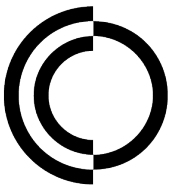

Collective Health®

2019 Plan Details

Ensign Copay 5000

Hello!

Welcome to your Ensign Copay 5000 plan, presented in partnership with Collective Health.

We always try to keep things simple at Collective Health. This booklet is not exactly short, but here's why it's important to share it with you: this is your summary plan description (SPD). It describes the benefits of your health insurance plan and it's something that you can refer to when you have questions.

This SPD is organized by topic so you can quickly find what you need. Here are some of the topics that you can read about inside:

- What's covered by the plan, what's not covered, and how much you can expect to pay for your healthcare
- Who is eligible for coverage, and how to enroll
- When your coverage begins and ends, and when you might be able to continue coverage
- How to submit a claim, and what to do if your claim is denied
- Your rights and responsibilities as a member of this plan

Collective Health wants to help you understand everything about your healthcare benefits and what's covered for you and your dependents. You can get 24/7 access to information about your plan and your healthcare claims by activating your account at my.collectivehealth.com. If you have any additional questions, get in touch with us by calling 833-743-3221 or chatting with one of our Member Advocates through the Collective Health website or mobile app from 6 am to 6 pm PT, Monday through Friday. You can also email help@collectivehealth.com at any time.

Here's to a happy and healthy year ahead!

Este folleto tiene un resumen en inglés de los derechos y beneficios de tu Copay 5000 plan. Si tienes dificultades entendiendo la información que se encuentra aquí, por favor contacta 833-743-3221.

本手册含有您 Copay 5000 保险计划提供的福利和权利的英文总结。如果您对本手册的内容有任何疑问，请拨打 833-743-3221

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Fast Facts About Your Health Plan

What kind of health insurance plan is this?

This is a "PPO" (preferred provider organization) plan. This includes a preferred network (Blue Shield of California) that includes many, but not all, doctors and hospitals. You do not need to designate a primary care physician or get your primary care physician's referrals to see specialists; you can see the doctors you choose for your medical needs. If you see in-network doctors, you will generally pay less than if you see doctors out-of-network.

Who pays?

The Ensign Copay 5000 is a self-insured healthcare plan. That means there is no health insurance company paying for your claims; Ensign Services, Inc. ("Ensign") is the plan sponsor, and they pay doctors and hospitals for the medical care you receive. Collective Health partners with Ensign and takes on many administrative responsibilities for this plan (such as processing your claims and answering your questions). Blue Shield of California provides the medical network for the plan, and gives you access to a nationwide network of healthcare providers through the BlueCard program. CVS/Caremark provides pharmacy benefit management services for the plan. You help pay for the cost of your healthcare under this plan. More information about cost-sharing is in Section 3.

Key Plan Information

- The plan year begins on January 1 and ends on December 31.
- Depending on how many people you enroll, your in-network deductible will be:
    - $5,000 for an individual
    - $10,000 for your family
- Depending on how many people you enroll, your in-network out-of-pocket maximum will be:
    - $7,000 for an individual
    - $14,000 for your family
- Find information about what's covered in Section 5. Information about what's not covered is in Section 6.

Questions? We're here to help.

Register for 24/7 access to your healthcare information at my.collectivehealth.com. Collective Health Member Advocates are available at help@collectivehealth.com or 833-743-3221.

Section 1: Who Is Eligible for Coverage

Eligible Employees

You—a full-time employee at Ensign and its family of companies ("the Company")—are eligible to participate in this plan if you are an active, full-time employee, meaning you have begun working for the Company, you are normally scheduled to work at least 32 hours per week, and you are on the Company's regular payroll. If you choose to participate in this plan, in addition to covering yourself, you may also elect to cover your spouse, eligible child dependents, and dependents of dependents; coverage for domestic partners is not available.

If you are an active part-time employee, meaning you have begun working for the Company, you are normally scheduled to work at least 30-31 hours per week, and you are on the Company's regular payroll, you are also eligible to participate in this plan. You can cover yourself, your eligible child dependents, your spouse, and dependents of dependents; domestic partner coverage is not available.

If you are an active on-call employee, meaning you have begun working for the Company and you are on the Company's regular payroll, you are also eligible to participate in this plan. You can cover yourself, your eligible child dependents, your spouse, and dependents of dependents; domestic partner coverage is not available.

Eligible Dependents

When you enroll someone in addition to yourself on your plan, they are called your "dependent." They become eligible for coverage when you become eligible for coverage. Your contribution each month may be higher if you choose to enroll your dependents.

Your spouse is your lawfully-wed spouse (Ensign's self-insured plan considers a spouse to be lawfully wed only if the employee and the spouse have a state-issued marriage certificate reflecting the marriage. Ensign's self-insured plan does not cover spouses of employees who are or may be considered married under the common law). You will be required to provide documentation that an individual is your spouse, such as a marriage license or registration certificate.

For a child to be eligible to join this plan as your dependent, they must be one of the following:

- Your natural child
- Your spouse's natural child
- Your stepchild
- Your adopted child
- Your spouse's adopted child
- A child placed with you for adoption (meaning the legal process of adoption has begun, and you have taken some responsibility for that child)
- A child placed with your spouse for adoption (meaning the legal process of adoption has begun, and you have taken some responsibility for that child)

- A child for whom you have been named legal guardian
- A child for whom your spouse has been named legal guardian
- A child for whom you must provide coverage because of a qualified medical child support order

A child dependent can be deemed eligible for medical coverage up until the end of the month that they turn 26. The child must be a resident of the US.

If you have a child that has a severe physical or mental condition that makes them indefinitely dependent on you for primary support, then they will continue to be eligible after age 26, as long as their condition and dependency persists. You will be required to provide information or documents to prove your children's eligibility for coverage (such as birth certificates, court documents or documentation of your child's disability). You will be required to provide information or documents to prove your children's eligibility for coverage (such as birth certificates, court documents or documentation of your child's disability).

Who Cannot Be Your Dependent?

Some people are not eligible to participate in this plan as your dependents, even if they meet the criteria above:

- Your former spouse, if you are legally separated or divorced
- Anyone who is separately covered under this plan as an employee
- Any child who is separately covered under this plan as another employee's dependent
- Siblings of subscriber
- Grandchildren of subscriber
- Parents of subscriber

Section 2: Enrollment & When Coverage Begins

You must be enrolled in this plan to receive benefits from this plan. If you want your dependents to receive benefits, you must enroll them too. No one can receive the benefits of this plan without being enrolled for coverage.

Each year, the Company will set the procedures for all eligible employees to enroll themselves and their dependents for health benefits. You must follow these procedures to enroll yourself and your dependents, including authorizing the Company to deduct your contribution every month directly from your paycheck.

You can only enroll yourself and your dependents at specific times of the year:

- During the annual open enrollment period
- After you are newly hired or first become eligible
- During a special enrollment period after a qualifying event

If you miss your enrollment window, your enrollment will be considered “late” and your coverage will not begin until the next plan year. You must enroll on time to get covered on time.

Annual Open Enrollment Period

Each year, before the new plan year begins, there will be an open enrollment period. During the open enrollment period, you may choose whether you would like to be covered by this plan for the next plan year, and you may add or remove dependents. If multiple health benefits options are available, you will be able to choose the package you prefer. The Company will determine when and how long the open enrollment period will be.

The selections you make during open enrollment will become effective at the beginning of the next plan year, which is January 1st. You won’t be able to change your selections again until the next open enrollment period, unless you experience a qualifying event during the year.

If you don't make a selection during open enrollment, you may be enrolled in the default plan option, which will be selected by the Company.

New Hire or Newly Eligible Employee Enrollment

If you begin work at the Company and are eligible for health benefits, you will have an opportunity to choose whether you would like to participate in this plan, and whether you want to enroll your dependents. The same is true if you become newly eligible while employed at the Company (for example, if you switch from part-time to full-time). You must enroll for coverage within 30 days of becoming eligible.

Coverage for new full-time Service Center Employees (including all Remote Resources and Cornet Employees (non-California Service Center Employees), AITs, AIT interns, and Executive Leadership of an Ensign-affiliated company, Department Heads/Leadership, Registered Nurses, Licensed Vocational Nurses, Licensed Practical Nurses, Therapists, & Therapy Assistants) will begin on the first day of the month following date of hire. If you are a new non-Service Center Employee, you must satisfy a 60-day waiting period before you become eligible for healthcare benefits. After you satisfy the waiting period, which starts on the first day you meet the eligibility criteria (for new hires: on your date of hire), your coverage will begin on the first day of the month after or coinciding with the date you become eligible. Coverage for newly eligible full-time employees (both Service Center and non-Service Center Employees) will begin on the first day of the month following status change.

If you are a new part-time employee, you must satisfy a 60-day waiting period before you become eligible for healthcare benefits. After you satisfy the waiting period, which starts on the first day you meet the eligibility criteria (for new hires: on your date of hire), your coverage will begin on the first day of the month after or coinciding with the date you become eligible. Coverage for newly eligible part-time employees will begin on the first day of the month following status change.

If you are a new on-call employee, you must satisfy a 60-day waiting period before you become eligible for healthcare benefits. After you satisfy the waiting period, which starts on the first day you meet the eligibility

criteria (for new hires: on your date of hire), your coverage will begin on the first day of the month after or coinciding with the date you become eligible. Coverage for newly eligible on-call employees will begin on the first day of the month following status change.

Special Enrollment Periods

In general, once you make your coverage selections during open enrollment or new hire enrollment, those choices are fixed for the plan year and can't be changed. But certain events trigger special enrollment periods, where you will be allowed to make changes to your coverage selections outside of open enrollment.

1. You can enroll mid-year if you lose other healthcare coverage. You might initially decline coverage because you or your dependents are already covered by another group health plan or by insurance from another source (including COBRA). For example, you may be a dependent on your spouse's plan, and for that reason you may decline to enroll in Ensign's health benefits during open enrollment. If you or your dependents lose your healthcare coverage from that other source (or if your dependent's company stops contributing toward that other coverage), you have the right to enroll yourself and all of your eligible dependents in this plan. But you must enroll within 30 days after the other coverage ends (or the company stops contributing). If you enroll on time, your coverage will be retroactive to the date you lost your other healthcare coverage.

2. You can enroll if you get married or have a child. If you acquire a new dependent (spouse or child) as described in the "Eligible Dependents" section through an event such as marriage, birth, adoption, placement for adoption, or a qualified medical child support order (QMSCO), you have the right to enroll yourself and your eligible dependents in your company's health plan. But you must enroll within 30 days after that life event (for example, after your marriage or after your child is born). If the special enrollment is due to the birth or adoption of a child, coverage will be retroactive to the date of birth or adoption. Otherwise, your family's coverage will begin on the first day of the month after you submit your enrollment request.

3. You can enroll if you gain or lose coverage under Medicaid or a state children's health insurance program. If you or your dependents lose coverage under your state's Medicaid or children's health insurance program (CHIP), or you become eligible for health insurance subsidies under one of those programs, you will have the opportunity to enroll your family in this plan. You must enroll within 60 days of your Medicaid or CHIP eligibility change. If you enroll on time, your family's coverage under this plan will be retroactive to the date you gained or lost Medicaid or CHIP coverage.

These special enrollment periods are governed by the Health Insurance Portability and Accountability Act (HIPAA) and will be interpreted to comply with HIPAA regulations and requirements. QMSCOs are governed by ERISA and will be interpreted to comply with ERISA regulations and requirements. Note that domestic partners and their children are not eligible for the HIPAA special enrollment rights described above.

There may be more circumstances where you have the right to enroll for coverage in the middle of a plan year. These circumstances are described in the governing documents describing Ensign's employee benefits plans. Contact Ensign's Benefit Center for more information.

Section 3: Your Contributions & Costs

Your membership in this plan includes a responsibility to contribute to the cost of your healthcare benefits. Each month, you may be required to pay an employee contribution. In most cases, when you actually receive healthcare services, you must also pay part of the cost of those services. The plan is designed so you generally pay less when you use providers and facilities in the Blue Shield of California network.

Employee Contribution

Ensign may require you to pay an employee contribution every month, via payroll deduction, in order to enroll in this plan. The cost may vary depending on if you have dependents (and how many) and may also depend on other factors, which are set by Ensign. Once you enroll in a plan option, your contribution is fixed: you'll have to pay it whether you use any health services or not. In exchange for your contribution each month, you get access to the plan's benefits to help you pay for the healthcare you need.

Your contribution will generally remain constant throughout the plan year, but Ensign has discretion to change it. If there is a substantial increase in costs each month, you may be given an opportunity to change your benefits selections.

How the Network Can Work for You

Your membership in this plan includes access to a network of healthcare service providers (doctors, nurses, and other licensed professionals) and facilities (such as hospitals, urgent care centers, and pharmacies). The providers and facilities in this network have agreed to accept negotiated rates for the services they provide to you and your dependents. Because health services from in-network providers and facilities often cost less than the same services outside the network, this plan is designed to encourage you to use in-network services whenever possible.

- Blue Shield of California is this plan's preferred medical network. Through Blue Shield of California, you have access to providers outside of California in the BlueCard program. You can find additional important information about Blue Shield of California and BlueCard in Appendix A. The providers you have access to through this network may vary based on the state where you reside. If you would like more information about your preferred medical network, please contact Collective Health. Blue Shield of California, an independent member of the Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.
- This plan's preferred pharmacy network is CVS/Caremark, which includes all major retail pharmacies as well as a mail order pharmacy option.
- The plan may also have preferential arrangements that provide enhanced benefits if you use specific healthcare facilities or services.

In most circumstances, this plan provides richer benefits for services provided by in-network healthcare providers or facilities. If you receive services out-of-network, you will generally be responsible for a greater share of the cost.

If your in-network doctor refers you to an out-of-network provider or facility for medical care you need, or you choose to see an out-of-network provider because there is no in-network provider available, the plan may authorize the in-network benefits to apply to a claim for a covered service you receive from an out-of-network provider. If this applies to your situation, please contact Collective Health in advance of obtaining the covered service. If you receive authorization for in-network benefits to apply to a covered service received from an out-of-network provider, you may still be responsible for the difference between the allowed amount and the out-of-network provider's billed amount.

Ultimately, the choice of which provider or facility to use (whether in- or out-of-network) is yours. To find out whether a doctor is in your network, check my.collectivehealth.com or contact a Collective Health Member Advocate. Because provider or facility network status may change throughout the year, it is best practice to always double check with the provider or facility on their current status with the Blue Shield of California network.

This plan requires your provider to have specific credentials in order to cover your treatment. This helps the plan ensure that you receive medically necessary, quality care. In most cases, the required credentials are state medical licenses, which must be active and unrestricted in the state where you are receiving care.

If a provider's license is not active or current, your claim will not be covered. If a provider has active professional certification to provide covered benefits in that state, the claim will be covered. If a mental or behavioral health provider, with the appropriate and relevant training, is practicing under the guidance of a licensed and active provider, the claim will be covered as long as the services rendered are covered benefits on your plan.

The following table provides examples of specific provider credentials required for plan coverage. If you choose to visit an out-of-network provider, make sure to confirm that the provider has the appropriate credentials to administer the care you need. You may be responsible for submitting validation of their credentials. Contact Collective Health if you have questions about your specific provider. Remember that services still need to be medically necessary to be covered by your plan.

Provider Type	**Sample Credentials by Provider Type**
Audiologist	Doctor of Audiology (Au.D) American Board of Audiology (ABA) Certified Audiologist
Chiropractor	Doctor of Chiropractic (DC)
Dentist	Doctor of Dental Surgery (DDS) Doctor of Medicine in Dentistry (DMD)
Lactation consultant	International Board Certified Lactation Consultant (IBCLC), Academy of Lactation Policy and Practice (ALPP)
Midwife	Certified Nurse Midwife (CNM) (certified midwives are not covered)

Provider Type	Sample Credentials by Provider Type
Naturopath	Doctor of Naturopathy (ND) Doctor of Naturopathic Medicine (NMD)
Nurse	Nurse Practitioner (NP) Registered Nurse (RN) Licensed Vocational Nurse (LVN)
Nutritionist or Registered Dietician	Licensed Dietitian (LD) Licensed Nutritionist (LN) Licensed Dietician Nutritionist (LDN)
Occupational Therapist	Registered/Licensed Occupational Therapist (OTR)
Optometrist	Doctor of Optometry (OD)
Pharmacist	Doctor of Pharmacy (PharmD)
Physician	Doctor of Medicine (MD) Doctor of Osteopathy (DO)
Physical Therapist	Physical Therapist (PT) Masters in Physical Therapy (MPT or MSPT) Doctorate in Physical Therapy (DPT)
Physician Assistant	Physician Assistant (PA)
Podiatrist	Doctor of Podiatric Medicine (DPM)
Psychiatrist	Doctor of Medicine (MD)
Psychologist	Clinical Psychologist (PhD) Doctor of Psychology (PsyD)
Respiratory Care Practitioner	Certified Respiratory Therapist (CRT) Registered Respiratory Therapist (RRT)
Speech Therapist/Pathologist	Licensed Speech Language Pathologist (SLP)
Therapist/Counselor/Social Worker	Licensed Clinical Social Worker (LCSW) Licensed Master Social Worker (LMSW) Marriage and Family Therapist (MFT)

If you have questions about whether your provider may be covered by your plan, contact Collective Health.

Allowed Amounts

One benefit of visiting an in-network doctor or hospital is that Blue Shield of California has negotiated the rates for most healthcare services in advance. When you choose to visit an out-of-network provider or facility for medical treatment, it's much harder to know how much your treatment might cost. The providers may charge a reasonable rate for the services they provide you, or they may charge a lot more.

