise Billing Protection](#).

For both Premera health plans and the KFHPWA HMO plan, solely for purposes of determining your cost-sharing obligations for claims subject to [Federal No Surprise Billing Protection](#), the allowed amount or allowable charge is the lesser of (1) the out-of-network provider's or facility's billed charges, or (2) the Plan's median in-network rate for the same or similar service provided in the same or similar specialty in the same geographic region (or any other amount specified for this purpose under applicable law).

Annual maximum—is the most the plan will pay for services for a member within a calendar year. If your employment or dependent status under the plan ends and you are hired or rehired within the same calendar year, the accumulated amount for that benefit carries over to your new enrollment.

Appeal—A written request to reconsider a written or official verbal adverse determination to deny, modify, reduce or end payment, coverage or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to, and continued stays in, a facility. The process also applies to Flexible Spending Account appeals for reimbursement but does not apply to appeals of denied COBRA eligibility claims.

Coinsurance—The percentage of the allowable charge that you are required to pay for certain covered services.

Coinsurance maximum—The maximum amount that you could pay each year in coinsurance amounts for covered services. If you seek care with out-of-network providers, only the allowable charge applies to the coinsurance maximum.

Copayment—A fixed, up-front dollar amount that you're required to pay for certain covered services.

Deductible—The amount of covered medical costs you must pay each calendar year before the plan begins to pay its share of allowable charges.

Evidence of Coverage (EOC)—A document outlining details of benefits coverage under the Kaiser Permanente HMO Plan.

Explanation of benefits statement (EOB)—The statement you receive from Premera Blue Cross, KFHPWA, or Kaiser Permanente detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

Health Maintenance Organization (HMO)—A health care plan such as Woodgrove Financial offers with KFHPWA or Kaiser Permanente that covers only those services and supplies that are received from in-network providers and facilities. Out-of-network care is covered only under a few circumstances. Providers are all part of the same integrated health care system, so they can quickly share your medical records to help make informed decisions about care.

Independent review organization (IRO)—An independent organization of medical experts who are qualified to review medical and other relevant information.

In-network—Physicians, hospitals and other providers who have contracted with your plan administrator (Premera, KFHPWA or Kaiser Permanente) to provide services at a negotiated discount rate. In-network providers agree to accept network rates and will not bill you for any amount in excess of those rates. In-network providers also agree to bill your medical plan directly, so you will not have to pay up front and submit your own claim to Premera for reimbursement.

Lifetime benefit maximum—Generally the maximum amount a plan will pay toward a benefit for a member. For more information, refer to the section of this SPD describing the specific benefit and plan at issue.

Medically necessary—A covered service or supply that meet certain criteria including:

- It is essential to the diagnosis or the treatment of an illness, accidental injury, or condition that is harmful or threatening to the enrollee's life or health, unless it is provided for preventive services when specified as covered under this plan.
- It is appropriate for the medical condition as specified in accordance with authoritative medical or scientific literature and generally accepted standards of medical practice.
- It is a medically effective treatment of the diagnosis as demonstrated by the following criteria:
 - There is sufficient evidence to draw conclusions about the positive effect of the health intervention on health outcome
 - The evidence demonstrates that the health intervention can be expected to produce its intended effects on health outcomes
 - The expected beneficial effects of the health intervention on health outcomes outweigh the expected harmful effects of the health intervention.
- It is cost-effective, as determined by being the least expensive of the alternative supplies or levels of service that are medically effective and that can be safely provided to the enrollee. A health intervention is cost-effective if no other available health intervention offers a clinically appropriate benefit at a lower cost.
- It is not primarily for research or data accumulation.

- It is not primarily for the comfort or convenience of the enrollee, the enrollee's family, the enrollee's physician or another provider.
- It is not recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature that is generally recognized

by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas, and any other relevant factors.

Other benefit maximum—is the most the plan will pay for services for a member within the time specified for that benefit. If your employment or dependent status under the plan ends and you are hired or rehired within such specified time, the accumulated amount for that benefit carries over to your new enrollment.

Out-of-pocket maximum—The maximum amount that you could pay each plan year for covered services and supplies, including deductibles, copayments, and coinsurance, as applicable, unless otherwise provided in this SPD.

Personal Health Support—The plan offers participation in Premera's personal health support services to help members with such things as managing complex medical conditions, a recent surgery, or admission to a hospital. Services include:

- Helping to overcome barriers to health improvement or following providers' treatment plan
- Coordinating care services including access
- Helping to understand the health plan's coverage
- Finding community resources

Participation is voluntary. To learn more about the personal health support programs, contact Customer Service at the phone number listed on the back of your ID card.

Prior authorization—An advance determination by Premera or KFHPWA that the service is medically necessary, and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Although not required, prior authorization is available and strongly recommended to ensure that coverage will be provided for services that include (but are not limited to) the following:

- Scheduled admission into hospitals or skilled nursing facilities
- Advanced imaging, such as MRIs and CT scans
- Some planned outpatient procedures, such as facility sleep studies and varicose vein treatment
- Some injectable medications you get in a health care provider's office, such as Interferon, Synagis and Xolair
- Knee arthroscopy or knee arthroplasty
- Home medical equipment costing \$500 or more

Qualified Medical Child Support Order (QMCSO)—An order or judgment from a court or administrative body directing the plan to cover the child of a member as required by applicable law.

Residential treatment center or services—Facility-based treatment providing active treatment in a controlled environment. At least weekly physician visits are required, and services must offer treatment by a multi-disciplinary team of licensed professionals.

Standard reference compendia—Refers to the American Hospital Formulary Service—Drug Information; the American Medical Association Drug Evaluation; 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. "Peer-reviewed medical literature" means scientific studies printed in health care 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.

