Regence

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

SDIS SPECIAL DISTRICTS INSURANCE SERVICES

Special Districts Insurance Services

SDIS Blue VI Plan

Effective July 1, 2019 through June 30, 2020

Cost Share Details		In-Network	Out-of-Network
Annual Deductible	The total deductible you pay per calendar year	$2,000 Individual $4,000 Family	
Annual Out-of-Pocket Maximum	The combined total for your deductible, coinsurance and copays per calendar year	$5,500 Individual $13,500 Family	$5,000 Individual
Be aware that your actual costs for Covered Services provided by an Out-of-Network provider may exceed the Out-of-Pocket Maximum amount. In addition, Out-of-Network providers can bill you for the difference between the amount charged and our allowed amount and that amount does not count toward any Out-of-Pocket Maximum.			
Medical Benefits (unless stated otherwise, a deductible applies)		What You Pay	
Primary Care Visits (for Illness or Injury)		$25 copay per visit ($12 for BDTC providers), deductible waived.	40% coinsurance.
Specialist Visits		$25 copay per visit ($12 for BDTC providers), deductible waived.	40% coinsurance.
Urgent Care Visits		$25 copay per visit ($12 for BDTC providers), deductible waived.	40% coinsurance.
Other Professional Services		20% coinsurance.	40% coinsurance.
Preventive Care/Immunizations	• Preventive services and immunizations are covered according to guidelines set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) • Childhood Immunizations covered at no cost	0% coinsurance, deductible waived.	40% coinsurance.
Ambulance Services		Ground: 20% coinsurance. Air: 50% coinsurance.	Ground: 20% coinsurance. Air: 50% coinsurance.
Ambulatory Surgical Center		20% coinsurance.	40% coinsurance.
Complementary Care	• Chiropractic spinal manipulations and acupuncture services from any licensed provider • $1,500 limit per Calendar year	$25 copay per visit, deductible waived.	40% coinsurance.
Emergency Room (Including Professional Charges)		$250 copay per visit; deductible waived.	$250 copay per visit; deductible waived.
Hearing Aids & Evaluations		20% coinsurance.	40% coinsurance.
Hearing Examinations	• Limit: 1 exam per Calendar year	$25 copay per visit, deductible waived.	40% coinsurance.
Home Health Care	• Limit: 130 visits per Calendar year	20% coinsurance.	40% coinsurance.
Hospice Care	• Limit: 30 inpatient or outpatient respite care days per lifetime	20% coinsurance.	40% coinsurance.
Hospital Care		20% coinsurance.	40% coinsurance.
Maternity Care - Professional Services		$200 copay per pregnancy, deductible waived.	40% coinsurance.
Maternity Care - Other	• Office visits and facility services	20% coinsurance.	40% coinsurance.

Medical Benefits (unless stated otherwise, a deductible applies)		What You Pay	
Mental Health/Substance Use Disorder - Inpatient		20% coinsurance.	40% coinsurance.
Mental Health/Substance Use Disorder - Outpatient		$25 copay per outpatient office/psychotherapy visit ($12 for BDTC providers), deductible waived.	40% coinsurance.
Neurodevelopmental Therapy - Outpatient	• Limit: 30 visits per Calendar year • Children up to the age of 18	20% coinsurance, deductible waived.	40% coinsurance.
Nutritional Counseling	• Limit: 5 visits per lifetime.	20% coinsurance.	40% coinsurance.
Radiology and Laboratory - Outpatient		20% coinsurance, deductible waived.	40% coinsurance.
Advanced Imaging	• CT, PET, MRA, SPECT, Bone Density, MRI	20% coinsurance.	40% coinsurance.
Rehabilitation Services - Inpatient	• 30 days per Calendar year	20% coinsurance	40% coinsurance.
Rehabilitation Services - Outpatient	• 30 visits combined per Calendar year	20% coinsurance, deductible waived.	40% coinsurance.
Skilled Nursing Facility (SNF) Care	• Limit: 60 days per Calendar year	20% coinsurance.	40% coinsurance.
Telehealth		$0 copay per session, deductible waived	Not covered

Vision Benefits		What You Pay	
Routine Eye Exam	• Limit: 1 per Calendar year	$25 copay, deductible waived	No charge up to $40
Hardware		No charge up to $300 maximum per year	No charge up to $300 maximum per year