This plan will not pay charges that are excessive. Instead, this plan sets an allowed amount for each medical service, and this allowed amount is the most the plan will pay for that service when you receive it from an out-of-network provider. This plan may negotiate the allowed amount with out-of-network providers. When this plan cannot negotiate, the allowed amount will be set at 150% of Medicare's fee schedule, the 50th percentile of FAIR Health's benchmark, or according to other industry standard benchmarks. If Medicare and FAIR Health pricing is not available, the plan will set the allowed amount to 40% of charges.

Because the plan doesn't have contracts in place with out-of-network providers, those providers may charge more than the allowed amount for the treatment you receive. Your benefits under this plan will be based on the allowed amount, and the provider may bill you for the excess. (This practice is called balance billing.) It is your responsibility to pay any amounts in excess of the allowed amount—in addition to any deductibles, copays, or coinsurance. Balance billed charges can be significant, and they also don't count toward your out-of-pocket maximum. If you choose to see an out-of-network provider, you may want to ask them about their billed charges before you receive care.

If you can gather some information from your out-of-network provider in advance, Collective Health can help you determine whether you're likely to be balance billed. Contact Collective Health for guidance.

If you are balance billed by an out-of-network provider at an in-network facility or after an out-of-network ambulance ride or emergency room visit, you may be able to negotiate with the provider to reduce the amount you owe. Please contact Collective Health for more information.

Paying for Treatment You Receive

For most healthcare services, the plan pays for some, but not all, of the cost of treatment. Generally, you and the plan share the cost of your care. This plan shares the cost of healthcare with you in a couple of ways: an annual deductible, copays, coinsurance, and an out-of-pocket maximum (OOPM).

Until you hit your OOPM, you'll have to share the cost of your healthcare with the plan. You'll have to meet a calendar year deductible, and also pay a copay or coinsurance for most services you receive.

Coverage Tier	In-Network Deductible	Out-of-Network Deductible
Individual	$5,000	$10,000
Family	$10,000	$20,000

What is a deductible?

- A deductible is the amount you'll pay up-front for care until your benefits kick in. This applies only to some benefits.

- Remember that in-network preventive care is free for you, even if you haven't met your deductible yet.

What's the difference between copays ($) and coinsurance (%)?

- Copays are fixed dollar amounts. You typically pay the copay at the time you receive a medical service or fill a drug.
- Coinsurance is a percentage of the cost of care. Your provider will typically bill you later.
- The cost-sharing for each medical service, and whether or not the deductible applies to the benefit, is listed in the benefits table in Section 5.

What spending counts toward your deductible?

- Unless you're receiving preventive care medications, with this plan you'll pay full price for all prescriptions until you meet your deductible—whichever type of pharmacy you use, retail or mail order.
- Benefits can interact differently with your deductible:
    - Some benefits are entirely separate from your deductible. For these benefits, if a service requires a copay or coinsurance, you only pay that amount, even if you haven't met your deductible. However, when you pay these copay or coinsurance benefits, that amount doesn't accumulate toward your deductible.
    - For other benefits, you must pay the full cost of care for services until you meet your deductible for the year. After you've met your deductible, the benefits will kick in, and you'll be responsible only for your copay or coinsurance amount.
- The amounts you pay for covered medical care in-network only count toward your in-network deductible. Likewise, the amounts you pay for covered medical care out-of-network only count toward your out-of-network deductible.
- Your employee contributions don't count toward your deductible, and neither do the amounts you pay for non-covered services (like cosmetic surgery) or amounts in excess of the allowed amount.

How do deductibles work if you have a family plan?

- When you don't have any dependents, you only have to worry about the individual deductible. After you meet your individual deductible, your coinsurance benefits will kick in.
- If you have dependents, then your family has a family deductible. Before coinsurance benefits kick in for any member of your family, you will have to (combined) pay enough to meet the family deductible.

The OOPM is the most you'll be required to pay for covered services in a plan year.

Coverage Tier	In-Network Out-of-Pocket Max	Out-of-Network Out-of-Pocket Max
Individual	$7,000	$14,000
Family	$14,000	$28,000

What spending counts toward your OOPM?

- All money you pay for covered medical and pharmacy services counts toward your OOPM (including your deductible, copays, and coinsurance).
- The amounts you pay for covered medical and pharmacy services in-network only count toward your in-network OOPM. Likewise, the amounts you pay for covered medical and pharmacy services out-of-network only count toward your out-of-network OOPM.
- Your employee contributions don't count toward your OOPM, and neither do the amounts you pay for non-covered services (like cosmetic surgery), balance-billed amounts, or out-of-network pharmacy expenses.

What happens after you hit your OOPM?

- Once you meet your OOPM for in-network care, the plan will pay for all of your covered in-network healthcare costs for the rest of the plan year. Your out-of-network OOPM works the same way.
- Remember that the OOPM only applies to covered services; even after you hit your OOPM, the plan won't pay for non-covered services or amounts in excess of the allowed amount.

How do OOPMs work if you have a family plan?

- Each person on the plan has an individual OOPM. After an individual reaches their individual OOPM, their healthcare will be fully covered by the plan, and they won't have to share the cost of medical and pharmacy services.
- Your whole family's costs are also capped at the family OOPM amount. Once your family's covered medical and pharmacy costs hit the OOPM, all enrolled members will have full coverage for the rest of the plan year. This is true even if some individuals haven't yet hit their individual OOPM.

Assignment of Benefits

You (or your dependents) may not assign or transfer in any manner your benefits or other rights that you have under this plan (other than with the express written consent of the plan sponsor or plan administrator or as expressly required by law). For example, you may not assign your rights to receive payment for medical services under this plan to your doctor.

Section 4: Quality & Value Programs

Maximum Medical Benefits

This plan does not cap the total aggregate value of medical benefits you can receive, either in a given year or over your lifetime as a plan member. So long as you remain eligible, and your treatment falls within the scope of the plan and the allowed amount, your healthcare costs will continue to be covered by the plan.

If specific services have maximum visits or benefit caps, that information will be clearly stated alongside the service costs in the benefit table in Section 5.

Prior Authorization for Certain Procedures

This plan requires your provider to receive prior authorization for certain services. This means the provider must get clearance from the plan in advance, before providing treatment to you. If the provider does not get prior authorization for a service that requires it, the plan may not pay for the treatment. You may be responsible for the full cost of your care in the following cases:

- Your provider does not apply for prior authorization or a post-service review (also called a "post authorization") with the medical network.
- The prior authorization or post-service review is denied.
- You sign a waiver promising to pay for charges not allowed by your plan.

Prior authorization is typically required anytime you will be admitted to the hospital on an elective (non-emergency) basis—for example, if you need to be admitted for a scheduled surgery. Prior authorization may also be required for services such as non-emergency imaging services (CT, MRI, MRA, and PET scans), rental or purchase of certain durable medical equipment, and intensive spinal procedures (surgery, injections, and implants). Routine preventive care services never require prior authorization. When a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain, your provider should request expedited processing.

The prior authorization requirements change from time to time. The current list of services requiring prior authorization will always be available from Blue Shield of California. Please contact Collective Health for help accessing this list.

If prior authorization is denied, your physician can appeal that denial. You can also file your own appeal with Blue Shield of California to contest a prior authorization denial (see Section 9).

If you have questions about prior authorization in general, or about whether a specific treatment needs prior authorization, contact Collective Health. If you would like to request a prior authorization, contact Blue Shield of California.

Case Management Services

This plan's preferred medical network, Blue Shield of California, also provides a case management program for members whose healthcare requirements are more complicated than usual. The purpose of case management is to improve both the quality and value of healthcare treatments.

Collective Health and Blue Shield of California will identify members who are likely to benefit from the case management program. If you are identified, a case manager (usually, a registered nurse) will reach out to you, your caregivers, and your healthcare providers. Your case manager can help you manage your healthcare by explaining your treatment options, coordinating care between multiple providers or facilities, and dealing with related issues holistically.

Participation in the case management program is totally and completely voluntary. You do not have to speak to the case manager if you prefer not to. Your participation (or not) in the case management program will not affect your benefits.

If you feel you could benefit from case management services but no one has reached out to you, you can contact Collective Health for a referral.

Get a Second Opinion

A second opinion is a process where you consult with an expert in the field of your diagnosis to make sure that your diagnosis is correct and that you are set on the right treatment path. We encourage you to get a second opinion under the following circumstances:

- You have, or are diagnosed with, a rare or complex condition that requires the navigation and understanding of treatment options.
- Whenever your doctor recommends that you have surgery—that is, any surgery that can be scheduled in advance (not an emergency). Surgery can't fix everything. Even if your doctor recommends surgery, there may be other, less invasive treatment options that could give you as good (or better) results. In some cases, having surgery could actually make your overall health worse.

In these situations, not only can you get a second opinion—you can even get a third opinion if you wish. A second or third opinion is 100% voluntary, and you are not required to get one if you prefer not to. You can choose to get a second or third opinion anytime your doctor recommends elective surgery, for any reason.

The doctor who gives you a second (or third) opinion about your complex condition or elective surgery would be independent from the doctor who either diagnosed you or recommended the surgery in the first place.

How much will this cost? The plan will cover second and third opinions like other covered services described in Section 5. So, if you visit a specialist's office to get a second opinion, you will pay your regular copay or coinsurance for a specialist doctor visit. When you choose to visit an out-of-network provider or facility for medical treatment, the plan will cover the allowed amount, and the provider may balance bill you for any excess. It is your responsibility to pay any amounts in excess of the allowed amount—in addition to any deductibles, copays, or coinsurance.

Section 5: What's Covered & How Much It Costs

This section describes your plan's benefits in detail. Benefits are split into three categories: preventive care, emergency care, and everything else.

This plan covers most medically necessary healthcare services, except those that are specifically excluded. The plan administrator and/or claims administrator has full discretionary authority to adjudicate benefit claims, including taking a holistic view of the member's healthcare needs and condition, and current and future financial implications. Section 6 of this document includes a definition of medical necessity as well as a list of services that are excluded from your plan.

Preventive Care

Preventive care is generally provided when you are well and is intended to keep you healthy. The federal government—specifically, the U.S. Preventive Services Task Force, the Health Resources and Services Administration, and the Centers for Disease Control and Prevention—has recommended certain healthcare services as preventive care.

This plan must cover the full cost of in-network preventive care services, even if you haven't met your deductible. This plan will not pay for any out-of-network preventive care, unless no in-network provider of a specific preventive care service is available in your geographic area; in that case, the plan will provide in-network benefits for that out-of-network care.

Certain medical services qualify as "preventive care" depending on your age, biological sex, medical conditions, or timing. The following services are examples of preventive care:

- Breastfeeding supplies and support (including breast pumps) if you become pregnant, both during pregnancy and while nursing.
- Colorectal cancer screening (including colonoscopy) as recommended every few years for adults aged 50 to 75.
- Immunizations against whooping cough, measles, chickenpox, and other diseases for children from birth to age 18, at recommended doses and cadence.

Preventive and diagnostic care may occur during the same visit. For more information about which preventive services are recommended for you, visit www.healthcare.gov/coverage/preventive-care-benefits. Please contact the Member Advocate team for more information on the specific procedure and diagnosis codes that comprise your preventive benefits.

Service	Description	What You Pay
Preventive care for adults	Routine annual physical exam and associated counseling and screening, including immunizations and some lab services. The list of recommended services is available at: www.healthcare.gov/preventive-care-adults	**In-network:** Free for you (the plan pays 100%). You do not have to meet your deductible first. **Out-of-network:** Not covered.
Preventive care for women	Annual well-woman exam and associated counseling and screening, including contraception, routine recommended mammograms, and lab services. Includes preventive care during pregnancy and breastfeeding support and supplies. The list of covered services is available at: www.healthcare.gov/preventive-care-women	**In-network:** Free for you (the plan pays 100%). You do not have to meet your deductible first. **Out-of-network:** Not covered.
Preventive care for babies and children	Periodic exams and associated counseling and screening, including immunizations, behavioral assessments and autism screening, and lab services. Also includes routine care for your healthy newborn child while he or she is in the hospital immediately after birth. Newborn care charges are only covered if you enroll your newborn within 30 days of birth—otherwise, charges will not be covered. The list of covered services is available at: www.healthcare.gov/preventive-care-children	**In-network:** Free for you (the plan pays 100%). You do not have to meet your deductible first. **Out-of-network:** Not covered.

Emergency Care

Emergency care is designed to diagnose and treat an illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. You should seek emergency care in an urgent care center or in a hospital's emergency room.

Urgent care centers are generally cheaper than emergency rooms, especially if you use an urgent care center in your network. If you are in a position to choose—if you know your condition is not too serious—you should consider going to a local urgent care center instead of a hospital emergency room. If your condition is life-threatening (or you're not sure), you can and should go to the E.R.

This plan provides the same level of coverage for in-network and out-of-network emergency care in an emergency room. The same level of coverage is provided if you need emergency care when you are traveling outside the United States. The out-of-network provider may balance bill you for the difference between its charge and the allowed amount paid by the plan. If you are balance billed after an out-of-network ambulance ride or emergency room visit, you may be able to negotiate with the provider to reduce the amount you owe. Please contact Collective Health for more information. See Appendix A for additional information about access to Blue Shield of California's network services outside the U.S. These providers will be out-of-network but may assist with coordinating your coverage.

This plan covers medically necessary emergency air and ground ambulance services.

Ground emergency ambulance services are considered medically necessary when all of the following criteria are met:

- The ambulance is equipped with appropriate emergency and medical supplies and equipment;
- The patient's condition is such that any other form of transportation would not be advisable by a physician or other licensed medical provider; and
- The member is transported to the nearest hospital with the appropriate facilities and requisite level of care for the treatment of the member's illness or injury.

Air ambulance services are considered medically necessary when all of the criteria pertaining to ground transportation (listed above) are met and at least one of the following criteria are met:

- The member's medical condition requires immediate and rapid ambulance transport to the nearest appropriate medical facility that could not be reached by land ambulance;
- The point of pick-up is inaccessible by a ground ambulance;
- Great distances, limited time frames, or other obstacles limit the member's access to the nearest hospital with appropriate facilities for treatment; or
- The member's condition is such that the time needed to transport the member by land to the nearest appropriate medical facility poses a threat to the member's health.

Service	Description	What You Pay
Emergency ambulance	Medically necessary emergency transport by an air or ground ambulance to the nearest hospital with the appropriate facilities and requisite level of care for the treatment of the member's illness or injury. An ambulance is a specially designed vehicle that is staffed with qualified medical personnel and appropriately equipped to provide life-saving and supportive treatments or interventions during the transportation of ill or injured members. See "Emergency Care" above for more details on ambulance service requirements.	**In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the allowed amount; the plan pays the remainder of the allowed amount.
Emergency room expenses	Services and supplies in a hospital emergency room (including doctor fees), which are required to stabilize you or initiate treatment in an emergency. Follow-up treatment after you leave the emergency room is covered separately. If you go to an emergency room and you are admitted to the hospital, your emergency room copay is waived.	**In-network:** You pay a $500 copay per visit. Then, you'll pay the remaining cost of this service until you've met your deductible. After that, you pay 30% of the cost; the plan pays the rest. **Out-of-network:** You pay a $500 copay per visit. Then, you'll pay the remaining cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.
Urgent care center expenses	Services and supplies in a licensed urgent care center, for conditions reasonably requiring immediate treatment. An urgent care center is a clinic or acute-care facility that provides outpatient treatment for illnesses or injuries that require immediate treatment but are not necessarily life-threatening.	**In-network:** You pay a $75 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Treatment for Medical Conditions other than Preventive or Emergency Care

The benefits table on the following pages describes what the plan will pay for medical treatment other than preventive or emergency care. Different medical services may require you to pay different copays or coinsurance, and some services are subject to limits and annual benefit maximums. When you choose to visit an out-of-network provider or facility for medical treatment, the plan will cover the allowed amount, and the provider may balance bill you for any excess. It is your responsibility to pay any amounts in excess of the allowed amount—in addition to any deductibles, copays, or coinsurance.

The table below may not fully address every possible medical situation. If you have questions about how your unique medical needs may be covered by the plan, contact Collective Health.

Service	Description	What You Pay
Acupuncture	Acupuncture and associated treatment by a licensed acupuncturist.	**In-network:** Not covered. **Out-of-network:** Not covered.
Addiction treatment	Care by (or directed by) psychiatrists, psychologists, counselors, social workers, or other appropriate licensed healthcare providers to treat the dependency on, and excessive use of, chemical substances. Plan coverage for addiction treatment services depend on the setting of your treatment: in an office visit, in an outpatient facility, or in an inpatient or residential facility. Tobacco: Prescription therapies to quit smoking are covered by your pharmacy benefits.	<u>Office visits</u> **In-network:** You pay a $75 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		<u>Outpatient facility</u> *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		<u>Inpatient/Residential stay</u> *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Service	Description	What You Pay
Allergy care	Testing and appropriate treatment (including allergy serum and injections) by a healthcare provider.	<u>Allergy testing</u> **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		<u>Allergy serum/Allergy therapy</u> **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Ambulance (Non-Emergency)	Medically necessary, non-emergency transport by an ambulance to the nearest medical facility where you can receive the treatment you need. An ambulance is a specially designed vehicle that is staffed with qualified medical personnel and equipped to transport an ill or injured person.	**In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the allowed amount; the plan pays the remainder of the allowed amount.
Anesthesia	Medication, supplies, and administration of anesthetics when administered by a healthcare provider.	Anesthesia services and supplies are covered based on where you receive your treatment (for example, in a doctor's visit or while admitted to the hospital).
Autism	Diagnosis, care and treatment for adults and children with autism spectrum disorders, including applied behavioral analysis and speech, physical, and occupational therapies.	<u>Applied behavioral analysis/Applied behavioral therapy</u> **In-network:** Not covered. **Out-of-network:** Not covered.