Urgent situation—When an appeal is under consideration, a situation in which your provider concludes that the application of the standard time periods for making determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment.

Coordination of benefits terms

Coordination of benefits (COB)—A process where you or your covered dependents who have health benefit coverage through another employer, a government plan, or other motor vehicle or liability insurance, combine coverage to maximize benefits. All of your Woodgrove Financial health benefits—medical, dental, and vision—are subject to COB. The two plans coordinate their payment of benefits to ensure the total paid by both plans will not exceed the total amount charged.

Explanation of benefits statement (EOB)—The statement you receive from Premera Blue Cross, KFHPWA, or Kaiser Permanente detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

Primary plan—The health plan that pays benefits first when a member has coverage from more than one health plan.

Secondary plan—The health plan that pays benefits second when a member has coverage from more than one health plan. The secondary plan pays the balance for eligible expenses, subject to its plan benefits and limitations.

Long-term disability (LTD) terms

Absence of legal capacity—An individual is no longer able to act on their own behalf. Ultimately, the individual is not able to execute legal documents.

Chronic illness or disability—One in which there is one of the following:

- A loss of the ability to perform, without substantial assistance, at least two activities of daily living for a period of at least 30 consecutive days
- A severe cognitive impairment, which requires substantial supervision to protect the family member from threats to health and safety, for a period of at least 30 consecutive days

Confined or confinement—As related to the Maximum Period of Payment benefit, a hospital stay of at least eight hours per day.

Continued health care coverage costs means the actual costs to you for continued health care coverage provided through your employer, and which you elect under COBRA or similar state law.

Cognitive impairment—A loss or deterioration in intellectual capacity that is:

- Comparable to and includes Alzheimer's disease and similar forms of irreversible dementia

- Measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term or long-term memory, orientation as to person, place, or time; and deductive or abstract reasoning

Disability earnings—The earnings you receive while you are disabled and working, plus the earnings you could receive if you were working to your greatest extent possible. This would be, based on your restrictions and limitations, as follows:

- During the first 24 months of disability payments, the greatest extent of work you are able to do in your regular occupation that is reasonably available
- Beyond 24 months of disability payments, the greatest extent of work you are able to do in any occupation that is reasonably available, for which you are reasonably fitted by education, training, or experience

Earnings calculation date—Your Earnings Calculation Date is defined as the latest of (1) the date you meet the definition of disability under the Group Contract; (2) the date you commence an approved disability leave of absence or workers' compensation leave of absence; or (3) if you do not complete the 182-day elimination period within one year (365 days) from the date you met the definition of disability, and as a result you have to start a new 182-day elimination period, the date immediately preceding commencement of the new 182-day elimination period.

Elimination period—182 days of continuous disability from your injury or onset of your illness or when you've exhausted your short-term disability benefits, whichever is later, which must be satisfied before you are eligible to receive benefits from Prudential. If you become covered under a group LTD plan that replaces this plan during your elimination period, your elimination period under this plan will not be met.

Gainful occupation—An occupation, including self-employment, that can be expected to provide you with an income within 12 months of your return to work that exceeds your LTD payment, if you are not working, or 80% of your monthly earnings, if you are working.

Gross LTD payment—The benefit amount before Prudential subtracts deductible sources of income and disability earnings.

Indexed monthly earnings—Your monthly earnings, adjusted by the lesser of 10% or the current annual percentage increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W). Adjustments are made on each July 1, provided you were disabled for all of the 12 months before that date. Your indexed monthly earnings may increase or remain the same but will never decrease.

Material and substantial duties—Those duties normally required as part of a job that cannot be reasonably omitted or modified. If you are required to work on average more than 40

hours per week, you are considered able to meet this duty if you are able to work 40 hours per week.

Monthly earnings—Is your gross monthly income just prior to the Earnings Calculation Date. Monthly earnings include your base salary and the average commissions, bonuses and overtime pay earned per month during the shorter of: (i) the 12-month period just prior to the later of your Earnings Calculation Date; or (ii) your period of employment. Monthly earnings income does not include income received from any other extra compensation, or income received from sources other than Woodgrove Financial. If you become disabled while you are on a covered layoff or leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

Monthly payment—The payment you may receive if you become disabled while covered by this plan.

Preexisting Condition—You have a preexisting condition if both 1 and 2 are true:

1. You received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines, or followed treatment recommendation in the three months just prior to your effective date of coverage or the date an increase in benefits would otherwise be available
2. Your date of disability begins within 12 months of the date your coverage under the Plan becomes effective.

Recurrent disability—An injury or illness that worsens and is due to one or more of the same causes as a prior disability for which Prudential made an LTD payment.

Regular care—

- You personally visit a doctor as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition or conditions
- You are receiving the most appropriate treatment and care, which conforms with generally accepted medical standards, for your disabling condition or conditions by a doctor whose specialty or experience is the most appropriate for your disabling condition or conditions, according to generally accepted medical standards

Salary continuation or accumulated sick leave—Continued payments to you by Woodgrove Financial of all or part of your monthly earnings, including severance payments, after you become disabled as defined by the Group Contract. This continued payment must be part of an established plan or program maintained by Woodgrove Financial for the benefit of an employee covered under the Group Contract. Salary continuation or accumulated sick leave does not include compensation paid to you by Woodgrove Financial for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account as such, in calculating your monthly payment.

Substantial assistance—One of the following:

- The physical assistance of another person without which the family member would not be able to perform an activity of daily living
- The constant presence of another person within arm's reach who is necessary to prevent, by physical intervention, injury to the family member while the family member is performing an activity of daily living

Substantial supervision—Continual oversight that may include cueing by verbal prompting, gestures, or other demonstrations by another person, and that is necessary to protect you or the family from threats to your or the family member's health or safety.

