2022 BOOKLET FOR:

SPECIAL DISTRICTS INSURANCE SERVICES – OFCA GROUP

$2,500 Deductible

Group Number: 800000038

Medical Benefits

Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the BlueCross and BlueShield Association

Notice: Your Rights and Protections Against Surprise Medical Bills

When You get emergency care or get treated by an out-of-network Provider at an in-network Hospital or Ambulatory Surgical Center, You are protected from surprise billing or balance billing.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When You see a doctor or other health care Provider, You may owe certain out-of-pocket costs, such as a Copayment, Coinsurance, and/or a Deductible. You may have other costs or have to pay the entire bill if You see a Provider or visit a health care facility that isn't in Your health plan's network.

"Out-of-network" as used in this Notice, describes Providers and facilities that haven't signed a contract with Your health plan. Out-of-network Providers may be permitted to bill You for the difference between what Your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward Your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when You can't control who is involved in Your care - like when You have an emergency or when You schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network Provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If You have an Emergency Medical Condition and get emergency services from an out-of-network Provider or facility, the most the Provider or facility may bill You is Your plan's in-network cost-sharing amount (such as Copayments and Coinsurance). You **can't** be balance billed for these emergency services. This includes services You may get after You're in stable condition, unless You give written consent and give up Your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network Hospital or Ambulatory Surgical Center

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

If You get other services at these in-network facilities, out-of-network Providers **can't** balance bill You, unless You give written consent and give up Your protections.

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

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying Your share of the cost (like the Copayments, Coinsurance, and Deductibles that You would pay if the Provider or facility was in-network). Your health plan will pay out-of-network Providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring You to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network Providers.
  - Base what You owe the Provider or facility (cost-sharing) on what it would pay an in-network Provider or facility and show that amount in Your explanation of benefits.
  - Count any amount You pay for emergency services or out-of-network services toward Your Deductible and out-of-pocket limit.

If You believe You've been wrongly billed by Us, You may contact the Oregon Division of Financial Regulation by:

- calling the Consumer Hotline at 1 (888) 877-4894;
- e-mail at: **DFR.InsuranceHelp@dcbs.oregon.gov**; or
- filing a complaint at: https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx.

If You believe You've been wrongly billed by a Provider, You may contact **www.cms.gov/nosurprises/consumers** or call the No Surprises Help Desk at 1 (800) 985-3059.

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

NONDISCRIMINATION NOTICE

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

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

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

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

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

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

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

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

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

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Introduction

This Booklet provides the written description of the terms and benefits of coverage available under the Plan. The administrative services contract between Your employer and Regence BlueCross BlueShield of Oregon (called the "Agreement") contains all the terms of coverage. Your employer has a copy.

This Booklet describes benefits effective **July 1, 2022**, or the date Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Regence BlueCross BlueShield of Oregon and makes it void. The "identification card" issued to You includes Your name and Your identification number for this coverage. Present Your identification card to Your Provider before receiving care.

In this Booklet, the term "Claims Administrator" refers to Regence BlueCross BlueShield of Oregon (hereafter referred to as "Regence BlueCross BlueShield of Oregon") and the term "Plan Sponsor" means the association through which Your employer has made arrangements for its employees to participate under this coverage. References to "You" and "Your" refer to the Participant and/or Beneficiaries. Other terms are defined in the Definitions Section or where they are first used and are designated by the first letter being capitalized.

EMPLOYER PAID BENEFITS
This self-funded group health plan (hereafter referred to as "Plan") is an employer-paid benefits plan administered by the Claims Administrator. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. This means that the Plan Sponsor, not Regence BlueCross BlueShield of Oregon, pays for Your covered medical services and supplies. Your claims will be paid only after the Plan Sponsor provides the Claims Administrator with the funds to pay Your benefits and pay all other charges due under the Plan.

Mental Health Parity and Addiction Equity Act of 2008
This coverage complies with the Mental Health Parity and Addiction Equity Act of 2008.

Risk-Sharing Arrangements with Providers
This Plan includes "risk-sharing" arrangements with Providers who provide services to the Claimants of this Plan. Under a risk-sharing arrangement, the Providers that are responsible for delivering health care services are subject to some financial risk or reward for the services they deliver. Additional information on the Claims Administrator's risk-sharing arrangements is available upon request by calling Customer Service at the number listed below.

Notice of Privacy Practices: Regence BlueCross BlueShield of Oregon has a Notice of Privacy Practices that is available by calling Customer Service or visiting the Web site listed below.

CONTACT INFORMATION
Customer Service: 1 (866) 240-9580

(TTY: 711)

Phone lines are open Monday – Friday 5 a.m. – 8 p.m. and Saturday 8 a.m. – 4:30 p.m. Pacific Time.

Contact Customer Service:

- if You have questions;
- if You would like to learn more about Your coverage;
- if You would like to request written or electronic information regarding any other plan that the Claims Administrator offers;
- to talk with one of the Claims Administrator's Customer Service representatives;
- via the Claims Administrator's Web site, **regence.com**, to submit a claim online or chat live with a Customer Service representative;
- to request a copy of Your identification card (or print a copy via the Claims Administrator's Web site); or
- for assistance in a language other than English.

Case Management: Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. For additional information, refer to the Medical Benefits Section or call Case Management at 1 (866) 543-5765.

BlueCard® Program: This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area Regence BlueCross BlueShield of Oregon serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Call Customer Service to learn how to have access to care through the BlueCard Program.

Using Your Booklet

ACCESSING PROVIDERS

You are not restricted in Your choice of Provider for care or treatment of an Illness or Injury. You control Your out-of-pocket expenses by choosing between "In-Network" and "Out-of-Network" Providers.

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

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

SERVICES RECEIVED FROM AN OREGON OUT-OF-NETWORK PROVIDER IN AN IN-NETWORK HEALTHCARE FACILITY

Regardless of any provision to the contrary, if You receive services from an Oregon licensed or certified Out-of-Network Provider at an In-Network Hospital, Ambulatory Surgical Center, freestanding birthing center, or outpatient renal dialysis center, You may not be responsible for their charges in excess of any In-Network cost-share for:

- emergency services; or
- other inpatient or outpatient services, unless the Out-of-Network Provider obtained Your informed consent in advance of the services in a manner established by the state.

This does not apply to:

- a residential facility licensed by the Department of Human Services or the Oregon Health Authority under Oregon law;
- an establishment furnishing primarily domiciliary care as described under Oregon law;
- a residential facility licensed or approved under the rules of the Department of Corrections;
- facilities established through the Oregon Health Authority for the treatment of substance abuse disorders;
- community mental health programs or community developmental disabilities programs established under Oregon law; or
- a long-term care facility.

ADDITIONAL ADVANTAGES OF PARTICIPATION

The Claims Administrator provides access to discounts on select items and services, personalized health care planning information, health-related events and innovative

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

- **Go to regence.com or the Claims Administrator's mobile application.** You can use the Claims Administrator's secure applications to:
    - view recent claims, benefits and coverage;
    - find a contracting Provider or identify Participating Pharmacies;
    - use tools to estimate upcoming health care costs and otherwise help You manage health care expenses;
    - get suggestions to improve or maintain wellness and participate in self-guided motivational online wellness programs;
    - learn about prescriptions for various Illnesses;
    - compare medications based upon performance and cost and get assistance in switching to less costly, equally effective alternative medications, if You wish; and
    - access information about Regence Advantages. Regence Advantages is a discount program that gives You access to savings on a variety of health-related products and services. The Claims Administrator has contracted with several program partners, listed on the secure applications, to offer discounts on their products and services, such as hearing care, health and wellness products and vision care.*

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

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

- **Enhanced convenience and options for access to medical care.** These may include additional resources for You to receive covered medical care, such as enhanced virtual care options that are integrated with Your telehealth and telemedicine, Durable Medical Equipment, preventive, behavioral health, and/or other benefits. You may also be offered increased ease in accessing non-Covered Services, such as cosmetic services or in integrating care for complex and multi-Provider conditions.
- **Healthcare and vitality assistance tools.** You may have tools that enable You to make and track medical appointments; manage health care expenses; receive

support in caring for others; remember to timely refill prescriptions and perform regular self-care; track weight, food, and exercise statistics; and more.

- **Non-medical lifestyle enhancements.** These may include access or assistance with non-medical services, such as resilience, mindfulness, yoga or stress reduction programs, and pet wellness and insurances services.

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

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Understanding Your Benefits

This section provides information to help You understand the terms Maximum Benefits, Deductibles (if any), Copayments, Coinsurance and Out-of-Pocket Maximum. These terms are types of cost-sharing specific to Your benefits. You will need to refer to the Medical Benefits and Prescription Medications Sections to see what Your benefits are.

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

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

DEDUCTIBLES
The Deductible is the amount You must pay each Calendar Year before the Plan will provide payments for Covered Services. The Deductible is satisfied by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible.

The Family Deductible is satisfied when the Family members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Deductible amount. However, no one Claimant will be required to meet more than the individual Deductible amount toward the Family Deductible in a Calendar Year.

The Plan does not pay for services applied toward the Deductible. Refer to the benefit sections to see what Covered Services are subject to the Deductible. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not apply toward the Deductible.

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

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

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the maximum amount You could pay in a Calendar Year for Covered Services. The Out-of-Pocket Maximum is satisfied by Your payments of any Deductible, Copayments and/or Coinsurance, unless specified otherwise. There are two Out-of-Pocket Maximum amounts: one for In-Network benefits and another for Out-of-Network benefits.

There are also two Family Out-of-Pocket Maximum amounts: one for In-Network benefits and another for Out-of-Network benefits. The Family Out-of-Pocket Maximum is satisfied when the Family members' Deductibles, Copayments and Coinsurance for Covered Services for that Calendar Year total and meet the Family Out-of-Pocket Maximum amount. However, no one Claimant will be required to meet more than the individual Out-of-Pocket Maximum amount toward the Family Out-of-Pocket Maximum in a Calendar Year.

A Claimant's payment of any Deductible, Copayment and/or Coinsurance for ambulance, blood bank, emergency room services and Prescription Medications will apply toward the In-Network Out-of-Pocket Maximum amount. Additionally, services provided by a Provider that has an effective participating contract with the Claims Administrator but is not designated as an In-Network Provider (as further defined in the Definitions Section) will apply to the In-Network Out-of-Pocket Maximum amount. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. Your payments of Copayment and/or Coinsurance for Prescription Medications count toward the Out-of-Pocket Maximum, however, any reduction in Your cost-sharing for Prescription Medications resulting from the use of a drug manufacturer coupon does not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach the Out-of-Pocket Maximum.

Once You reach the Out-of-Pocket Maximum, benefits subject to the Out-of-Pocket Maximum will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year. The Coinsurance does not change to a higher payment level or apply to the Out-of-Pocket Maximum for some benefits. Refer to the benefit sections to determine if a Covered Service does not apply to the Out-of-Pocket Maximum.

HOW CALENDAR YEAR BENEFITS RENEW

The Deductible, Out-of-Pocket Maximum and Maximum Benefits are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again. Some benefits have a separate Maximum Benefit based upon a Claimant's Lifetime and do not renew every Calendar Year.

The Agreement is renewed each Plan Year. A Plan Year is the 12-month period following either the Agreement's original Effective Date or subsequent renewal date. A Plan Year may or may not be the same as a Calendar Year. If the Agreement renews on a day other than January 1 of any year, any Deductible or Out-of-Pocket Maximum amounts You satisfied before the Agreement's renewal date will carry over into the next Plan Year. If the Deductible and/or Out-of-Pocket Maximum amounts increase during

the Calendar Year, You will need to meet the new requirement minus any amount already satisfied from the previous Agreement during that same Calendar Year.

Medical Benefits

This section explains Your benefits and cost-sharing responsibilities for Covered Services. Referrals are not required before You can use any of the benefits of this coverage. All benefits are listed alphabetically, with the exception of Preventive Care and Immunizations, Office or Urgent Care Visits and Other Professional Services.

Medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care) and received from a Provider practicing within the scope of their license. All covered benefits are subject to the limitations, exclusions and provisions of this Plan. In some cases, the Plan may limit benefits or coverage to a less costly and Medically Necessary alternative item. A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service. See the Definitions Section for descriptions of Medically Necessary and the types of Providers who deliver Covered Services.

If benefits change while You are in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.

Reimbursement may be available when You purchase new medical supplies, equipment and devices from a Provider or from an approved Commercial Seller. New medical supplies, equipment and devices purchased through an approved Commercial Seller are covered at the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item or the retail market value for that item. To learn more about how to access reimbursable new retail medical supplies, equipment and devices, visit the Claims Administrator's Web site or contact Customer Service.

NOTE: If You choose to access new medical supplies, equipment and devices through the Claims Administrator's Web site, the Claims Administrator may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. **ANY SUCH DISCOUNTS OR COUPONS ARE A COMPLEMENT TO THE PLAN, BUT ARE NOT INSURANCE.**

CASE MANAGEMENT

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

PRIOR AUTHORIZATION

Prior authorization refers to the process by which the Claims Administrator determines that a proposed service or supply is Medically Necessary and provides approval for it before it is rendered.

Prior authorization is performed to ensure that the medical services You receive are aligned with evidence-based criteria and to determine whether the requested service

meets the Claims Administrator's Medical Necessity criteria. Prior authorization also ensures that services or supplies You receive are safe, effective and appropriate.

Contracted Providers
Contracted Providers may be required to obtain prior authorization in advance for certain services provided to You. You will not be penalized if the contracted Provider does not obtain those approvals in advance and the service is determined to be not covered in this Booklet.

Non-Contracted Providers
Non-contracted Providers are not required to obtain prior authorization of any service or supply in order to be eligible for coverage of that service or supply. A claim for a non-contracted Provider's service or supply that is otherwise covered under the Plan will not be denied solely for lack of prior authorization. Benefits will be paid for services and supplies covered under the Plan only if all terms and conditions of the Plan are met, including (unless specified to the contrary) Medical Necessity. You may request that a non-contracted Provider prior authorize services on Your behalf to determine Medical Necessity prior to receiving those services.

Services Requiring Prior Authorization
A comprehensive list of services and supplies that must be prior authorized may be obtained by visiting the Claims Administrator's Web site or contacting Customer Service. Prior authorization requests should be submitted by Your Provider following the instructions on the Claims Administrator's Web site.

Prior authorization is not required for Emergency Room services or other services and supplies which by law do not require prior authorization.

Time Frame for Response
You will be notified in writing within two business days after the Claims Administrator receives the prior authorization request to let You know whether the request has been approved, denied, or if more information is needed to make a determination. When more information is needed to make a determination, the Claims Administrator will notify You in writing of the determination within two business days after the Claims Administrator receives the additional information or within 15 calendar days of the original two business days if no additional information is received unless a longer time period to respond is allowed under federal law.

If a service or supply (from a contracted or non-contracted Provider) is prior authorized, the Plan is bound to cover it as follows:

- If Your coverage terminates within five business days of the prior authorization date, the Plan will cover the prior authorized service or supply if the service or supply is actually incurred within those five business days regardless of the termination date unless the Claims Administrator is aware the coverage is about to terminate and the Claims Administrator discloses this information in its written prior authorization. In that case, the Plan will only cover the prior authorized service or supply if incurred before termination.

- If Your coverage terminates later than five business days after the prior authorization date, but before the end of 30 calendar days, the Plan will not cover services incurred after termination even if the services were prior authorized.
- If coverage remains in effect for at least 30 calendar days after the prior authorization, the Plan will cover the prior authorized service or supply if incurred within the 30 calendar days.

When counting the days described above, day one will begin on the calendar or business day after the Claims Administrator prior authorizes the service or supply.

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

Your Provider's classification of the service as either preventive or diagnostic and any other terms in this Booklet will determine the benefit that applies. For example, colonoscopies and mammograms are covered in the Preventive Care and Immunizations benefit if Your Provider bills them as preventive and they fall within the recommendations identified in that benefit. Otherwise, colonoscopies and mammograms are covered the same as any other Illness or Injury. You may want to ask Your Provider why a Covered Service is ordered or requested.

CALENDAR YEAR DEDUCTIBLES
Per Claimant: $2,500
Per Family: $5,000

CALENDAR YEAR OUT-OF-POCKET MAXIMUM
In-Network
Per Claimant: $5,000
Per Family: $10,000

Out-of-Network
Per Claimant: $9,000
Per Family: $18,000

PREVENTIVE CARE AND IMMUNIZATIONS
In addition to Covered Services for Preventive Care and Immunizations by an In-Network Provider, Covered Services for Preventive Care and Immunizations provided by a Provider that has any form of participating contract to provide services and supplies to Claimants in accordance with the provisions of this coverage, will be covered as an In-Network benefit as explained below.