Prescription Medication Services	
Your prescription drug coverage is administered through CVS/Caremark, via RxBenefits. Regence BlueCross BlueShield of Oregon assumes no liability for the accuracy of your prescription drug benefits information. *Please contact the RxBenefits Inc. member services team at (800) 334-8134 or visit www.Caremark.com for all of your CVS/Caremark prescription drug coverage questions.*	
Generic	$10 retail prescription. $10 mail order prescription.
Preferred Brand	$30 retail prescription. $60 mail order prescription.
Nonpreferred Brand	$50 retail prescription. $100 mail order prescription.
Specialty	30% coinsurance to $200 maximum per prescription.

This benefit summary provides a brief description of your plan benefits, limitations and/or exclusions under your plan and is not a guarantee of payment. Once enrolled, you can view your benefits booklet online at regence.com. PLEASE REFER TO YOUR BENEFITS BOOKLET OR SUMMARY PLAN DESCRIPTION FOR A COMPLETE LIST OF BENEFITS, THE LIMITATIONS AND/OR EXCLUSIONS THAT APPLY, AND A DEFINITION OF MEDICAL NECESSITY. Regence is providing this benefit summary for illustrative purposes only. Regence makes no warranties or representations regarding compliance with applicable federal, state, or local laws, or the accuracy of the benefit summary. This document is not the legally required Summary of Benefits and Coverage that an employer is required to provide to employees and members under Federal law, and the group must provide a legally compliant Summary of Benefits and Coverage to its employees and members.

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.

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- 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:

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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
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Portland, OR 97207-1271
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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

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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).

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D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-888-344-6347 (TTY: 711.)

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

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

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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)

2019 BOOKLET FOR:

SPECIAL DISTRICTS INSURANCE SERVICES

SDIS Special Districts Insurance Services

BLUE PLAN VI

Group Number: 800000031

Medical Plan

Regence

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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.)

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Introduction

Welcome to participation in the self-funded group health plan (hereafter referred to as "Plan") provided for You by Your employer and Special Districts Insurance Services (SDIS). SDIS has chosen Regence BlueCross BlueShield of Oregon to administer claims for Your group health plan. Throughout this Booklet, SDIS may be referred to as the "Plan Sponsor" or "Plan Administrator."

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

Because of their extensive experience and reputation of service, Regence BlueCross BlueShield of Oregon has been chosen as the Claims Administrator of Your Plan.

The following pages are the Booklet, the written description of the terms and benefits of coverage available under the Plan. This Booklet describes benefits effective January 1, 2019, or the date after that on which 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.

As You read this Booklet, please keep in mind that references to "You" and "Your" refer to both the Participant and Beneficiaries (except that in the Who Is Eligible, How To Enroll And When Coverage Begins, When Coverage Ends, COBRA Continuation of Coverage, and Other Continuation Options sections, the terms "You" and "Your" mean the Participant only). The term "Claims Administrator" refers to 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. The term "Agreement" refers to the administrative services contract between the Plan Sponsor and the Claims Administrator. Other terms are defined in the Definitions Section at the back of this Booklet or where they are first used and are designated by the first letter being capitalized.

Federal law mandates coverage for certain breast reconstruction services in connection with a covered mastectomy. See Women's Health and Cancer Rights in the General Provisions Section of this Booklet for details.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act:
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

(e.g., Your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers 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, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain preauthorization 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 preauthorization. For information on preauthorization, contact Your Claims Administrator.

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 Physicians 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
If You have questions, would like to learn more about Your coverage or would like to request written or electronic information regarding any other plan that the Claims Administrator offers, talk with one of the Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. – 6 p.m. Pacific Time.

Customer Service: 1 (866) 240-9580
(TTY: 711)

Or visit the Claims Administrator's Web site at: **regence.com**

For assistance in a language other than English, please call the Customer Service telephone number.

Case Management. You can request that a case manager be assigned or You may be assigned a case manager to help You and Your Physician best use Your benefits and navigate the health care system in the best way possible. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. Call Case Management at 1 (866) 543-5765.

BlueCard® Program. Call Customer Service to learn how to have access to care through the 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.