How to get help

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General benefits questions

Benefits contact information	Active employees/dependents	COBRA enrollees
Email address	benefits@Woodgrove Financial.com	n/a
Website	http://benefits.me.Woodgrove Financial.com	http://cobra.me.Woodgrove Financial.com
Telephone number	(425) 706-8853	(833) 253-4929

Medical and vision

Premera plans

Premera plans contact information	
Email address	Woodgrove Financial@premera.com
Website	https://www.premera.com/
Telephone number	(800) 676-1411
Group Number	1000010

HMO plan (Kaiser Foundation Health Plan of Washington)—Washington only

Kaiser Foundation Health Plan of Washington contact information	
Email address	Email Member Services
Website	Kaiser Foundation Health Plan of Washington

Telephone number	(206) 630-4636 or (888) 901-4636
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Kaiser Foundation Health Plan of Washington contact information

Group Number	172300
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HMO plan (Kaiser Permanente)—California only

Kaiser Permanente California contact information

Website	Kaiser Permanente
Telephone number	(800) 464-4000
Group Number	Northern California 603873 Southern California 231325

Dental

Premera plans contact information

Email address	Woodgrove.Financial@premera.com
Website	https://www.premera.com/
Telephone number	(800) 676-1411
Group Number	1000010

Spring Health employee assistance program (EAP)

Spring Health contact information

Website	Spring Health
Telephone number	(855) 629-0554

Flexible spending accounts

Premera plans contact information

Email address	Woodgrove.Financial@premera.com
Website	https://www.premera.com/
Telephone number	(800) 676-1411
Group Number	1000010

Life insurance

If you want to...	Go here...
Learn more about your life insurance coverage or Evidence of Insurability (EOI)	Contact Prudential at (800) 778-3827 or Woodgrove Financial@prudential.com Group Number: 43994
Change or designate a beneficiary	Benefits Enrollment tool

Accidental death & dismemberment (AD&D)

Prudential contact information	
Email address	Woodgrove Financial@prudential.com
Website	Prudential website
Telephone number	(800) 778-3827
Group Number	43994

Legal insurance

ARAG contact information	
Email address	Service@ARAGgroup.com
Website	Active employees ARAG Legal Center COBRA enrollees https://www.araglegal.com/
Telephone number	(800) 331-3425 5:00 AM-5:00 PM, Pacific Time Monday through Friday

Section XV: Important notices

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COBRA enrollees – the Important notices section applies

Administrative information

ERISA requires that certain information be furnished to each participant in an employee benefit plan.

- **Plan name**
Woodgrove Financial Corporation Welfare Plan
- **Plan number**
501
- **Plan year**
January 1 to December 31
- **Plan sponsor**
Woodgrove Financial Corporation
- **Employer identification number**
91-1144442
- **Type of plan**
Welfare benefit plan providing health and welfare benefits
- **Plan administrator and named fiduciary**
Woodgrove
Financial
Corporation One
Woodgrove
Financial Way

Redmond, WA 98052-6399

(425) 882-8080
- **Participating employers**

Participating employer name	Company code
Vexcel Corporation	1693
Woodgrove Financial Payments, Inc	1888
Woodgrove Financial Open Technologies, Inc	1899
Woodgrove Financial Operations Licensing Corporation	1654
Woodgrove Financial Online, Inc	1548
Woodgrove Financial Technology Licensing	1988

- **Source of contributions**
Pre-tax and after-tax employee contributions, and employer contributions

- Funding

Health care and dependent care reimbursement benefits	Funded through the employer's general assets
Health, vision, and dental benefits	Funded from the general assets of Woodgrove Financial Corporation and employee contributions
Group term life insurance	Provided through the purchase of insurance from Prudential Life Insurance
Long-term disability benefits	Provided through the purchase of insurance from Prudential Insurance
Accidental death and dismemberment benefits	Provided through the purchase of insurance from Prudential Insurance
Employee assistance benefits	Funded through the employer's general assets

Health care and dependent care reimbursement benefits	Funded through the employer's general assets
Legal insurance benefits	Provided through the purchase of insurance from ARAG

- **Type of administration**

The Plan is administered by Woodgrove Financial according to the terms of the plan documents. Under the terms of the plan, Woodgrove Financial has the authority to delegate the day-to-day administrative duties to a third party. Woodgrove Financial shall have complete discretion to interpret and construe the provisions of the plan options, programs, and policies described in this SPD, to determine eligibility for participation and for benefits, make findings of fact, correct errors and supply omissions. All decisions and interpretations Woodgrove Financial made pursuant to the plan options, programs and policies described in this SPD shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious, or unless found by an independent medical review organization, after external review, to be made in error. Woodgrove Financial may delegate this discretionary authority to select service providers, and hereby delegates such authority to each service provider to the extent that the service provider is responsible for reviewing and issuing claims and appeals determinations under the respective plan options, programs, and policies described in this SPD.

- **Agent for legal process**

Senior Vice-President, Law and Corporate Affairs
Woodgrove Financial Corporation

One Woodgrove
Financial Way
Redmond, WA 98052-
6399

Service of process may also be made upon the Plan Administrator.

Woodgrove Financial, as plan sponsor, has reserved the right to amend or terminate the Welfare Plan and any Component Plan, in whole or in part, at any time and for any reason, including contributions to the Plan. See [Right to amend or terminate plan](#) section for more information.



If you have questions regarding the Plan's administration, contact Benefits by e-mail at benefits@WoodgroveFinancial.com or by phone at (425) 706-8853.