Service	Description	What You Pay
		<u>Other rehabilitation services for mental health treatment</u> **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Auditory rehabilitation	Auditory rehabilitation, by a licensed therapist, as part of a short-term rehabilitative program following illness or injury.	**In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Bariatric surgery	*Coverage for bariatric surgery recipients only.* Surgical procedures performed to induce weight loss in people for whom it is medically necessary. *Travel expenses for bariatric surgery are not covered.*	<u>Inpatient surgery</u> **In-network:** Not covered. **Out-of-network:** Not covered.
		<u>Ambulatory surgery center</u> **In-network:** Not covered. **Out-of-network:** Not covered.
		<u>Outpatient surgery</u> **In-network:** Not covered. **Out-of-network:** Not covered.

Service	Description	What You Pay
Birth control	Coverage for preventive contraceptives includes prescription barrier methods, female condoms, generic hormonal methods, implanted devices, and emergency contraception. Coverage for non-preventive contraceptives includes male sterilization and medically-necessary termination of pregnancy. Elective abortions are not covered.	**Preventive contraceptive services (generic)** **In-network:** Free for you (the plan pays 100%). You do not have to meet your deductible first. **Out-of-network:** Not covered. **Non-preventive covered birth control services** Covered based on what care you receive and where (for example, a brand-name prescription, OB/GYN appointment, or outpatient surgery).
Cancer treatment	Diagnosis and treatment for cancer, including doctor visits, labs and scans, radiation and chemotherapy treatment, and routine patient care costs for clinical trials (please see "Clinical trials," below). *Travel expenses for cancer treatment are not covered.*	**Specialist visit** **In-network:** You pay a $75 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		Labs *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Service	Description	What You Pay
		<u>X-rays</u> *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		<u>Scans</u> *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		<u>Chemotherapy & radiation</u> *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Service	Description	What You Pay
Cardiac rehabilitation	Cardiac rehabilitation to treat or prevent heart attack, heart failure, or coronary artery disease, or to recover after heart surgery.	**In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Chiropractic care	Chiropractic treatment and spinal manipulation by a licensed provider.	*Limited to 40 sessions per year per member.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Clinical trials	Routine patient care (as defined by the ACA) costs provided as part of a clinical trial that is recommended by your physician and covered by the plan, when the trial is intended to treat cancer or another life-threatening disease or condition, as determined upon review. Routine patient care includes the non-experimental health services you receive during the clinical trial (doctor's visits, medical equipment, treatment of complications), but does not include the cost of unapproved drugs (including the subject of the trial) or research administration costs.	*May require a prior authorization.* Services and supplies are covered based on who provides your care and where you receive your treatment (for example, an oncologist visit, medical equipment, or labs/scans).

Service	Description	What You Pay
Diabetes	Diagnosis, care and treatment for adults and children with diabetes (type I and II), including diagnostic testing, doctor visits, foot care, medical equipment, and education and training for diabetes patients in disease management (when recommended by your physician). Insulin and other prescription medications are covered by your pharmacy benefits.	<u>Specialist visit</u> **In-network:** You pay a $75 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		<u>Diabetes self-management training</u> **In-network:** You pay a $45 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		<u>Labs</u> *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Service	Description	What You Pay
		Medical equipment *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Dialysis	Kidney dialysis services for hemodialysis, peritoneal dialysis, and home dialysis.	*May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Doctor's office visits	Visits and services from your primary care provider or specialist healthcare provider when you need treatment for a medical condition. In-network preventive care visits are free for you. Please contact the Member Advocate team for more information on the specific procedure and diagnosis codes that comprise your preventive benefits.	**Primary care provider** **In-network:** You pay a $45 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Service	Description	What You Pay
		<u>Specialist provider</u> **In-network:** You pay a $75 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Eye care	Medically necessary eye care related to specific medical conditions, including but not limited to diabetic retinopathy, glaucoma, cataracts, and other diseases and infections of the eye. Routine eye care, such as vision screenings (including refraction), is not covered by this plan. Some routine eye care may be considered preventive for individuals under the age of 18. Please contact the Member Advocate team for more information on the specific procedure and diagnosis codes that comprise your preventive benefits.	Services and supplies are covered based on what care you receive and who provides it (for example, medical equipment or outpatient surgery).
Fertility	This plan only provides coverage for treatment of underlying medical conditions (such as endometriosis) that also cause infertility. Fertility-specific treatments are not covered.	Diagnosis and treatment of underlying medical conditions are covered based on what care you receive and who provides it (for example, medical equipment or outpatient surgery). Otherwise, not covered.

Service	Description	What You Pay
Foot care	Exams by podiatrists, foot care associated with metabolic or peripheral-vascular disease (including related to diabetes), and custom-made foot orthotics, when prescribed by a physician. Pedicures, spa treatments, and cosmetic treatment of corns, calluses, or toenails are not covered.	<u>Podiatrist visit</u> **In-network:** You pay a $75 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		<u>Orthotics</u> **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Hearing screening & aids	Hearing exams for newborns and children as part of preventive care, or for adults when recommended by a medical provider. Additional services and supplies associated with hearing aids are excluded.	<u>Preventive hearing screenings for newborns and children (office visit)</u> **In-network:** Free for you (the plan pays 100%). You do not have to meet your deductible first. **Out-of-network:** Not covered.
		<u>Non-preventive hearing screenings</u> **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Service	Description	What You Pay
		<u>Hearing aids</u> **In-network:** Not covered. **Out-of-network:** Not covered.
Home-based care	At-home care and treatment of an illness or injury, with a prescription from your doctor that specifies how long you'll need home care. Includes visits by trained medical personnel (including nurses) and supplies.	*Limited to 100 days per year per member.* *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** Not covered.
Hospice care	Hospice care is an integrated program that provides comfort and support services for people who are terminally ill (usually meaning they are not expected to live more than six months). Hospice care often includes emotional support services for the immediate family. Respite care provides caregivers a temporary rest from caregiving. Respite care as part of hospice care is covered under this benefit.	*May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** Not covered.
Hospital stays	Inpatient hospital stays (admission for a scheduled procedure, or admission after an emergency). Includes room & board, doctor visits, supplies (like dressings, splints, or other materials), and medications or other substances (like blood, oxygen, fluids) during your stay. See "Surgery" below for more details on costs for surgical procedures.	*May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Service	Description	What You Pay
Infusion therapy	Intravenous or other infusion-based administration of medication in a medical facility (hospital or outpatient center) or as part of an office or home healthcare visit, under the care of a physician.	*May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Injectable medications	Injections (other than allergy injections or other benefits separately listed in this chart) administered by a medical provider. Includes, for example, steroid or pain medication injections when medically necessary. Drugs you take yourself (not administered by a healthcare provider) are covered separately, under your pharmacy benefits.	*May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Medical equipment and supplies	Rental or purchase of durable medical equipment, which is medical equipment that is not disposable and is customarily used for a medical purpose, and associated supplies. A prescription from your physician is required. You may repair or replace equipment that is outgrown or after reasonable wear and tear.	*May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Medical tests	Medically necessary diagnostic tests, including laboratory tests, radiology (such as X-rays or ultrasounds), and advanced imaging (such as MRI, PET, or CT scans), when recommended by a healthcare provider.	<u>Preventive care tests</u> **In-network:** Free for you (the plan pays 100%). You do not have to meet your deductible first. **Out-of-network:** Not covered.

Service	Description	What You Pay
	Preventive care medical tests (for example, routine recommended mammograms) are covered at 100% in-network.	<u>Diagnostic labs</u> *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		<u>Radiology</u> *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		<u>Advanced imaging</u> *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Service	Description	What You Pay
Mental health	Care and treatment by (or directed by) psychiatrists, psychologists, counselors, social workers, or other qualified medical professionals to address conditions impairing behavior, emotion reaction, or thought process.	**Office visits** **In-network:** You pay a $75 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		Rehabilitative services (physical, occupational, and speech therapy) for mental health treatment **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		Outpatient facility *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Service	Description	What You Pay
		<u>Inpatient/residential stays</u> *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Mouth, tooth & jaw injury	Routine dental care (such as cleanings or fillings) is not covered by this plan. Coverage is limited to: • Medical treatment of jaw joint disorders (like TMJ) • Excision of tumors and benign bony growths in the jaw or mouth • Emergency repair of natural teeth after injury • Surgical repair of jaws, cheeks, lips, tongue, and floor/roof of mouth after injury • External incision and drainage of cellulitis • Incision of sensory sinuses, salivary glands or ducts • Removal of impacted teeth	Services and supplies are covered based on who provides your care and where you receive your treatment (for example, in a doctor's visit or while admitted to the hospital).
Nutritional counseling	Nutritional evaluation and counseling by a registered dietitian or licensed nutritionist.	**In-network:** Not covered. **Out-of-network:** Not covered.
Occupational therapy	Occupational therapy, by a licensed therapist and under the direction of a physician, as part of a short-term rehabilitative program following illness or injury. Recreational or exercise programs are not covered.	**In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Service	Description	What You Pay
Orthotics	Initial purchase, fitting, and repair of orthotic appliances (like back braces or leg splints) required to support a body part that is disabled after injury or because of a congenital condition. Also includes custom-made foot orthotics, when prescribed by a physician, to treat weak, unstable, unbalanced, or flat feet.	**In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Physical therapy	Physical therapy, by a licensed therapist and under the direction of a physician when required, as part of a short-term rehabilitative program following illness or injury. Recreational or exercise programs are not covered.	**In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Pregnancy & childbirth	Care and treatment during pregnancy and childbirth, including required prenatal care, hospital stays, physician services, surgery, breastfeeding support and supplies, and hospital nursery care for your newborn child. Please keep in mind that some services related to your pregnancy may be considered preventive and will be covered under the plan's preventive care benefit. The plan covers inpatient care for at least 48 hours after delivery (96 hours after cesarean section), though your physician may discharge you earlier.	**Prenatal care (primary care visits)** **In-network:** You pay a $45 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Service	Description	What You Pay
	Newborn care charges are only covered if you enroll your newborn within 30 days of birth—otherwise, charges will not be covered. If you are pregnant or you have just given birth, rental or purchase of a commercial breast pump (manual or electric) is covered during and after the pregnancy. Many traditional retailers stock a variety of breast pumps at a comparable cost to in-network breast pumps. To make it easier for you to obtain a breast pump in a timely manner, your plan covers out-of-network breast pumps and accessories with the same cost sharing as your in-network preventive benefit, up to an allowable amount. Please contact Collective Health to find out what the allowable amount is for an out-of-network breast pump based on your geographic area. If the cost of the out-of-network breast pump and supplies you purchase is less than or equal to the allowed amount, they will be covered with no additional cost to you. If the cost of the out-of-network breast pump and supplies you purchase is greater than the allowed amount, you will be responsible for the difference.	**Prenatal care (specialist visits)** **In-network:** You pay a $75 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		Genetic testing *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		Ultrasounds *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Service	Description	What You Pay
		Hospital admission for delivery *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		Newborn nursery *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
		Breastfeeding support and counseling (excluding breast pumps and accessories) **In-network:** Free for you (the plan pays 100%). You do not have to meet your deductible first. **Out-of-network:** Not covered.
		Breast pumps and accessories *Limited to 1 device per year per member.* **In-network:** Free for you (the plan pays 100%). You do not have to meet your deductible first. **Out-of-network:** The plan pays 100% of the allowed amount. You do not have to meet your deductible first.

Service	Description	What You Pay
Prosthetics	Initial purchase, fitting, and repair of artificial limbs and other prosthetic devices to replace body parts that are missing after amputation or because of a congenital condition. Includes replacement for prosthetic devices that have been outgrown or that require replacement due to reasonable wear and tear.	*May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Respiratory rehabilitation	Respiratory rehabilitation, by a licensed therapist, as part of a short-term rehabilitative program following illness or injury.	**In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Skilled nursing facilities	Inpatient care at a skilled nursing facility, after or in place of hospitalization or home healthcare, with a doctor's prescription (which specifies how long you should stay at the facility). A skilled nursing facility is licensed by Medicare to provide 24-hour inpatient care by registered nurses, directed by a physician, for patients convalescing from physical illness or injury (also known as a rehab hospital, nursing home, or extended care facility). Coverage includes care by doctors and nurses, supplies (like dressings, splints, or other materials), and medications or other substances (like blood, oxygen, fluids) during your stay.	*Limited to 100 days per year per member.* *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Service	Description	What You Pay
Speech therapy	Speech therapy by a licensed therapist as part of a short-term rehabilitative program.	**In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Surgery	Professional services, supplies, medications, and other services provided with or during surgery. "Surgery" includes open or minimally-invasive surgical operations, sutures and skin grafts, and manipulation of broken bones and dislocations. Surgery performed to improve your appearance is considered cosmetic and is not covered, but reconstructive surgery of abnormal congenital conditions and reconstructive surgery after a mastectomy are covered.	**Ambulatory surgery center** **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount. **Hospital outpatient** *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Service	Description	What You Pay
		Hospital inpatient *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Telemedicine	Your employer has partnered with Teladoc to provide access to telemedicine services. This plan also covers telemedicine visits with any provider and you are not limited to using Teladoc.	**Teladoc medical visits** **In-network:** You pay a $25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). **Out-of-network:** Not covered.
		Teladoc mental health visits **In-network:** Not covered. **Out-of-network:** Not covered.
		Medical visits **In-network:** Not covered. **Out-of-network:** Not covered.
		Mental health visits **In-network:** You pay a $75 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). **Out-of-network:** Not covered.

Service	Description	What You Pay
Transgender services	*Coverage for transgender services recipients only.* Diagnosis and treatment for services related to transgender care. Gender affirmation surgery is not covered on this plan. Hormones will be covered by your pharmacy benefits; see the "Pharmacy Benefits" section below. *Travel expenses for transgender surgery are not covered.*	<u>Counseling (office visit)</u> **In-network:** You pay a $75 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Inpatient surgery</u> **In-network:** Not covered. **Out-of-network:** Not covered.
Transplants	Transplants are defined as the transplant of organs or tissues from human to human or the transplantation of bone marrow, stem cell or cord blood. If you are the recipient, this plan will cover the cost of your and your donor's evaluations, harvesting and transplant surgeries, transportation of the organ, and post-surgical treatments. If you are the donor, your recipient's plan will pay first, and this plan will cover the allowable amount that is left. *Travel expenses for transplant services at a Blue Distinction Center are reimbursed to a maximum of $10,000 per year per member for reasonable expenses. You do not have to meet your deductible first.* *If needed, search expenses to find an organ donor who is not related to you are reimbursed to a maximum of $30,000 per year per member for reasonable expenses. You do not have to meet your deductible first.*	<u>Inpatient surgery</u> *May require a prior authorization.* **In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** Not covered.

Service	Description	What You Pay
Vaccines	Immunizations for children and adults at recommended ages and doses, along with additional elective vaccines (for example, if recommended for foreign travel) recommended and administered by a physician. The recommended vaccine schedule is available at www.vaccines.gov.	**Preventive vaccines** **In-network:** Free for you (the plan pays 100%). You do not have to meet your deductible first. **Out-of-network:** Not covered.
		Travel vaccines **In-network:** Not covered. **Out-of-network:** Not covered.
Walk-In Retail Clinic	Services supplied in a licensed walk-in retail clinic, such as one located in a drug store or supermarket. A walk-in retail clinic provides services for less complex conditions like a sore throat or earache, or preventive care like vaccines.	**In-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. **Out-of-network:** You'll owe the full cost of this service until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Pharmacy Benefits

The pharmacy benefits in this plan help you pay for the medications you need. In general, this plan covers all medically necessary medications prescribed to you by your doctor, except those that are specifically excluded (see Section 6 and Appendix B for more on exclusions).

The benefits described below cover the medications you get from a pharmacy. The drugs administered to you by a healthcare provider during an office visit, outpatient procedure, or hospital stay are covered separately by your medical benefits. In addition, certain infusions or implantable products (such as plasma, blood products, or implantable androgen products) are covered by your medical benefits and not your pharmacy benefits.

Your Pharmacy Network

CVS/caremark is the pharmacy benefits manager for this plan, and most retail pharmacies are in-network. As is the case with the rest of your benefits under this plan, you will typically pay less if you use an in-network pharmacy than if you go out-of-network. To find out whether a pharmacy is in your network, you can contact

Collective Health, you can check the CVS/caremark website by logging in via my.collectivehealth.com, then navigating to Get Care and clicking on “Pharmacy”, or you can ask the pharmacist whether the pharmacy is in the CVS/caremark network.

You can get your medications from an in-network retail pharmacy or CVS/caremark's mail order pharmacy. If your drugs are available through mail order, they may cost less overall, for you and for the plan, so these benefits are designed to encourage you to use mail order whenever possible. If you use out-of-network retail pharmacies, you will need to submit a claim for reimbursement after you purchase your medication. Contact Collective Health for guidance.

Types of Prescriptions

Certain medications are classified as “preventive care.” (These include medications like hormonal birth control, aspirin for heart attack prevention, and tobacco cessation products.) For preventive care prescriptions, if you use in-network pharmacies and select generic alternatives, your plan will cover 100% of the cost. If you’d like to know if your medication is considered preventive, you can contact Collective Health for help.

On this plan, some medications will cost you more than others. Generic prescriptions are less expensive versions of brand name drugs. Generic drugs are considered identical to their brand name equivalents (in terms of efficacy and safety) by the FDA.

If you take a brand name drug, it’s important to know that some brands are treated differently under this plan. Brand name drugs are more expensive than generics, but your plan has negotiated discounts on some—these are called preferred brand drugs. Non-preferred brands aren't discounted, so you'll pay more for these. Often, there will be generic options for medications prescribed by your doctor. When you fill your prescription, you can ask the pharmacist whether a generic or preferred brand name version of your medication is available.

You must fill a prescription within the time specified by the doctor. Only the number of refills specified by the doctor will be covered.