Using Your Booklet

YOUR PARTNER IN HEALTH CARE

This Plan, administered by Regence, provides You with great benefits that are quickly accessible and easy to understand, thanks to broad access to Providers and innovative tools. With this health care coverage, You will discover more personal freedom to make informed health care decisions, as well as the assistance You need to navigate the health care system.

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

Your Plan gives You broad access to Providers and allows You to control Your out-of-pocket expenses, such as Copayments and Coinsurance, for each Covered Service. Here's how it works - You control Your out-of-pocket expenses by choosing Your Provider under two choices called: "In-Network" and "Out-of-Network."

- **In-Network.** You choose to see an In-Network Provider and save the most in Your out-of-pocket expenses. Choosing this provider option means You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. In addition, there are a select group of In-Network Providers referred to as Blue Distinction Total Care (BDTC) Providers. When You see a BDTC Provider, You will have even lower out-of-pocket expense for most office visits.
- **Out-of-Network.** You choose to see an Out-of-Network Provider and Your out-of-pocket expenses will generally be higher than an In-Network Provider. Also, choosing this provider option means You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. This is sometimes referred to as balance billing.

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

ADDITIONAL PARTICIPATION ADVANTAGES

Your Plan offers You access to valuable services. The advantages of Regence involvement as the Claims Administrator include access to discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to **regence.com**, an interactive environment that can help You navigate Your way through health care decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE GROUP HEALTH PLAN, BUT ARE NOT INSURANCE.**

- **Go to regence.com.** It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your

health care dollar. Have Your Plan identification card handy to log on. Use the secure Web site to:

- view recent claims, benefits and coverage;
- find a contracting Provider;
- participate in online wellness programs and use tools to estimate upcoming healthcare costs; and
- discover discounts on select items and services*.

ENHANCED SERVICES, SUPPORT, AND ACCESS
Your Plan Sponsor has chosen to include enhanced services, support, and access. These enhancements will allow You to take increased advantage of Your health plan and 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; receive coaching; 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'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 employer, and the Claims Administrator. **ANY SUCH ENHANCED SERVICES, SUPPORT, AND ACCESS ARE COMPLEMENTS TO THE GROUP HEALTH PLAN, BUT ARE NOT INSURANCE**.

Table of Contents

Understanding Your Benefits

In this section, You will discover information to help You understand what is meant by Your Maximum Benefits, Deductibles (if any), Copayments, Coinsurance and Out-of-Pocket Maximum. Other terms are defined in the Definitions Section at the back of this Booklet or where they are first used and are designated by the first letter being capitalized.

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

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

OUT-OF-POCKET MAXIMUM
Claimants can meet the Out-of-Pocket Maximum by payments of Deductibles, Copayments and Coinsurance as specifically indicated in the Medical Benefits Section. Pharmacy Copayments and Coinsurance do apply to the Out-of-Pocket Maximum. There are two Out-of-Pocket Maximum amounts: one for In-Network benefits and another for Out-of-Network benefits. The Medical Benefits Section describes this more fully, but in this Booklet, the term is referred to simply as "the Out-of-Pocket Maximum." A Claimant's payment of any Deductible, Copayment, and/or Coinsurance for detoxification, emergency room services and benefits listed in the Medical Benefits Section that show under the Provider "All" 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 at the back of this Booklet) 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. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach this Plan's 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 for some benefits of this Plan does not change to a higher payment level or apply to the Out-of-Pocket Maximum. Those exceptions are specifically noted in the Medical Benefits Section of this Booklet.

The Family In-Network Out-of-Pocket Maximum for a Calendar Year is satisfied when Deductibles, Copayments and Coinsurance for Covered Services for that Calendar Year

total and meet the Family's Out-of-Pocket Maximum amount. One Claimant may not contribute more than the individual Out-of-Pocket Maximum amount.

COPAYMENTS
Copayments are the fixed dollar amount that You must pay directly to the Provider of services or supplies at the time the service or supply is furnished. The Copayment will be the lesser of the fixed dollar amount or the Allowed Amount for the service. Refer to the Medical Benefits Section to understand what Copayments You are responsible for.