Preventive Care

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Immunizations – Adult

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Immunizations – Childhood

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Preventive care and immunization services provided by a professional Provider, facility or Retail Clinic that are within age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA), or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) are covered for the following:

- routine physical examinations, well-women's care, well-baby care and routine health screenings (including screening and counseling for some cancer genes such as BRCA1 or BRCA2);
- Provider counseling and Prescription Medications prescribed for tobacco use cessation;
- immunizations for adults and children;
- breast pumps (including its accompanying supplies) as follows:
    - new non-Hospital grade breast pumps at the In-Network benefit level when obtained from a Provider (including a Durable Medical Equipment supplier); or
    - a comparable new breast pump may be obtained from an approved Commercial Seller in lieu of a Provider. Benefits for a comparable new breast pump obtained from an approved Commercial Seller will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value.
- United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods for women, including, but not limited to:
    - female condoms;
    - diaphragm with spermicide;

- sponge with spermicide;
- cervical cap with spermicide;
- spermicide;
- oral contraceptives (combined pill, mini pill, and extended/continuous use pill);
- contraceptive patch;
- vaginal ring;
- contraceptive shot/injection;
- emergency contraceptives (both levonorgestrel and ulipristal acetate-containing products);
- intrauterine devices (both copper and those with progestin);
- implantable contraceptive rod;
- surgical implants; and
- surgical sterilization.

Prostate cancer screening is also covered when recommended by a Physician or Practitioner. Covered Services for prostate cancer screening include digital rectal examinations and prostate-specific antigen (PSA) tests.

NOTE: Covered Services that do not meet these criteria (for example, diagnostic mammograms) will be covered the same as any other Illness or Injury. In the event HRSA, USPSTF or the CDC adopt a new or revised recommendation, the Claims Administrator has up to one year before coverage of the related services must be available and effective in this Booklet.

For a list of Covered Services, including information about obtaining a new breast pump from an approved Commercial Seller, visit the Claims Administrator's Web site or contact Customer Service. You can also visit the HRSA Web site at: **http://www.hrsa.gov/womensguidelines/** for women's preventive services guidelines, and the USPSTF Web site at: **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations** for a list of A and B preventive services.

Expanded Immunizations

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Immunizations that do not meet age limits and frequency guidelines according to, and as recommended by, the USPSTF, HRSA or by the CDC are covered. Covered Services include immunizations for travel, occupation or residency in a foreign country. Contact Customer Service to verify what expanded immunizations are covered.

OFFICE OR URGENT CARE VISITS – ILLNESS OR INJURY

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $30 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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

OTHER PROFESSIONAL SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible*, You pay 20% of the Allowed Amount. **Payment for colonoscopies:** No charge. *The Deductible does not apply to outpatient radiology and laboratory services (not including complex imaging procedures).	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Services and supplies provided by a professional Provider are covered, subject to any Deductible and/or Coinsurance and any specified limits as explained in the following paragraphs:

Medical Services and Supplies

Professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider. Services and supplies also include those to treat a congenital anomaly, foot care associated with diabetes and Medically Necessary foot care obtained from a professional Provider due to hazards of a systemic condition causing severe circulatory dysfunction or diminished sensation in the legs or feet.

Dental and orthodontic services that are for the treatment of craniofacial anomalies and are Medically Necessary to restore function are also covered. A "craniofacial anomaly" is a physical disorder, identifiable at birth, that affects the bony structures of the face or head, including, but not limited to, cleft palate, cleft lip, craniosynotosis, craniofacial microsomia and Treacher Collins syndrome. Coverage does not include treatment of temporomandibular joint disorder or developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth.

Additionally, coverage includes some Medically Necessary supplies (for example, compression stockings, active wound care supplies and sterile gloves) that are new and obtained from an approved Commercial Seller. Benefits for eligible new supplies will be

covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible new medical supplies, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit the Claims Administrator's Web site or contact Customer Service.

Breast, Pelvic and Pap Smear Examinations
Breast, pelvic and Pap smear examinations not covered in the Preventive Care and Immunizations benefit.

Complex Imaging Procedures
We cover the following complex imaging procedures: Computer Tomography (CT) Scan, Positron Emission Tomography (PET), Magnetic Resonance Angiogram (MRA), Single Photon Emission Computerized Tomography (SPECT), Bone Density Study and Magnetic Resonance Imaging (MRI).

Diabetes Management Associated with Pregnancy
Management of a pregnant Claimant's diabetes from the date of conception through six weeks postpartum (for each pregnancy) that is Medically Necessary and a Covered Service is not subject to any Deductible, Copayment and/or Coinsurance when provided by an In-Network Provider.

Diagnostic Procedures
Services for diagnostic procedures including cardiovascular testing, pulmonary function studies, stress test, sleep studies and neurology/neuromuscular procedures.

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

Medical Colonoscopy
Medical colonoscopy performed as a result of a positive fecal test for a Claimant age 50 or older is not subject to any Deductible, Copayment, and/or Coinsurance when provided by an In-Network Provider. Diagnostic medical colonoscopies are also not subject to the Deductible, Copayment and/or Coinsurance when provided by an In-Network Provider. Preventive colonoscopies, including for those Claimants at high-risk, are covered in the Preventive Care and Immunizations benefit. Preventive colonoscopy supplies such as bowel prep kits on the Claims Administrator's Drug List are covered in the Prescription Medications Section with a Prescription Order. Colonoscopy services include all associated services such as double contrast barium enemas, anesthesia and pathology.

Professional Inpatient
Professional inpatient visits for treatment of Illness or Injury. If pre-arranged procedures are performed by an In-Network Provider and You are admitted to an In-Network Hospital, the Plan will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by an Out-of-Network Provider at the In-Network benefit level. However, an Out-of-Network Provider may bill You for

balances beyond any Deductible, Copayment and/or Coinsurance. Contact Customer Service for further information and guidance.

Radiology and Laboratory
Diagnostic services for treatment of Illness or Injury, including, but not limited to:

- genetic testing, when performed for a medical reason or for a condition that requires genetic testing, provided the results of the testing have the potential to improve Health Outcomes;
- diagnostic mammography services not covered in the Preventive Care and Immunizations benefit; and
- HIV testing.

Claims for independent clinical laboratory services will be submitted to the Blue plan in the locale in which the referring Provider is located, regardless of where the examination of the specimen occurred. Refer to Your Blue plan network where the referring Provider is located for coverage of independent clinical laboratory services.

Surgical Services
Surgical services and supplies including cochlear implants (programming and reprogramming, cost of repair and replacement parts if the repair or parts are not covered by a warranty and are Medically Necessary for the device to be functional) for the treatment of hearing loss and the services of a surgeon, an assistant surgeon and an anesthesiologist.

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

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

ACUPUNCTURE

Provider: In-Network	**Provider: Out-of-Network**
Payment: You pay $30 Copayment per visit.	**Payment:** You pay $30 Copayment per visit and the balance of billed charges.
Limit: 12 visits per Claimant per Calendar Year	

Acupuncture is covered.

ALLERGY TREATMENT

Provider: In-Network	**Provider: Out-of-Network**
Payment: You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Allergy treatment services and supplies are covered, including, but not limited to:

- allergens and administration; and

- skin tests.

All other services and supplies, including associated office visits, are subject to the applicable benefit for such service.

AMBULANCE SERVICES

Provider: All
Payment: After Deductible, You pay 20% of the Allowed Amount.
Limit: 6 trips combined for air and ground transportation per Claimant per Calendar Year

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

Claims for ambulance services must include the locations You were transported to and from. The claim should also show the date of service, the patient's name, the group and Your identification numbers. Payment for Covered Services will be paid directly to the ambulance service Provider.

AMBULATORY SURGICAL CENTER

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 10% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Outpatient services and supplies of an Ambulatory Surgical Center (including services of staff Providers) are covered for treatment of Illness or Injury.

APPROVED CLINICAL TRIALS

If an In-Network Provider is participating in an Approved Clinical Trial and will accept You as a trial participant, benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If an Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care. Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating are covered as specified in the Medical Benefits and Prescription Medications Sections. Additional specified limits are as further defined.

Definitions

The following definitions apply to this Approved Clinical Trials benefit:

Approved Clinical Trial means a clinical trial that is a study or investigation:

- approved or funded by one or more of:
  - the National Institutes of Health (NIH), the CDC, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid or a cooperative

group or center of any of those entities; or, a cooperative group or center of the Department of Defense (DOD) or the Department of Veteran's Affairs (VA);
- a qualified non-governmental research entity identified in guidelines issued by the NIH for center approval grants; or
- the VA, DOD, or Department of Energy, provided it is reviewed and approved through a peer review system that the Department of Health and Human Services has determined both is comparable to that of the NIH and assures unbiased review of the highest scientific standards by qualified individuals without an interest in the outcome of the review.

- conducted under an investigational new drug application reviewed by the FDA or that is a drug trial exempt from having an investigational new drug application.

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

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

BIOFEEDBACK

Provider: In-Network	**Provider: Out-of-Network**
Payment: You pay $30 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 10 visits per Claimant Lifetime	

Biofeedback to treat migraine headaches, treatment of tension or stress urinary incontinence is covered. Biofeedback is not covered for other conditions. Biofeedback visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

BLOOD BANK

Provider: All
Payment: After Deductible, You pay 20% of the Allowed Amount.

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

CHILD ABUSE MEDICAL ASSESSMENT

Child Abuse Medical Assessments including those services provided by an Oregon Community Assessment Center in conducting a Child Abuse Medical Assessment of a child enrolled on this plan are covered as specified in the Medical Benefits Section. The services include, but are not limited to, a forensic interview and Mental Health treatment.

Definitions
The following definitions apply to this Child Abuse Medical Assessment benefit:

Child Abuse Medical Assessment means an assessment by or under the direction of a licensed Physician or other licensed health care professional trained in the evaluation, diagnosis and treatment of child abuse. Child Abuse Medical Assessment includes the taking of a thorough medical history, a complete physical examination and an interview for the purpose of making a medical diagnosis, determining whether or not the child has been abused and identifying the appropriate treatment or referral for follow-up for the child.

Community Assessment Center means a neutral, child-sensitive community-based facility or service Provider to which a child from the community may be referred to receive a thorough Child Abuse Medical Assessment for the purpose of determining whether the child has been abused or neglected.

DENTAL HOSPITALIZATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

When necessary to safeguard Your health, hospitalization for Dental Services is covered. Covered Services include inpatient and outpatient services and supplies (including anesthesia) at an Ambulatory Surgical Center or Hospital.

DETOXIFICATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Medically Necessary detoxification is covered.

DIABETIC EDUCATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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

DIALYSIS
Inpatient

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Outpatient Initial Treatment Period

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: three months per Claimant (42 treatments of hemodialysis or 30 days peritoneal dialysis) for the initial treatment period	

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

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

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

Outpatient Supplemental Treatment Period (Following Initial Treatment Period)

Provider: In-Network	Provider: Out-of-Network
Payment: No charge. If the Claims Administrator's agreement with the Provider expressly specifies that its terms supersede Your benefits (or this benefit), You pay 0% of the Allowed Amount. Otherwise, the Plan pays 150% of the Medicare allowed amount at the time of service.	**Payment:** The Plan pays 150% of the Medicare allowed amount at the time of service. If You are not enrolled in Medicare Part B, You pay the balance of billed charges. Only the difference between the Plan's payment and the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

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

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

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

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

To learn more or to enroll in Case Management, call the Claims Administrator's Customer Service.

DURABLE MEDICAL EQUIPMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Durable Medical Equipment is covered, including, but not limited to, oxygen equipment, wheelchairs and supplies or equipment associated with diabetes.

Additionally, new Durable Medical Equipment is covered when obtained from an approved Commercial Seller. Benefits for eligible new Durable Medical Equipment will

be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible new Durable Medical Equipment, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit the Claims Administrator's Web site or contact Customer Service.

Claims for the purchase of Durable Medical Equipment will be submitted to the Blue plan in the locale in which the equipment was received. Durable Medical Equipment is received where it is purchased at retail or, if shipped, where the Durable Medical Equipment is shipped to. Refer to Your Blue plan network where supplies were received for coverage of shipped Durable Medical Equipment.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $100 Copayment per visit. This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	**Payment:** You pay $100 Copayment per visit and the balance of billed charges. This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.

Emergency room services and supplies are covered, including outpatient charges for patient observation and medical screening examinations that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be prior authorized.

"Stabilization" means to provide Medically Necessary treatment:

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

If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. However, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Contact Customer Service for further information and guidance.

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

Provider: Centers of Excellence	Provider: All Other Providers
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** You pay 100% of billed charges. Your payment will not be applied toward the Deductible or the Out-of-Pocket Maximum.

Gene therapies, adoptive cellular therapies as well as associated services and supplies are covered for Claimants who fulfill the Medical Necessity criteria.

To be covered at the Centers of Excellence (COE) benefit level, gene therapy and/or adoptive cellular therapy must be received from one of the Claims Administrator's COE facilities that is expressly identified as a COE for that therapy. However, if a COE has not been identified for a covered gene therapy and/or adoptive cellular therapy, that therapy must be received from an In-Network Provider to be covered at the COE benefit level. For a list of covered therapies or to identify a COE facility, contact the Claims Administrator's Customer Service as the lists are subject to change.

Travel Expenses

Payment: After Deductible, You pay 100% of billed charges. Your payment may be reimbursed up to the travel expense limit.
Limit: $7,500 per Claimant per course of treatment, including companion(s), for transportation, lodging and meal expenses. Additional limitations included below.

Transportation, lodging and meal expenses are covered, subject to the following specified limits:

- based on the generally accepted course of treatment in the United States, the therapy would require an overnight stay of seven or more consecutive nights away from home and within reasonable proximity to the treatment area;
- if a COE has been identified for the specified covered therapy, covered treatment must be received from the COE;
- if a COE has not been identified for the specified covered therapy, covered treatment must be received from an In-Network Provider;
- coverage is for the Claimant and one companion (or two companions if the Claimant is under the age of 19);
- commercial lodging expenses are limited to $300 per night for the Claimant and companion(s) combined;
- meal expenses are limited to $80 per day for each Claimant or companion(s); and
- covered transportation expenses to and from the treatment area include only:
    - commercial airfare;
    - commercial train fare; or
    - documented auto mileage (calculated per IRS medical allowances).

Additionally, local ground transportation within the treatment area to and from the treatment site is covered during the course of treatment. The Plan will reimburse You for Covered Services associated with these travel expenses. Documentation of all travel expenses should be retained for reimbursement. Contact Customer Service for further information and guidance.

Coverage does not include incidentals outside of transportation, lodging and meals.

HEARING AIDS AND HEARING ASSISTIVE TECHNOLOGY SYSTEMS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limits: one hearing aid per ear per Claimant every 36 months or more frequently if modifications to an existing hearing aid will not meet the needs of the Claimant. One box of replacement batteries for each hearing aid per Claimant per Calendar Year. Bone-conduction sound processors every 36 months, if necessary for appropriate amplification of the hearing loss. Ear molds and replacement ear molds up to four times per Calendar Year. Hearing assistive technology systems every 36 months, if necessary for appropriate amplification of hearing loss. Necessary diagnostic and treatment services at least twice per Calendar Year.	

Covered Services include the following:

- hearing aids and supplies;
- hearing assistive technology systems;
- diagnostic and treatment services including hearing tests appropriate for a Claimant's age or developmental need;
- hearing aids checks and aided testing; and
- bone conduction sound processors when necessary for the treatment of hearing loss.

"Hearing aid" means any nondisposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device. "Hearing assistive technology systems" means devices used with or without hearing aids or cochlear implants to improve the ability of a user with hearing loss to hear in various listening situations, such as being located a distance from a speaker, in an environment with competing background noise or in a room with poor acoustics or reverberation.

Services and supplies that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. This coverage does not include routine hearing examinations or the cost of cords.

HOME HEALTH CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 140 visits per Calendar Year	

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

Home health care visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with home health care services is covered in the Durable Medical Equipment benefit.

HOSPICE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 30 inpatient or outpatient respite care days per Claimant Lifetime	

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

Respite care is also covered to provide continuous care of the Claimant and allow temporary relief to family members from the duties of caring for the Claimant. Respite days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment associated with hospice care is covered in the Durable Medical Equipment benefit.

HOSPITAL CARE – INPATIENT AND OUTPATIENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Services and supplies of a Hospital (including services of staff Providers) are covered for treatment of Illness or Injury. Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If admitted to an Out-of-Network Hospital directly from the emergency room, services will

be covered at the In-Network benefit level. An Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Contact Customer Service for further information and guidance.

MATERNITY CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy, and related conditions are covered. There is no limit for the patient's length of inpatient stay. The attending Provider will determine an appropriate discharge time in consultation with the patient. When provided by an In-Network Provider, any Deductible, Copayment and/or Coinsurance do not apply to Medically Necessary Covered Services for management of a pregnant Claimant's diabetes from the date of conception through six weeks postpartum for each pregnancy.

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

Surrogacy

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

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

Definitions

The following definition applies to this Maternity Care benefit:

Acting (or Act) as a Surrogate means You agree to become pregnant and to surrender, relinquish or otherwise give up any parental rights to the baby (or babies) produced by that pregnancy to another person or persons who intend to raise the baby (or babies), whether or not You receive payment, the agreement is written and/or the parties to the agreement meet their obligations.