What You Pay

- Unless you're receiving preventive care medications, with this plan you'll pay full price for all prescriptions until you meet your deductible—whichever type of pharmacy you use, retail or mail order. Your medical out-of-pocket maximum applies to these pharmacy benefits as well.
- Money you spend on covered prescriptions will accumulate toward your out-of-pocket maximum just like money you spend on covered medical care.
- You can get preventive care medications for free from in-network pharmacies from day one on this plan. But to learn how much you will owe for any other medications, see the table below.
- Once you hit the deductible, if the total cost for a medication is less than your copay, you’ll only have to pay the lesser amount.
- Maintenance medications are typically prescribed for chronic, long-term conditions and are taken on a regular, recurring basis. Maintenance medications include those used to treat high blood pressure,

heart disease, asthma, or diabetes. In addition to allowing you to pick up a 30-day supply of your medication at a CVS retail pharmacy, your plan also allows you to pick up your medication for a 90-day supply through a CVS retail pharmacy or a CVS mail-order pharmacy.

- If you or your provider chooses a brand-name medication when a generic version is available, you'll pay what you usually do for brand-name drug cost-sharing, plus the difference in cost between the generic and brand-name drug. The difference you pay does not accumulate towards your deductible or your out-of-pocket maximum. Though you will not be responsible for the drug cost-sharing, you will continue to be responsible for the difference in cost after you have met your out-of-pocket maximum.
- Your plan will require you to obtain specialty medications through a CVS Specialty pharmacy. If you would like to know if your medication is considered specialty, please contact Collective Health for help.
- Some medications are excluded from coverage. See Appendix B for more information.

Drug Type	In-Network Retail Pharmacy	In-Network Mail Order Pharmacy (90-day supply)	Out-of-Network
Preventive drugs	Free for you (the plan pays 100%). You do not have to meet your deductible first.	Free for you (the plan pays 100%). You do not have to meet your deductible first.	You'll pay the full cost of this medication until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Generic drugs	You pay a $10 copay; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).	You pay a $20 copay; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).	You'll pay the full cost of this medication until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.

Drug Type	In-Network Retail Pharmacy	In-Network Mail Order Pharmacy (90-day supply)	Out-of-Network
Preferred brand drugs	You'll owe the full cost of this medication until you've met your deductible. After that, you pay a $25 copay; the plan pays the rest.	You'll owe the full cost of this medication until you've met your deductible. After that, you pay a $50 copay; the plan pays the rest.	You'll pay the full cost of this medication until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Non-preferred brand drugs	You'll owe the full cost of this medication until you've met your deductible. After that, you pay a $40 copay; the plan pays the rest.	You'll owe the full cost of this medication until you've met your deductible. After that, you pay a $80 copay; the plan pays the rest.	You'll pay the full cost of this medication until you've met your deductible. After that, you pay 60% of the allowed amount; the plan pays the remainder of the allowed amount.
Specialty drugs	You'll owe the full cost of this medication until you've met your deductible. After that, you pay 20% (up to $125) of the cost; the plan pays the rest.	You'll owe the full cost of this medication until you've met your deductible. After that, you pay 20% (up to $125) of the cost; the plan pays the rest. *Specialty medication is limited to a 30-day supply.*	Not covered.
Fertility medication	Not covered.	Not covered.	Not covered.

When you go to an in-network retail pharmacy, you can pick up a 30-day supply of your medication. Enroll in mail order if you would like to receive more than a 30-day supply at a time. See the table above to check if any limits apply to mail order medications.

You will not be able to collect more than the numbered day supply indicated in the above table in one order whether you purchase at an in-network or out-of-network retail pharmacy or mail order pharmacy. You will have to wait until your supply is low before you can refill your prescription.

Over-the-Counter Medications

Over-the-counter medications (ibuprofen, vitamins, etc.) are not covered by this plan. There are four exceptions to this exclusion:

- When a drug is prescribed by your doctor and you purchase it behind the counter, from the pharmacist (for example, aspirin or folic acid), then you may be able to use your pharmacy benefits even if the drug is also available over-the-counter.
- Over-the-counter supplies for treating diabetes (such as insulin and blood sugar detection equipment) are not excluded from coverage.
- If covered contraceptives are available over-the-counter in your area, those will be covered by this plan if prescribed by a doctor.
- Over-the-counter smoking cessation treatments are covered by this plan if prescribed by a doctor.

If you have questions about your pharmacy benefits, including whether certain medications are preferred, non-preferred, or excluded, you can always contact Collective Health for help.

Section 6: What's Not Covered (Exclusions)

Some treatments and services are not covered by this plan. Items that are not covered are called exclusions and are listed below. Certain exclusions may also be described in the benefits table in Section 5.

Any service, item, or treatment that is not medically necessary is excluded. Services are medically necessary if all the following criteria are met:

1. Recommended and provided by a licensed physician, dentist or other medical practitioner who is covered by the plan and practicing within the scope of their license;
2. Generally accepted as the standard of medical practice and care for the diagnosis and treatment of your condition, or for preventive care;
3. Appropriate (in terms of type, frequency, duration, and other factors) for your condition;
4. Not performed mainly for your convenience or the convenience of your doctor;
5. Approved by the FDA, if applicable.

The plan administrator and/or claims administrator has full discretionary authority to adjudicate benefit claims, including taking a holistic view of the member's healthcare needs and condition, and current and future financial implications. This plan may not cover all possible medically necessary treatments; in other words, some services are excluded from coverage even if they would be medically necessary for you.

Non-medical services are excluded:

- Any type of education or training, except as expressly stated in Section 5 as covered or services that are medically necessary and performed by licensed medical professionals
- Exercise programs (except for physician-supervised cardiac rehabilitation, physical therapy, or occupational therapy expressly stated in Section 5 as covered)
- Dietary or nutrition supplements, except when prescribed to treat specific medical conditions (such as PKU)
- Charges for travel or non-medical accommodations, except as expressly stated in Section 5 as covered
- Hypnotherapy
- Rest cures
- Personal comfort items, including:
  - Air conditioners
  - Air purification units
  - Humidifiers
  - Electric heating units
  - First aid supplies
  - Elastic bandages or stockings
  - Non-hospital adjustable beds
  - Orthopedic mattresses
  - Non-prescription drugs and medicines, except as expressly stated in Section 5 as covered
  - Scales

This plan excludes any care you receive when you are not a member. Healthcare services you receive before your coverage effective date are excluded—even if you are charged for the services after your coverage begins. Services you receive after your coverage ends are excluded—even if you got sick while you were still covered.

This plan also excludes the following services, supplies, or treatments:

- **Respite care**, unless received as part of hospice care.
- **Private duty nursing** provided in a setting outside the home.
- **Compound medication** ingredients that have not shown clinical benefit over lower-cost alternatives, or bulk ingredients used in compound medications where a standard equivalent exists.
- **Concierge membership fees**, retainers, or premiums paid to a concierge medical practice in order to access the medical services provided by that practice, except for fees that may be paid on your behalf by Ensign in its sole discretion.
- Charges for **cosmetic procedures** or pharmaceuticals, which are procedures performed or medications taken for plastic, reconstructive, or cosmetic purposes, or which are intended primarily to improve, alter, or enhance appearance.
  - Treatments for hair loss, including wigs and transplants, are excluded, except for wigs provided for the loss of hair resulting from chemotherapy or radiation to treat cancer.
  - Drugs for cosmetic effect, such as Retin-A or hair removal substances, are excluded unless they are medically necessary to treat a medical condition.

- Growth hormones, anabolic steroids, and appetite suppressants are excluded unless they are prescribed by a physician to treat a covered medical condition (such as HGH deficiency).
- Reconstructive surgery to correct congenital abnormality or deformity caused by accident, injury, or illness (including after mastectomy) is not excluded.

- Routine **dental care**, except specific treatments for mouth, tooth, or gum injury expressly stated in Section 5 as covered.
- **Excess charges** for services, items, or treatment—in other words, charges by out-of-network providers that exceed the allowed amount for the services provided.
- Care or treatment provided or prescribed by **excluded providers**, including:
  - Yourself;
  - A member of your immediate family by birth, adoption, or marriage;
  - A person residing in your household;
  - A provider operating without a license or operating outside the scope of his or her license.
  - If you are treated by a hospital or other healthcare facility, additional payments to an employee or contractor of that facility are excluded, when the facility is itself obligated to pay that individual for their services.
- Charges associated with **experimental treatments**, which are treatments that are not accepted as good medical practice by most practitioners or that lack credible evidence to support positive short- or long-term outcomes for patients.
  - Treatments include any treatment, procedure, service, device, supply or drug provided to a covered person.
  - Drugs that are not approved by the FDA for any use are considered unproven and experimental and are excluded. Off-Label Drug Use is defined as the use of a drug for a purpose other than that for which it was approved by the FDA. Off-Label Drug Use may be covered on the plan if:

    1. The drug is not excluded under your plan; and
    2. The drug has been approved by the FDA; and
    3. It can be demonstrated that the Off-Label Drug Use is appropriate for the condition being treated.

  - Experimental treatment provided as part of a clinical trial is not covered by this plan, unless determined to be eligible for coverage upon review. Routine patient care costs for approved clinical trials may be covered by this plan, as described in Section 5.
- Routine **eye care** and vision-correction surgery, except:
  - Care and treatment of aphakia and aniridia.
  - Lenses or shells for use as corneal bandages.
  - As otherwise covered by the Preventive Care provisions of this plan.
  - As expressly stated in Section 5 as covered.
- Charges beyond the plan's **financial obligations**, including:
  - Amounts in excess of the "allowed amount."
  - Medical treatments outside the plan's scope (i.e., services that are not listed as covered benefits).
  - Services, items, medications, or treatment for which there would not have been a charge, if no coverage were available.

  - Expenses actually incurred by other persons (not you or your covered dependents).
  - Charges that should be repaid to the plan under the subrogation, reimbursement, or third-party responsibility provisions (Section 12).
  - Expenses for services that are also covered under any government-sponsored plan or program (e.g., Tricare, CHAMPUS, VA), unless the government program expressly provides otherwise.
  - For services you obtain before you were covered under this plan.
  - For services you obtain after your coverage under this plan ends.
- Non-medical **foot treatments**, such as pedicure or spa treatments or non-medical treatment of corns, calluses, or toenails.
- **Hearing aids**, except as expressly stated in Section 5 as covered.
- **Illegal drugs**, including otherwise legal medications (such as oxycodone) procured through illegal means.
- Elective abortions are not covered by the plan.
- Care, supplies, medications, and services for the treatment of **infertility**, except as expressly stated in Section 5 as covered.
  - Fertility services are not covered if your infertility is the result of a prior voluntary sterilization procedure.
  - The purchase of donor sperm and purchase of donor oocytes or embryos and any charges associated with care of the donor required for donor oocytes retrievals or transfers or gestational carriers (surrogacy); all charges associated with a gestational carrier program for the person acting as the carrier (if that person is not a member of this plan), including but not limited to fees for laboratory tests.
  - Home ovulations prediction kits.
  - Services and supplies furnished by an out of network provider.
- **Marijuana** or marijuana-derived substances (like THC oil), even if you have a prescription and marijuana is legal in the state where you live.
- Charges for services provided by **massage therapists**.
- Charges for services provided by a **naturopath**.
- Non-emergency medical care outside the United States, including all **medical tourism.**
  - Emergency care outside the U.S. is covered. See Appendix A for more information.
- **Over-the-counter drugs**, except as expressly stated in Section 5 as covered.
- **Pharmaceutical medications** that are specifically excluded by CVS/Caremark from coverage. See Appendix B for more information.
- Treatments for intentionally **self-inflicted injuries**—but if the injury is due to a medical or mental health condition, this exclusion does not apply.
  - Treatments for injuries that you sustain while incarcerated are also excluded.
- Charges for **sterilization reversal** procedures, except as expressly stated in Section 5 as covered.
- Charges for services provided by a **doula**.
- **Vitamins** or other dietary supplements, except as expressly stated in Section 5 as covered.
- Charges for health services received as a result of an act of **war** or foreign terrorism.
- Services, items, or treatment for **work-related** illness or injury—that is, an illness or injury that arises from work for wage or profit (including self-employment).

Section 7: When Your Coverage Ends

Certain events will cause your coverage under this plan to end. If multiple terminating events happen around the same time, your coverage will end on the earliest possible termination date.

Triggering Event		What It Means for You
If the entire plan ends.	Ensign has the right to terminate this plan, and any other health plans (in other words, to stop offering coverage for employees), at any time and for any reason.	Your coverage and your dependents' coverage will end on the date the plan ends. The plan administrator is responsible for notifying you that your coverage has ended.
If you are no longer eligible for coverage.	You and your dependents are only covered under this plan as long as you and they continue to meet the eligibility requirements described in Section 1 of this SPD.	If you become ineligible, your dependents will also automatically become ineligible. Your coverage and your family's coverage will end on the last day of the month that eligibility ends. You may have the right to continue coverage under COBRA (see Section 10).
If you stop paying for coverage.	If you are required to pay an employee contribution to receive benefits under this plan, then you must pay each period to continue coverage.	Your coverage and your dependents' coverage will end on the last day of the last fully-paid period.
If you defraud the plan.	Your coverage can be terminated if you commit fraud on the plan, or if you make an intentional, material misrepresentation to the plan, in the course of obtaining coverage or benefits. (For example, if you submit false claims for reimbursement.)	Ensign has discretion to determine when your coverage or your dependents' coverage will terminate. Your termination may be retroactive—if so, you may be required to repay the plan for prior coverage (this is called rescission). The plan administrator or Collective Health will give you 30 days' notice of rescission, and you will have the right to appeal this determination.

There may be more circumstances where your coverage may terminate in the middle of the plan year, including factors that give you a right to discontinue your coverage. These circumstances are described in the

governing documents describing Ensign's employee benefits plans. Contact Ensign's Benefit Center for more information.

After your coverage ends, the plan will still pay claims for services you received before your coverage ended. However, once your coverage ends, your benefits under this plan end immediately—even if you are hospitalized, and even if you need further treatment for conditions that occurred before your end date.

If your coverage ends, your dependents' coverage will also end. But in some circumstances, if your dependent's coverage ends (for example, if your child turns 26), you and your remaining dependents may continue to receive coverage.

If your employment with Ensign ends, and you are rehired after more than 30 days have passed, you will be treated as a new hire, and you and any family members will need to satisfy all of the eligibility and enrollment requirements detailed in Sections 1 and 2. If you are rehired within 30 days after you leave Ensign and are still eligible for benefits, you will be reinstated with the same healthcare benefits when you return.

Section 8: How to File a Claim

When you use in-network services, the provider will generally collect your copay from you at the time of your treatment and send a claim to the plan for payment. Sometimes out-of-network providers will do the same. Other times, out-of-network providers may bill you for the total cost of your treatment, and you will need to submit the claim to the plan to be paid. Whether you pay out-of-pocket or your provider bills the plan directly, you are still entitled to the same benefits.

If you receive a bill from your doctor (whether in- or out-of-network) for the plan's portion of the costs, or you pay for your medical care out of pocket and need to be reimbursed, you must submit a claim to the plan. This section summarizes the procedures you must follow to submit a claim for payment, and the procedures the plan will use to determine whether and how much to pay for that claim. Your claim will be decided in accordance with its claims procedures, as required by ERISA. If your claim is denied in whole or in part, you will receive a written notification setting forth the reasons for the denial and describing your rights, including your right to appeal the decision.

Claims are considered filed and received by the plan when they are received by Collective Health. If you would like more details about claims procedures and your rights and responsibilities, contact Collective Health.

Regular Post-Service Claims

Post-service claims are non-urgent claims after you have received treatment. (Other types of claims have different timelines and requirements; see below.) Generally, you do not need to file a claim for services from in-network providers—the provider, Blue Shield of California, and Collective Health will handle the processing

of the claim. For out-of-network providers that do not bill insurance, or if you receive emergency care outside the United States and are seeking reimbursement from the plan, you can submit a claim using this procedure.

You can submit a post-service claim by mail, by email, or through my.collectivehealth.com. You will need to provide several pieces of information for Collective Health to be able to process your claim and determine the appropriate plan benefits:

- The name and birthdate of the patient who received the care
- The member ID listed on the patient ID card
- An itemized bill from the patient's provider, which must include:
  - The provider's name, address, and license number (if available)
  - The date(s) the patient received care
  - The medical diagnosis and procedure codes for each service provided
  - The charges for each service provided
- Information about any other health coverage the patient has
- Proof of payment may be requested to substantiate your claim but is not required upon initial submission to Collective Health

For breast pumps, an itemized bill is not required. Instead, please submit a detailed receipt.

Contact Collective Health if you have any questions on the items above.

Your claim must be submitted within one year from the date you received the healthcare services. If your claim relates to an inpatient stay, the date you were admitted counts as the date you received the healthcare service for claims purposes.

Within 30 days of Collective Health receiving your claim, you'll receive a decision. Claims will be processed when administratively feasible, typically in the order they are received. If we need more information on a claim, we will reach out to you to provide that additional information, but we will still make a decision on your claim within 30 days. If you are able to submit the requested additional information after a decision has been made, we may adjust our decision and reprocess your claim accordingly.

Claims for pharmacy benefits will be reviewed by CVS/caremark. Claims for medical (non-pharmacy) benefits will be reviewed by Collective Health and/or Blue Shield of California depending on the type of claim. If more time is needed to decide your claim, the plan may make a one-time extension of not more than 15 days.

If your claim is ultimately denied, you'll receive an explanation of why it was denied and how you can appeal. This explanation will include the specific reason(s) for the denial; reference to the specific plan provision(s) on which the denial is based; a description of additional material or information necessary to perfect the claim; a description of the plan's review procedures and applicable time limits; and a statement that a copy of any rule, guideline, protocol, or other similar standard relied on in the denial will be provided free of charge upon request. If the denial is based on medical necessity or experimental treatment, an explanation of the determination or a statement that an explanation will be provided free of charge upon request.