False or misleading statements

Any falsification, misrepresentation, or omission of facts or information by you on your enrollment form, benefits enrollment tool, or claim form may result in your loss of coverage and in disciplinary action, up to and including your dismissal from employment at Woodgrove Financial. Electronic communications on enrollment or claims are considered written and signed representations. If you lose your coverage, you will not be eligible for any continuation of coverage except to the extent required by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). The company retains the right to request confirmation of a dependent relationship by way of birth and/or marriage certificate, domestic partnership affidavit, court documents, and so on, and to recoup any payments made to you in error or in reliance on inaccurate or incomplete information.

Fraud and abuse

Any participant who willfully and knowingly engages in an activity intended to defraud the plan will face disciplinary action that may include Woodgrove Financial rescinding the participant's coverage under this plan, the termination of employment, and prosecution. Examples of fraud include falsifying a claim to obtain

benefits or trying to obtain services for someone who is not an eligible dependent or who is no longer enrolled in the plan. The company retains the right to request confirmation of a dependent relationship by way of birth and/or marriage certificate, domestic partnership affidavit, court documents, and so on, to deny coverage for any dependents if such confirmation is not provided, and to recoup any payments made to you in error or in reliance on inaccurate or incomplete information.

If you have questions regarding the Plan's administration, contact Benefits.		
	Active employees/dependents go here...	COBRA enrollees go here...
	e-mail benefits@WoodgroveFinancial.com phone (425) 706-8853	e-mail benefits@benefits.WoodgroveFinancial.com phone (833) 253-4929

Right to review

The plan may have any patient examined by an appropriate health care professional when there is a question of fraud or abuse of plan benefits.

How to report suspicious activity to Premera or Kaiser Foundation Health Plan of Washington

If you suspect fraud or abuse, there are several reporting options available to you. All reports are confidential and can be anonymous, if you choose. You are not required to include your name, address, or other identifying information.

For Premera, you may contact the Special Investigations Unit 24 hours a day by leaving a telephone message on the confidential fraud hotline or by mail.

Hotline: (800) 848-0244

Mailing address:

Attention Special Investigations
Unit Premera Blue Cross

7001 220th Street
SW Mail Stop 219

Mountlake Terrace, WA 98043

For Kaiser Foundation Health Plan of Washington, you may contact the Fraud, Waste and Abuse (FWA) Department by e-mail, phone or mail.

E-mail: FWA@kp.org

Confidential, toll-free hotline: (888) 774-9100

FWA Department: (206) 988-

2967 Mailing address:

Kaiser Foundation Health Plan of Washington
Regional Fraud Control

PO Box 9813

Mailstop RCP-C3W-08

Renton, WA 98057-9813

When reporting suspected fraud, remember to include the names of all applicable parties involved. Specify which person you believe is committing the fraud, identify the dates of service or issues in question, and describe in detail why you believe a fraudulent act may have occurred. If possible, include your name and telephone number so Premera or Kaiser Foundation Health Plan of Washington may contact you if they have any questions during their investigation.

Right to amend or terminate plan

Woodgrove Financial has reserved the right to amend or terminate the Welfare Plan and any Component Plan, in whole or in part, at any time and for any reason, including contributions to the Plan. Payment of claims incurred at the time of such amendment or termination will not be adversely affected.

Coverage under the Dependent Care Reimbursement Plan, Health Care Reimbursement Plan, and Limited Purpose Health Care Reimbursement Plan will provide reimbursement of Eligible Expenses incurred prior to the date of termination of such Component Plan. Such Expenses will be reimbursed only if the Request for Reimbursement is submitted within ninety (90) days after date of termination.

Important information due to the coronavirus pandemic

In response to the ongoing coronavirus pandemic, recent guidance from the Internal Revenue Service (IRS) and Department of Labor (DOL) provides flexibility and relief to participants and beneficiaries covered by group health plans that affect some Woodgrove Financial benefit plans and may affect you and your family.

Additionally, under this temporary relief, the “Outbreak Period” – which is defined as the period starting March 1, 2020 and ending 60 days after the COVID-19 National Emergency ultimately is declared to have ended – is disregarded for purposes of determining certain timeframes and deadlines that otherwise would apply under the SPD, as stated in this notice.

COVID-19 diagnostic, testing and screening services

Premera Plans

All testing and screening services related to a COVID-19 diagnosis will be covered in full for employees and dependents. This coverage applies for COVID-19 screening and testing-related visits and services, whether performed in network, out of network, in a health provider’s office, urgent care clinic, emergency room, or through a telehealth visit. Any

testing or diagnostics to determine whether a COVID-19 diagnosis can be ruled out will also be covered in full. The Woodgrove Financial health plans provided under Premera will provide this enhanced coverage for the duration of the public health emergency.

Enrolled employees and dependents can also purchase a Food and Drug Administration (FDA) approved/emergency use authorization (EUA) home test out of pocket and file for reimbursement by completing the [Premera claim form](#) and providing an itemized invoice.

You do not need pre-approval from the health plan for these services, but your health care provider may need to obtain approval from a public health official before administering testing for COVID-19. If you are diagnosed with COVID-19, treatment will be covered in accordance with Plan provisions.

Kaiser Plans

To review information about testing provided by the Kaiser Foundation Health Plan of Washington or Kaiser Permanente (California), go to:

[Kaiser Southern California](#)
[Kaiser Northern California](#)
[Kaiser Washington](#)

To learn more, [contact](#) your health plan.

COVID-19 treatment

Kaiser Permanente (California) will also cover COVID-19 treatment in full from April 1, 2020, through the last day of the month following the end of the national public health emergency, (unless superseded by government action or extended by Kaiser Permanente).