MEDICAL FOODS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Medical foods for inborn errors of metabolism are covered, including, but not limited to, formulas for Phenylketonuria (PKU). "Medical food" means a food which is formulated to be consumed or administered orally or enterally under the supervision of a Physician. Medical foods are intended for specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. Other services and supplies such as office visits and formula to treat severe intestinal malabsorption are otherwise covered under the appropriate provision in this Medical Benefits Section.

MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES
Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Outpatient Office / Psychotherapy Visits

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $30 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Other Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Inpatient and outpatient Mental Health and Substance Use Disorder Services, including Applied Behavioral Analysis (ABA) therapy services, behavioral health assessments and gender-affirmation treatment services are covered. "Gender-affirming treatment" is treatment whose purpose is to bring a person's outward appearance into closer alignment with that person's actual gender identity. Benefits include the following when provided for treatment of a Mental Health Condition:

- physical therapy;
- occupational therapy;
- speech therapy;
- radiology and laboratory services;

- durable medical equipment; and
- surgery.

Definitions
The following definitions apply to this Mental Health or Substance Use Disorder Services benefit:

Applied Behavioral Analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human social behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior. ABA therapy services must be provided by a licensed Provider qualified to prescribe and perform ABA therapy services.

Habilitative means health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services and devices may include physical and occupational therapy, speech-language pathology and other services and devices for people with disabilities in a variety of inpatient or outpatient settings.

Mental Health and Substance Use Disorder Services mean Medically Necessary outpatient services, Residential Care, partial hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health Provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is Medically Necessary). These services include Habilitative and Rehabilitative services for Mental Health Conditions or Substance Use Disorders without any visit or day limits.

Mental Health Condition means any mental disorder covered by diagnostic categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, including autism spectrum disorders and Pervasive Developmental Disorder (PDD). Pervasive Developmental Disorder means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability or intellectual disability. Mental disorders that accompany an excluded diagnosis are covered.

Rehabilitative means inpatient or outpatient physical, occupational and speech therapy services to restore or improve lost function caused by Illness or Injury.

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

term social needs. However, services by Physicians or Practitioners in such settings may be covered if they are billed independently and would otherwise be a Covered Service.

Substance Use Disorder means any substance-related disorder covered by diagnostic categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Substance Use Disorder does not include addiction to or dependency on tobacco, tobacco products, or foods.

NEURODEVELOPMENTAL THERAPY

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $30 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 30 visits per Claimant per Calendar Year for all therapies combined	

Physical therapy, occupational therapy or speech therapy services by a Physician or Practitioner are covered for neurological conditions that are not a Mental Health Condition or Substance Use Disorder (e.g. failure to thrive in newborn, lack of physiological development in childhood) to restore or improve function based on developmental delay for a Claimant age 17 and under. Covered Services include maintenance services if significant deterioration of a Claimant's condition would result without the service. (Services for Mental Health Conditions or Substance Use Disorders are covered in the Mental Health or Substance Use Disorder Services benefit and are not subject to age or visit limits.)

Neurodevelopmental therapy visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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

NEWBORN HOME VISITS

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** You pay 100% of billed charges. Your payment will not be applied toward the Deductible or the Out-of-Pocket Maximum.
Limit: Within six months of age, at least one visit during the first three months of life with an opportunity to choose up to three more visits	

Home visits provided as part of the Oregon Health Authority's (OHA's) home visiting program are covered for enrolled newborns up to six months of age if:

- the newborn resides in an area of the state that is served by a universal newborn nurse home visiting program approved by the OHA; and
- the home visits are provided by an Oregon licensed registered nurse who is certified by the OHA to participate in that program.

NUTRITIONAL COUNSELING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: five visits per Claimant Lifetime (diabetic counseling is not subject to this limit)	

Services for nutritional counseling and nutritional therapy, such as diabetic counseling, discussions on eating habits, lifestyle choices and dietary interventions are covered for all conditions, including obesity. Nutritional counseling visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

ORTHOTIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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

- braces;
- splints; and
- orthopedic appliances.

Additionally, some orthotic devices that are new are covered when obtained from an approved Commercial Seller. Benefits for eligible new orthotic devices will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the

amount paid to an In-Network Provider or the retail market value. To verify eligible new orthotic devices, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, visit the Claims Administrator's Web site or contact Customer Service.

The Plan may elect to provide benefits for a less costly alternative item. Covered Services do not include orthopedic shoes and off-the-shelf shoe inserts.

PALLIATIVE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 30 visits per Claimant per Calendar Year	

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

Palliative care visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. All other Covered Services for a Claimant receiving palliative care remain covered the same as any other Illness or Injury.

PROSTHETIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Prosthetic devices for functional reasons are covered to replace a missing body part, including:

- artificial limbs;
- external or internal breast prostheses following a Mastectomy; and
- maxillofacial prostheses.

"Maxillofacial prostheses services" are restoration and management of head and facial structures that are not replaceable with living tissue and are defective because of disease, trauma, or birth or developmental deformities. Covered maxillofacial prostheses services must be either for the purpose of controlling or eliminating infection or pain or for restoring facial configuration or functions (e.g., speech, swallowing, chewing). Restoration of facial configuration that is cosmetic to improve on the normal range of conditions is not covered.

Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered in the appropriate facility benefit. Additionally, the repair or replacement of a prosthetic device due to normal use or growth of a child is covered.

REHABILITATION SERVICES

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 30 inpatient days per Claimant per Calendar Year	

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $30 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 30 outpatient visits combined per Claimant per Calendar Year	

Inpatient and outpatient rehabilitation services and accommodations are covered as appropriate and necessary to restore or improve lost function caused by Illness or Injury that is not a Mental Health Condition or Substance Use Disorder. (Rehabilitation services for mental diagnoses are covered in the Mental Health or Substance Use Disorder Services benefit.)

"Rehabilitation services" mean physical, occupational and speech therapy services only, including associated services such as massage when provided as a therapeutic intervention.

Rehabilitation services that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

REPAIR OF TEETH

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: $5,000 per Claimant Lifetime	

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

REPRODUCTIVE HEALTH CARE SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Reproductive health care services and supplies are covered, including abortion, vasectomy and screening for pregnancy that are not covered in the Preventive Care and Immunizations benefit.

RETAIL CLINIC OFFICE VISITS

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $30 Copayment per visit.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Office visits in a Retail Clinic are covered for treatment of Illness or Injury. All other professional services performed in the Retail Clinic, not billed as an office visit, or that are not related to the actual visit are not considered an office visit.

SKILLED NURSING FACILITY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: 60 inpatient days per Claimant per Calendar Year	

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

Skilled Nursing Facility days that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. Ancillary services and supplies, such as physical therapy, Prescription Medications, and radiology and laboratory services, billed as part of a Skilled Nursing Facility admission also apply toward any Maximum Benefit limit on Skilled Nursing Facility care.

SPINAL MANIPULATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: You pay $30 Copayment per visit.	**Payment:** You pay $30 Copayment per visit and the balance of billed charges.

Chiropractic and osteopathic spinal manipulations are covered.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.
Limit: $3,000 per Claimant Lifetime	

Inpatient and outpatient services are covered for treatment of TMJ disorders which have one or more of the following characteristics:

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

Covered Services include services that are:

- reasonable and appropriate for the treatment of a TMJ disorder;
- effective for the control or elimination of one or more of the following TMJ disorders:
    - pain;
    - infection;
    - disease;
    - difficulty in speaking; or
    - difficulty in chewing or swallowing food.

TOBACCO USE CESSATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Tobacco use cessation services not covered in the Preventive Care and Immunizations benefit are covered in this Tobacco Use Cessation benefit. A "tobacco use cessation service" means a service that follows the United States Public Health Service guidelines for tobacco use cessation, including education and medical treatment components designed to assist a person in ceasing the use of tobacco products.

TRANSPLANTS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

Transplants are covered, including transplant-related services and supplies. Covered Services for a transplant recipient include the following:

- heart;

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

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

For a list of covered transplants, contact the Claims Administrator's Customer Service, as the list is subject to change. Gene and/or adoptive cellular therapies are covered in the Gene Therapy and Adoptive Cellular Therapy benefit.

Donor Organ Benefits
Donor organ procurement costs are covered for a recipient. Procurement benefits are limited to:

- selection;
- removal of the organ;
- storage; and
- transportation of the surgical harvesting team and the organ.

VIRTUAL CARE
Virtual care services are covered for the use of telehealth, telemedicine or store and forward services received from a remote Provider, rather than an in-person office visit, for the diagnosis, treatment or management of a covered medical condition. Some Providers or virtual care vendors may provide virtual care services at a lower cost, resulting in a reduction of Your cost-share.

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

Store and Forward Services

Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

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

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

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

Telehealth

Provider: Virtual Care Vendor	Provider: In-Network	Provider: Out-of-Network
Payment: No charge.	**Payment:** No charge.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

"Telehealth" means Your live services (real-time audio-only or audio and video communication) with a remote Provider through a secure HIPAA compliant platform when You are not in a Provider's office or healthcare facility. For example, telehealth includes a live video call from Your home to discuss a possible eye infection with Your Provider.

Telemedicine

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

"Telemedicine" means You are located at, and using, a Provider's office or healthcare facility's equipment for Your live services (real-time audio-only or audio and video communication) with a remote Provider through a secure HIPAA compliant platform. For example, telemedicine includes using the equipment at Your local Provider's office

to have a live video call with a secondary Provider such as a cardiologist in a different city.

NOTE: You will receive a separate charge from the secondary Provider You contacted, in addition to the charge from the Provider's office or healthcare facility where You are physically located.

Prescription Medications

This section explains Your benefits and cost-sharing responsibilities for Prescription Medications. Benefits will be paid in this Prescription Medications benefit, not any other provision, if a medication or supply is covered by both.

Prescription Medications listed on the Drug List are covered. Prescription Medications not on the Drug List may be covered as described in the Drug List Exception Process provision. The Drug List may be viewed on the Claims Administrator's Web site or by contacting Customer Service.

PRESCRIPTION MEDICATION CALENDAR YEAR DEDUCTIBLES
Not applicable

COPAYMENTS AND/OR COINSURANCE
You are responsible for paying the following Copayment and/or Coinsurance amounts at the time of purchase, if the Pharmacy submits the claim electronically. Your Copayment and/or Coinsurance will be applied toward the In-Network Out-of-Pocket Maximum as further specified in the Understanding Your Benefits Section.

You are not responsible for any Copayment and/or Coinsurance when You fill prescriptions for:

- Medically Necessary Prescription Medications for management of a pregnant Claimant's diabetes from the date of conception through six weeks postpartum for each pregnancy;
- women's contraceptive methods that are not covered in the Preventive Care and Immunizations benefit; or
- medications intended to treat opioid overdose that are on the Naloxone Value List found on the Claims Administrator's Web site or by contacting Customer Service.

When You fill a prescription for insulin, Your cost-share will not exceed $75 per a 30-day supply from a Pharmacy or $225 per a 90-day supply from a Mail-Order Supplier.

For any Prescription Medication that is a Compound Medication, Your Coinsurance is 50 percent.

Prescription Medications from a Pharmacy (for Each 30-Day Supply)

• You pay $2 for each Preferred Generic Medication; $10 for each Self-Administrable Cancer Chemotherapy Medication
• You pay $10 for each Generic Medication; $10 for each Self-Administrable Cancer Chemotherapy Medication
• You pay $30 for each Preferred Brand-Name Medication; $50 for each Self-Administrable Cancer Chemotherapy Medication
• You pay $50 for each Brand-Name Medication; $50 for each Self-Administrable Cancer Chemotherapy Medication
• You pay $50 for each Preferred Specialty Medication; $100 for each Self-Administrable Cancer Chemotherapy Medication
• You pay $50 for each Specialty Medication; $100 for each Self-Administrable Cancer Chemotherapy Medication

Prescription Medications from a Mail-Order Supplier (for Each 90-Day Supply)

• You pay $3 for each Preferred Generic Medication
• You pay $15 for each Generic Medication
• You pay $45 for each Preferred Brand-Name Medication
• You pay $75 for each Brand-Name Medication

Brand-Name Prescription Medication Instead of Generic
If You choose to fill a Prescription Order with a Brand-Name Medication and an equivalent Generic Medication is available, You will be responsible for paying the difference in cost. At the time of purchase, You will be responsible for the applicable Copayment and/or Coinsurance for the Brand-Name Medication in addition to the difference in cost between the equivalent Generic Medication and the Brand-Name Medication. The difference in cost does not apply toward any Out-of-Pocket Maximum. If the prescribing Provider specifies that the Brand-Name Medication must be dispensed, You will not be responsible for the difference in cost.

PRESCRIPTION MEDICATION CALENDAR YEAR OUT-OF-POCKET MAXIMUM
Not applicable

COVERED PRESCRIPTION MEDICATIONS
Prescription Medication benefits are available for the following:

- Prescription Medications;
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Injectable Medications) and teaching doses by which a Claimant is educated to self-inject;
- diabetic supplies, when obtained with a Prescription Order, including:

  - lancets;
  - test strips;
  - glucagon emergency kits; and
  - insulin syringes.

- certain continuous glucose monitors and insulin pumps that are on the Drug List may be purchased from a Pharmacy, when obtained with a Prescription Order; related supplies and other continuous glucose monitors or other insulin pumps are covered in the Durable Medical Equipment benefit;
- Compound Medications;
- Specialty Medications (including, but not limited to, medications for multiple sclerosis, rheumatoid arthritis, cancer, clotting factor for hemophilia or similar clotting disorders and hepatitis C);
- Self-Administrable Cancer Chemotherapy Medication;
- antiretroviral therapy medications obtained from either a Participating Pharmacy or Nonparticipating Pharmacy;
- immunizations for travel, occupation or residency in a foreign country; and
- certain Prescription Medications that are administered by Your Provider as determined by the Pharmacy and Therapeutics (P&T) Committee.

Additionally, the following preventive medications obtained from a Participating Pharmacy are covered at no charge to You, including, but not limited to:

- immunizations for adults and children according to, and as recommended by the CDC and/or USPSTF;
- certain preventive medications according to, and as recommended by the USPSTF, that are on the Drug List and when obtained with a Prescription Order, such as:

  - aspirin;
  - fluoride;
  - iron;
  - folic acid supplements; and
  - medications for tobacco use cessation.

- FDA-approved women's prescription and over-the-counter contraception methods, according to, and as recommended by the HRSA:

  - female condoms;
  - diaphragm with spermicide;
  - sponge with spermicide;
  - cervical cap with spermicide;
  - spermicide;
  - oral contraceptives (combined pill, mini pill, and extended/continuous use pill);
  - contraceptive patch;
  - vaginal ring;
  - contraceptive shot/injection; and
  - emergency contraceptives (both levonorgestrel and ulipristal acetate-containing products).

You must submit a claim for reimbursement for the purchase of over-the-counter contraception items. To receive reimbursement for these items, complete a Prescription Medication claim form and mail the form and receipt to the Claims Administrator for processing. The Prescription Medication claim form is available by visiting the Claims Administrator's Web site or contacting Customer Service.

When preventive medications or immunizations are obtained from a Nonparticipating Pharmacy, You will be responsible for any Deductible, Copayment and/or Coinsurance listed above for Prescription Medications. If Your Provider believes that the Plan's covered preventive medications, including women's contraceptives, are medically inappropriate for You, You may request a coverage exception for an equivalent preventive medication by contacting Customer Service. For additional information on covered Prescription Medications, visit the Claims Administrator's Web site or contact Customer Service.

PRESCRIPTION MEDICATIONS CLAIMS AND ADMINISTRATION

Prior Authorization

Some Prescription Medications may require prior authorization before they are dispensed. The Claims Administrator will notify participating Providers, including Pharmacies, which Prescription Medications require prior authorization. Prescription Medications that require prior authorization must have medical information provided by the prescribing Provider to determine Medical Necessity. Prescribed Medications that require prior authorization will not be covered until they are prior authorized. For a list of medications that require prior authorization or if You have any questions, visit the Claims Administrator's Web site or contact Customer Service.

Drug List Changes

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

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

Drug List Exception Process

Non-Drug List medications are not covered by Your Prescription Medications benefit. However, a Prescription Medication not on the Drug List may be covered in certain circumstances.

"Non-Drug List" means those self-administered Prescription Medications not listed on the Drug List.

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

- medication policy criteria are met, if applicable;
- You are not able to tolerate a covered Prescription Medication(s) on the Drug List;
- Your Provider determines that the Prescription Medication(s) on the Drug List is not therapeutically effective for treating Your covered condition; or
- Your Provider determines that a dosage required for effective treatment of Your covered condition differs from the Prescription Medication on the Drug List dosage limitation.

The specific medication policy criteria to determine if a Prescription Medication not on the Drug List is Medically Necessary are available on the Claims Administrator's Web site. You or Your Provider may request prior authorization by calling Customer Service or by completing and submitting the form on the Claims Administrator's Web site.