Urgent Care Claims

An urgent care claim is a special type of prior authorization that occurs when a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain. Because your provider is the one who initiates prior authorization with Blue Shield of California, it will usually be your provider who will request expedited processing. If a physician with knowledge of your medical condition determines that the claim is an urgent care claim as described above, then the plan will treat the claim as an urgent are claim. Urgent care claims will be decided within 72 hours after submission. Urgent care claims filed improperly or missing information may be denied.

If your urgent care claim is denied, you'll receive an explanation of why it was denied and how you can appeal (including how to request expedited review).

Concurrent Care Claims

In some cases, you may have an ongoing course of treatment approved for a specific period of time or a specific number of treatments, and you will want to extend that course of treatment. This is called a concurrent care claim.

If your extension request is not "urgent" (as defined in the previous section), your request will be considered a new request and will be decided according to the applicable procedures and timeframes. If your request for an extension is urgent and you submit the claim at least 24 hours before the end of the course of treatment, the claims administrator will notify you of the determination within 24 hours.

Section 9: How to Appeal

Whenever the plan makes a decision about your benefits that adversely impacts you (an adverse benefit determination), you have the right to appeal. You cannot appeal changes to the plan's terms, termination of the plan, or other decisions that affect plan members beyond you and your family; adverse benefit determinations must be specific to you and/or your dependents.

Adverse benefit determinations include:

- A decision that you are not eligible to participate in the plan
- Determinations that certain benefits are not covered benefits
- Rescission of coverage
- Determinations that certain treatments are not medically necessary
- Termination of your membership in this plan

Some things that are not adverse benefit determinations are:

- If Ensign decides to stop offering this plan to employees

- If the contribution each month is increased
- If the plan is amended to exclude certain treatments

Blue Shield of California and Collective Health share responsibility of rendering appeal determinations. This section describes your appeal rights and the steps you must take to exercise those rights with each party.

If you are confused or dissatisfied about a determination of your benefits (for example, if a particular claim has been paid at a lower rate or denied), we encourage you to contact Collective Health before filing an appeal. You are not required to call Collective Health first, but reaching out to the Member Advocate team may help clear up any preliminary questions you have about why a particular decision was made. The Member Advocate team can also help guide you as you compile the information you need to submit an appeal.

The section below explains where to submit different types of appeals. If you are still unsure of where to submit your appeal, please reach out to Collective Health for assistance. If your appeal is submitted to the incorrect party, we will coordinate to get it to the right place. Please note, the appeal determination timeline begins when the appropriate party receives the appeal.

How to Appeal Prior Authorization and Medical Necessity Determinations

Because your provider is the one who initiates prior authorizations (including urgent claims) with Blue Shield of California, it will usually be your provider who appeals if prior authorization is denied. You can choose to appeal the denial if you wish—for example, if your provider doesn't want to pursue an appeal.

You must appeal a denial of prior authorization to Blue Shield of California, not Collective Health, but if you need or want help navigating this process, you can contact Collective Health for assistance.

To appeal a prior authorization denial, first call Blue Shield of California's customer service department at (800) 219-0030, Option 1 (hearing and speech impaired members: (888) 852-5345 or TTY/TDD (800) 241-1823). Blue Shield of California will direct you to send them a letter that explains the basis for your appeal and includes any relevant documents you can provide. You must begin your appeal process within 180 days of receiving the denial. Blue Shield will consider your appeal and make a decision within the applicable legal timeframes.

You have the right to an expedited decision if delay could seriously jeopardize your life or health or cause you severe pain. Urgent care appeals may be submitted by telephone or fax. Blue Shield of California will direct you through their expedited processes. If you specifically request an expedited appeal, Blue Shield will make a decision within 72 hours.

How to Appeal Non-Urgent Adverse Benefit Decisions

This section describes Collective Health's appeals process for any adverse benefit determination other than a prior authorization or medical necessity denial by Blue Shield of California (for example, if your benefits have been rescinded, or if coverage for a particular treatment has been denied because it is outside the scope of this plan).

Use this procedure for benefit determinations, including pharmacy determinations. You must appeal an adverse benefit decision within 180 days of receiving the decision.

To appeal, you must submit the following information to Collective Health in writing:

- Enough information to identify the adverse benefit determination that is the subject of your appeal—either attach a copy of the relevant Medical Benefit Statement, or provide:
  - Member ID
  - Patient name
  - Claim number
  - Provider name
  - Date of the medical service
- Your explanation of what happened and why you believe the original decision was incorrect
- Any documents or other information that support your appeal—for example:
  - A letter or prescription from your doctor
  - A receipt for money you paid
  - Relevant excerpts of your medical records

Appeals must be submitted in writing. A regular letter from you to Collective Health is sufficient.

You can send the appeal submission and attachments by mail or email.

Collective Health
85 Bluxome Street
San Francisco, CA 94107
help@collectivehealth.com
Phone: 833-743-3221

Collective Health will review your appeal and issue a decision within 60 days. If a medical opinion is required, it will be provided by a medical professional appropriate for the issue being appealed. You can request copies of the information relating to your appeal, including billing and diagnosis codes, and the name and title of any experts who assisted with the determination. If Collective Health upholds the original adverse benefit determination, you will receive a notice of final adverse benefit determination that explains the reason for that decision and describes your rights (How to Appeal Prior Authorizations and Urgent Claim Denials has more information on what is included in this determination). In all cases, your appeal will be reviewed by individuals who were not involved in the original decision, and who will thoroughly review your claim and come to a complete and final answer. Because of this exhaustive review, Collective Health only does one level of appeal. If your internal appeal is denied, you may have the right to an external appeal as described below.

External Review Program

If you have exhausted your internal appeals and are not satisfied with Collective Health's or Blue Shield of California's determination of your claim, you may have the right to request review by an independent review organization (IRO). All external reviews are facilitated by Collective Health, regardless of which party rendered

the initial appeal determination. The plan has entered into agreements with three or more IROs that have agreed to perform external reviews. The external review process is available at no charge to you.

External review is available only when Collective Health's or Blue Shield of California's adverse benefit determination is based on one of the following:

- Medical necessity or clinical reasons;
- The plan exclusions for experimental, investigational, or unproven services;
- Rescission of coverage (coverage that was cancelled retroactively); or
- As otherwise required by applicable law.

In most situations, your external review will be in the "standard" category below. In urgent situations, you can request an "expedited" external review, which has shorter timelines.

Every external review request should include all of the following information:

- A specific request for an external review
- The subscriber's name, patient's name, and member ID and group number
- If you have an authorized representative, that person's name and contact information
- The service that was denied
- Any new, relevant information that was not provided during the internal appeal

Appeal determinations provide information about the external review program, including the mailing address, email address, and phone number where review requests may be submitted. A request for external review must be made within four months after you receive the initial determination.

Standard External Review

When you submit a request for standard external review, here's what will happen:

First, Collective Health will do a preliminary review of your request within five business days. This preliminary review will confirm that:

- The patient was covered by the plan at the time they received the healthcare service
- The patient has finished the internal appeal process (this is called "exhaustion")
- The claim or appeal decision is eligible for external review
- All of the required information has been provided

After that, Collective Health will provide a notification to you in writing about its preliminary review. If all four criteria are met, your case will be assigned to an IRO for review. Collective Health will choose among its IROs by using a random selection process, so your review is not biased. The IRO will then confirm with you that your request has been accepted for external review.

Then, the IRO will review your case. You may send the IRO any additional information you think will be helpful, within 10 business days of receiving the IRO's acceptance notice. If you submit information later than that, the

IRO may (but is not required to) consider that additional information. Either way, Collective Health will give the IRO all of the documents and information that were used in making the determination, such as:

- Relevant medical records
- Any other documents relied upon by Collective Health
- All other information or evidence that you or your physician submitted for consideration

Finally, the IRO will make a decision. The IRO will take a look at your case with fresh eyes: it will not be bound by any decisions or conclusions reached by Collective Health in the past. The IRO will provide its final external review decision to you in writing within 45 days after it receives the request for the external review—unless they request additional time, and you agree. The IRO will deliver the notice of final external review decision to you and to Collective Health, and it will include the clinical basis for the determination.

If the IRO reverses Collective Health's determination, the plan will immediately provide coverage or payment for your claim, in accordance with the terms of the plan. The external appeal is the final level of appeal available under the Plan.

Expedited External Review

An expedited external review is just like a standard external review, except shorter. If your case qualifies for expedited external review, you can submit for review before you've completed the internal appeals process.

When does a case qualify for expedited external review? When Collective Health's determination involves a medical condition where the standard review timeline would seriously jeopardize the patient's life, health, or ability to regain maximum function. In addition, if the case concerns emergency services and the patient hasn't yet been discharged from the medical facility, expedited external review is also available.

Requests for expedited external review do not need to be submitted in writing; you may request review by phone, by calling Collective Health.

Collective Health will use the quickest means to submit your case to the IRO, such as by phone or digital transmission. The IRO's decision-making process will be the same, except that the IRO will notify you within 72 hours of receiving your request. The IRO may notify you of its decision by phone; if so, you'll also receive written confirmation within 48 hours after that.

Limitation on Your Right to Sue

You generally cannot bring any legal action against the plan, the plan administrator, or Collective Health unless you first complete all the steps in the appeal process described in this SPD. The appeal process is complete only when you have received a final decision from the plan administrator.

After completing the appeal process, if you want to bring a legal action, you must do so within two years of the date you are notified of the final decision on your appeal. If you do not sue within two years, you lose any rights to bring such an action against the plan, the plan administrator, or Collective Health.

Section 10: Your Rights to Continue Coverage

This plan is sponsored by your employer; it's intended to cover you (and your dependents, if any) only while you are employed by the Company and you meet the plan's eligibility requirements. But in some circumstances, you may have the right to continue your membership in this plan beyond the time when your coverage would otherwise end. This section describes when and how you can keep yourself and your dependents covered:

- Continuing your benefits coverage under COBRA.
- Continuing your benefits coverage during uniformed service.
- Continuing your benefits coverage during a leave of absence from work.

Continuing Your Benefits Coverage Under COBRA

COBRA is a federal law that gives you and your family the opportunity to extend your Ensign healthcare benefits in certain circumstances where your coverage would otherwise end. This section describes your COBRA rights and responsibilities. You may also receive a separate notice from Ensign's COBRA administrator, which describes COBRA in more detail.

What is COBRA? When something happens that would cause your coverage under this plan to end (for example, if you lose your job with Ensign), COBRA may give you the right to a temporary extension of your coverage. COBRA allows you to continue coverage only in certain circumstances (called qualifying events), and only if you and your dependents meet certain criteria (if you are qualified beneficiaries). To get COBRA coverage, you will have to follow very specific rules for notifying the plan, you may have to pay more than your normal employee contribution, and you will have to pay on time every month until your COBRA coverage ends. While you have COBRA coverage, your right participate in open enrollment also continues.

Who is in charge of COBRA administration? Ensign uses a company named Discovery Benefits (Discovery) to administer its COBRA program. If you experience a qualifying event, Discovery will send you a COBRA packet with information and election instructions. If you elect to receive COBRA benefits, you will send your payments to Discovery, and they may reach out to you directly as part of their administration responsibilities. You should contact Discovery with any COBRA-specific questions, or reach out to Collective Health for general assistance.

Discovery Benefits
866-451-3399
https://www.discoverybenefits.com

What are the qualifying events that trigger COBRA rights? A qualifying event is one of the following events, which would cause you or your dependents to lose your Ensign healthcare benefits:

- If you quit your job at Ensign, or if you are fired (except if you are fired for gross misconduct).
- If your work hours are reduced enough that you are no longer eligible for benefits under this plan.

- If your marriage ends by divorce or legal separation.
- If your dependent child stops being eligible for benefits under this plan (because they turn 26 or are no longer disabled).
- If you become entitled to Medicare and this results in you losing coverage under this plan.
- In the case of your dependents' rights to continue coverage, if you die.

If you and/or your dependents experience a qualifying event, you each may have a right to continue coverage under this plan.

Who are the qualified beneficiaries who have COBRA rights? You (an employee of Ensign), your spouse, and your children (including qualified medical child support order children) are qualified beneficiaries if you were each enrolled in this plan the day before the qualifying event happened, and if the qualifying event caused you to lose coverage under this plan.

For example: if you lose your job at Ensign, your coverage and your enrolled dependents' coverage will terminate. All of you will be qualified COBRA beneficiaries.

Another example: if you divorce your dependent spouse but retain custody of your children, your spouse's coverage will terminate, but yours (and your enrolled children's) will not. Your spouse will be the only qualified COBRA beneficiary.

If you are covered by COBRA, and you have a child (naturally or through adoption) during your COBRA coverage, your new child is also a qualified beneficiary with COBRA rights.

You can elect to receive COBRA coverage even if you are already eligible for Medicare or you are already covered under another group health plan. However, keep in mind:

- If you are eligible for or enrolled in Medicare, this plan may reduce its benefits as if you were covered by Medicare.
- If you are covered under another plan, your COBRA coverage may be secondary.

How much will it cost me to have COBRA coverage? Ensign will not subsidize your healthcare benefits under this plan. Your COBRA packet will tell you exactly what your COBRA premium will be.

What do I have to do to get COBRA coverage? Your notice responsibilities and the amount of time you have to elect COBRA coverage will vary depending on what qualifying event you experience.

If you get divorced or separated, or if your dependent child loses eligibility:

- You must notify Ensign's Benefit Center in writing.
- You must provide the notice form to Ensign within 60 days of the qualifying event or the date you were notified of your right to continue coverage. THERE ARE NO EXCEPTIONS: if you miss the 60-day notice window, all qualified beneficiaries will lose their right to elect COBRA.
- If your qualifying event was the end of your marriage, you may be required to provide a copy of your legal divorce decree or separation document to Ensign.

- You must pay your COBRA premium within 45 days of the day you elect COBRA. THERE ARE NO EXCEPTIONS: if you miss the 45-day payment window for your first payment, all qualified beneficiaries will lose their COBRA benefits.

If you lose your job, your hours are reduced, or you become Medicare-eligible:

- You do not need to notify anyone of your qualifying event or request materials. You should automatically receive a COBRA packet, including election paperwork, in the mail from Discovery shortly after your qualifying event. Your packet will have all of the forms and instructions you need to make your election.
- You must return your election form within 60 days of the date you receive your COBRA packet or the date your coverage would terminate, whichever is later.
- You must pay your COBRA premium within 45 days of the day you elect COBRA. THERE ARE NO EXCEPTIONS: if you miss the 45-day payment window for your first payment, all qualified beneficiaries will lose their COBRA benefits.

Notice or election by any other method is not acceptable. You must follow the procedures exactly to ensure you and your dependents receive your COBRA coverage. Contact Discovery with any specific questions, or reach out to Collective Health for general guidance.

How long does COBRA coverage last? The amount of time you can keep COBRA benefits will vary based on what qualifying event you experience.

- If you lose your job or have a reduction in work hours, you have up to 18 months of COBRA coverage.
  - If your family has a second qualifying event during these 18 months—if your dependent child loses eligibility, your marriage ends, you enroll in Medicare, or you die—your dependents' coverage will be extended to 36 months from the date of the original qualifying event. The same notice requirements apply.
  - If you or your dependents are determined to have been disabled (for Social Security disability purposes) at the time of, or within 60 days after, the COBRA qualifying event, you may extend your COBRA coverage for all qualified beneficiaries for up to 29 months total, from the date of the original qualifying event. You must notify Discovery of the disability determination within 60 days of the disability determination or the qualifying event, whichever is later (and before the expiration of the original 18-month period).
- If you became eligible for Medicare while an active employee of Ensign and then, within 18 months, lose your job or have a reduction in work hours, your spouse or dependents will have up to 36 months of COBRA coverage from the date you became eligible for Medicare.
- If you have a divorce or legal separation, your dependent loses dependent status, you enroll in Medicare or you die, you (and your family members that are qualified beneficiaries) have up to 36 months of COBRA coverage.

In some cases, your COBRA coverage will end before your 18, 29, or 36 months are up. Your coverage will terminate immediately:

- If Ensign stops providing healthcare benefits to its employees.
- If you don't pay your COBRA premium on time. (After the first payment, which must be on time, you will have a 30-day grace period for remaining payments.)
- On the day you begin coverage under another group health plan after electing COBRA coverage.
- When you first enroll in Medicare after electing COBRA coverage.
- For cause under the plan (such as if you commit fraud), to the extent permitted by law.
- If Social Security makes a final determination that you or your dependent is not disabled, and this disability was the basis for your COBRA coverage.

I still don't understand COBRA. Help? You're not alone—COBRA can be very confusing, and the procedures you must follow to make sure you retain your COBRA rights are very specific. Don't hesitate to ask questions: contact Discovery, reach out to Collective Health, or ask Ensign's Benefit Center if you need assistance.

Continuing Your Benefits Coverage During Uniformed Service

USERRA (the Uniformed Services Employment and Reemployment Rights Act) protects the job rights of individuals who—voluntarily or involuntarily—leave their jobs to serve in this country's uniformed services. This protection extends to the healthcare benefits that you received as part of your employment.

If you leave your job to perform qualifying service, you have the right to continue your existing employer-sponsored health plan coverage for you and your dependents (if any) for up to 24 months while you serve. (USERRA continuation coverage will run concurrently with any COBRA continuation coverage.) You must notify Ensign or Collective Health that you want USERRA coverage within 60 days of your first day of qualifying service (in other words, within 60 days from the first day you are absent from work because you are performing service). Your coverage will be retroactive to your first day of qualifying service. Unlike COBRA, USERRA doesn't provide independent continuation rights to your dependents: they will only be eligible for continued coverage if you elect USERRA coverage for yourself. Any USERRA coverage you have runs concurrently with any rights to COBRA coverage.