Newly eligible expenses for HSA and Healthcare FSA

The Coronavirus Aid, Relief, and Economic Security Act of 2020 (“CARES Act”) expanded the list of eligible expenses for Health Savings Accounts (HSA) and the Health Care Flexible Spending Account (HCFSA) to include the items below.

- Over-the-counter drugs/medicines, which can be purchased without a prescription.
- Menstrual care products, such as tampons, pads, liners, cups, sponges, or similar products used with respect to menstruation.

Note: These menstrual care items and over-the-counter drugs/medicines aren’t reimbursable under the Dental and Vision Flexible Spending Account (DVFSAs).

To review a detailed list of eligible expenses, go to Premiera’s [Eligible Expenses Guide](#).

Carryover of unused FSA funds

Under federal law, you could carry over unused FSA funds from 2020 into 2021 and again from 2021 into 2022. In a typical year, there would be no carryover option allowed under the dependent care FSA, and health care FSA carryovers would be subject to a limit (\$570 for 2023). This temporary provision applies to the Health Care, Dental & Vision, and Dependent Care FSA plans and is unlimited in amount. This means that all your unused 2020 FSA dollars were carried into 2021 automatically, and all your unused 2021 FSA dollars were carried into 2022 automatically. It's suggested that you plan carefully, as once the temporary carryover relief expires after 2022, any unused funds left in your dependent care FSA, and any unused

funds left in your Health Care or Dental & Vision FSA in excess of the IRS-announced limit for 2022, will be subject to forfeiture.

Note: This carryover did not affect the FSA contribution limits under the plans for 2021 and 2022, respectively.


Personal Protective Equipment (PPE)

The Woodgrove Financial Health Care FSA and HSA will allow reimbursement of Personal Protective Equipment (PPE) such as face masks, hand sanitizer, and sanitizing wipes that are purchased for the primary purpose of preventing the spread of COVID-19, effective January 1, 2020.

Extension of certain timelines

During the “Outbreak Period” (defined above), the IRS and DOL have suspended certain timeframes and deadlines affecting the rights of employees (and their eligible spouses, domestic partners, and dependents) to healthcare and other benefits coverage and claims, and continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). The Outbreak Period began March 1, 2020, and ends one year after the relief has applied to each respective timeframe or deadline (or, if earlier, 60 days after the COVID-19 National Emergency is declared to have ended). This relief provides extra time to:

- Make a change to your benefits enrollment due to a qualified life event (such as birth/adoption or marriage).
- Enroll in COBRA continuation coverage and/or make premium payments for that coverage.
- Submit for reimbursement of any eligible expenses incurred in 2021 under the Health Care FSA or the Dental & Vision FSA (to the extent you have any remaining unused funds from 2021).
- For the 2021 plan year for the Health, Dental & Vision, and Dependent Care FSAs, the claim submission deadline will be extended by one year (until March 31, 2023), or 90 days after the end of the Outbreak Period, whichever is earlier. Whether the claim submission deadline for 2022 FSAs will be extended is not yet known and will depend on when the Outbreak Period ends. If the Outbreak Period ends in 2022, then the regular claim submission deadline (that is, March 31, 2023) will apply.

To submit your claim for reimbursement		
	Active employees go here...	COBRA enrollees go here...
	Pay Me Back	Premiera (800) 646-1411
	Premiera (800) 646-1411	

- **Note:** For the 2019 and 2020 plan years for the Health, Dental & Vision, and Dependent Care FSAs, the claim submission deadline was extended to March 31, 2021, and March 31, 2022, respectively, each of which was one year from the original claim submission due date of March 31, 2020 and March 31, 2021, respectively.
- File a claim, appeal a denied claim, or, for certain denied appeals under the medical plan, request an external review of claims.

To make a benefit enrollment change due to a qualified life event under this relief, outside of the normal timeframe for that event, sign in to the [Benefits Enrollment Tool](#) and then select **I need to change my benefits**. From the list under **Benefit Enrollment Updates**, you will see an option to update your benefits by selecting the **COVID Special Enrollment** option that fits your situation.

Participant rights under ERISA

The Employee Retirement Income Security Act (ERISA) provides that all plan participants are entitled to the following:

- Examine, without charge, all documents that govern the plan including insurance contracts and a copy of the latest annual report (Form 5500 Series), which the plan files with the U.S. Department of Labor and is available at the Public Disclosure Room of the Employee Benefits Security Administration, at the plan administrator's office, and at other specified locations, such as worksites
- Obtain, upon written request to the plan administrator, copies of documents that govern the operation of the plan, including insurance contracts, copies of the latest annual report (Form 5500 Series), and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.
- Receive the Summary Annual Report for Woodgrove Financial Corporation Welfare Plan. The plan administrator is required by law to furnish each participant with a copy of this summary financial report.
- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review this summary plan description and the documents that govern the plan about the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes obligations on those responsible for the operation of an employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of all plan participants and beneficiaries.

No one, including Woodgrove Financial or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If a claim for a benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents that relate to the decision (without charge), and to appeal any denial all within certain time schedules.

Under ERISA, there are steps you can take to enforce the previously stated rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to US\$110 a day until you receive the materials, unless the plan administrator did not send the materials because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support

order, you may file suit in federal court. If plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds the claim to be frivolous.

If you have any questions about your plan, you should contact Woodgrove Financial. If you have any questions about this statement or about your rights under ERISA, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor that your telephone directory lists, or you can contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S.

Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.



To access plan administrator information, see [Administrative Information](#) or contact Benefits.

Special notice about Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers that offer group insurance coverage generally may not, under federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

This plan complies with these requirements.