PERCENTAGE PAID UNDER THE PLAN (COINSURANCE)
Once You have satisfied any applicable Deductible and any applicable Copayment, the Plan pays a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). Your Coinsurance will be based upon the lesser of the billed charges or the Allowed Amount. The percentage the Plan pays varies, depending on the kind of service or supply You received and who rendered it.

The Plan does not reimburse Providers for charges above the Allowed Amount. An In-Network Provider will not charge You for any balances for Covered Services beyond Your Deductible, Copayment and/or Coinsurance amount. Out-of-Network Providers, however, may bill You for any balances over the Plan payment level in addition to any Deductible, Copayment and/or Coinsurance amount. See the Definitions Section for descriptions of Providers.

DEDUCTIBLES
The Plan will begin to pay benefits for Covered Services in any Calendar Year only after a Claimant satisfies the Calendar Year Deductible. A Claimant satisfies the Deductible by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible.

The Family Calendar Year Deductible is satisfied when two or more covered Family members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Deductible amount. One Claimant may not contribute more than the individual Deductible amount.

The Plan does not pay for services applied toward the Deductible. Refer to the Medical Benefits Section to see if a particular service is subject to the Deductible. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not count toward the Deductible.

HOW CALENDAR YEAR BENEFITS RENEW
Many provisions of the Plan (for example, Deductibles, Out-of-Pocket Maximum, and certain benefit maximums) are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again.

Some benefits of the Plan have a separate Maximum Benefit based upon a Claimant's Lifetime and do not renew every Calendar Year. Those exceptions are specifically noted in the benefits sections of this Booklet.

Medical Benefits

In this section, You will learn about Your health plan's benefits and how Your coverage pays for Covered Services. There are no referrals required before You can use any of the benefits of this coverage. For Your ease in finding the information regarding benefits most important to You, the Plan has listed these benefits alphabetically, with the exception of the Preventive Care and Immunizations, Office Visits and Other Professional Services benefits.

All covered benefits are subject to the limitations, exclusions and provisions of this plan. In some cases, the Claims Administrator may limit benefits or coverage to a less costly and Medically Necessary alternative item. To be covered, medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Also, a Provider practicing within the scope of his or her license must render the service. Please see the Definitions Section in the back of this Booklet for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

Reimbursement may be available under Your coverage for some medical supplies, equipment and devices You purchase from a Provider or from an approved Commercial Seller, even though that seller is not a Provider. Medical supplies, equipment and devices, such as a breast pump or wheelchair, 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 retail medical supplies, equipment and devices, please visit the Claims Administrator's Web site or contact Customer Service.

NOTE: If You choose to access 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 GROUP HEALTH PLAN, BUT ARE NOT INSURANCE**.

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

If benefits under the Plan 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.

CALENDAR YEAR OUT-OF-POCKET MAXIMUM
In-Network
Per Claimant: $4,000
Per Family: $10,500

Out-of-Network
Per Claimant: $5,000

COPAYMENTS AND COINSURANCE
Copayments and Coinsurance are listed in the tables for Covered Services for each applicable benefit.

CALENDAR YEAR DEDUCTIBLES
Per Claimant: $2,000
Per Family: $4,000

You do not need to meet any Deductible before receiving benefits for:

- In-Network Preventive Care and Immunizations;
- In-Network Office Visits – Illness or Injury;
- In-Network Diabetes Management Associated with Pregnancy;
- In-Network medical colonoscopy associated with positive fecal test;
- In-Network outpatient radiology and laboratory services (not including complex imaging procedures);
- In-Network Allergy Treatment;
- In-Network Complementary Care;
- emergency room services;
- In-Network maternity professional services;
- In-Network outpatient visits for Neurodevelopmental Therapy;
- In-Network outpatient visits for Rehabilitation Services;
- In-Network Routine Hearing Examinations;
- In-Network outpatient office / psychotherapy visits for Mental Health or Substance Use Disorder Services;
- In-Network Osteopathic Spinal Manipulations; and
- In-Network Telehealth.

SERVICES RECEIVED FROM AN OREGON OUT-OF-NETWORK PROVIDER IN AN IN-NETWORK HEALTHCARE FACILITY
Regardless of any provision of this Summary Plan Description to the contrary, if You receive services at an In-Network Healthcare Facility from an Oregon licensed or certified Out-of-Network Provider, 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.