Once prior authorization has been approved, the Prescription Medication not on the Drug List will be available for coverage at the Substituted Medication Copayment and/or Coinsurance level determined by Your Plan and will apply toward any Deductible or Out-of-Pocket Maximum.

Pharmacy Network Information
A nationwide network of Participating Pharmacies is available to You. You can find Participating Pharmacies on the Claims Administrator's Web site or by contacting Customer Service.

You must present Your identification card to identify Yourself as a Claimant of this Plan when obtaining Prescription Medications from a Pharmacy or Mail-Order Supplier. If You do not present Your identification card You may be charged more than the Covered Prescription Medication Expense.

Claims Submitted Electronically
Participating Pharmacies will submit claims electronically. If a Nonparticipating Pharmacy provides Your Prescription Medication and submits the claim electronically, the Nonparticipating Pharmacy will be paid directly. Nonparticipating Pharmacies, however, may charge amounts in excess of Covered Prescription Medication Expenses. If that happens, You will be responsible for the excess amounts, as well as any Deductible, Copayment and/or Coinsurance shown electronically to the Nonparticipating Pharmacy at the time of purchase.

Claims Not Submitted Electronically
It is best to use a Participating Pharmacy so Your claims can be submitted electronically, and so You won't have to pay the difference between the Pharmacy's charges and the Covered Prescription Medication Expense in addition to Your Deductible, Copayment and/or Coinsurance.

However, when a claim is not submitted electronically, You pay for the Prescription Medication in full at the time of purchase. For reimbursement, complete a Prescription Medication claim form and mail a copy of the form and the Prescription Medication receipt to the Claims Administrator. To find the Prescription Medication claim form visit the Claims Administrator's Web site or contact Customer Service.

You will be reimbursed directly based on the Covered Prescription Medication Expense, minus the applicable Deductible, Copayment and/or Coinsurance that would have been required had the medication been purchased from a Participating Pharmacy.

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

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

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

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

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

Refills
Refills obtained from:

- a Pharmacy are covered when You have taken 75 percent of the previous prescription;
    - except, Schedule II or III controlled substance medications may be refilled only after You have taken 85 percent of the previous prescription.
- a Mail-Order Supplier are covered after You have taken all but 20 days of the previous Prescription Order.

However, if You:

- choose to refill Your Prescription Medications sooner, You will be responsible for the full cost of the Prescription Medication and those costs will not apply toward any Deductible and/or Out-of-Pocket Maximum.
- feel You need a refill sooner than allowed, a refill exception will be considered on a case-by-case basis. You may request an exception by calling Customer Service.
- receive maintenance medications for chronic conditions, You may qualify for the Claims Administrator's prescription refill synchronization which allows refilling Prescription Medications from a Pharmacy on the same day of the month.

For further information on prescription refills or refill synchronization, please call Customer Service.

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

LIMITATIONS
The following limitations apply to this Prescription Medications Section, except for certain preventive medications as specified in the Covered Prescription Medications Section:

Prescription Medication Supply Limits

- **30-Day Supply Limit:**
  - **Specialty Medications** – the largest allowable quantity for a Specialty Medication purchased from a Specialty Pharmacy, is a 30-day supply. The first fill is allowed at a Pharmacy. Additional fills must be provided at a Specialty Pharmacy. However, some Specialty Medications must have the first and subsequent fills at a Specialty Pharmacy. For more information on those medications, please visit the Claims Administrator's Web site or contact Customer Service. Specialty Medications are not allowed through mail-order.
- **3-Month Supply Limit:**
  - **Prescription Contraceptives** – the largest allowable quantity for the first fill of a prescription contraceptive purchased from a Pharmacy or Mail-Order Supplier is a three-month supply (which may be dispensed in a Provider's office, if available). After the first fill, a 12-month supply is allowed for subsequent fills of the same contraceptive. The Copayment and/or Coinsurance, if applicable, is based on each 30-day supply from a Pharmacy and each 90-day supply from a Mail-Order Supplier.
- **90-Day Supply Limit:**
  - **Pharmacy** – the largest allowable quantity of a Prescription Medication purchased from a Pharmacy is a 90-day supply. A Provider may prescribe or You may purchase, some medications in smaller quantities. The Copayment and/or Coinsurance is based on each 30-day supply.

- **Mail-Order Supplier** – the largest allowable quantity of a Prescription Medication purchased from a Mail-Order Supplier is a 90-day supply. A Provider may prescribe or You may purchase some medications in smaller quantities.
- **Multiple-Month Supply** – except for prescription contraceptives, the largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Pharmacy is a 90-day supply (even if the packaging includes a larger supply). The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The Copayment and/or Coinsurance is based on each 30-day supply within that multiple-month supply.

- **Maximum Quantity Limit:**

  - For certain Prescription Medications, the Claims Administrator establishes maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. The Claims Administrator uses information from the FDA and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your identification card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service.
  - For certain Self-Administrable Cancer Chemotherapy Medications, due to safety factors and the Claimant's ability to tolerate these medications, the Prescription Medication may be reduced to an initial 14-day or 15-day supply before larger quantities are dispensed.
  - Any amount over the established maximum quantity is not covered, except if the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

EXCLUSIONS
The following exclusions apply to this Prescription Medications Section and are not covered:

Biological Sera, Blood or Blood Plasma

Bulk Powders
Except as included on the Claims Administrator's Drug List and presented with a Prescription Order, bulk powders are not covered.

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

- removal, inhibition or stimulation of hair growth;
- anti-aging;
- repair of sun-damaged skin; or
- reduction of redness associated with rosacea.

Devices or Appliances
Except as provided in the Medical Benefits Section devices or appliances of any type, even if they require a Prescription Order are not covered.

Diagnostic Agents
Except as provided in the Medical Benefits Section, diagnostic agents used to aid in diagnosis rather than treatment are not covered.

Foreign Prescription Medications
Foreign Prescription Medications are not covered, except for the following:

- Prescription Medications associated with an Emergency Medical Condition while You are traveling outside the United States; or
- Prescription Medications You purchase while residing outside the United States.

These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered in this section if obtained in the United States.

General Anesthetics
Except as provided in the Medical Benefits Section, general anesthetics are not covered.

Medical Foods
Except as provided in the Medical Benefits Section, medical foods are not covered.

Medications That Are Not Self-Administrable
Except as provided in the Medical Benefits Section or as specifically indicated in this Prescription Medications Section, medications that are not considered self-administrable are not covered.

Nonprescription Medications
Nonprescription medications that by law do not require a Prescription Order are not covered, except for the following:

- medications included on the Claims Administrator's Drug List;
- medications approved by the FDA; or
- a Prescription Order by a Physician or Practitioner.

Nonprescription medications include, but are not limited to:

- over-the-counter medications (except for over-the-counter contraceptives);
- vitamins (except for folic acid supplements);
- minerals;
- food supplements;
- homeopathic medicines;
- nutritional supplements; and
- any medications listed as over-the-counter (except for over-the-counter contraceptives) in standard drug references, regardless of state law prescription requirements, such as pseudoephedrine and cough syrup products.

NOTE: Over-the-counter contraceptives and folic acid supplements are covered under this Prescription Medications Section.

Prescription Medications Dispensed in a Facility
Prescription Medications dispensed to You while You are a patient in a Hospital, Skilled Nursing Facility, nursing home or other health care institution. Medications dispensed upon discharge should be processed by this benefit if obtained from a Pharmacy.

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

Prescription Medications Not Approved by the FDA

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

Prescription Medications Not on the Drug List
Except as provided through the Drug List Exception Process, Prescription Medications that are not on the Drug List are not covered.

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

Prescription Medications with Lower Cost Alternatives
Prescription Medications for which there are covered therapeutically equivalent (similar safety and efficacy) alternatives, or over-the-counter (nonprescription) alternatives, unless the higher cost Prescription Medications are Medically Necessary.

Prescription Medications without Examination
Except as provided in the Virtual Care benefit, whether the Prescription Order is provided by mail, telephone, internet or some other means, Prescription Medications without a recent and relevant in-person examination by a Provider, are not covered. Additionally, this exclusion does not apply for:

- hormonal contraceptive patches; or
- self-administered hormonal contraceptives prescribed by a Pharmacist.

An examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.

Professional Charges for Administration of Any Medication

Repackaged Medications, Institutional Packs and Clinic Packs

DEFINITIONS
The following definitions apply to this Prescription Medications Section:

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

Medication that has been approved by the FDA and may be subject to review for Medical Necessity.

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

Drug List means the Claims Administrator's list of selected Prescription Medications. The Claims Administrator established and routinely reviews and updates the Drug List. It is available on the Claims Administrator's Web site or by calling Customer Service. Medications are reviewed and selected for inclusion on the Drug List by an outside committee of Providers, including Physicians and Pharmacists.

Mail-Order Supplier means a mail-order Pharmacy with which the Claims Administrator has contracted for mail-order services.

Nonparticipating Pharmacy means a Pharmacy with which the Claims Administrator neither has a contract nor has contracted access to any network it belongs to. Nonparticipating Pharmacies may not be able to or choose not to submit claims electronically.

Participating Pharmacy means either a Pharmacy with which the Claims Administrator has a contract or a Pharmacy that participates in a network for which the Claims Administrator has contracted to have access. Participating Pharmacies have the capability of submitting claims electronically.

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

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed.

Pharmacy and Therapeutics (P&T) Committee means an officially chartered group of practicing Physicians and Pharmacists who review the medical and scientific literature regarding medication use. The P&T Committee also provides input and oversight of the development of the Claims Administrator's Drug List and medication policies. Additionally, the P&T Committee is free from conflict of interest of drug manufacturers and the majority of whom are also free from conflict of interest of Your coverage.

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

Preferred Generic Medication and Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references (or specified by the Claims Administrator) as a Generic Medication.

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

Preferred Specialty Medications and Specialty Medications mean medications that may be used to treat complex conditions, including, but not limited to:

- multiple sclerosis;
- rheumatoid arthritis;
- cancer;
- clotting factor for hemophilia or similar clotting disorders; and
- hepatitis C.

Information from the manufacturer, scientific literature, practice standards, Medicare practices and other information that is considered relevant and reliable is used to determine a Specialty Medication. For a list of such medications, visit the Claims Administrator's Web site or contact Customer Service.

Prescription Medications and Prescribed Medications mean medications and biologicals that:

- relate directly to the treatment of an Illness or Injury;
- legally cannot be dispensed without a Prescription Order;
- by law must bear the legend, "Prescription Only"; or
- are specifically included on the Claims Administrator's Drug List.

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

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

Specialty Pharmacy means a Pharmacy or designated Hemophilia Treatment Center (HTC) that specializes in the distribution and medication management services of high

cost injectables and Specialty Medications. To find a Specialty Pharmacy, visit the Claims Administrator's Web site or contact Customer Service.

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

General Exclusions

The following are the general exclusions from coverage. Other exclusions may apply as described elsewhere in this Booklet.

SPECIFIC EXCLUSIONS
The following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**, are not covered. However, these exclusions will not apply with regard to a Covered Service for:

- an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by federal law;
- a preventive service as specified in the Preventive Care and Immunizations benefit and/or in the Prescription Medications Section; or
- services and supplies furnished in an emergency room for stabilization of a patient.

Activity Therapy
The following activity therapy services are not covered:

- creative arts;
- play;
- dance;
- aroma;
- music;
- equine or other animal-assisted;
- recreational or similar therapy; and
- sensory movement groups.

Adventure, Outdoor, or Wilderness Interventions and Camps
Outward Bound, outdoor youth or outdoor behavioral programs, or courses or camps that primarily utilize an outdoor or similar non-traditional setting to provide services that are primarily supportive in nature and rendered by individuals who are not Providers, are not covered, including, but not limited to, interventions or camps focused on:

- building self-esteem or leadership skills;
- losing weight;
- managing diabetes;
- contending with cancer or a terminal diagnosis; or
- living with, controlling or overcoming:
    - blindness;
    - deafness/hardness of hearing;
    - a Mental Health Condition; or
    - a Substance Use Disorder.

Services by Physicians or Practitioners in adventure, outdoor or wilderness settings may be covered if they are billed independently and would otherwise be a Covered Service in this Booklet.

Assisted Reproductive Technologies
Assisted reproductive technologies, regardless of underlying condition or circumstance are not covered, including, but not limited to:

- cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo;
- in vitro fertilization;
- artificial insemination;
- embryo transfer;
- other artificial means of conception; or
- any associated surgery, medications, testing or supplies.

Cosmetic/Reconstructive Services and Supplies
Cosmetic and/or reconstructive services and supplies are not covered, except for the treatment of the following:

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

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

"Mastectomy" means the surgical removal of all or part of a breast or a breast tumor suspected to be malignant.

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

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

Custodial Care
Except as provided in the Palliative Care benefit, non-skilled care and helping with activities of daily living is not covered.

Dental Services
Except as provided in the Repair of Teeth or Other Professional Services benefit, Dental Services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues are not covered, including treatment that restores the function of teeth.

Expenses Before Coverage Begins or After Coverage Ends
Services and supplies incurred before Your Effective Date under the Plan or after Your termination under the Plan. However, when the Agreement is terminated and coverage for all Claimants under the Plan is immediately replaced by another group agreement

and You are in the Hospital on the day this coverage ends, the Plan will continue to provide benefits for that hospitalization until Your discharge from the Hospital or Your benefits have been exhausted, whichever comes first. (This exception does not apply to a Skilled Nursing Facility or any other type of facility, except a Hospital.)

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

Fees, Taxes, Interest
Except as required by law, the following fees, taxes and interest are not covered:

- charges for shipping and handling, postage, interest or finance charges that a Provider might bill;
- excise, sales or other taxes;
- surcharges;
- tariffs;
- duties;
- assessments; or
- other similar charges whether made by federal, state or local government or by another entity.

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

Additionally, government facilities or government facilities outside the service area are not covered, except for the following:

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

Hearing Care
Except as provided in the Medical Benefits Section, hearing care is not covered.

Hypnotherapy and Hypnosis Services
Hypnotherapy and hypnosis services and associated expenses are not covered, including, but not limited to:

- treatment of painful physical conditions;
- mental health and substance use disorders; or
- for anesthesia purposes.

Illegal Activity
Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by a Claimant's **voluntary participation in** an activity where the Claimant is found guilty of an illegal activity in a criminal proceeding or is found liable for the activity in a civil proceeding. A guilty finding includes a plea of guilty or a no contest

plea. If benefits already have been paid before the finding of guilt or liability is reached, the Plan may recover the payment from the person paid or anyone else who has benefited from it.

Illegal Services, Substances and Supplies
Services, substances and supplies that are illegal as defined by state or federal law.

Individualized Education Program (IEP)
Services or supplies, including, but not limited to, supplementary aids and supports, as provided in an IEP developed and adopted pursuant to the Individuals with Disabilities Education Act.

Infertility
Except to the extent Covered Services are required to diagnose such condition, treatment of infertility is not covered, including, but not limited to:

- surgery;
- uterine transplants;
- fertility medications; and
- other medications associated with fertility treatment.

Investigational Services
Except as provided in the Approved Clinical Trials benefit, Investigational services are not covered, including, but not limited to:

- services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions); and
- any services or supplies provided by an Investigational protocol.

Liposuction for the Treatment of Lipedema

Motor Vehicle Coverage and Other Available Insurance
When motor vehicle coverage, other available insurance or contract is either issued to, or makes benefits available to a Claimant (whether or not the Claimant makes a claim with such coverage), expenses are not covered for services and supplies that are payable by any:

- automobile medical;
- personal injury protection (PIP);
- automobile no-fault coverage;
- underinsured or uninsured motorist coverage;
- homeowner's coverage;
- commercial premises coverage;
- excess coverage; or
- similar contract or insurance.

Further, the Claimant is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits in such contract or insurance are exhausted or considered to no longer be Injury-related by the no-fault provisions of the contract, benefits will be provided accordingly.

Non-Direct Patient Care
Except as provided in the Virtual Care benefit, non-direct patient care services are not covered, including, but not limited to:

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

Non-Duplication of Medicare
When, by law, this coverage would not be primary to Medicare Part B had You properly enrolled in Medicare Part B when first eligible, benefits will be reduced to the extent that those benefits are or would have been provided by any part of Medicare Part B regardless of whether or not You choose to accept those benefits.

Obesity or Weight Reduction/Control
Except as provided in the Nutritional Counseling benefit or as required by law, such as for Preventive Care and Immunizations, services or supplies that are intended to result in or relate to weight reduction (regardless of diagnosis or psychological conditions) are not covered, including, but not limited to:

- medical treatment;
- medications;
- surgical treatment (including revisions, reversals, and treatment of complications); or
- programs.

Orthognathic Surgery
Orthognathic surgery is not covered, except for the treatment of the following:

- orthognathic surgery due to an Injury;
- temporomandibular joint disorder;
- sleep apnea (specifically, telegnathic surgery);
- developmental anomalies; or
- congenital anomaly (including craniofacial anomalies).

"Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development performed to restore the proper anatomic and functional relationship of the facial bones.

"Telegnathic surgery" means skeletal (maxillary, mandibular and hyoid) advancement to anatomically enlarge and physiologically stabilize the pharyngeal airway to treat obstructive sleep apnea.

Over-the-Counter Contraceptives
Except as provided in the Prescription Medications Section or as required by law, over-the-counter contraceptive supplies are not covered unless approved by the FDA.

Personal Items
Items that are primarily for comfort, convenience, contentment, cosmetics, hygiene, environmental control, education or general physical fitness are not covered, including, but not limited to:

- telephones;
- televisions;
- air conditioners, air filters or humidifiers;
- whirlpools;
- heat lamps;
- light boxes;
- weightlifting equipment; and
- therapy or service animals, including the cost of training and maintenance.

Physical Exercise Programs and Equipment
Physical exercise programs or equipment are not covered (even if recommended or prescribed by Your Provider), including, but not limited to:

- hot tubs; or
- membership fees to spas, health clubs or other such facilities.

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

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

Routine Foot Care

Routine Hearing Examinations

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

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

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family are not covered.

"Immediate family" means:

- You and Your parents, parents' spouses or Eligible Domestic Partners, spouse or Eligible Domestic Partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or Eligible Domestic Partner's parents, parents' spouses or Eligible Domestic Partners, siblings and half-siblings;
- Your child's or stepchild's spouse or Eligible Domestic Partner; and
- any other of Your relatives by blood or marriage who shares a residence with You.

Services and Supplies That Are Not Medically Necessary
Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Services Required by an Employer or for Administrative or Qualification Purposes
Physical or mental examinations and associated services (laboratory or similar tests) required by an employer or primarily for administrative or qualification purposes are not covered.

Administrative or qualification purposes include, but are not limited to:

- admission to or remaining in:
    - school;
    - a camp;
    - a sports team;
    - the military; or
    - any other institution.
- athletic training evaluation;
- legal proceedings (establishing paternity or custody);
- qualification for:
    - employment or return to work;
    - marriage;
    - insurance;
    - occupational Injury benefits;
    - licensure; or
    - certification.
- travel, immigration or emigration.

Sexual Dysfunction
Except for Medically Necessary mental health services and supplies for a diagnosis of sexual dysfunction which are covered in the Mental Health or Substance Use Disorder Services benefit, services and supplies are not covered for or in connection with sexual dysfunction.

Surrogacy
Maternity and related medical services received by You Acting as a Surrogate are not Covered Services up to the amount You or any other person or entity is entitled to receive as payment or other compensation arising out of, or in any way related to, You

Acting as a Surrogate. "Maternity and related medical services" include otherwise Covered Services for conception, prenatal, maternity, delivery and postpartum care. Refer to the Maternity Care and/or Subrogation and Right of Recovery Sections for more information.

Therapies, Counseling and Training
Except as provided in the Employee Assistance Program (EAP), if applicable, the following therapies, counseling and training services are not covered:

- educational;
- vocational;
- social;
- image;
- self-esteem;
- milieu or marathon group therapy;
- premarital or marital counseling;
- EAP services; and
- job skills or sensitivity training.

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

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

Varicose Veins Treatment
Treatment of varicose veins is not covered, except for the following:

- when there is associated venous ulceration; or
- persistent or recurrent bleeding from ruptured veins.

Vision Care
Vision care services are not covered, including, but not limited to:

- routine eye examinations;
- vision hardware;
- visual therapy;
- training and eye exercises;
- vision orthoptics;
- surgical procedures to correct refractive errors/astigmatism; and
- reversals or revisions of surgical procedures which alter the refractive character of the eye.

War-Related Conditions
The treatment of any condition caused by or arising out of an act of war, armed invasion, or aggression, or while in the service of the armed forces unless not covered by the Claimant's military or veterans coverage.

Wigs
Wigs or other hair replacements regardless of the reason for hair loss or absence.

Work Injury/Illness
When You have filed a claim with workers' compensation and Your work-related Illness or Injury has been accepted by workers' compensation, any services and supplies arising out of that accepted work-related Illness or Injury are not covered. Subject to applicable state or federal workers' compensation law, services and supplies received for work-related Illnesses or Injuries where You and Your Beneficiaries fail to file a claim for workers' compensation benefits are not covered. The only exception is if You and Your Beneficiaries are exempt from state or federal workers' compensation law.

Claims Administration

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

SUBMISSION OF CLAIMS AND REIMBURSEMENT
When claims are submitted and payment is due, the Claims Administrator decides whether to pay You, the Provider or You and the Provider jointly. The Plan may make benefit payments for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child. If a person entitled to receive payment in this Plan has died, is a minor or is incompetent, benefits may be paid up to $1,000 to a relative by blood or marriage of that person when it is believed that person is equitably entitled to the payment. A payment made in good faith will fully discharge the Plan to the extent of the payment.

If the Claims Administrator receives an inquiry regarding a properly submitted claim and believes that You expect a response to that inquiry, they will respond to the inquiry within 30 days of the date they first received it.

In-Network Provider Claims and Reimbursement
You must present Your identification card to an In-Network Provider and furnish any additional information requested. The Provider will submit the necessary forms and information to the Claims Administrator for processing Your claim.

The Plan will pay an In-Network Provider directly for Covered Services. These Providers may require You to pay any Deductible, Copayment and/or Coinsurance at the time You receive care or treatment. In-Network Providers have agreed not to bill You for balances beyond any Deductible, Copayment and/or Coinsurance and to accept the Allowed Amount as payment in full for Covered Services.

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

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

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

Out-of-Network Providers have not agreed to accept the Allowed Amount as payment in full for Covered Services. You generally are responsible for paying any difference between the amount billed by the Out-of-Network Provider and the Allowed Amount in addition to any amount You must pay due to Deductible, Copayment and/or Coinsurance. (See Services Received From An Oregon Out-of-Network Provider In An In-Network Healthcare Facility in the Medical Benefits Section for an exception to balance billing.) For Out-of-Network Providers, the Allowed Amount may be based upon the billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.

Reimbursement Examples by Provider
Here are reimbursement examples for In-Network or Out-of-Network Providers. Let's assume the Plan pays 80 percent of the Allowed Amount for In-Network Providers and 60 percent of the Allowed Amount for Out-of-Network Providers. The benefit table would appear as follows:

Provider: In-Network	**Provider: Out-of-Network**
Payment: After Deductible, You pay 20% of the Allowed Amount.	**Payment:** After Deductible, You pay 40% of the Allowed Amount and the balance of billed charges.

In this example, the Provider's charge for a service is $5,000 and the Allowed Amount for that charge is $4,000 for an In-Network Provider. Let's assume that You have met the Deductible and that You have not met the Out-of-Pocket Maximum:

- In-Network Provider: the Plan would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:
  - Amount In-Network Provider must "write-off" (that is, cannot charge You for): $1,000
  - Amount the Plan pays (80% of the $4,000 Allowed Amount): $3,200
  - **Amount You pay** (20% of the $4,000 Allowed Amount): **$800**
  - Total: $5,000
- Out-of-Network Provider: the Plan would pay 60 percent of the Allowed Amount. Because the Out-of-Network Provider does not accept the Allowed Amount, You would pay 40 percent of the Allowed Amount, plus the $1,000 difference between the Out-of-Network Provider's billed charges and the Allowed Amount, as follows:
  - Amount the Plan pays (60% of the $4,000 Allowed Amount): $2,400
  - **Amount You pay** (40% of the $4,000 Allowed Amount and the $1,000 difference between the billed charges and the Allowed Amount): **$2,600**
    Total: $5,000

The actual benefits may vary, so review the benefit sections to determine how Your benefits are paid. For example, the Allowed Amount may vary for a Covered Service depending upon the selected Provider.

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

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

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

Explanation of Benefits
The Claims Administrator uses a form called an Explanation of Benefits (EOB). It is not a bill. It explains how a claim was processed and includes the date of service, the amount billed, the amount covered, the amount the Plan paid and any balance You may be responsible for. If all or part of a claim is denied, the reason for the denial will be stated on the EOB. The EOB will also include instructions for filing an Appeal if You disagree with the action.

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

When You receive care outside the Claims Administrator's service area, You may receive it from one of three kinds of Providers. Providers that contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue") as a preferred Provider are paid at the In-Network Provider level and will not bill You for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. Providers that contract with the Host Blue as a participating Provider are paid at the Out-of-Network Provider level and may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Some Providers ("Out-of-Network Providers") don't contract with the Host Blue. The Claims Administrator further explains below how these different kinds of Providers are paid.

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

Whenever You receive Covered Services outside the Claims Administrator's service area and the claim is processed through the BlueCard Program, the amount You pay for Covered Services is calculated based on the lower of:

- the billed covered charges for Your Covered Services; or
- the negotiated price that the Host Blue makes available to the Claims Administrator.

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

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

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

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

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

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees
Federal law or state law may require a surcharge, tax or other fee that applies to insured accounts. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

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

BLUE CROSS BLUE SHIELD GLOBAL® CORE
If You are outside the United States (hereinafter "BlueCard service area"), You may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is 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 Providers and submit the claims Yourself to obtain reimbursement for these services.

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

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

- **Outpatient Services**

Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require You to pay in full at the time of services. You must submit a claim to obtain reimbursement for Covered Services.

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

CLAIMS RECOVERY

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

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

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

SUBROGATION AND RIGHT OF RECOVERY

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

The Plan's Right of Subrogation or reimbursement, as set forth below, extend to all insurance coverage available to You due to an Injury, Illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage,

medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

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

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

Motor Vehicle Accidents Subject to the Oregon Insurance Code
To the extent that You sustain injuries due to a motor vehicle accident in the state of Oregon and incur claims that are subject to the Oregon Insurance Code, the Plan's rights set forth in this section shall be subject to the terms of applicable Oregon statutes. These statutory terms may include but are not limited to a requirement that You notify the Plan when You make a claim or bring a legal action and a restriction on the Plan's reimbursement or subrogation rights to the extent You do not receive full compensation for Your injuries.

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

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

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

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

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

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

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

Cooperation
You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is Your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your Injury, Illness or condition. You and Your agents agree to provide the Plan or its representatives notice of any recovery You or Your agents obtain prior to receipt of such recovery funds or within five days if no notice was given prior to receipt of recovery funds. Further, You and Your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and Your agents shall provide all information requested by the Plan, the Claims Administrator or its representative, including, but not limited to, completing and submitting any applications or other forms or statements as

the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery You receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of Your health benefits or the institution of court proceedings against You.

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

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

Workers' Compensation
The Plan will expedite prior authorization during the interim period before workers' compensation initially accepts or denies Your work-related Injury or occupational disease.

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

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

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

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

COORDINATION OF BENEFITS

If You are covered by any other individual or group medical contract or plan (referred to as "Other Plan" and defined below), the benefits in this Plan and those of the Other Plan will be coordinated in accordance with the provisions of this section.

Definitions

The following are definitions that apply to this Coordination of Benefits provision:

Allowable Expense means, with regard to services that are covered in full or part by this Plan or any Other Plan(s) covering You, the amount on which that plan would base its benefit payment for a service, including Coinsurance or Copayments, if any, and without reduction for any applicable Deductible. The following are examples of expenses that are not an Allowable Expense:

- An expense or portion of an expense not covered by any of Your involved plans.
- The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room, unless one of Your involved plans provides coverage for private Hospital rooms.
- Any expenses for other types of coverage or benefits when this Plan restricts coordination of benefits to certain types of coverage or benefits. This Coordination of Benefits provision applies to all benefits provided in this Booklet.
- Any amount by which a Primary Plan's benefits were reduced because You did not comply with that plan's provisions regarding second surgical opinion or precertification of services or failed to use a preferred provider (except, if the Primary Plan is a closed panel plan and does not pay because a nonpanel provider is used, the Secondary Plan (if it is not a closed panel plan) shall pay as if it were the Primary Plan).
- A Primary Plan's deductible, if the Primary Plan is a high-deductible health plan as defined in the Internal Revenue Code and the Claims Administrator is notified both that all plans covering a person are high-deductible health plans and that the person intends to contribute to a health savings account in accordance with the Internal Revenue Code.
- An expense that a provider is prohibited by law or contract from charging You.

When a plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered both an Allowable Expense and a benefit paid.

Birthday means only the day and month of birth, regardless of the year.

Claim Determination Period means a Calendar Year. A Claim Determination Period does not include any time when You were not enrolled under this Plan.

Custodial Parent means the parent awarded custody of a child by a court decree. In the absence of a court decree, the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation is the Custodial Parent.

Group-Type Coverage is a coverage that is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group, including blanket coverage. Group-Type Coverage

does not include an individually underwritten and issued guaranteed renewable coverage, even if the coverage is purchased through payroll deduction at a premium savings to the covered person.

Other Plan means any of the following with which this coverage coordinates benefits:

- group, blanket, individual, and franchise health insurance and prepayment coverage;
- group, blanket, individual, and franchise health maintenance organization or other closed panel plan coverage;
- Group-Type Coverage;
- labor-management trust plan, union welfare plan, employer organization plan, and employee benefit organization plan coverage;
- uninsured group or Group-Type Coverage arrangements;
- medical care components of group long-term care coverage, such as skilled nursing care; and
- hospital, medical, and surgical benefits of Medicare and other governmental coverages, as permitted by law.

Other Plan does not include:

- independent noncoordinated hospital indemnity coverage or other fixed indemnity coverage;
- school accident-type coverage that covers students for accidents only, including athletic injuries, either on a 24-hour basis or a "to and from school basis";
- group long-term care insurance for non-medical services (such as personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care, and Custodial Care) or that pay a fixed daily benefit without regard to actual expenses incurred or services received;
- accident only coverage;
- specified disease or specified accident coverage;
- Medicare supplement coverage;
- a Medicaid state plan; or
- a governmental plan that, by law, provides benefits that are excess to those of private insurance or other nongovernmental coverage.

Primary Plan means the plan that must determine its benefits for Your health care before the benefits of an Other Plan and without taking the existence of that Other Plan into consideration. (This is also referred to as that plan being "primary" to that Other Plan.) There may be more than one Primary Plan. A plan is a Primary Plan with regard to another plan in any of the following circumstances:

- the plan has no order of benefit determination provision;
- the plan is prohibited by law from using any order of benefits determination provision other than the one included herein and the plan contains a different order of benefit determination; or
- both plans use the order of benefit determination provision included herein and by that provision the plan determines its benefits first.

Secondary Plan means a plan that is not a Primary Plan. You may have more than one Secondary Plan. If You are covered by more than one Secondary Plan, the order of benefit determination provision decides the order in which Your Secondary Plans' benefits are determined in relation to each other.

Year means Calendar Year (January 1 through December 31).

Order of Benefit Determination
The order of benefit determination is identified by using the first of the following rules that apply:

Non-dependent Coverage: A plan that covers You other than as a dependent will be primary to a plan for which You are covered as a dependent.

Dependent Coverage: Except where the order of benefit determination is being identified among plans covering You as the dependent of Your parents who are separated or divorced and/or those parents' spouses, a plan that covers You as the dependent of Your parent whose Birthday occurs earlier in the Year will be primary over a plan that covers You as the dependent of Your parent whose Birthday occurs later in the Year. If both parents covering You as a dependent have the same Birthday, the plan of the parent who has been covered by their plan longer shall be primary to the plan of the parent who has been covered by their plan for a shorter period.

If a court decree specifies that Your parent is responsible for Your health care expenses or health care coverage and that parent's plan has actual knowledge of that term of the decree, the plan of that parent is primary to the plan of Your other parent. If the parent with that responsibility has no coverage for You, but that parent's spouse does and the spouse's plan has actual knowledge of that term in the decree, the plan of the spouse shall be primary to the plan of Your other parent. If benefits have been paid or provided by a plan before it has actual knowledge of the term in the court decree, these rules do not apply until that plan's next Calendar Year.

If a court decree awards joint custody of You without specifying that one of Your parents is responsible for Your health care expenses or health care coverage, a plan that covers You as the dependent of Your parent whose Birthday occurs earlier in the Year will be primary over a plan that covers You as the dependent of Your parent whose Birthday occurs later in the Year. If both parents have the same Birthday, the plan of the parent who has been covered by their plan longer shall be primary to the plan of the other parent. If the Other Plan does not contain this dependent rule, the Other Plan's dependent rule will govern.

If none of the above dependent rules identifies the order of benefits determination among plans covering You as the dependent of parents who are separated or divorced and/or those parents' spouses:

- The plan of Your Custodial Parent shall be primary to the plan of Your Custodial Parent's spouse.
- The plan of Your Custodial Parent's spouse shall be primary to the plan of Your noncustodial parent.

- Then the plan of Your noncustodial parent shall be primary to the plan of Your noncustodial parent's spouse.