Special notice about Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act of 1998, the plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. You can contact Benefits or call (425) 706-8853 for more information.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996

Notice of your right to documentation

Prior to the Patient Protection and Affordable Care Act (ACA), federal law allowed employers to apply limitations on paying benefits for preexisting medical conditions for newly hired or newly eligible employees and covered family members. The ACA outlawed this practice as of 1/1/2014 for most health insurance plans. If you terminate employment with Woodgrove Financial and begin to work for another employer, you should receive the full benefit for any covered condition, subject to your new plan's standard cost sharing or other limitations, as applicable once you meet the employer's eligibility criteria and enroll in

benefits. Should you need a statement confirming you previously had coverage under a Woodgrove Financial plan, you can obtain one by contacting Benefits.

Notice of your special enrollment rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days* after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you or any of your dependents were covered under a Medicaid or State child health plan and you or your dependents lose eligibility for that coverage, or if you or any of your dependents become eligible for assistance with respect to coverage under this plan due to a Medicaid or State child health plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' other coverage ends, or within 60 days* of becoming eligible for assistance.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, or establishment of a domestic partnership you may be able to enroll yourself and your dependents. However, you must request enrollment within 90 days after the marriage, birth, adoption, or placement for adoption.

*Note that these deadlines may differ during the COVID-19 national emergency. See [Important information due to the coronavirus pandemic](#).



To request special enrollment or obtain more information, see the [Life event enrollment](#) section or contact Benefits

HIPAA Notice of Privacy Practices

Woodgrove Financial Corporation Welfare Plan HIPAA Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Review this Notice carefully.

Effective Date: April 14, 2003, revised effective October 17, 2016

This Notice is from the Woodgrove Financial Corporation Welfare Plan (the "Plan"), which is sponsored by Woodgrove Financial Corporation. A federal regulation, known as the HIPAA Privacy Rule, requires that a health plan provide detailed notice in writing of its privacy

practices. You may receive other notices of privacy practices from other parties that are considered “covered entities” under HIPAA (for instance, physicians, the Living Well Health Center, Kaiser Permanente).

The Woodgrove Financial Corporation Welfare Plan includes health care benefits, making it a health plan covered by the HIPAA Privacy Rule. Health care benefits under the Plan include the medical, prescription drug, vision, and dental benefits; the employee assistance program; and the flexible spending arrangements (namely the Woodgrove Financial Health Care and Dental & Vision Care Reimbursement Plans). Non-health care benefits under the Plan, including long-term and short-term disability plans, are not covered by the HIPAA Privacy Rule.

I. OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a participant, or where there is a reasonable basis to believe the information can be used to identify a participant. This information is called "protected health information" or "PHI." Generally, PHI also includes genetic and demographic information, collected from you or created or received by the Plan, that relates to (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

This Notice describes your rights as a health plan participant and our obligations regarding the use and disclosure of PHI. We are required by law to comply with all of the following:

- Maintain the privacy of PHI about you
- Provide you with certain rights with respect to your PHI
- Give you this Notice of our legal duties and privacy practices with respect to PHI
- Comply with the terms of our Notice of Privacy Practices that is currently in effect
- Notify you of a breach of your unsecured PHI

In some situations, federal and state laws provide special protections for specific kinds of PHI and require authorization from you before we can disclose that specially protected PHI. Examples of PHI that is sometimes specially protected include PHI involving mental health, HIV/AIDS, reproductive health, or chemical dependency. We may refuse to disclose the specially protected PHI, or we may contact you for the necessary authorization.

We reserve the right to make changes to this Notice and to make such changes effective for all PHI we may already have about you.

II. HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

We may use or disclose your PHI under certain circumstances as permitted or required by law or if you (or your authorized representative) give us permission. The following describes the different ways we may use and disclose your PHI.

Treatment: We may use and disclose PHI about you to assist your health care provider in coordinating or managing your health care and related services. For example, a doctor may send us information about your diagnosis and treatment plan, so we can arrange additional services.

Payment: We may use or disclose PHI to pay or deny your claims, to collect premiums, or for the payment activities of your health care providers or your other insurer(s). For example, we may use and disclose PHI to tell you, your health care providers, or your other caregivers whether a particular type of health care service is covered under your policy.

Health Care Operations: We may use and disclose PHI in performing business activities that are called "health care operations." For example, we may use and disclose PHI about you in reviewing and improving the quality, efficiency, and cost of our operations. We may disclose PHI to other entities, if any, in an organized health care arrangement with the Plan. For example, if a health care provider, company, or other health plan that is required to comply with the HIPAA Privacy Rule has or once had a relationship with you, we may disclose PHI about you for certain health care operations of that health care provider or company.

Business Associates: We may contract with individuals or entities known as "business associates" to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or to provide these services, business associates will receive, create, maintain, use and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI. For example, we may disclose your PHI to a business associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation.

Individuals Involved in Your Care or Payment for Your Care: If you do not object after an opportunity to do so, or if you are incapacitated or if it is an emergency situation, we may disclose to your family member, close friend, or any other person identified by you, PHI about you that is directly relevant to that person's involvement in your care or payment for your care. We may also use and disclose PHI necessary to notify these persons of your location, general condition, or death. State laws will vary, but in many states a teenage minor must consent to use, or disclosure of PHI related to their mental health, chemical dependency, HIV/AIDS, or sexual health. Therefore, the Plan may require the child's authorization before releasing PHI to anyone, including their parents.

Disaster Relief: We also may share PHI about you with disaster relief agencies such as the Red Cross for disaster relief purposes.

Required by Law: We may use and disclose PHI to the extent required by law.

Incidental Disclosures: Disclosures that are incidental to permitted or required uses or disclosures under HIPAA are permissible so long as we implement safeguards to avoid such disclosures and limit the PHI exposed through these incidental disclosures.