PREVENTIVE CARE AND IMMUNIZATIONS
Benefits will be covered under this Preventive Care and Immunizations benefit, not any other provision in this Booklet, if services are in accordance with 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). In the event any of these bodies adopts a new or revised recommendation, this Plan has up to one year before coverage

of the related services must be available and effective under this benefit. For a list of services covered under this benefit, please 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. NOTE: Covered Services that do not meet these criteria will be covered the same as any other Illness or Injury.

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: The Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers preventive care services provided by a professional Provider or facility. Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care, routine immunizations and routine health screenings. Also included is Provider counseling for tobacco use cessation. Coverage for all such services is provided only for preventive care as designated above (which designation may be modified from time to time).

The Plan covers one non-Hospital grade breast pump (including its accompanying supplies) per pregnancy at the In-Network benefit level when obtained from a Provider (including a Durable Medical Equipment supplier). Alternatively, a comparable breast pump may be obtained from an approved Commercial Seller in lieu of a Provider. Benefits for a comparable 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. To verify eligible breast pumps, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, please visit the Claims Administrator's Web site or contact Customer Service.

Immunizations – Adult

Provider: In-Network	Provider: Out-of-Network
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers immunizations for adults, according to, and as recommended by, the USPSTF and the CDC. Covered expenses do not include immunizations if the Claimant receives them only for purposes of travel, occupation or residence in a foreign country.

Immunizations – Childhood

Provider: In-Network	Provider: Out-of-Network
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.

The Plan covers immunizations for children (up to 18 years of age), according to, and as recommended by, the USPSTF and the CDC.

OFFICE VISITS – ILLNESS OR INJURY

Provider: In-Network	Provider: Out-of-Network
Payment for BDTC Providers: After $12 Copayment per visit, the Plan pays 100% of the Allowed Amount. **Payment for all other Providers:** After $25 Copayment per visit, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers office visits for treatment of Illness or Injury. The Copayment applies to visits in the office, home or Hospital outpatient department only. All other professional services performed in the office, not billed as an office visit, or that are not related to the actual visit (such as, separate facility fees billed in conjunction with the office visit) are not considered an office visit under this benefit. For example, the Plan will pay for a surgical procedure performed in the office according to the Other Professional Services benefit.

OTHER PROFESSIONAL SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible,* the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum. *The Deductible does not apply to outpatient radiology and laboratory services (not including complex imaging procedures).	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers services and supplies provided by a professional Provider subject to any Deductible and/or Coinsurance and any specified limits as explained in the following paragraphs:

Medical Services and Supplies
The Plan covers professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider, that are generally recognized and accepted non-surgical procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury. Covered services and supplies also include those to treat a congenital anomaly for Claimants up to age 26 and foot care associated with diabetes, as well as dental and orthodontic services that are for the treatment of craniofacial anomalies and are Medically Necessary to restore function. 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 is not provided under this benefit for the treatment of temporomandibular joint disorder or developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth.

Additionally, the Plan covers some Medically Necessary supplies (for example, compression stockings, active wound care supplies and sterile gloves) that are obtained from an approved Commercial Seller. Benefits for eligible 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 medical supplies, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, please visit the Claims Administrator's Web site or contact Customer Service.

Breast, Pelvic and Pap Smear Examinations
The Plan covers breast, pelvic and Pap smear examinations not covered under the Preventive Care and Immunizations benefit.

Complex Imaging Procedures
The Plan covers the following complex imaging procedures: Computer Tomography (CT) Scan, Positron Emission Tomography (PET), Magnetic Resonance Angiogram

(MRA), Single-Proton Emission Computerized Tomography (SPECT), Bone Density Study, and Magnetic Resonance Imaging (MRI).

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 Copayments, Coinsurance, or Deductible when provided by an In-Network Provider.

Diagnostic Procedures
The Plan covers services for diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies, stress test, sleep studies and neurology/neuromuscular procedures.