If You are covered by more than one plan of individuals who are not Your parents, the above Dependent Coverage rules shall be applied to determine the order of benefit determination as if those individuals were Your parents.

If You are covered by either or both of Your parents' plans and as a dependent under Your spouse's plan, the rule in the Longer/shorter length of coverage section below shall be applied to determine the order of benefit determination. If Your coverage under Your spouse's plan began on the same date as Your coverage under one or both of Your parents' plans, the order of benefit determination between or among those plans shall be determined by applying the birthday rule in the first paragraph of this Dependent Coverage section to Your parent(s) and spouse.

Active/inactive employees: A plan that covers You as an employee who is neither laid off nor retired (or as that employee's dependent) is primary to a plan by which You are covered as a laid off or retired employee (or as the dependent of a laid off or retired employee). If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

Continuation coverage: A plan which covers You as an employee or retired employee, or as an employee's or retired employee's dependent, will be primary to a plan that is providing continuation coverage. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

Longer/shorter length of coverage: When none of the paragraphs above establishes an order of benefit determination, the benefits of the plan that has covered You for the longer period of time will be determined before the benefits of the plan that has covered You for the shorter period of time. To determine the length of time You have been covered by a plan, two plans will be treated as one if You were eligible by the second within 24 hours after the first ended. The start of a new plan does not include:

- a change in the amount or scope of a plan's benefits;
- a change in the entity that pays, provides or administers the plan's benefits; or
- a change from one type of plan to another (such as from a single-employer plan to that of a multiple employer plan).

Your length of time covered by a plan is measured from Your first date of coverage with that plan. If that date is not readily available for a group plan, the date You first became a member of the group will be used as the date from which to determine the length of time coverage with the present plan has been in force.

If an order of benefit determination is not identified by the preceding rules, the plans shall share equally in the Allowable Expenses.

Each of the plans by which You are covered, and each of the benefits within the plan, will be considered separately in administering this Coordination of Benefits provision.

Primary Health Plan Benefits
When, in accordance with the order of benefit determination, this coverage is the Primary Plan, the benefits in this Plan will be paid as if no Other Plan exists.

Secondary Health Plan Benefits
If, in accordance with the order of benefit determination, one or more Other Plans are primary to this Plan, the benefits of this Plan will be calculated as follows:

The benefits that would have been paid under this Plan for a service if this Plan were the Primary Plan will be calculated. The Allowable Expense under this Plan for that service will be compared to the Allowable Expense for it with the Other Plan(s) by which You are covered. This Plan will pay the lesser of:

- the unpaid charges for the service, up to the higher (highest) Allowable Expenses among the involved plans; or
- the benefits that would have been paid under this Plan for the service if this Plan were the Primary Plan.

Deductibles, Coinsurance and Copayments, if any, under this Plan will be used in the calculation of the benefits that would have been paid if this were the Primary Plan, but they will not be applied to the unpaid charges You owe after the Primary Plan's payment. This Plan's payment therefore will be reduced so that it, when combined with the Primary Plan's payment, does not exceed the higher (highest) Allowable Expense among the involved plans and any amount that would have been credited to the Deductible if this Plan had been the only plan will be credited toward any Deductible under this Plan.

If this Plan is the Secondary Health Plan according to the order of benefit determination and any Other Plan(s) claim to be "always secondary" or use order of benefit determination rules inconsistent with those in this Plan, this Plan will pay its benefits first, but the amount paid will be calculated as if this Plan is a Secondary Health Plan. If the Other Plan(s) do not provide the Claims Administrator with the information necessary for them to determine appropriate secondary benefits payment within a reasonable time after their request, it will be assumed their benefits are identical to this Plan's and benefits under this Plan will be paid accordingly, subject to adjustment upon receipt of the information requested from the Other Plan(s) within two years of this Plan's payment.

Nothing contained in this Coordination of Benefits provision requires this Plan to pay for all or part of any service that is not covered by this coverage. Further, in no event will this Coordination of Benefits provision operate to increase payment over what would have been paid under this Plan in the absence of this Coordination of Benefits provision.

In the event federal law makes Medicare primary to this Plan and You are covered under both this Plan and a Medicare Supplement plan, the Medicare Supplement plan also will be primary to this Plan. In that event, the benefits of this Plan will be reduced by the payments of Medicare and the Medicare Supplement plan.

Right to Receive and Release Needed Information
Certain facts are needed to apply coordination of benefits provisions. The Claims Administrator has the right to decide which facts they need. The Claims Administrator may get needed facts from, or give them to, any other organization or person as permitted by law, and need not tell or get the consent of any person to do this. You will promptly furnish to the Claims Administrator any information necessary or appropriate to administer this Coordination of Benefits provision. Receipt of such information by the Claims Administrator will be a condition precedent to this Plan's obligation to provide benefits.

Facility of Payment
Any payment made by any Other Plan(s) may include an amount that should have been paid by this Plan. If so, that amount may be paid under this Plan to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this Plan. That amount will not have to be paid under this Plan again. The term "payment made" includes providing benefits in the form of services, in which case payment made means reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If benefits were provided to or on behalf of You in excess of the amount that would have been payable in this Booklet by reason of Your coverage with any Other Plan(s), this Plan will be entitled to recover from You, Your assignee or beneficiary, or from the Other Plan(s) upon request.

A Secondary Plan that provides benefits in the form of services may recover the reasonable cash value of the services from the Primary Plan to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by it.

Resolving Your Concerns

If You believe a policy, action or decision is incorrect, contact the Claims Administrator's Customer Service department.

If You have concerns regarding a decision, action or statement by Your Provider, the Claims Administrator encourages You to discuss these concerns with the Provider. If You remain dissatisfied after discussing Your concern with Your Provider, You may contact the Claims Administrator's Customer Service for assistance.

The Plan's Grievance process is designed to help You resolve Your complaint or concern and to allow You to appeal an Adverse Benefit Determination. The Plan offers two internal levels of appeal of the Claims Administrator's Adverse Benefit Determinations. The Plan also offers an external appeal with an Independent Review Organization (IRO) for some of the Claims Administrator's Adverse Benefit Determinations if You remain dissatisfied with the Claims Administrator's Internal Appeal decisions. See External Appeal – IRO later in this section for more information.

Each level of Internal Appeal, including expedited appeals, must be pursued within 180 days of Your receipt of the Claims Administrator's Adverse Benefit Determination. If You don't act within this time period, You will not be able to continue to pursue the appeal process and may jeopardize Your ability to pursue the matter in any forum.

You have two levels of review within the Internal Appeal process. Appeals are reviewed by an employee or employees who were not involved in, or subordinate to anyone involved in, the initial decision that You are appealing. In appeals that involve issues requiring medical judgment, the decision is made by the Claims Administrator's staff of health care professionals. You or Your Representative may submit written materials supporting Your appeal, including written testimony on Your behalf. For Post-Service appeals, a written notice of the decision will be sent within 30 days of receipt of the appeal. For appeals involving a Pre-Service issue, the Claims Administrator will send a written notice of the decision within 15 days of receipt of the appeal.

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

You are entitled to receive continued coverage of the disputed item or service pending the conclusion of the Internal Appeal process. However, You will be responsible for any amounts the Plan pays for the item or service during this time should You not prevail.

You may contact the Claims Administrator either in writing or verbally with a Grievance or to request an appeal. A written request can be made by sending it to the Claims Administrator at: Attn: ASO Appeals and Grievances, Regence BlueCross BlueShield of Oregon, P.O. Box 91015, Seattle, WA 98111-9115 or facsimile 1 (877) 663-7526. Verbal requests can be made by calling Customer Service. The Claims Administrator will acknowledge receipt of a Grievance or an appeal within seven days of receiving it.

An Adverse Benefit Determination may be overturned by the Claims Administrator at any time during the Appeal process if the Claims Administrator receives newly submitted documentation and/or information which establishes coverage, or upon the discovery of an error the correction of which would result in overturning the Adverse Benefit Determination.

EXTERNAL APPEAL – IRO

You have the right to an external review by an IRO. An appeal to an IRO is available only after You have exhausted the Internal Appeal process, unless:

- You and the Claims Administrator have mutually agreed to waive the exhaustion requirement;
- the Claims Administrator failed to strictly comply with state and federal requirements for Internal Appeals; or
- You request expedited external appeal at the same time You request expedited Internal Appeal.

The Claims Administrator will coordinate external appeals, but the decision is made by an IRO at no cost to You. **The Claims Administrator is bound by the decision of the IRO and may be penalized by the Oregon Division of Financial Regulation if the Claims Administrator fails to comply with the IRO's decision. You have the right to sue the Claims Administrator if the decision of the IRO is not implemented.**

The issue being submitted to the IRO for external review must be a dispute over an Adverse Benefit Determination the Claims Administrator has made concerning whether a course or plan of treatment is:

- Medically Necessary;
- experimental or Investigational;
- part of an active course of treatment for purposes of continuity of care;
- delivered in an appropriate health care setting at the appropriate level of care; or
- whether an exception to the Claims Administrator's Drug List should be granted.

External review can be initiated through either written or verbal request. A written request can be made by sending it to the Claims Administrator at: Attn: ASO Appeals and Grievances, Regence BlueCross BlueShield of Oregon, P.O. Box 91015, Seattle, WA 98111-9115. Verbal requests can be made by calling Customer Service.

You may also initiate an external appeal by submitting Your request to the Oregon Division of Financial Regulation at P.O. Box 14480, Salem, OR 97309-0405.

When the Claims Administrator notifies You of their Internal Appeal decision, the Claims Administrator will send You instructions on how to request external review and **may include a waiver which is a HIPAA release form that allows the Claims Administrator to provide Your medical records to the IRO to review Your request**. The Claims Administrator must notify the Oregon Division of Financial Regulation of Your request by the second business day after the Claims Administrator receives it even if You have not provided all the documents required.

The Oregon Division of Financial Regulation will select an IRO and notify You of the IRO selection. You may submit additional information to the IRO within five business days after You receive notice of the IRO's appointment. The Claims Administrator will provide the IRO with specific documentation regarding their Adverse Benefit Determination and the signed waiver granting access to Your medical records within five business days of receiving the IRO selection. The IRO will make its decision within 30 days after You apply for external review. The IRO will send You written notice of its decision within five days of the decision. If the IRO decides to reverse the original determination, then, upon receipt of the IRO's notice of this decision, the Plan will provide coverage or payment of the claim.

If You want more information regarding IRO review, contact the Claims Administrator's Customer Service department. You can also contact the Oregon Division of Financial Regulation by:

- calling (503) 947-7984 or the toll-free message line at 1 (888) 877-4894;
- writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405;
- visiting the Oregon Division of Financial Regulation Web site: **https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx**; or
- e-mail at: **DFR.InsuranceHelp@oregon.gov**.

Exercise of Your right to IRO review is at Your option. Alternatively, You may use another forum as the final level of appeal under a state statute or rule.

EXPEDITED APPEALS
An expedited appeal is available in clinically urgent situations if:

- the Adverse Benefit Determination concerns an admission, the availability of care, a continued stay, or a health care service for a medical condition for which You received emergency services, and You have not yet been discharged from a health care facility;
- a Provider with whom You have an established clinical relationship certifies in writing and provides supporting documentation that the ordinary time period for external review would seriously jeopardize Your life or health or Your ability to regain maximum function; or
- according to a Physician with knowledge of Your medical condition, the regular appeals time frame would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

Internal Expedited Appeal
Internal expedited appeals can be initiated through either written or verbal request. A written request can be made by sending it to the Claims Administrator at: Attn: ASO Appeals and Grievances, Regence BlueCross BlueShield of Oregon, P.O. Box 91015, Seattle, WA 98111-9115. Verbal requests can be made by calling Customer Service.

The internal expedited appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the appeal decision. You or Your Representative, on Your behalf, will be given the opportunity (within the

constraints of the expedited appeal time frame) to provide written materials, including written testimony on Your behalf. Verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but not later than 72 hours after receipt of the expedited appeal. This will be followed by written notification within three days of the verbal notice.

External Expedited Appeal – IRO
If You disagree with the decision made in the internal expedited appeal, You may request an external expedited appeal to an IRO if:

- the Adverse Benefit Determination concerns an admission, the availability of care, a continued stay, or a health care service for a medical condition for which You received emergency services, and You have not yet been discharged from a health care facility;
- a Provider with whom You have an established clinical relationship certifies in writing and provides supporting documentation that the ordinary time period for external review would seriously jeopardize Your life or health or Your ability to regain maximum function; or
- according to a Physician with knowledge of Your medical condition, the regular appeals time frame would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

The issues an IRO will consider are the same as described in the External Appeal – IRO Section. You may request an external expedited review at the same time You request an internal expedited appeal from the Claims Administrator.

External expedited appeals can be initiated through either written or verbal request. A written request can be made by sending it to the Claims Administrator at: Attn: ASO Appeals and Grievances, Regence BlueCross BlueShield of Oregon, P.O. Box 91015, Seattle, WA 98111-9115. Verbal requests can be made by calling Customer Service. The Claims Administrator must notify the Oregon Division of Financial Regulation of Your request by the second business day after the Claims Administrator receives it.

You may also request an external expedited appeal by submitting Your request to the Oregon Division of Financial Regulation at P.O. Box 14480, Salem, OR 97309-0405.

The Claims Administrator coordinates external expedited appeals, but the decision is made by an IRO at no cost to You. **The Claims Administrator may request a waiver which is a HIPAA release form that grants the IRO access to medical records that may be required to be reviewed for the purpose of reaching a decision on the expedited appeal**. The Claims Administrator will provide the IRO with the expedited appeal documentation. You may submit additional information to the IRO no later than 24 hours after the appointment of the IRO. Verbal notice of the IRO's decision will be provided to You and Your Representative as soon as possible after the decision, but no later than within 72 hours of Your request. The IRO decision is binding, except to the extent other remedies are available under state or federal law.

Exercise of Your right to IRO review is at Your option. Alternatively, You may use another forum as the final level of expedited appeal.

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

You also have the right to file a complaint and seek assistance from the Oregon Division of Financial Regulation. Assistance is available by:

- calling (503) 947-7984 or the toll-free message line at 1 (888) 877-4894;
- writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405;
- visiting the Oregon Division of Financial Regulation Web site: **https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx**; or
- e-mail at: **DFR.InsuranceHelp@oregon.gov**.

You also are entitled to receive from the Claims Administrator, upon request and free of charge, reasonable access to and copies of all documents, records, and other information considered, relied upon, or generated in, or otherwise relevant to, an Adverse Benefit Determination.

DEFINITIONS
The following definitions apply to this Resolving Your Concerns Section:

Adverse Benefit Determination means the Claims Administrator's denial, reduction or termination of a health care item or service, or the Claims Administrator's failure or refusal to provide or to make a payment in whole or in part for a health care item or service that is based on the Claims Administrator's:

- denial of eligibility for or termination of enrollment;
- rescission or cancellation of a policy;
- imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;
- determination that a health care item or service is experimental, Investigational or not Medically Necessary, effective or appropriate; or
- determination that a course or plan of treatment that You are undergoing is an active course of treatment for purposes of continuity of care.

Grievance means a submission by You or Your authorized Representative that either is a written or oral request for Internal Appeal or external review (including expedited appeal or review), or is a written complaint regarding:

- health care service availability, delivery, or quality;
- payment, handling, or reimbursement of a health care service claim; or
- contractual matters between You and the Plan.

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

Internal Appeal means a review by the Claims Administrator of an Adverse Benefit Determination made by the Claims Administrator.

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

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

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

Eligibility and Enrollment

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

NOTE: Where a reference is made to spouse, all of the same terms and conditions of the Plan will be applied to an Eligible Domestic Partner.

INITIALLY ELIGIBLE AND WHEN COVERAGE BEGINS
You will be entitled to enroll in coverage for Yourself and Your eligible dependents within 30 days of initially becoming eligible for coverage per the eligibility requirements in effect with the Plan Sponsor and as stated in the following paragraphs. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

If You and/or Your eligible dependents do not enroll for coverage under the Plan when first eligible or You do not enroll in a timely manner, You and/or Your eligible dependents must wait until the next annual open enrollment period to enroll, except as described in the Special Enrollment provision below.

Employees
You become eligible to enroll in coverage on the date You have worked for a Member Employer long enough to satisfy any probationary period required by the Member Employer.

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

- The person to whom You are legally married (spouse).
- Your Oregon-Registered Domestic Partner. Oregon-Registered Domestic Partnership means a contract, in accordance with Oregon law, entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon.
- Your (or Your spouse's or Your Eligible Domestic Partner's) child who is under age 26 and who meets any of the following criteria:
    - Your (or Your spouse's or Your Eligible Domestic Partner's) natural child, stepchild, adopted child or child legally placed with You (or Your spouse or Your Eligible Domestic Partner) for adoption;
    - a child for whom You (or Your spouse or Your Eligible Domestic Partner) have court-appointed legal guardianship; or
    - a child for whom You (or Your spouse or Your Eligible Domestic Partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).