Health Plan Sponsor: Under certain conditions, we may disclose PHI to the Plan Sponsor of this Plan (Woodgrove Financial Corporation), but only after it certifies to us that it will take certain steps to protect the confidentiality of your PHI.

Public Health or Oversight Activities: We may use and disclose PHI to authorized persons to carry out certain activities related to public health. We may disclose PHI to a health oversight agency to monitor the health care system, government health care programs, and compliance with certain laws

Abuse, Neglect, or Domestic Violence: We may disclose PHI in certain cases to proper government authorities if we reasonably believe that a participant has been a victim of domestic violence, abuse, or neglect.

Lawsuits and Other Legal Proceedings: We may use or disclose PHI when required by a court order, administrative agency order, subpoenas, discovery requests, or other lawful process, when efforts have been made to advise you of the disclosure or to obtain an order protecting the information requested.

To Law Enforcement or to Avert a Serious Threat to Health or Safety: Under certain conditions, we may disclose PHI to law enforcement officials. We may use and disclose your PHI under limited circumstances when necessary to prevent a threat to the health or safety of a person or to the public.

Coroners, Medical Examiners, Funeral Directors: We may disclose PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death, or to funeral directors, as authorized by law, so that they may carry out their jobs.

Organ and Tissue Donation: If you are an organ donor, we may use or disclose PHI to facilitate an organ, eye, or tissue donation and transplantation.

Research: We may use and disclose PHI about you for research purposes under certain limited circumstances.

Specialized Government Functions: Under certain conditions, we may disclose PHI for military activities, national security, or other specialized government functions.

Workers' Compensation: We may disclose PHI to the extent necessary to comply with laws that provide benefits for work-related injuries or illness.

Disclosures Required by HIPAA Privacy Rule: We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule.

Other Uses and Disclosures: All other uses and disclosures of your PHI will be made only with your written permission (an "authorization"). We generally may not use or disclose your PHI for marketing purposes or sell your PHI without your authorization. If you have given us authorization to use or disclose your PHI, you may later take back ("revoke") your

authorization at any time, except to the extent we have already acted based on your permission.

Genetic Information: We may not use or disclose PHI that is genetic information for underwriting purposes.

III. YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

Under federal law, you have the following rights regarding PHI about you. Unless otherwise noted, you may exercise any of these rights by contacting the Privacy Operations Official or Privacy Official identified in Section V below.

Right to Request Restrictions: You have the right to request additional restrictions on the use of your PHI for treatment, payment, and health care operations, or on the disclosure of your PHI to individuals involved in your care. We are not required to agree to your request unless the disclosure is to a health

plan for purposes of carrying out payment or health care operations (not treatment), and the PHI pertains solely to a health care item or service for which the health care provider has been paid out of pocket in full.

Right to Receive Confidential Communications: If you tell us that disclosure of your PHI could endanger you, you have the right to request in writing that we communicate your PHI to you in a certain manner or at a certain location. For example, you may request that we contact you at home, rather than at work. We are required to meet only reasonable requests.

Right to Inspect and Copy: You can request the opportunity to inspect and receive a copy of your PHI in certain records that we maintain. We may charge you reasonable fees for the cost of providing a copy.

Right to Amend: You have the right to request that we amend your health plan PHI if you give us an appropriate reason for the request.

Right to Receive an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures that we have made of your PHI. This is a list of disclosures made by us during a specified period of up to six years prior to the request, other than disclosures made for treatment, payment, and health care operations; to family members or friends involved in your care; to you directly; pursuant to an authorization of you or your personal representative; for certain notification purposes (including national security, intelligence, and law enforcement purposes); of a "limited data set" in compliance with our policies and procedures for this kind of data; or incidental to otherwise permitted or required uses and disclosures. The first list you request in a 12-month period will be free, but we may charge you for our reasonable costs of providing additional lists in the same 12-month period. We will tell you about these costs, and you may choose to cancel your request at any time before costs are incurred.

Right to a Paper Copy of this Notice: You have a right to receive a paper copy of this Notice at any time even if you have agreed to receive this notice electronically. Email [Benefits@Woodgrove Financial.com](mailto:Benefits@WoodgroveFinancial.com) or call 425- 706-8853 for a paper copy.

IV. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us. To file a complaint with us, contact our Privacy Operations Official. You may also file a complaint directly with the Office for Civil Rights of the United States Department of Health and Human Services ("OCR"). We will not retaliate or take action against you for filing a complaint.

V. PRIVACY OPERATIONS OFFICIAL AND PRIVACY OFFICIAL CONTACT INFORMATION

If you have questions, you may contact our Privacy Operations Official or Privacy Official at the following addresses and phone numbers:

Privacy Operations Official

Woodgrove
Financial
Corporation One
Woodgrove
Financial Way

Redmond, WA 98052

(425) 707-0531

Privacy Official

Woodgrove Financial

Corporation One

Woodgrove Financial

Way Redmond, WA

98052

(425) 421-4459

CHIP Notice

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial (877) KIDS-NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call (866) 444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. You should contact your state for further information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
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<p>Website: http://myalhipp.com/</p> <p>Phone: (855) 692-5447</p>	<p>The AK Health Insurance Premium Payment Program</p> <p>Website: http://myakhipp.com/</p> <p>Phone: (866) 251-4861</p> <p>Email: CustomerService@MyAKHIPP.com</p> <p>Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</p>
ARKANSAS – Medicaid	CALIFORNIA – Medicaid