Medical Colonoscopy
Medical colonoscopy (and all associated services, such as anesthesia and pathology) performed as a result of a positive fecal test for a Claimant age 50 or older is not subject to any Copayments, Coinsurance, or Deductible when provided by an In-Network Provider. Preventive colonoscopies are covered under the Preventive Care and Immunizations benefit. All other colonoscopies, including for those Claimants at high-risk, are covered subject to the Deductible, Copayment and/or Coinsurance.

Professional Inpatient
The Plan covers professional inpatient visits for Illness or Injury. If pre-arranged procedures are performed by an In-Network Provider and You are admitted to an In-Network Hospital, 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. Please contact Customer Service for further information and guidance.

Radiology and Laboratory
The Plan covers services for treatment of Illness or Injury. This includes, but is not limited to, Medically Necessary mammography services not covered under the Preventive Care and Immunizations benefit.

Surgical Services
The Plan covers surgical services and supplies including cochlear implants and the services of a surgeon, an assistant surgeon and an anesthesiologist.

Therapeutic Injections
The Plan covers therapeutic injections and related supplies when given in a professional Provider's office.

Teaching doses for self-administrable injectable medications (by which a Provider educates the Claimant to self-inject) are covered up to a limit of three doses per medication per Claimant Lifetime. Teaching doses that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

ALLERGY TREATMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After $5 Copayment per visit, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers allergy treatment services, including, but not limited to, allergens and their administration and skin tests. All other services and supplies are subject to the applicable benefit for such service.

AMBULANCE SERVICES

Provider: All
Payment for Ground Ambulance: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. **Payment for Air Ambulance:** After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers services of a state certified ground or air ambulance when private transportation is medically inappropriate because the acute medical condition requires paramedic support. Benefits are provided for emergency ambulance service and/or transport to the nearest Hospital capable of treating the condition. Air ambulance service is covered only when group transportation is medically or physically inappropriate. Reimbursement to air ambulance services are based on 200% of Medicare allowance. In some cases Medicare allowance may be significantly lower than the Provider's billed amount. The Provider may hold you responsible for the amount they bill in excess of the Medicare allowance, as well as applicable Deductibles and Coinsurance.

AMBULATORY SURGICAL CENTER

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers outpatient services and supplies of an Ambulatory Surgical Center (including services of staff Providers) for Injury and Illness.

APPROVED CLINICAL TRIALS

The Plan covers Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating subject to the Deductible, Coinsurance and/or Copayments and Maximum Benefits as specified in the Medical Benefits in this Booklet. Additional specified limits are as further defined. If an In-Network Provider is participating in the Approved Clinical Trial and will accept You as a trial participant, these benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If the Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care.

Definitions

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

Approved Clinical Trial means a 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 of the Department of Defense (DOD) or the Department of Veteran's Affairs (VA);
  - A qualified non-governmental research entity identified in guidelines issued by the NIH for center approval grants; or
  - The VA, DOD, or Department of Energy, provided it is reviewed and approved through a peer review system that the Department of Health and Human Services has determined both is comparable to that of the NIH and assures unbiased review of the highest scientific standards by qualified individuals without an interest in the outcome of the review; or
- Conducted under an investigational new drug application reviewed by the Food and Drug Administration or that is a drug trial exempt from having an investigational new drug application.

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.

BLOOD BANK

Provider: All
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers the services and supplies of a blood bank, excluding storage costs.

CHILD ABUSE MEDICAL ASSESSMENT

The Plan covers 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 subject to the Deductible, Coinsurance and/or Copayments and Maximum Benefits, if any, as specified in the Medical Benefits of this Booklet. The services include, but are not limited to, a forensic interview and Mental Health treatment.

Definitions

In addition to the definitions in the Definitions Section, 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.

COMPLEMENTARY CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After $25 Copayment per visit, the Plan pays 100% of the Allowed Amount. Your Copayment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: $1,500 for all complementary care combined per Claimant per Calendar Year	

The Plan covers acupuncture and chiropractic spinal manipulations under this benefit when performed by any Provider.

DENTAL HOSPITALIZATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers inpatient and outpatient services and supplies for hospitalization for Dental Services (including anesthesia), if hospitalization in an Ambulatory Surgical Center or Hospital is necessary to safeguard Your health.

DETOXIFICATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After In-Network Deductible, the Plan pays 80% of the Allowed Amount and You pay balance of billed charges. Your 20% payment of the Allowed Amount will be applied toward the In-Network Out-of-Pocket Maximum.