During Military Leave, employees may continue all Core Health Benefits for 30 days and receive the company contribution for these benefits, if any. If Military Leave extends beyond 30 days the employee is offered USERRA Coverage for a period of up to 24 months. Your coverage will be retroactive to your first day of qualifying service. Unlike COBRA, USERRA doesn't provide independent continuation rights to your dependents: they will only be eligible for continued coverage if you elect USERRA coverage for yourself. The cost of USERRA Coverage for Medical, Dental and Vision equals the entire premium (both the employee and employer portions) plus 2% and is paid entirely by the employee directly to the company's USERRA Coverage Administrator.

Your USERRA coverage may be terminated if:

- Ensign stops providing group health coverage to its employees.
- You fail to return from service or re-apply for employment with the Company.
- There is good cause to terminate your coverage under the terms of this plan (for example, if you submit fraudulent claims).

Even if you don't elect to continue coverage during your service, you have the right to be reinstated in your employer-sponsored health plan when you are re-employed. However, the plan will not cover service-connected illnesses or injuries (which should be covered by your military insurance).

Continuing Your Benefits Coverage During a Leave of Absence from Work

During Protected Leaves of Absence, employees may continue all Core Health Benefits and receive the company contribution, if any, for these benefits. Employees are not allowed to make any changes to Core Health Benefit elections solely on account of the leave of absence, but they may elect to suspend/waive benefits during the leave of absence period (waivers are discussed further below). If an employee does not return to work once Protected Leave is exhausted, the employee is eligible for COBRA Coverage with respect to Core Health Benefits in which the employee was enrolled when the Protected Leave of Absence began. In some situations, when leave is briefly extended beyond the Protected Leave of Absence period as a reasonable accommodation, a continuation of Core Health Benefits coverage is permitted.

During Unprotected Leaves of Absence, employees may continue all Core Health Benefits for 30 days and receive the company contribution, if any, for these benefits. Employees are not allowed to make any changes to Core Health Benefit elections pursuant to IRS Cafeteria Plan Rules, but they may elect to suspend/waive benefits during the leave of absence period (waivers are discussed further below). If an employee does not return to work once the 30-day leave duration has exhausted the employee loses eligibility for Core Health Benefits and, as applicable, is offered COBRA Coverage. In some situations, when an Unprotected Leave of Absence is briefly extended beyond 30 days as a reasonable accommodation, continuation of Core Health Benefits coverage is permitted. When an Unprotected Leave of Absence is briefly extended beyond 30 days due to a reasonable accommodation, and the employee is covered under the ACA current plan stability period, the employee may be eligible to continue Medical and HSA coverage only (including the company contribution).

Family and Medical Leave: This plan will comply with the Family and Medical Leave Act of 1993 (FMLA) and the Department of Labor regulations that implement FMLA, along with applicable state and local leave laws. While on FMLA leave, your coverage will continue on the same terms (and at the same cost to you monthly) as you had before your leave began, for the full period of your FMLA leave. If you choose to end your coverage for the period of your FMLA leave or other legally mandated leave, your coverage will be reinstated when you return to work.

Other employer-approved leave of absence: If you take a leave of absence that is approved by Ensign and that is a paid leave (meaning you continue receiving your wages while you are on leave), your coverage will continue on the same terms (and at the same cost to you monthly) as you had before your leave began. This is true if, for example, you take a statutory, parental, medical, or other contractually protected leave of absence.

While you are on leave, you will have the same rights to participate in open enrollment as all other participating employees who are not on leave. This means that if open enrollment falls during your leave, you will still be able to make elections for coverage for the next plan year, as long as you and your dependents still meet the eligibility requirements.

All of these determinations will be made in accordance with Ensign's leave of absence policies. Contact Ensign's Benefit Center for information about how you can continue coverage while you are on leave.

Section 11: Coordination of Benefits

This section describes how benefits under this plan will be coordinated with any other healthcare plan that provides benefits to you or your dependents. For example, if you are a member of this plan and also enrolled as a dependent on your spouse's employer-sponsored health plan, this plan will coordinate its benefits with your other plan's benefits. One plan will pay out full benefits first (called primary), and then the other plan will begin paying benefits (called secondary), until all of the benefits are exhausted or until the allowed amount for your care is paid. Your total benefits from all of your healthcare plans will never exceed the actual cost of your care.

The rules governing who pays primary and who pays secondary are different depending on the other healthcare benefits plan you have. This section lays out those rules. If you are confused or have any questions, you can contact Collective Health for guidance.

When the Plan Will Coordinate Benefits

This plan will coordinate benefits with any insurance, program, or other arrangement that entitles you or your dependents to payment or reimbursement of medical expenses. For example: if you are also covered under your spouse's employer-sponsored healthcare plan; if you have disability insurance that reimburses medical expenses; or if you are covered by Medicare or Tricare. The only time we will not is when coordination of benefits is legally prohibited.

How is Collective Health informed of your additional insurance?

Sometimes we receive an indication of an additional insurance plan on a claim your provider submits. When this occurs, we'll send you a form to confirm whether you or your dependent has another insurance plan. If you respond and it is determined that this plan is the member's primary plan, we'll process the claim and apply benefits to covered services. If this plan is determined to be the member's secondary plan and the primary plan has not processed the claim, we will deny the claim so that the primary plan can process it first. Then, the provider can re-submit the claim to us so we can apply secondary benefits to it. Please note that if you do not respond, the claim will be denied until you have confirmed whether you or your dependent has additional insurance.

You don't have to wait to receive a claim in order reach out to Collective Health to let us know whether you or your dependents have an additional insurance plan. Please contact a Member Advocate to inform them of your or your dependents' additional coverage (or lack thereof).

This Plan's Coordination Rules

1. Does the other plan have a coordination of benefits (COB) provision—a section like this one? If it does not, then the other plan will always pay primary.
2. No-fault auto coverage, personal injury protection coverage, and home, auto, and commercial medical payment coverage are always primary to this plan.
3. The plan that covers a person as a retiree or laid-off employee (not an active employee), including COBRA, will pay secondary to a plan covering that person as an active employee.
    a. Not all plans have this "retiree" rule in their COB provisions. If the other plan does not have the retiree rule, and that results in a conflict over who pays secondary, the retiree rule does not apply.
4. If a person is covered under a disability extension from a previous plan, that plan will pay primary and this plan will pay secondary.
5. The plan that covers a person as an active employee will always pay primary over the plan that covers that person as a dependent. (For example: if your spouse is covered by her work and is also a dependent on your Ensign plan, your spouse's work plan pays primary for her, and this plan pays secondary for her.)
6. For a dependent child covered by more than one parent (including step-parents):
    a. If there is a court order establishing that one parent has financial responsibility for the healthcare expenses of the child (or a qualified medical child support order), that parent's plan will <u>always</u> pay primary.
    b. If the child's parents are married (not separated or divorced):
        i. The plan of the parent whose birthday is earlier in the calendar year will pay primary, and the plan of the other parent will pay secondary. (For example: if you [DOB Jan. 12, 1960] and your spouse [DOB Nov. 15, 1955] both cover your child as a dependent, your plan will pay primary and your spouse's plan will pay secondary.)
        ii. Not all plans have this "birthday" rule in their COB provisions. If the other plan that covers a dependent child does not have the birthday rule, and that results in a conflict over who should pay primary, the other plan (the one without the birthday rule) will control.
    c. If the child's parents are separated or divorced:
        i. The plan of the parent with custody of the child will pay primary.
        ii. If the parent with custody has remarried, the plan of that parent's spouse (the child's step-parent) will pay secondary.
        iii. The plan of the parent without custody of the child will be the last to pay.
7. Medicare, Tricare, and state children's health insurance plans will pay primary, secondary, or last as required by federal and state laws.
    a. To the extent permitted by law, if you are eligible for Medicare but have not enrolled in Medicare, and Medicare would have paid primary if you were enrolled, this plan may reduce its benefits as if you were covered by Medicare.
    b. This plan will pay primary (and Medicare will pay secondary) for Medicare-eligible individuals who:
        i. Are active current employees age 65 and older, and spouses age 65 and older of active current employees;
        ii. Have end-stage renal disease, for a limited period of time; or

iii. Are active current employees and disabled.

8. If none of the rules above apply, then the plan that has covered the person for a longer period of time will pay primary. (For example: if this plan has covered you for four months and your other plan has covered you for four years, the other plan will pay primary and this plan will pay secondary.)
9. The plan will never reduce benefits because you or your dependents are eligible for or covered by Medicaid.

What Coordination Means for Your Benefits

If this plan is paying primary, then the plan will pay benefits as usual, without any reduction. In other words, the fact that you have additional secondary coverage will not reduce your benefits under this plan. Your providers may invoice your secondary plan to cover your copay or excess charges.

If this plan is secondary to another plan, the plan will calculate its standard benefit payment for the services in absence of another insurer. The standard benefit payment will be calculated using this plan's allowed amount in all cases, with the exception of the primary insurer being Medicare; in that case, this plan will always use Medicare's allowed amount. The plan will only pay as secondary if the amount your primary plan paid is less than what the plan would have paid according to the standard benefit payment for the services. If the amount that your primary plan paid is greater than or equal to what the plan would have paid according to the standard benefit payment for the services, the plan will not pay out any secondary benefits. The plan's secondary payment will not exceed its normal benefit payment in the absence of a primary insurer. This payment methodology is called "non-duplication of benefits."

If your primary plan does not cover certain services that are covered by this plan, then this plan will pay for those services as primary. If this plan is supposed to pay primary, but your secondary coverage pays instead, Collective Health may provide repayment to your other coverage. This repayment will be considered benefits to you under this plan.

Section 12: The Plan's Right to Repayment

In some circumstances, this plan will be entitled to a refund for some or all of the benefits it pays for your medical care—for example, because a third party is responsible for your injuries, or your provider over-billed the plan, or the plan made a payment in error. This section describes the plan's rights to seek recovery from the person responsible for your injuries and refunds of overpayments.

Read this section carefully, because it describes your obligations to the plan and the potential consequences of not meeting those obligations.

Recovery from the Person Responsible for Your Injuries

Your illness or injury may be someone else's fault. For example, if you are in a car accident and you dislocate your shoulder, the other driver may be held responsible for the accident and for your resulting injuries. The plan may pay for the treatment of your dislocated shoulder in the first instance after your accident. But if you receive money from the person responsible for your injuries, the plan is entitled to be paid back from those proceeds. Even if you choose not to pursue your claim, the plan is entitled to seek recovery from the person who is financially responsible for your injuries (in the car accident example, this could be the other driver or his insurance company or even your own insurance company).

This section describes the rules that apply when another person or entity (a "third party") may be responsible for your injury or illness. Third party includes, but is not limited to, no-fault auto coverage, personal injury protection coverage, medical payment coverage, uninsured and underinsured motorist coverage, and third-party assets and insurance coverage. The rights and obligations described in this section apply to you and also independently to your dependents.

By accepting healthcare benefits under this plan, you agree to automatically assign to the plan any rights you may have to recover from third parties for your injuries.

- The plan has the right to repayment for the full cost of your care (both medical and pharmacy), from the first dollar you recover, up to 100% of what the third party pays you. But the plan will not seek recovery for amounts over what the plan paid for your care.
- The plan is entitled to any funds you recover from the third party, even if they are labeled as something other than medical costs, such as "non-economic damages" or "punitive damages."
- The plan has the right to recover funds even if you are not made whole. The "make whole" doctrine does not apply.
- The plan is not required to reimburse you for any attorneys' fees or costs that you incur during the process of seeking damages from a third party. The "common fund," "fund," or "attorneys' fund" doctrines do not apply.
- Whether or not you decide to pursue a claim against the third party responsible for your illness or injury, the plan can make its own claim against the third party.
- You must cooperate with the plan's efforts to seek recovery from a responsible third party. Specifically, you must:
  - Respond to any requests for information about any accidents or injuries. These requests may come from someone other than Collective Health.
  - Provide any relevant information requested.
  - Sign, and deliver, any required documents.
  - Notify the plan of any legal claims you may have against third parties for your injuries or illness.
  - Participate as needed in the plan's efforts to recover funds, including participating in medical examinations and appearing at legal proceedings (such as depositions or court hearings).
  - If requested, assign to the plan all rights of recovery you have against third parties, to the extent the plan paid benefits to you.

- You may not settle or release your claims against the third party without first obtaining the consent of the plan administrator.
- If you receive any payment from a third party, and the plan claims that those funds are owed to the plan, you must hold those funds in trust—either in a separate bank account in your name, or in your attorney's trust account. You must serve as trustee over those funds, to the extent the plan paid benefits to you.
- You must promptly reimburse the plan if you receive any recovery related to your injuries or illness.
- The plan's rights under this section apply even if you die as a result of your injuries, if a third party is responsible to your survivors.

If a child receives benefits from the plan for an illness or injury caused by a third party, then these rules apply to the parents, guardians, or other representatives of that child.

If you fail to meet your obligations under this section, the plan may refuse to pay benefits for your injuries, or may reduce your future benefits until the plan has been fully repaid.

Refund of Overpayments

When you need medical treatment, this plan may pay benefits first and ask questions later so that your care is not unnecessarily delayed. Sometimes, this approach may result in the plan paying more for your care than it should. This is called overpayment.

You or your provider may need to submit specific information with a claim, such as medical information and coordination of benefits information. The plan cannot always wait until all of the information has been submitted, or verify the accuracy of all the information, before the claim is treated as filed. For example, the plan may pay a physician's invoice for your treatment, and later discover that the invoice was billed for services you didn't receive. Or, the plan may pay the provider and reimburse you for the same treatment. In any case where the plan pays more than it should (even if the mistake was ours), the plan may seek a refund.

In the case of overpayment, the plan has the right to seek a refund from you, your physician, a medical facility, another health benefit plan, or other person or entity as appropriate. You agree, as a member of this plan, to refund the plan or have your future claims offset if you receive the overpayment, and to assist the plan in recovering overpayments from others.

If you fail to meet your obligations under this section, the plan may refuse to pay benefits for your injuries or may reduce your future benefits until the plan has been fully repaid.

Section 13: Changes to This Plan's Terms

Ensign (as the plan's sponsor) reserves the right to change, interpret, modify, withdraw or add benefits to, or terminate this plan—at any time, in its sole discretion, and without your approval. Any amendments, changes,

or termination are effective on the date specified by Ensign. If the terms of this plan or its costs change substantially, you may be given a right to change your enrollment selection mid-year.

If this plan is terminated, your rights and benefits are limited to the healthcare services you incurred before termination. Ensign may set a deadline for submission of claims after termination of the plan.

Any amendment to or termination of the plan will be made in writing, and you will receive notice of termination or any material modification to the plan. No one has the authority to make any oral modification to this plan's terms.

Section 14: Plan Administration

Plan Administrator's Responsibilities

Ensign Services, Inc. (referred to as "Ensign") is the sponsor of this plan. Ensign is also the plan administrator for this plan. At its discretion, Ensign may appoint an individual or committee to serve as plan administrator.

The plan administrator has the sole and exclusive discretion to:

- Interpret this SPD;
- Develop policies, practices, and procedures for this plan; and
- Administer this plan in accordance with those policies, practices, and procedures.

The plan administrator will exercise its discretion and fulfill its responsibilities in accordance with the provisions of ERISA. The plan administrator may delegate some of its responsibilities to Collective Health or to other individuals or entities as appropriate. Collective Health is the claims administrator. This plan is self-insured, therefore Collective Health is not an insurer and is not responsible for the payments of benefits or claims.

The plan administrator serves without compensation. However, all expenses for administration of the plan (including compensation for hired services) will be paid by the plan, unless paid by Ensign.

Plan Information Summary

Plan name	Ensign Services, Inc. Comprehensive Health and Welfare Benefit Plan Administrator Component Plan Name: Ensign Copay 5000 plan
Plan sponsor's Employer Identification Number (EIN)	113645368
Plan number	506
Plan year	January 1 through December 31
Type of plan	Group health plan
Type of administration	Self-insured, with Collective Health serving as the third-party administrator
Plan administrator	Ensign Services, Inc. 27101 Puerta Real Suite 450 Mission Viejo, CA 92691
Plan sponsor	Ensign Services, Inc. 27101 Puerta Real Suite 450 Mission Viejo, CA 92691
Agent for legal service	Ensign Services, Inc. 27101 Puerta Real Suite 450 Mission Viejo, CA 92691 Service of legal process may be made to the head of the legal department or on the plan administrator.
Named fiduciary	Ensign Services, Inc. 27101 Puerta Real Suite 450 Mission Viejo, CA 92691

Medical claims administrator	CollectiveHealth Administrators, LLC 85 Bluxome Street San Francisco, CA 94107 833-743-3221
Funding medium and contributions	This plan is self-insured: benefits are paid from the general assets of the plan sponsor (Ensign Services, Inc.) and not guaranteed under an insurance policy or contract. The cost of this plan is paid with contributions by the plan sponsor (Ensign Services, Inc.) and contributions by participating employees. Employee contributions will be used first to cover benefits under the plan.

Section 15: Legal Provisions and Your Legal Rights

Your ERISA Rights

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

- Receive information about your plan and benefits

You may examine, without charge, at the plan administrator's office and at other specified locations, all documents governing the plan.

You may obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan and updated SPD. The plan administrator may make a reasonable charge for the copies.

- Continue group health plan coverage

You may continue healthcare coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Prudent actions by plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

- Enforce your rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that 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 you may 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 you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- Assistance with your questions

If you have any questions about this plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Your HIPAA Privacy Rights

Federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) require group health plans to safeguard the privacy of your protected health information (PHI). However, as explained below, the plan may use and disclose PHI, including your PHI, in some cases.

PHI is data about a past, present or future physical or medical condition, treatment received, or payment for healthcare that also identifies the person it relates to. Your PHI will not be used or disclosed by the plan without a written authorization from you, except as described in the HIPAA notice of privacy practices you received from the plan. The plan is allowed to use or disclose PHI for a variety of reasons, including (but not limited to): for treatment, payment and healthcare operations, pursuant to your authorization, for public health

purposes, to Ensign as the plan sponsor for its plan administrative purposes, as required by law, and as described in the HIPAA notice of privacy practices. If the plan discovers an unauthorized access, use, disclosure, modification, or destruction of your PHI (also called a "breach"), the plan will notify you.