Website: http://myarhipp.com/ Phone: (855) MyARHIPP (855-692-7447)	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: (916) 440-5676
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP +)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: (800) 221-3943/State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: (800) 359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: (855) 692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: (877) 357-3268
GEORGIA – Medicaid	INDIANA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: (678) 564-1162 extension 2131	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: (877) 438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: (800) 338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: (800) 257-8563	Website: http://www.kdheks.gov/hcf/default.htm Phone: (800) 792-4884

KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</p> <p>Phone: (855) 459-6328</p> <p>Email: KIHIPPPROGRAM@ky.gov</p> <p>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx</p> <p>Phone: (877) 524-4718</p> <p>Kentucky Medicaid Website: https://chfs.ky.gov</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp</p> <p>Phone: (888) 342-6207 (Medicaid hotline) or (855) 618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms</p> <p>Phone: (800) 442-6003</p> <p>TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms</p> <p>Phone: (800) 977-6740</p> <p>TTY: Maine relay 711</p>	<p>Website: http://www.mass.gov/eohhs/gov/departments/ma sshealth/</p> <p>Phone: (800) 862-4840</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</p> <p>Phone: (800) 657-3739</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</p> <p>Phone: (573) 751-2005</p>
MONTANA – Medicaid	NEBRASKA – Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</p> <p>Phone: (800) 694-3084</p>	<p>Website: http://www.ACCESSNebraska.ne.gov</p> <p>Phone: (855) 632-7633</p> <p>Lincoln: (402) 473-7000</p> <p>Omaha: (402) 595-1178</p>

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
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<p>Medicaid Website: http://dhcfp.nv.gov</p> <p>Medicaid Phone: (800) 992-0900</p>	<p>Website: https://www.dhhs.nh.gov/oii/hipp.htm</p> <p>Phone: (603) 271-5218</p> <p>Toll free number for the HIPP program: (800) 852-3345, extension 5218</p>
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</p> <p>Medicaid Phone: (609) 631-2392</p> <p>CHIP Website: http://www.njfamilycare.org/index.html</p> <p>CHIP Phone: (800) 701-0710</p>	<p>Website: http://www.nyhealth.gov/health_care/medicaid/</p> <p>Phone: (800) 541-2831</p>
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: https://medicaid.ncdhhs.gov/</p> <p>Phone: (919) 855-4100</p>	<p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/</p> <p>Phone: (844) 854-4825</p>
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
<p>Website: http://www.insureoklahoma.org</p> <p>Phone: (888) 365-3742</p>	<p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html</p> <p>Phone: (800) 699-9075</p>
PENNSYLVANIA – Medicaid	RHODE ISLAND – Medicaid and CHIP
<p>Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx</p> <p>Phone: (800) 692-7462</p>	<p>Website: http://www.eohhs.ri.gov/</p> <p>Phone: (855) 697-4347, or (401) 462-0311 (Direct Rlte Share Line)</p>
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
<p>Website: http://www.scdhhs.gov</p> <p>Phone: (888) 549-0820</p>	<p>Website: http://dss.sd.gov</p> <p>Phone: (888) 828-0059</p>
TEXAS – Medicaid	UTAH – Medicaid and CHIP

Website: http://gethipptexas.com/ Phone: (800) 440-0493	Medicaid website: https://medicaid.utah.gov/ CHIP website: http://health.utah.gov/chip Phone: (877) 543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.greenmountaincare.org/ Phone: (800) 250-8427	Website: https://www.coverva.org/hipp/ Medicaid Phone: (800) 432-5924 CHIP Phone: (855) 242-8282
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.hca.wa.gov/ Phone: (800) 562-3022	Website: http://mywvhipp.com/ Toll-free phone: (855) MyWVHIPP (855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: (800) 362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: (800) 251-1269

To see if any more states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor

U.S. Department of Health and Human

Services Employee Benefits Security Administration

Centers for Medicare &

Medicaid Services <https://www.dol.gov/agencies/ebsa>

www.cms.hhs.gov

(866) 444-EBSA (3272)

(877) 267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2023)

Summary Annual Report for Woodgrove Financial Corporation Welfare Plan

This is a summary of the annual report for Woodgrove Financial Corporation Welfare Plan, Plan 501, EIN: 91-1144442 for the period 01/01/2020 to 12/31/2020. This is a welfare benefit plan

offering health, life, dental, vision, group legal, long-term disability, accidental death & dismemberment, flexible spending account, paid leave, and an employee assistance plan.

The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

Woodgrove Financial Corporation has committed itself to pay all medical, vision, and dental claims incurred under the terms of the plan.

Insurer	Type of Claim
Prudential Life Insurance Company	Life, Long-Term Disability, Paid Leave, and Accidental Death & Dismemberment
ARAG Insurance Company	Group Legal
Kaiser Foundation Health Plan Inc.	Health
Kaiser Foundation Health Plan of Washington	Health
Spring Health	Employee Assistance Program short-term counseling sessions (24 per calendar year.

The total premiums paid for the plan year ending 12/31/2020 were \$118,052,324.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report.

- Insurance information, including sales commissions paid by insurance carriers

To obtain a copy of the full annual report, or any part thereof, write or call the office of Woodgrove Financial Corporation, Woodgrove Financial Corporation Welfare Plan Sponsor, One Woodgrove Financial Way, Redmond, WA 98052, and at the main office phone of (425) 882-8080.

You also have the legally protected right to examine the annual report at the main office of the plan One Woodgrove Financial Way, Redmond, WA 98052, and at the U.S. Department of Labor in Washington, D.C. or to obtain a copy from the U.S. Department of Labor upon payment of copying costs.

Requests to the Department should be addressed to:

Public Disclosure Room, N1513

Employee Benefits Security Administration

U.S. Department of Labor

200 Constitution Avenue, N.W.
Washington, DC 20210

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays

a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N- 1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.