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

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

The Claims Administrator's affidavit of dependent eligibility form is available by visiting their Web site or by calling Customer Service.

NEWLY ELIGIBLE DEPENDENTS
You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request (and, for an Eligible Domestic Partner who is not an Oregon-Registered Domestic Partner, an affidavit of qualifying domestic partnership form).

Enrollment requests must be made according to the following:

- within 60 days of the date of birth, adoption or placement for adoption for a new child.
- within 30 days of the dependent's attaining eligibility for all other newly eligible dependents.

Coverage for such dependents will begin on their Effective Dates (which, for a new child by birth, adoption or placement for adoption, is the date of birth, adoption or placement for adoption, if enrolled within the specified 60 days).

SPECIAL ENROLLMENT
There are certain situations when You may enroll Yourself and/or Your eligible dependents, even though You didn't do so when first eligible, and You do not have to wait for an annual open enrollment period. You must submit an enrollment form on behalf of all individuals who become eligible based on the provisions below.

If You declined coverage for Yourself or any eligible dependent(s) when first eligible, You (unless already enrolled) and Your eligible dependent(s) are eligible to enroll for coverage under the Plan within 30 days from the date of one of the following qualifying events (except that where the qualifying event is involuntary loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP), You have 60 days from the date of the qualifying event to enroll):

- You and/or Your eligible dependent(s) lose coverage under another group or individual Health Benefit Plan due to one of the following:

    - an employer's contributions to that other plan are terminated;
    - exhaustion of federal COBRA or any state continuation; or

- loss of eligibility, such as legal separation, divorce, termination of domestic partnership, death, termination of employment or reduction in hours.

- You involuntarily lose coverage under Medicare, CHAMPUS/Tricare, Indian Health Service or a publicly sponsored or subsidized health plan (other than CHIP, see below).
- You lose coverage under Medicaid or CHIP.

For the above qualifying events coverage will be effective on the day after the prior coverage ended. Loss of eligibility does not include a loss because You failed to timely pay Your portion of the premium or when termination of coverage was due to fraud. It also doesn't include Your decision to terminate coverage. However, it may include Your decision to take another action (for example, terminating employment) that results in a loss of eligibility.

If You declined coverage for Yourself or any eligible dependent(s) when first eligible, You (unless already enrolled) and Your eligible dependent(s) are eligible to enroll for coverage under the Plan within 30 days from the date of one of the following qualifying events:

- You marry or begin a domestic partnership; or
- You acquire a new child by birth, adoption or placement for adoption. NOTE: Your Eligible Domestic Partner is not eligible to enroll for coverage under the Plan in this situation.

If You declined coverage for Yourself or any eligible dependent(s) when first eligible, You (unless already enrolled) and Your eligible dependent(s) are eligible to enroll for coverage under the Plan within 60 days from the date of the following qualifying event:

- You and/or Your eligible dependent(s) become eligible for premium assistance with Medicaid or CHIP.

For the above qualifying events coverage will be effective on the first of the calendar month following the date of the qualifying event. However, if the qualifying event is a child's birth, adoption or placement for adoption, coverage is effective from the date of the birth, adoption or placement.

ANNUAL OPEN ENROLLMENT PERIOD
The annual open enrollment period is the period of time before the Plan Sponsor's Renewal Date and is the only time, other than initial eligibility or a special enrollment period, during which You and/or Your eligible dependents may enroll. You must submit an enrollment form on behalf of all individuals You want enrolled. Coverage will begin on the Effective Date.

DOCUMENTATION OF ELIGIBILITY
You must promptly provide (or coordinate) any necessary and appropriate information to determine the eligibility of a dependent. The Claims Administrator must receive such information before enrolling a person as a dependent under the Plan.

When Coverage Ends

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

No person will have a right to receive any benefits after the date coverage is terminated. Termination of Your or Your Beneficiary's coverage under the Plan for any reason will completely end all the Plan's obligations to provide You or Your Beneficiary benefits for Covered Services received after the date of termination. This applies whether or not You or Your Beneficiary is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while the Plan was in effect. However, when the Agreement is terminated and coverage for all Claimants under the Plan is immediately replaced by another group agreement and You are in the Hospital on the day this coverage ends, the Plan will continue to provide benefits for that hospitalization until Your discharge from the Hospital or Your benefits have been exhausted, whichever comes first. (This exception does not apply to a Skilled Nursing Facility or any other type of facility, except a Hospital.)

AGREEMENT TERMINATION
If the Agreement is terminated or not renewed by the Plan Sponsor, claims administration by Regence BlueCross BlueShield of Oregon ends for You and Your Beneficiaries on the date the Agreement is terminated or not renewed. Regence BlueCross BlueShield of Oregon may administer certain claims for Covered Services that Claimants received before the Agreement termination or nonrenewal, if agreed between the Plan Sponsor and the Claims Administrator.

MEMBER EMPLOYER TERMINATION
If Your employer ceases to be a Member Employer, coverage ends for You and Your Beneficiaries on the date Your employer ceases to participate under the Plan.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE
If You are no longer eligible as explained in the following paragraphs, coverage ends for You and Your Beneficiaries on the last day of the monthly period in which Your eligibility ends. However, it may be possible for You and/or Your Beneficiaries to continue coverage under the Plan according to the COBRA Continuation of Coverage or the Other Continuation Options provisions.

Termination of Your Employment or You are No Longer Eligible
If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Plan, coverage will end for You and all Beneficiaries on the last day of the monthly period in which eligibility ends.

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

WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs, coverage ends for Your Beneficiaries on the last day of the monthly period in which their eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Plan according to the COBRA Continuation of Coverage or the Other Continuation Options provisions.

Divorce or Annulment

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

Death of the Participant

If You die, coverage for Your Beneficiaries ends on the last day of the monthly period in which Your death occurs.

Dissolution or Annulment of Oregon-Registered Domestic Partnership

If the contract with Your Oregon-Registered Domestic Partner ends, eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the monthly period following the date the dissolution or annulment was final.

Loss of Dependent Status

- Eligibility ends on the last day of the monthly period in which an enrolled child exceeds the dependent age limit.
- Eligibility ends on the date in which an enrolled child is removed from placement due to disruption of placement before legal adoption.
- Eligibility ends on the last day of the monthly period in which an enrolled child is no longer an eligible dependent for any other cause not described above.

OTHER CAUSES OF TERMINATION

Claimants terminated for either of the following reasons may be able to continue coverage under the Plan according to the COBRA Continuation of Coverage or the Other Continuation Options provisions.

Fraudulent Use of Benefits

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

Fraud or Misrepresentation in Application

The Plan is issued in reliance upon all information furnished to the Claims Administrator by You or on behalf of You and Your Beneficiaries. In the event of any intentional misrepresentation of material fact or fraud regarding a Claimant (including, but not limited to, a person who is listed as a dependent, but does not meet the eligibility requirements in effect with the Member Employer), any action allowed by law or contract may be taken, including denial of benefits or termination of coverage and may subject the person making the misrepresentation or fraud to prosecution for insurance fraud and associated penalties.

If the Plan rescinds Your coverage, other than for failure to make premium contributions, the Plan will provide You with at least 30 days advance written notice prior to rescinding coverage.

FAMILY AND MEDICAL LEAVE

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

- You and Your Beneficiaries will remain eligible to be enrolled under the Plan during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
    - to care for Your newborn child;
    - to care for Your spouse, child or parent with a serious health condition;
    - the placement of a child with You for adoption or foster care; or
    - You suffer a serious physical or Mental Health Condition.

During the FMLA leave, You must continue to make payments for coverage through Your employer to the Plan Sponsor on time. The provisions described here will not be available if the Plan terminates or Your employer ceases to be a Member Employer.

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

You and/or Your Beneficiaries will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage according to this provision. Entitlement to FMLA leave does not constitute a qualifying event for COBRA continuation. However, a person who does not return to active employment following FMLA leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave.

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. This leave provision is available only to groups that are required by law to comply. The Plan Sponsor must keep the Claims Administrator advised regarding the

eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

LEAVE OF ABSENCE

If You are granted a non-FMLA temporary leave of absence by Your employer and approved by the Plan Sponsor, You can continue coverage for up to three months. Payments must be made through Your employer to the Plan Sponsor in order to maintain coverage during a leave of absence.

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

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

COBRA Continuation of Coverage

COBRA is a continuation of this coverage for a limited time after certain events cause a loss of eligibility. COBRA continuation does not apply to all groups.

If the Plan is subject to COBRA, COBRA continuation is available to Your Beneficiaries if they lose eligibility because:

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

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

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

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

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

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

The Member Employer also must meet certain notification, election and payment deadline requirements. It is very important that You keep Your employer and the Plan

Sponsor informed of the current address of all Claimants who are or may become qualified beneficiaries.

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

Notice
The Agreement includes additional details on the COBRA Continuation provisions outlined here and complete details are available from Your employer or the Plan Sponsor.

Other Continuation Options

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

Strike or Lockout
If You are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, Your coverage can be continued for up to six months. You must pay the full payment, including any part usually paid by Your employer or the Plan Sponsor, directly to the union or trust that represents You. The union or trust must continue to make payments to the Claims Administrator according to the Agreement. Coverage cannot be continued if less than 75 percent of those normally enrolled continue coverage or if You otherwise lose eligibility under the Plan. This six months of continued coverage is in lieu of and not in addition to any continuation of coverage provisions of the Plan.

Workers' Compensation Claim
If You are no longer eligible due to an Illness or Injury for which You have filed a Workers' Compensation claim, You can continue coverage for up to six months after Your eligibility ends, or until You obtain full-time employment with another employer, whichever happens first. You must make payment of premiums for the coverage to Your employer or the Plan Sponsor, as instructed and within the established time frame in order to maintain coverage during this period. This six months of continued coverage runs simultaneously with any leave under the FMLA. Any continuation of coverage will apply following the conclusion of Your workers' compensation coverage.

Continuation of Certain Surviving and Former Dependents
If a Participant or enrolled spouse or domestic partner is covered under this Plan through an employer of 20 or more employees and the Participant dies or the Participant either dissolves their marriage or terminates their domestic partnership, the Participant's former or surviving spouse or domestic partner who is age 55 or over at the time coverage otherwise would end due to the death, dissolution or termination of domestic partnership may remain enrolled. Enrolled children of the Participant's former or surviving spouse or domestic partner who lose eligibility in these circumstances also may remain enrolled with the Participant's former or surviving spouse or domestic partner as long as they are otherwise eligible under this Plan. To receive this continuation, the Participant's former or surviving spouse or domestic partner must notify the Plan Sponsor (including providing their mailing address) within 60 days following a dissolution of marriage or domestic partnership or within 30 days following the Participant's death and will be required to pay applicable premiums. The Plan Sponsor then will provide the Participant's former or surviving spouse or domestic partner with further information. Continuation coverage may be maintained until the earliest of the date the Participant's former or surviving spouse or domestic partner becomes covered by another group health plan or becomes eligible for Medicare, the date the Participant's former spouse or domestic partner remarries, or the date of termination of this Plan (subject to a right to continue on any replacement coverage).

General Provisions and Legal Notices

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

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

GOVERNING LAW
The Plan will be governed by and construed in accordance with the laws of the United States of America and by the laws of the state of Oregon without regard to its conflict of law rules.

LIMITATIONS ON LIABILITY
You have the exclusive right to choose a health care Provider. The Plan and the Claims Administrator are not responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since the Plan and the Claims Administrator do not provide any health care services, neither can be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither employees nor agents of the Plan or the Claims Administrator.

Under state law, Providers contracting with a health care service contractor like Regence BlueCross BlueShield of Oregon to provide services to its Claimants agree to look only to the health care service contractor for payment of services that are covered by the Plan and may not bill You if the health care service contractor fails to pay the Provider for whatever reason. The Provider may bill You for applicable Deductible, Copayment and/or Coinsurance and for non-Covered Services, except as may be restricted in the Provider contract.

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT – STATEMENT OF RIGHTS
Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending Provider, after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, the Plan or issuer may not, under federal law, require that a Physician or other health care provider obtain prior authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce

Your out-of-pocket costs, You may be required to obtain prior authorization. Contact the Claims Administrator's Customer Service for additional information on prior authorization.

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

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

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

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

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION
The Plan Sponsor on behalf of itself and its Claimants expressly acknowledges its understanding that the Agreement constitutes an agreement solely between the Plan Sponsor and Regence BlueCross BlueShield of Oregon, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association,

an association of independent Blue Cross and Blue Shield Plans (the Association), permitting the Claims Administrator to use the Blue Cross and Blue Shield Service Marks in the state of Oregon and in Clark County in the state of Washington and that the Claims Administrator is not contracting as the agent of the Association. The Plan Sponsor on behalf of itself, its Member Employers and its Claimants further acknowledges and agrees that it has not entered into the Agreement based upon representations by any person or entity other than Regence BlueCross BlueShield of Oregon and that no person or entity other than Regence BlueCross BlueShield of Oregon will be held accountable or liable to the Plan Sponsor, its Member Employers or the Claimants for any of the Claims Administrator's obligations to the Plan Sponsor or the Claimants created under the Agreement. This paragraph will not create any additional obligations whatsoever on the part of Regence BlueCross BlueShield of Oregon other than those obligations created under other provisions of the Agreement.

REPRESENTATIONS ARE NOT WARRANTIES

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

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

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

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

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

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

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

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

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

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

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

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

The expense of a service is incurred on the day the service is provided and the expense of a supply is incurred on the day the supply is delivered to You. However, when the Agreement is terminated and coverage for all Claimants under the Plan is immediately replaced by another group agreement and You are in the Hospital on the day this coverage ends, the Plan will continue to provide benefits for that hospitalization until Your discharge from the Hospital or Your benefits have been exhausted, whichever comes first. (This exception does not apply to a Skilled Nursing Facility or any other type of facility, except a Hospital.)

WOMEN'S HEALTH AND CANCER RIGHTS
If You are receiving benefits in connection with a Mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, the Plan will provide coverage (subject to the same provisions as any other benefit) for:

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

The Claims Administrator will provide a single determination of prior authorization for all services related to a covered Mastectomy that are part of Your course or plan of treatment.

Definitions

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

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

Allowed Amount means:

- For In-Network Providers, the amount that they have contractually agreed to accept as payment in full for Covered Services.
- For Out-of-Network Providers who are not accessed through the BlueCard Program, the amount the Claims Administrator has determined to be Reasonable Charges for Covered Services. The Allowed Amount may be based upon the billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.
- For Out-of-Network Providers accessed through the BlueCard Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to the Claims Administrator as the amount on which it would base a payment to that Provider. In exceptional circumstances, such as if the Host Blue does not identify an amount on which it would base payment, the Claims Administrator may substitute another payment basis.

Charges in excess of the Allowed Amount are not considered Reasonable Charges and are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, contact the Claims Administrator's Customer Service.

Ambulatory Surgical Center means a facility or that portion of a facility licensed by the state in which it is located, that operates exclusively to provide surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission.

Ambulatory Surgical Center does not mean:

- individual or group practice offices of private Physicians or dentists that do not contain a distinct area used for outpatient surgical treatment on a regular and organized basis, or that only provide surgery routinely provided in a Physician's or dentist's office using local anesthesia or conscious sedation; or
- a portion of a licensed Hospital designated for outpatient surgical treatment.

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

Booklet is the description of the benefits for this coverage. The Booklet is part of the Agreement between the Plan Sponsor and the Claims Administrator.

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

Center of Excellence means a Provider organization certified to deliver a gene therapy (or therapies) that meets or exceeds a set of clinical service and quality standards (including available clinical services, patient selection criteria, and outcome reporting), maintains a set of clinical protocols and certifications required for gene therapy delivery, and maintains or exceeds a foundation of rigorous and sustainable cost controls.

Claimant means a Participant or a Beneficiary.

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

Covered Service means a service, supply, treatment or accommodation that is listed in the benefit sections in this Booklet.

Custodial Care means care for watching and protecting a patient, rather than being a Health Intervention. Custodial Care includes care that helps the patient conduct activities of daily living that can be provided by a person without medical or paramedical skills and/or is primarily to separate the patient from others or prevent self-harm.

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

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

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

Eligible Domestic Partner means a domestic partner who meets the dependent eligibility requirements in the Eligibility and Enrollment Section.

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

- placing the Claimant's health, or with respect to a pregnant Claimant, the health of the unborn child, in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part; or
- a behavioral health crisis. "Behavioral health crisis" means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a

Hospital to prevent a serious deterioration in the individual's mental or physical health.

Emergency Medical Condition also includes a condition with respect to a pregnant Claimant who is having contractions, for which there is inadequate time for a safe transfer to another Hospital before delivery or for which transfer may pose a threat to the health or safety of the Claimant or unborn child.

Family means a Participant and any Beneficiaries.

Health Benefit Plan means any Hospital-medical-surgical expenses policy or certificate including any benefit plan provided by a multiple employer welfare arrangement or by another benefit arrangement, as defined in the Federal Employee Retirement Income Security Act of 1974 as amended (ERISA).