You and your covered dependents will have the rights set forth in the plan's HIPAA notice of privacy practices and any other rights and protections required under HIPAA. The notice may periodically be revised.

To receive more information about the plan's privacy practices or your rights, or to request a copy of the healthcare components of the plan's notice of privacy practices, you may contact the plan's Privacy Officer, whose contact information is provided below. You may receive the notice of privacy practices by email if you wish.

The plan has established a complaint procedure concerning the handling of PHI. The notice of privacy practices that has been distributed to you explains the complaint procedure. This notice is also available on request. All complaints or issues raised by plan members with respect to the use of their PHI must be submitted in writing to the Privacy Officer.

Debbie Miller
27101 Puerta Real Suite 450
Mission Viejo, CA 92691

A response will be provided within a reasonable period of time, including time to investigate and resolve any issues, after the receipt of the written complaint. The Privacy Officer has full discretion in resolving the complaint and making any required interpretations and factual determinations. The decision of the Privacy Officer will be final and be given full deference by all parties.

Nondiscrimination Policy

This plan will not discriminate against any individual based on race, color, religion, national origin, disability, gender, sexual orientation, or age. This plan will not establish rules for eligibility based on health status, medical condition, claims experience, receipt of healthcare, medical history, evidence of insurability, genetic information, or disability.

This plan intends to be nondiscriminatory and to meet the requirements under applicable provisions of the Internal Revenue Code of 1986. If the plan administrator determines before or during any plan year that this plan may fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated individuals, the plan administrator shall take such action as the plan administrator deems appropriate, under rules uniformly applicable to similarly situated covered employees, to assure compliance with such requirements or limitation.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Qualified Medical Child Support Order Procedures

The plan will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA Section 609(a) or National Medical Support Notice. For a copy of the plan's QMCSO procedures, please contact Ensign's Benefit Center. The healthcare components of the plan will also provide benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children, in accordance with ERISA Section 609(c).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For more information, please contact Collective Health.

Mental Health Parity and Addiction Equity

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, as amended, this plan applies its terms uniformly and enforces parity between covered medical/surgical and covered mental health or substance use disorder benefits. Claims that are billed with a primary or principal diagnosis code categorized by the International Statistical Classification of Diseases and Related Health Problems (ICD-10) as a mental health condition, behavioral health condition, or substance use disorder are adjudicated as mental health claims. For further details, please contact Collective Health.

Genetic Information Nondiscrimination Act

This plan will be operated and maintained in a manner consistent with the Genetic Information Nondiscrimination Act, which provides federal protection from genetic discrimination in health insurance and employment.

Affordable Care Act

This section describes some of the applicable provisions of the federal healthcare reform laws (known as the Affordable Care Act). These provisions have been incorporated into the plan.

- You can cover your adult children to age 26.
- You do not need prior authorization to see an in-network OB/GYN provider.
- If your medical coverage requires you to designate a primary care physician, you have the right to designate any in-network primary care physician accepting new patients and may designate an in-network pediatrician for your children.
- You may seek emergency medical services at an in-network or out-of-network provider without having to obtain prior authorization and with the same cost-sharing; however, the out-of-network provider may balance bill you for the difference between its charge and the allowed amount paid by the plan.
- Your medical coverage cannot be retroactively cancelled, unless you fail to timely pay premiums or commit intentional misrepresentation or fraud or as otherwise permitted by applicable law. In other circumstances, you will generally be provided advance notice of cancellation.
- There are no pre-existing condition exclusions and no aggregate annual or lifetime limits.
- You are not required to pay a co-payment or other cost-sharing for in-network preventive and wellness services, such as routine exams, immunizations, mammograms, and routine baby care (see www.healthcare.gov for more information).
- The plan provides minimum value and is affordable as required under the Affordable Care Act.
- You may be entitled to external review of certain healthcare claims. More detailed information may be found in Section 9.

Appendix A: Information About the Extended Blues Network

This information is provided by Blue Shield of California and describes benefits you may receive through the BlueCard Program.

Out-of-Area Services

Overview

The Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Plans Licensees. Generally these relationships are called Inter-Plan Arrangements and they work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you receive Services outside of California, the claims for these services may be processed through one of these Inter-Plan Arrangements described below.

When you access Covered Services outside of California, but within the United States, the Commonwealth of Puerto Rico, or the U. S. Virgin Islands (BlueCard® Service Area), you will receive the care from one of two kinds of providers. Participating providers contract with the local Blue Cross and/or Blue Shield. Licensee in that other geographic area (Host Blue). Non-participating providers don't contract with the Host Blue. The Administrator's payment practices for both kinds of providers are described below.

Inter-Plan Arrangements

Emergency Services

Members who experience an Emergency Medical Condition while traveling outside of California should seek immediate care from the nearest Hospital. The Benefits of this plan will be provided anywhere in the world for treatment of an Emergency Medical Condition.

BlueCard Program

Under the BlueCard® Program, benefits will be provided for Covered Services received outside of California, but within the BlueCard Service Area (the United States, Puerto Rico, and U.S. Virgin Islands). When you receive Covered Services within the geographic area served by a Host Blue, the plan will remain responsible for providing the benefits described in this SPD. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers, including direct payment to the provider.

The BlueCard Program enables you to obtain Covered Services outside of California, as defined, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member Copayment, Coinsurance and Deductible amounts, if any, as stated in this SPD.

The plan calculates the Member's share of cost either as a percentage of the Allowable Amount or a dollar Copayment, as defined in this booklet. Whenever you receive Covered Services outside of California, within the BlueCard Service Area, and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar copayment, is calculated based on the lower of:

1) The billed charges for Covered Services; or
2) The negotiated price that the Host Blue makes available to the plan.

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims as noted above. However, such adjustments will not affect the price the plan used for your claim because these adjustments will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

To find participating BlueCard providers you can call BlueCard Access® at 1-800-810-BLUE (2583) or go online at www.bcbs.com and select "Find a Doctor".

Prior authorization may be required for non-emergency services. To receive prior authorization, the out-of-area provider should call the provider customer service number noted on the back of your identification card.

Non-participating Providers Outside of California

When Covered Services are provided outside of California and within the BlueCard Service Area by non-participating providers, the amount you pay for such services will normally be based on either the Host Blue's non-participating provider local payment, the Allowable Amount the plan pays a Non-Participating Provider in California if the Host Blue has no non-participating provider allowance, or the pricing arrangements required by applicable state law. In these situations, you will be responsible for any difference between the amount that the non-participating provider bills and the payment the plan will make for Covered Services as set forth in this paragraph.

If you do not see a participating provider through the BlueCard Program, you will have to pay the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan, or to Collective Health directly for reimbursement. Collective Health will review your claim and notify you of the plan's coverage determination within 30 days after receipt of the claim; you will be reimbursed as described in the preceding paragraph. Remember, your share of cost is higher when you see a non-participating provider.

Federal or state law, as applicable, will govern payments for out-of-network Emergency Services. The plan pays claims for covered Emergency Services based on the Allowable Amount as defined in this SPD.

Prior authorization is not required for Emergency Services. In an emergency, go directly to the nearest hospital. Please notify the Administrator of your emergency admission within 24 hours or as soon as it is reasonably possible following medical stabilization.

Blue Shield Global® Core

Care for Covered Urgent and Emergency Services Outside the BlueCard Service Area

If you are outside of the BlueCard® Service Area, you may be able to take advantage of Blue Shield Global Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global Core is unlike the BlueCard Program available within the BlueCard Service Area in certain ways. For instance, although Blue Shield Global Core assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard Service Area, you will typically have to pay the provider and submit the claim yourself to obtain reimbursement for these services.

If you need assistance locating a doctor or hospital outside the BlueCard Service Area you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. Provider information is also available online at www.bcbs.com: select “Find a Doctor” and then “Blue Shield Global Core”.

Submitting a Blue Shield Global Core Claim

When you pay directly for services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global Core claim form and send the claim form along with the provider’s itemized bill to the service center at the address provided on the form to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Collective Health, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Special Cases: Value-Based Programs

Claims Administrator Value-Based Programs

You may have access to Covered Services from providers that participate in a Value-Based Program. Claims Administrator Value-Based Programs include, but are not limited to, Accountable Care Organizations, Episode Based Payments, Patient Centered Medical Homes and Shared Savings arrangements.

BlueCard® Program

If you receive covered services under a Value-Based Program inside a Host Blue’s service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a

part of such an arrangement, except when a Host Blue passes these fees to Blue Shield through average pricing or fee schedule adjustments.

Appendix B: Pharmacy Benefit Exclusions

January 2019

Medications Requiring Prior Authorization for Medical Necessity

Below is a list of medicines by drug class that will not be covered without a prior authorization for medical necessity. If you continue using one of these drugs without prior approval for medical necessity, you may be required to pay the full cost.

If you are currently using one of the drugs requiring prior authorization for medical necessity, ask your doctor to choose one of the generic or brand formulary options listed below.

Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity [1]	Formulary Options
Allergies Nasal Steroids / Combinations	BECONASE AQ OMNARIS QNASL ZETONNA	*flunisolide spray, fluticasone spray, mometasone spray, triamcinolone spray,* DYMISTA
Anticonvulsants	ZONEGRAN	*carbamazepine, carbamazepine ext-rel, divalproex sodium, divalproex sodium ext-rel, gabapentin, lamotrigine, lamotrigine ext-rel, levetiracetam, levetiracetam ext-rel, oxcarbazepine, phenobarbital, phenytoin, phenytoin sodium extended, tiagabine, topiramate, valproic acid, zonisamide,* FYCOMPA, OXTELLAR XR, TROKENDI XR, VIMPAT
Anti-infectives, Antibacterials Erythromycins / Macrolides	E.E.S. GRANULES ERYPED	*erythromycins*
Anti-infectives, Antibacterials Tetracyclines	MINOCIN	*minocycline*
	ACTICLATE DORYX DORYX MPC TARGADOX	*doxycycline hyclate*
Anti-infectives, Antibacterials Miscellaneous	MACRODANTIN	*nitrofurantoin*
Anti-infectives, Antivirals Cytomegalovirus *	VALCYTE	*valganciclovir*
Anti-infectives, Antivirals Hepatitis C *	MAVYRET	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6), VOSEVI [2]
	DAKLINZA TECHNIVIE VIEKIRA PAK ZEPATIER	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
Anti-infectives, Antivirals Herpes *	VALTREX	*acyclovir, valacyclovir*
Anti-inflammatory Steroidal, Ophthalmic	PRED FORTE	*dexamethasone, prednisolone acetate 1%,* DUREZOL, FLAREX, FML FORTE, FML S.O.P., MAXIDEX, PRED MILD
Antiobesity	CONTRAVE QSYMIA	BELVIQ, BELVIQ XR, SAXENDA
*Asthma** Beta Agonists, Short-Acting	PROVENTIL HFA VENTOLIN HFA XOPENEX HFA	*levalbuterol tartrate CFC-free aerosol,* PROAIR HFA, PROAIR RESPICLICK
*Asthma** Severe Asthma Agents	FASENRA	NUCALA
*Asthma** Steroid Inhalants	ALVESCO	ARNUITY ELLIPTA, ASMANEX, FLOVENT, PULMICORT FLEXHALER, QVAR, QVAR REDIHALER

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Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity [1]	Formulary Options
*Asthma * or Chronic Obstructive Pulmonary Disease (COPD) ** Steroid / Beta Agonist Combinations	DULERA	ADVAIR, BREO ELLIPTA, SYMBICORT
*Attention Deficit Hyperactivity Disorder *	ADDERALL XR	*amphetamine-dextroamphetamine mixed salts ext-rel, methylphenidate ext-rel,* MYDAYIS, VYVANSE
	INTUNIV	*amphetamine-dextroamphetamine mixed salts ext-rel, atomoxetine, guanfacine ext-rel, methylphenidate ext-rel,* MYDAYIS, VYVANSE
Autoimmune Conditions	ACTEMRA	ENBREL, HUMIRA, KEVZARA, XELJANZ, XELJANZ XR
	CIMZIA	COSENTYX, ENBREL, HUMIRA, KEVZARA, OTEZLA, STELARA SUBCUTANEOUS (Plaque Psoriasis and Psoriatic Arthritis only), XELJANZ, XELJANZ XR
	ENTYVIO	HUMIRA, XELJANZ
	KINERET	ENBREL, HUMIRA, KEVZARA, XELJANZ, XELJANZ XR
	ORENCIA CLICKJECT ORENCIA INTRAVENOUS ORENCIA SUBCUTANEOUS	COSENTYX, ENBREL, HUMIRA, KEVZARA, OTEZLA, STELARA SUBCUTANEOUS (Plaque Psoriasis and Psoriatic Arthritis only), XELJANZ, XELJANZ XR
	SIMPONI	COSENTYX, ENBREL, HUMIRA, KEVZARA, OTEZLA, STELARA SUBCUTANEOUS (Plaque Psoriasis and Psoriatic Arthritis only), XELJANZ, XELJANZ XR
	TALTZ	COSENTYX, ENBREL, HUMIRA, OTEZLA, STELARA SUBCUTANEOUS (Plaque Psoriasis and Psoriatic Arthritis only), XELJANZ, XELJANZ XR
Cancer Chronic Myelogenous Leukemia *	GLEEVEC TASIGNA	*imatinib mesylate,* BOSULIF, SPRYCEL
Cancer Prostate * Hormonal Agents, Antiandrogens	NILANDRON	*bicalutamide,* XTANDI, ZYTIGA
Cardiovascular Antiarrhythmics	BETAPACE BETAPACE AF	*sotalol*
Cardiovascular Antilipemics Cholesterol Absorption Inhibitors	ZETIA	*ezetimibe*
Cardiovascular Antilipemics Fibrates	TRICOR	*fenofibrate, fenofibric acid*
Cardiovascular Antilipemics HMG-CoA Reductase Inhibitors (HMGs or Statins) / Combinations [3]	ALTOPREV CRESTOR LESCOL XL LIPITOR LIVALO	*atorvastatin, ezetimibe-simvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin*
Cardiovascular Antilipemics PCSK9 Inhibitors	PRALUENT	REPATHA
Cardiovascular Digitalis Glycosides	LANOXIN TABLET (125 MCG and 250 MCG only)	*digoxin*
Cardiovascular Diuretics	DYRENIUM	*amiloride*

Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity [1]	Formulary Options
Carnitine Deficiency	CARNITOR CARNITOR SF	*levocarnitine*
*Chronic Obstructive Pulmonary Disease (COPD) ** Anticholinergics	TUDORZA	INCRUSE ELLIPTA, SPIRIVA
*Cystic Fibrosis ** Inhaled Antibiotics	TOBI TOBI PODHALER	*tobramycin inhalation solution*, BETHKIS
*Depression ** Antidepressants, Selective Norepinephrine Reuptake Inhibitors (SNRIs)	*venlafaxine ext-rel tablet* (except 225 mg) CYMBALTA EFFEXOR XR VENLAFAXINE EXT-REL TABLET (except 225 MG)	*desvenlafaxine ext-rel, duloxetine, venlafaxine, venlafaxine ext-rel capsule*
*Depression ** Antidepressants, Miscellaneous Agents	OLEPTRO	*trazodone*
*Depression and/or Schizophrenia ** Antipsychotics, Atypicals	ABILIFY FANAPT SEROQUEL XR	*aripiprazole, clozapine, olanzapine, quetiapine, quetiapine ext-rel, risperidone, ziprasidone*, LATUDA, VRAYLAR
Dermatology Acne *	ACANYA BENZACLIN ONEXTON *Vanoxide-HC* VELTIN ZIANA	*adapalene, benzoyl peroxide, clindamycin solution, clindamycin-benzoyl peroxide, erythromycin solution, erythromycin-benzoyl peroxide, tretinoin*, ATRALIN, DIFFERIN, EPIDUO, RETIN-A MICRO, TAZORAC
Dermatology Actinic Keratosis *	*fluorouracil cream 0.5%* CARAC	*fluorouracil cream 5%, fluorouracil solution, imiquimod*, PICATO, TOLAK, ZYCLARA
Dermatology Antipsoriatics	SORILUX	*calcipotriene*
Dermatology Rosacea *	NORITATE	*metronidazole*, FINACEA, SOOLANTRA
Dermatology Skin Inflammation and Hives * Corticosteroids	*clobetasol spray* CLOBEX SPRAY OLUX-E	*clobetasol foam*
	APEXICON E	*desoximetasone, fluocinonide*
Dermatology Wound Care Products	ALEVICYN GEL ALEVICYN KIT ALEVICYN SG *Alevicyn solution*	*desonide, hydrocortisone*
Dermatology Miscellaneous Skin Conditions	ALCORTIN A BENSAL HP NOVACORT SYNERDERM	*desonide, hydrocortisone*
*Diabetes ** Biguanides	FORTAMET GLUMETZA RIOMET	*metformin, metformin ext-rel*
*Diabetes ** Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	NESINA ONGLYZA TRADJENTA	JANUVIA

Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity [1]	Formulary Options
Diabetes * Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combinations	JENTADUETO JENTADUETO XR KAZANO KOMBIGLYZE XR OSENI	JANUMET, JANUMET XR
Diabetes * Injectable Incretin Mimetics	BYDUREON BYETTA TANZEUM	OZEMPIC, TRULICITY, VICTOZA
Diabetes * Insulins	APIDRA HUMALOG	FIASP, NOVOLOG
	HUMALOG MIX 50/50	NOVOLOG MIX 70/30
	HUMALOG MIX 75/25	NOVOLOG MIX 70/30
	HUMULIN 70/30 [4]	NOVOLIN 70/30 [4]
	HUMULIN N [4]	NOVOLIN N [4]
	HUMULIN R [4]	NOVOLIN R [4]
	NOTE: *Humulin R U-500 concentrate will not be subject to prior authorization and will continue to be covered.*	
Diabetes * Long Acting Insulins	LANTUS TOUJEO	BASAGLAR, LEVEMIR, TRESIBA
Diabetes * Insulin Sensitizers	ACTOS	*pioglitazone*
Diabetes * Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitors	INVOKANA	FARXIGA, JARDIANCE
Diabetes * Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitor / Biguanide Combinations	INVOKAMET INVOKAMET XR	SYNJARDY, SYNJARDY XR, XIGDUO XR
Diabetes * Supplies, Needles [5]	NOVO NORDISK NEEDLES OWEN MUMFORD NEEDLES PERRIGO NEEDLES ULTIMED NEEDLES All other insulin needles that are not BD ULTRAFINE brand	BD ULTRAFINE NEEDLES
Diabetes * Supplies, Syringes [5]	ALLISON MEDICAL INSULIN SYRINGES TRIVIDIA INSULIN SYRINGES ULTIMED INSULIN SYRINGES All other insulin syringes that are not BD ULTRAFINE brand	BD ULTRAFINE INSULIN SYRINGES
Diabetes * Supplies, Test Strips and Kits [6, 7]	BREEZE 2 STRIPS AND KITS CONTOUR NEXT STRIPS AND KITS CONTOUR STRIPS AND KITS FREESTYLE STRIPS AND KITS ONETOUCH ULTRA STRIPS AND KITS ONETOUCH VERIO STRIPS AND KITS All other test strips that are not ACCU-CHEK brand	ACCU-CHEK AVIVA PLUS STRIPS AND KITS [6], ACCU-CHEK COMPACT PLUS STRIPS AND KITS [6], ACCU-CHEK GUIDE STRIPS AND KITS [6], ACCU-CHEK SMARTVIEW STRIPS AND KITS [6]
Erectile Dysfunction * Phosphodiesterase Inhibitors	STENDRA VIAGRA	*sildenafil*, CIALIS

Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity [1]	Formulary Options
Fertility Regulators Follicle-Stimulating Hormones	FOLLISTIM AQ	GONAL-F
Gastrointestinal Antiemetics	ZUPLENZ	*granisetron, ondansetron,* SANCUSO
Gastrointestinal Opioid-induced Constipation	RELISTOR	MOVANTIK
Gastrointestinal Proton Pump Inhibitors (PPIs)	NEXIUM PREVACID PROTONIX ZEGERID	*esomeprazole, lansoprazole, omeprazole, pantoprazole,* DEXILANT
Gaucher Disease	ELELYSO	CERDELGA, CEREZYME
Genitourinary Interstitial Cystitis	RIMSO-50	Consult doctor
Growth Hormones	NORDITROPIN NUTROPIN AQ OMNITROPE SAIZEN	GENOTROPIN, HUMATROPE
Hematologic Anticoagulants (oral)	PRADAXA	*warfarin,* ELIQUIS, XARELTO
Hematologic Hemophilia A	ELOCTATE HELIXATE FS	ADYNOVATE, JIVI, KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ
Hematologic Hemophilia B	ALPROLIX	Consult doctor
Hematologic Neutropenia Colony Stimulating Factors	NEUPOGEN	ZARXIO
Hematologic Platelet Aggregation Inhibitors	PLAVIX	*clopidogrel, prasugrel,* BRILINTA
High Blood Pressure * Angiotensin II Receptor Antagonists	ATACAND BENICAR DIOVAN EDARBI	*candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan, valsartan*
High Blood Pressure * Angiotensin II Receptor Antagonist / Diuretic Combinations	ATACAND HCT BENICAR HCT DIOVAN HCT EDARBYCLOR	*candesartan-hydrochlorothiazide, irbesartan-hydrochlorothiazide, losartan-hydrochlorothiazide, olmesartan -hydrochlorothiazide, telmisartan-hydrochlorothiazide, valsartan-hydrochlorothiazide*
High Blood Pressure * Angiotensin II Receptor Antagonist / Calcium Channel Blocker Combinations	EXFORGE	*amlodipine-olmesartan, amlodipine-telmisartan, amlodipine-valsartan*
High Blood Pressure * Angiotensin II Receptor Antagonist / Calcium Channel Blocker / Diuretic Combinations	EXFORGE HCT	*amlodipine-valsartan-hydrochlorothiazide, olmesartan-amlodipine-hydrochlorothiazide*
High Blood Pressure * Beta-blocker Combinations	DUTOPROL	*metoprolol succinate ext-rel* **WITH** *hydrochlorothiazide*

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Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity [1]	Formulary Options
High Blood Pressure * Calcium Channel Blockers	NORVASC	*amlodipine*
	CARDIZEM CARDIZEM CD CARDIZEM LA (and its generics) *Matzim LA*	*diltiazem ext-rel* (except generic of CARDIZEM LA)
Huntington's Disease	XENAZINE	*tetrabenazine*, AUSTEDO
Inflammatory Bowel Disease (IBD) Ulcerative Colitis * Aminosalicylates	ASACOL HD DELZICOL	*balsalazide, sulfasalazine, sulfasalazine delayed-rel*, APRISO, LIALDA, PENTASA
	COLAZAL	*balsalazide*
Kidney Disease * Phosphate Binders	FOSRENOL	*calcium acetate, lanthanum carbonate, sevelamer carbonate*, PHOSLYRA, VELPHORO
Multiple Sclerosis	EXTAVIA	*glatiramer*, AUBAGIO, BETASERON, COPAXONE, GILENYA, REBIF, TECFIDERA, TYSABRI
Musculoskeletal	AMRIX	*cyclobenzaprine*
Narcolepsy Wakefulness Promoters	NUVIGIL	*armodafinil*
Ophthalmic Miscellaneous	AVENOVA	Consult doctor
Opioid Reversal	EVZIO	*naloxone injection*, NARCAN NASAL SPRAY
Osteoarthritis * Viscosupplements	EUFLEXXA HYALGAN MONOVISC ORTHOVISC SYNVISC SYNVISC ONE	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
Osteoporosis *	MIACALCIN INJECTION	*alendronate, calcitonin-salmon, ibandronate, risedronate*, FORTEO, PROLIA, TYMLOS
	MIACALCIN NASAL SPRAY	*calcitonin-salmon*
Overactive Bladder / Incontinence * Urinary Antispasmodics	DETROL LA ENABLEX OXYTROL	*darifenacin ext-rel, oxybutynin ext-rel, tolterodine, tolterodine ext-rel, trospium, trospium ext-rel*, MYRBETRIQ, TOVIAZ, VESICARE
Pain Headache *	*butalbital-acetaminophen-caffeine capsule* FIORICET CAPSULE VANATOL LQ VANATOL S	*diclofenac sodium, naproxen*
	CAFERGOT	*eletriptan, ergotamine-caffeine, naratriptan, rizatriptan, sumatriptan, zolmitriptan*, ONZETRA XSAIL, ZEMBRACE SYMTOUCH, ZOMIG NASAL SPRAY
Pain Opioid Analgesics	LAZANDA	*fentanyl transmucosal lozenge*, ABSTRAL, SUBSYS
	levorphanol	*fentanyl transdermal, hydromorphone ext-rel, methadone, morphine ext-rel*, EMBEDA, HYSINGLA ER, NUCYNTA ER, OXYCONTIN
	PRIMLEV	*hydrocodone-acetaminophen, hydromorphone, morphine, oxycodone-acetaminophen*, NUCYNTA
Pain and Inflammation * Corticosteroids	DEXPAK MILLIPRED RAYOS	*dexamethasone, methylprednisolone, prednisolone solution, prednisone*

Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity [1]	Formulary Options
Pain and Inflammation * Nonsteroidal Anti-inflammatory Drugs (NSAIDs) / Combinations	ARTHROTEC	*celecoxib; diclofenac sodium, meloxicam* or *naproxen* **WITH** *esomeprazole, lansoprazole, omeprazole, pantoprazole* or DEXILANT
	PENNSAID	*diclofenac sodium, diclofenac sodium gel 1%, diclofenac sodium solution, meloxicam, naproxen*
	CAMBIA INDOCIN NAPRELAN SPRIX	*diclofenac sodium, meloxicam, naproxen*
Postherpetic Neuralgia	HORIZANT	*gabapentin,* GRALISE
Prostate Condition Benign Prostatic Hyperplasia *	JALYN	*dutasteride-tamsulosin; dutasteride* or *finasteride* **WITH** *alfuzosin ext-rel, doxazosin, tamsulosin, terazosin,* RAPAFLO
	UROXATRAL	*alfuzosin ext-rel, doxazosin, tamsulosin, terazosin,* RAPAFLO
Pulmonary Enzyme Deficiency	PROLASTIN-C ZEMAIRA	ARALAST NP, GLASSIA
Sleep Disorder Hypnotics, Non-benzodiazepines	INTERMEZZO LUNESTA ROZEREM ZOLPIMIST	*eszopiclone, zolpidem, zolpidem ext-rel, zolpidem sublingual,* BELSOMRA, SILENOR
Testosterone Replacement * Androgens	*testosterone gel 1%* [6] ANDROGEL 1% FORTESTA NATESTO TESTIM VOGELXO	*testosterone gel, testosterone solution,* ANDRODERM, ANDROGEL 1.62%
Thyroid Supplements	TIROSINT	*levothyroxine,* SYNTHROID

Category/ Drug Class	Other Considerations
Autoimmune and Hepatitis C *	For some clients, an Indication Based Formulary will be utilized for products in these classes and may result in additional products not covered without a medical exception.
Drugs for infusion into spaces other than the blood	A drug which must be infused into a space other than the blood will generally not be covered under the prescription drug benefit.
Generics	Limited source generics may be evaluated when appropriate and potentially not be covered without a medical exception.
Hyperinflation	On a quarterly basis, products with significant cost inflation that have clinically appropriate and more cost-effective alternatives may be evaluated and potentially not be covered without a medical exception.
New-to-Market Agents [1]	New-to-market products and new variations of products already in the marketplace will not be added to the formulary immediately. Each product will be evaluated for clinical appropriateness and cost-effectiveness. Recommended additions to the formulary will be presented to the CVS Caremark® National Pharmacy and Therapeutics Committee (or other appropriate reviewing body) for review and approval.
Specialty	As new specialty products launch, as well as quarterly throughout the year, CVS Caremark will re-evaluate existing specialty products to determine appropriate formulary placement, which includes potentially not covering without a medical exception, adding back or deleting these products.

The listed formulary options are subject to change.

List of Drugs Requiring Prior Authorization for Medical Necessity

ABILIFY
ACANYA
ACTEMRA
ACTICLATE
ACTOS
ADDERALL XR
ALCORTIN A
ALEVICYN GEL
ALEVICYN KIT
ALEVICYN SG
Alevicyn solution
ALLISON MEDICAL INSULIN SYRINGES [5]
ALPROLIX
ALTOPREV
ALVESCO
AMRIX
ANDROGEL 1%
APEXICON E
APIDRA
ARTHROTEC
ASACOL HD
ATACAND
ATACAND HCT
AVENOVA
BECONASE AQ
BENICAR
BENICAR HCT
BENSAL HP
BENZACLIN
BETAPACE
BETAPACE AF
BREEZE 2 STRIPS AND KITS [7]
butalbital-acetaminophen-caffeine capsule
BYDUREON
BYETTA
CAFERGOT
CAMBIA
CARAC
CARDIZEM
CARDIZEM CD
CARDIZEM LA (and its generics)
CARNITOR
CARNITOR SF
CIMZIA
clobetasol spray
CLOBEX SPRAY
COLAZAL
CONTOUR NEXT STRIPS AND KITS [7]
CONTOUR STRIPS AND KITS [7]
CONTRAVE
CRESTOR
CYMBALTA
DAKLINZA
DELZICOL
DETROL LA
DEXPAK
DIOVAN
DIOVAN HCT
DORYX
DORYX MPC
DULERA
DUTOPROL
DYRENIUM
EDARBI
EDARBYCLOR
E.E.S. GRANULES
EFFEXOR XR
ELELYSO
ELOCTATE
ENABLEX
ENTYVIO
ERYPED
EUFLEXXA
EVZIO
EXFORGE
EXFORGE HCT
EXTAVIA
FANAPT
FASENRA
FIORICET CAPSULE
fluorouracil cream 0.5%
FOLLISTIM AQ
FORTAMET
FORTESTA
FOSRENOL
FREESTYLE STRIPS AND KITS [7]
GLEEVEC
GLUMETZA
HELIXATE FS
HORIZANT
HUMALOG
HUMALOG MIX 50/50
HUMALOG MIX 75/25
HUMULIN 70/30 [4]
HUMULIN N [4]
HUMULIN R [4]
HYALGAN
INDOCIN
INTERMEZZO
INTUNIV
INVOKAMET
INVOKAMET XR
INVOKANA
JALYN
JENTADUETO
JENTADUETO XR
KAZANO
KINERET
KOMBIGLYZE XR
LANOXIN TABLET (125 MCG and 250 MCG only)
LANTUS
LAZANDA
LESCOL XL
levorphanol
LIPITOR
LIVALO
LUNESTA
MACRODANTIN
Matzim LA
MAVYRET
MIACALCIN INJECTION
MIACALCIN NASAL SPRAY
MILLIPRED
MINOCIN
MONOVISC
NAPRELAN
NATESTO
NESINA
NEUPOGEN
NEXIUM
NILANDRON
NORDITROPIN
NORITATE
NORVASC
NOVACORT
NOVO NORDISK NEEDLES [5]
NUTROPIN AQ
NUVIGIL
OLEPTRO
OLUX-E
OMNARIS
OMNITROPE
ONETOUCH ULTRA STRIPS AND KITS [7]
ONETOUCH VERIO STRIPS AND KITS [7]
ONEXTON
ONGLYZA
ORENCIA CLICKJECT
ORENCIA INTRAVENOUS
ORENCIA SUBCUTANEOUS
ORTHOVISC
OSENI
OWEN MUMFORD NEEDLES [5]
OXYTROL
PENNSAID
PERRIGO NEEDLES [5]
PLAVIX
PRADAXA
PRALUENT
PRED FORTE
PREVACID
PRIMLEV
PROLASTIN-C
PROTONIX
PROVENTIL HFA
QNASL
QSYMIA
RAYOS
RELISTOR
RIMSO-50
RIOMET
ROZEREM
SAIZEN
SEROQUEL XR
SIMPONI
SORILUX
SPRIX
STENDRA
SYNERDERM
SYNVISC
SYNVISC-ONE
TALTZ
TANZEUM
TARGADOX
TASIGNA
TECHNIVIE
TESTIM
testosterone gel 1% [8]
TIROSINT
TOBI
TOBI PODHALER
TOUJEO
TRADJENTA
TRICOR
TRIVIDIA INSULIN SYRINGES [5]
TUDORZA
ULTIMED INSULIN SYRINGES [5]
ULTIMED NEEDLES [5]
UROXATRAL
VALCYTE
VALTREX
VANATOL LQ
VANATOL S
Vanoxide-HC
VELTIN
venlafaxine ext-rel tablet (except 225 mg)
VENLAFAXINE EXT-REL TABLET (except 225 MG)
VENTOLIN HFA
VIAGRA
VIEKIRA PAK
VOGELXO
XENAZINE
XOPENEX HFA
ZEGERID
ZEMAIRA
ZEPATIER
ZETIA
ZETONNA
ZIANA
ZOLPIMIST
ZONEGRAN
ZUPLENZ

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There may be additional drugs subject to prior authorization or other plan design restrictions. Please consult your plan for further information.

This list represents brand products in CAPS, branded generics in upper- and lowercase *Italics*, and generic products in lowercase *italics*. This is not an all-inclusive list of available drug options. Log in to www.caremark.com to check coverage and copay information for a specific drug. Discuss this information with your doctor or health care provider. This information is not a substitute for medical advice or treatment. Talk to your doctor or health care provider about this information and any health-related questions you have. CVS Caremark assumes no liability whatsoever for the information provided or for any diagnosis or treatment made as a result of this information. This list is subject to change.

Subject to applicable laws and regulations.

* This list indicates the common uses for which the drug is prescribed. Some drugs are prescribed for more than one condition.
1 If your doctor believes you have a specific clinical need for one of these products, he or she should contact the Prior Authorization department at: 1-855-240-0536.
2 For use in patients previously treated with an HCV regimen containing an NS5A inhibitor (for genotypes 1-6) or sofosbuvir without an NS5A inhibitor (for genotypes 1a or 3).
3 If approved for coverage and prescribed for primary prevention of cardiovascular disease, may be covered without cost sharing through an exceptions process.
4 Rebranded or private label formulations are not covered without a prior authorization for medical necessity (i.e., RELION).
5 BD ULTRAFINE syringes and needles are the only preferred options.
6 An ACCU-CHEK blood glucose meter may be provided at no charge by the manufacturer to those individuals currently using a meter other than ACCU-CHEK. For more information on how to obtain a blood glucose meter, call: 1-877-418-4746.
7 ACCU-CHEK brand test strips are the only preferred options.
8 Listing reflects the authorized generics for TESTIM and VOGELXO.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

 106-25923B 010119 www.caremark.com

Appendix C: Nondiscrimination and Accessibility Requirements

blue of california

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

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

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (916) 350-7405
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

Blue Shield of California is an independent member of the Blue Shield Association A49939 (2/17)

Blue Shield of California
50 Beale Street, San Francisco, CA 94105

blueshieldca.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
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English: For assistance in English at no cost, call 1-866-346-7198.

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Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

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Arabic(العربية): لحصول على المساعدة في اللغة العربية مجانا ، تفضل باتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दीमेंबिना खर्च केसहायताकेलिए, 1-866-346-7198 परकॉलकरें।

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