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following:

- disease;
- Illness or Injury;
- genetic or congenital anomaly;
- pregnancy;
- biological or psychological condition that lies outside the range of normal age-appropriate human variation; or
- to maintain or restore functional ability.

A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

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

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

Illness means a:

- congenital malformation that causes functional impairment;
- condition, disease, ailment or bodily disorder, other than an Injury; or
- pregnancy.

Illness does not include any state of mental health or mental disorder which is otherwise defined in the Mental Health or Substance Use Disorder Services benefit.

Injury means physical damage to the body caused by:

- a foreign object;

- force;
- temperature;
- a corrosive chemical; or
- the direct result of an accident, independent of Illness or any other cause.

An Injury does not mean Injury to teeth due to chewing and does not include any condition related to pregnancy.

In-Network means a Provider that has an effective participating contract with the Claims Administrator that designates the Provider as in Your network to provide services and supplies to Claimants in accordance with the provisions of this coverage. Your network is Preferred. For In-Network Provider reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

Investigational means a Health Intervention that fails to meet any of the following criteria:

- A finding or conclusion that a Health Intervention is "experimental" shall be regarded as synonymous with a determination it is Investigational.
- The Health Intervention is recognized as in accordance with generally accepted standards of medical practice by the medical community in the service area in which it is received and has any required governmental agency approval at the time it is provided.
- The Health Intervention is provided in the United States by a Provider that has demonstrated proficiency in the Health Intervention outside a clinical trial or research setting.
- If a medication or device, the Health Intervention must have final approval from the FDA as being safe and effective for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the medication may be provided when so used. To be considered effective for other than its FDA-approved use, the Oregon Health Evidence Review Commission or the Pharmacy and Therapeutics Committee established to advise the Oregon Health Authority must have determined that the medication is effective for the treatment of that condition.
- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Illness or Injury, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- Medications approved under the FDA's Accelerated Approval Pathway must show improved Health Outcomes to be Medically Necessary.
- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting and the Health Intervention must be available outside of a clinical trial or research program for the Illness or condition being treated.

In applying the above criteria, the Claims Administrator will review Scientific Evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention.

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

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

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

Member Employer means a business entity qualifying for membership or participation through the Plan Sponsor and choosing to participate under the Plan to provide coverage to its employees and their dependents as Participants and Beneficiaries, respectively.

Out-of-Network means a Provider that is not In-Network. For Out-of-Network Provider services, You may be billed for balances over the Plan's payment level in addition to any Deductible, Copayment and/or Coinsurance amount for Covered Services provided inside or outside the area that the Claims Administrator or one of its Affiliates serves.

Participant means an employee of a Member Employer who is eligible under the terms of the Agreement, has completed an enrollment form and is enrolled under this coverage.

Physician means an individual who is duly licensed to practice medicine and/or surgery in all of its branches or to practice as an osteopathic Physician and/or surgeon. Physician also includes a podiatrist practicing within the scope of a license issued under ORS 677.805 to 677.840.

Practitioner means an individual who is duly licensed to provide medical or surgical services that are similar to those provided by Physicians. Practitioners include, but are not limited to:

- podiatrists who do not meet the definition of Physician;
- Physician's assistants;
- psychologists;
- licensed clinical social workers;
- certified nurse Practitioners;
- registered physical, occupational, speech or audiological therapists;
- registered nurses or licensed practical nurses, (but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill patients);
- dentists (doctor of medical dentistry or doctor of dental surgery, or a denturist); and
- other health care professionals practicing within the scope of their respective licenses.

Provider means:

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

Reasonable Charges means an amount, determined by the Claims Administrator, that falls within the range of average payments they make to Providers, who have an effective participating contract with them, for the same or similar service or supply in the Claims Administrator's service area. Regardless of anything in this Booklet to the contrary, if the Claims Administrator is required by applicable law to base payment on another amount, that amount will be Reasonable Charges.

Retail Clinic means a walk-in health clinic located within a retail operation and providing, on an ambulatory basis, preventive and primary care services. A Retail Clinic does not include:

- an office or independent clinic outside a retail operation;
- an Ambulatory Surgical Center;
- an urgent care center or facility;
- a Hospital;
- a Pharmacy;
- a rehabilitation facility; or
- a Skilled Nursing Facility.

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, Scientific Evidence shall not include published peer-reviewed literature

sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

Skilled Nursing Facility means a facility or distinct part of a facility which is licensed by the state in which it is located as a nursing care facility and which provides skilled nursing services by or under the direction and supervision of a registered nurse.

Appendix: Value-Added Services

This Plan includes access to the value-added services detailed in this Appendix. Services may be provided through third-party program partners who are solely responsible for their services. **THESE VALUE-ADDED SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS OF THIS BOOKLET.**

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

DIABETES MANAGEMENT
If You are identified to participate, the Diabetes Management program is an online program that has extensive support tools such as glucose tracking, live coaching and mental and emotional care to help You improve health and manage diabetes. To better track blood sugar levels and provide more focused support, You will be provided a cellular-enabled glucose monitor.

PREGNANCY PROGRAM
Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions. The Pregnancy Program can provide answers and assistance so that You can relax and enjoy those nine life-changing months.

If You are expecting a child, this program offers access to a nurse 24 hours a day, 7 days a week and educational materials tailored to Your needs. Since the Pregnancy Program is most beneficial when You enroll early in a pregnancy, call 1 (888) JOY-BABY (569-2229) or visit the Claims Administrator's Web site right away to get started.

REGENCE EMPOWER
Regence Empower is a well-being program that offers a range of tools, information and support for a healthy lifestyle. It may include the following:

- earning a $25 gift card for completion of online well-being activities such as an online health risk assessment;
- incentives to reward participation in healthy activities; and
- online tools that integrate with fitness apps and devices to track progress toward Your health and well-being goals.

Disclosure Statement Patient Protection Act

In accordance with Oregon law (Senate Bill 21, known as the Patient Protection Act), the following Disclosure Statement includes questions and answers to fully inform You about the benefits and policies of this health insurance plan.

WHAT ARE MY RIGHTS AND RESPONSIBILITIES AS A CLAIMANT OF REGENCE BLUECROSS BLUESHIELD OF OREGON?

No one can deny You the right to make Your own choices. As a Claimant, You have the right to:

- be treated with dignity and respect;
- impartial access to treatment and services without regard to race, religion, gender, national origin or disability;
- know the name of the Physicians, nurses or other health care professionals who are treating You;
- medical care necessary to correctly diagnose and treat any covered Illness or Injury;
- have Providers tell You about the diagnosis, the treatment ordered, the prognosis of the condition and instructions required for follow-up care;
- know why various tests, procedures or treatments are done, who the persons are who give them and any risks You need to be aware of;
- refuse to sign a consent form if You do not clearly understand its purpose, cross out any part of the form You don't want applied to care or have a change of mind about treatment You previously approved;
- refuse treatment and be told what medical consequences might result from Your refusal;
- be informed of policies regarding "living wills" as required by state and federal laws (these kinds of documents explain Your rights to make health care decisions, in advance, if You become unable to make them);
- expect privacy about care and confidentiality in all communications and in Your medical records;
- expect clear explanations about benefits and exclusions;
- contact Customer Service and ask questions or present complaints; and
- be informed of the right to appeal an action or denial and the related process.

You have a responsibility to:

- tell the Provider You are covered by Regence BlueCross BlueShield of Oregon and show Your identification card when requesting health care services;
- be on time for appointments and to call immediately if there is a need to cancel an appointment or if You will be late. You are responsible for any charges the Provider makes for "no shows" or late cancellations;
- provide complete health information to the Provider to help accurately diagnose and treat Your condition;
- follow instructions given by those providing health care to You;
- review this health care benefits Booklet to make sure services are covered by the Plan;

- make sure services are prior authorized when required by the Plan before receiving medical care;
- contact Customer Service if You believe adequate care is not being received;
- read and understand all materials about Your health benefits and make sure Your Beneficiaries covered under the Plan also understand them;
- give an identification card to Your enrolled Beneficiaries to show at the time of service; and
- pay any required Copayments at the time of service.

HOW DO I ACCESS CARE IN THE EVENT OF AN EMERGENCY?
If You experience an emergency situation, You should obtain care from the nearest appropriate facility, or dial 911 for help.

If there is any doubt about whether Your condition requires emergency treatment, You can always call the Provider for advice. The Provider is able to assist You in coordinating medical care and is an excellent resource to direct You to the appropriate care since they are familiar with Your medical history.

HOW WILL I KNOW IF MY BENEFITS CHANGE OR ARE TERMINATED?
If You are insured through a group plan at work, Your employee benefits administrator will let You know if and when Your benefits change. In the event Your Plan terminates and Your Plan Sponsor does not replace the coverage with another group plan, Your Plan Sponsor is required by law to advise You in writing of the termination.

WHAT HAPPENS IF I AM RECEIVING CARE AND MY DOCTOR IS NO LONGER A CONTRACTING PROVIDER?
When a Physician's or Practitioner's (herein Provider) contract ends with the Claims Administrator for any reason, the Claims Administrator will give notice to those Participants that the Claims Administrator knows, or should reasonably know, are under the care of the Provider of their rights to receive continued care (called "continuity of care"). The Claims Administrator will send this notice no later than ten days after the Provider's termination date or ten days after the date the Claims Administrator learns the identity of an affected Participant, whichever is later. The exception to the Claims Administrator sending the notice is when the Provider is part of a group of Providers and the Claims Administrator has agreed to allow the Provider group to provide continuity of care notification to Participants.

When Continuity Of Care Applies. If You are undergoing an active course of treatment by an In-Network Provider and benefits for that Provider would be denied (or paid at a level below the benefit for an Out-of-Network Provider) if the Provider's contract with the Claims Administrator is terminated or the Provider is no longer participating with the Claims Administrator, the Plan will continue to pay benefits for services and supplies provided by the Provider as long as:

- You and the Provider agree that continuity of care is desirable and You request continuity of care from the Claims Administrator;
- the care is Medically Necessary and otherwise covered under the Plan;
- You remain eligible for benefits and enrolled under the Plan; and

- the Plan has not terminated.

Continuity of care does not apply if the contractual relationship between the Provider and the Claims Administrator ends in accordance with quality of care provisions of the Plan between the Provider and the Claims Administrator, or because the Provider:

- retires;
- dies;
- no longer holds an active license;
- has relocated outside of the Claims Administrator's service area;
- has gone on sabbatical; or
- is prevented from continuing to care for patients because of other circumstances.

How Long Continuity Of Care Lasts. Except as follows for pregnancy care, the Plan will provide continuity of care until the earlier of the following dates:

- the day following the date on which the active course of treatment entitling You to continuity of care is completed; or
- the 120th day after notification of continuity of care.

If You become eligible for continuity of care after the second trimester of pregnancy, the Plan will provide continuity of care for that pregnancy until the earlier of the following dates:

- the 45th day after the birth;
- the day following the date on which the active course of treatment entitling You to continuity of care is completed; or
- the 120th day after notification of continuity of care.

The notification of continuity of care will be the earlier of the date the Claims Administrator or, if applicable, the Provider group notifies You of the right to continuity of care, or the date the Claims Administrator receive or approve the request for continuity of care.

COMPLAINT AND APPEALS: IF I AM NOT SATISFIED WITH MY HEALTH PLAN OR PROVIDER WHAT CAN I DO TO FILE A COMPLAINT OR GET OUTSIDE ASSISTANCE?

To voice a complaint with the Claims Administrator, simply follow the process outlined in the Resolving Your Concerns Section of this Booklet. This includes if applicable, information about filing an appeal through an IRO without charge to You.

You also have the right to file a complaint and seek assistance from the Oregon Division of Financial Regulation. Assistance is available by:

- calling (503) 947-7984 or the toll-free message line at 1 (888) 877-4894;
- writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405;
- visiting the Oregon Division of Financial Regulation Web site: **https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx**; or
- e-mail at: **DFR.InsuranceHelp@oregon.gov**.

HOW CAN I PARTICIPATE IN THE DEVELOPMENT OF YOUR CORPORATE POLICIES AND PRACTICES?

Your feedback is very important to the Claims Administrator. If You have suggestions for improvements about coverage or the Claims Administrator's services, the Claims Administrator would like to hear from You.

The Claims Administrator has formed several advisory committees to allow participation in the development of corporate policies and to provide feedback:

- the Member Advisory Committee for Participants;
- the Marketing Advisory Panel for employers; and
- the Provider Advisory Committee for health care professionals.

If You would like to become a member of the Member Advisory Committee, send Your name, identification number, address and phone number to the vice president of the Claims Administrator's Customer Service at the following address. The advisory committees generally meet two times per year.

Regence BlueCross BlueShield of Oregon ATTN: Vice President, Customer Service, P.O. Box 1827, MS CS B32B, Medford, OR 97501-9884 or send Your comments to the Claims Administrator's Web site.

Please note that the size of the committees may not allow the Claims Administrator to include all those who indicate an interest in participating.

WHAT ARE YOUR PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT CRITERIA?

Prior authorization is the process the Claims Administrator uses to determine the benefits, eligibility and Medical Necessity of a service before it is provided. Contact Customer Service at the phone number on the back of Your identification card or ask Your Provider for a list of services that need to be prior authorized. Many types of treatment may be available for certain conditions; the prior authorization process helps the Provider work together with You, other Providers and the Claims Administrator to determine the treatment that best meets Your medical needs and to avoid duplication of services.

This teamwork helps save thousands of dollars in premiums each year, which then translates into savings for You. Prior authorization is Your assurance that medical services won't be denied because they are not Medically Necessary.

Utilization management is a process in which the Claims Administrator examines services a Participant receives to ensure that they are Medically Necessary and appropriate with regard to widely accepted standards of good medical practice. For further explanation, look at the definition of Medically Necessary in the Definitions Section.

Let the Claims Administrator know if You would like a written summary of information that the Claims Administrator may consider in the Claims Administrator's utilization management of a particular condition or disease. Simply call the Customer Service

phone number on the back of Your identification card or log onto the Claims Administrator's Web site.

HOW ARE IMPORTANT DOCUMENTS (SUCH AS MY MEDICAL RECORDS) KEPT CONFIDENTIAL?

The Claims Administrator has a written policy to protect the confidentiality of health information. Only employees who need to know in order to do their jobs have access to a Participant's personal information. Disclosure outside the company is permitted only when necessary to perform functions related to providing Your coverage and/or when otherwise allowed by law. Note that with certain limited exceptions, Oregon law requires insurers/Claims Administrators to obtain a written authorization from the Participant or their representative before disclosing personal information. One exception to the need for a written authorization is disclosure to a designee acting on behalf of the insurer for the purpose of utilization management, quality assurance or peer review.

MY NEIGHBOR HAS A QUESTION ABOUT THEIR POLICY WITH YOU AND DOESN'T SPEAK ENGLISH VERY WELL. CAN YOU HELP?

Yes. Simply have Your neighbor call Customer Service at the number on their identification card. One of the Claims Administrator's representatives will coordinate the services of an interpreter over the phone. The Claims Administrator can help with sign language as well as spoken languages.

WHAT ADDITIONAL INFORMATION CAN I GET FROM YOU UPON REQUEST?

The following documents are available by calling a Customer Service representative:

- Rules related to the Claims Administrator's Drug List, including information on whether a particular medication is included or excluded from the Drug List.
- Provisions for referrals for specialty care, behavioral health services and Hospital services and how Participants may obtain the care or services.
- The Claims Administrator's annual report on complaints and appeals.
- A description of the Claims Administrator's risk-sharing arrangements with Physicians and other Providers consistent with risk-sharing information required by the Health Care Financing Administration. A description of the Claims Administrator's efforts to monitor and improve the quality of health services.
- Information about procedures for credentialing network Providers and how to obtain the names, qualifications and titles of the Providers responsible for a Participant's care.
- Information about the Claims Administrator's prior authorization and utilization management procedures.

WHAT OTHER SOURCE CAN I TURN TO FOR MORE INFORMATION ABOUT YOUR COMPANY?

The following information regarding the Health Benefit Plans of Regence BlueCross BlueShield of Oregon is available from the Oregon Division of Financial Regulation:

- The results of all publicly available accreditation surveys.
- A summary of the Claims Administrator's health promotion and disease prevention activities.

- Samples of the written summaries delivered to policyholders.
- An annual summary of Grievances and appeals.
- An annual summary of utilization management policies.
- An annual summary of quality assessment activities.
- An annual summary of scope of network and accessibility of services.

To obtain the mentioned information, contact the Claims Administrator's Customer Service department. You can also contact the Oregon Division of Financial Regulation by:

- calling (503) 947-7984 or the toll-free message line at 1 (888) 877-4894;
- writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405;
- visiting the Oregon Division of Financial Regulation Web site: **https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx**; or
- e-mail at: **DFR.InsuranceHelp@oregon.gov**.

For more information contact the Claims Administrator

at 1 (866) 240-9580 or You can write to P.O. Box 2998, Tacoma, WA 98401-2998

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