The Plan covers Medically Necessary detoxification.

DIABETES SUPPLIES AND EQUIPMENT

The Plan covers supplies and equipment for the treatment of diabetes. Please refer to the Other Professional Services, Diabetic Education, Durable Medical Equipment, Nutritional Counseling or Orthotic Devices benefits in this Booklet for coverage details of such covered supplies and equipment.

DIABETIC EDUCATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers services and supplies for diabetic self-management training and education. Nutritional therapy is covered under the Nutritional Counseling benefit.

DIALYSIS – OUTPATIENT
Initial Outpatient Treatment Period

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Outpatient limit: 42 treatments per Claimant	

The Plan covers professional services, supplies, medications, labs, and facility fees related to outpatient hemodialysis, peritoneal dialysis and hemofiltration services during the first treatment period. For the purpose of this benefit, the "first treatment period" will be three months (42 treatments) of hemodialysis treatment (or 30 days of peritoneal dialysis treatment). Dialysis treatments that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services. If more than 42 treatments are necessary in the first treatment period, the Claims Administrator must be contacted to approve the additional treatment and document Your progress. See the Supplemental Outpatient Treatment Period for coverage after the first 42 treatments in the first treatment period.

When Your Physician recommends dialysis, You should first contact the Claims Administrator to begin Case Management and confirm Your enrollment in the Supplemental Kidney Dialysis Program described below.

The Plan will pay regular Plan benefits when services are rendered outside the country, even if You have enrolled in the Supplemental Kidney Dialysis Program.

Supplemental Outpatient Treatment Period (Following Initial Outpatient Treatment Period)

Provider: In-Network	Provider: Out-of-Network
Payment: You pay no cost-sharing. If the Claims Administrator's agreement with the Provider expressly specifies that its terms supersede the benefits (or this benefit) of this Plan, the Plan pays 100% 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 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.

For any subsequent outpatient dialysis beyond the first treatment period, the Plan will provide supplemental coverage as described above.

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 under 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.

For the purpose of this benefit, "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 make a referral to case management, please call 1 (866) 240-9580.

DURABLE MEDICAL EQUIPMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

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. Examples include oxygen equipment and wheelchairs. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item.

Additionally, the Plan covers Durable Medical Equipment that is obtained from an approved Commercial Seller. Benefits for eligible 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 Durable Medical Equipment, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, please visit the Claims Administrator's Web site or contact Customer Service.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Provider: In-Network	Provider: Out-of-Network
Payment: After $250 Copayment per visit, the Plan pays 100% of the Allowed Amount. 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:** After $250 Copayment per visit, the Plan pays 100% of the Allowed Amount and You pay 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.

The Plan covers emergency room services and supplies, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. For the purpose of this benefit, "stabilization" means to provide Medically Necessary treatment: 1) 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 2) in the case of a covered Claimant, who is pregnant, to perform the delivery (including the placenta). Emergency room services do not need to be preauthorized. 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. Please contact Customer Service for further information and guidance. See the Hospital Care benefit in this Medical Benefits Section for coverage of inpatient Hospital admissions.

FAMILY PLANNING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers certain professional Provider contraceptive services and supplies not covered under the Preventive Care and Immunizations benefit, including, but not limited to, vasectomy.

Women's contraceptive methods, sterilization procedures, and patient education and counseling services in accordance with any frequency guidelines according to, and as recommended by HRSA are covered under the Preventive Care and Immunizations benefit.

GENETIC TESTING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

HEARING AIDS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: two devices per Claimant per every three Calendar Years	

The Plan covers hearing aids when necessary for the treatment of hearing loss. For the purpose of this benefit, 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. This coverage does not include routine hearing examinations or the cost of batteries or cords.

HOME HEALTH CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 130 visits per Claimant per Calendar Year	

The Plan covers home health care when provided by a licensed agency or facility for home health care. Home health care includes all services for patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility. Home health care visits that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services. Durable Medical Equipment associated with home health care services is covered under the Durable Medical Equipment benefit in this Booklet.

HOSPICE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 30 inpatient or outpatient respite care days per Claimant Lifetime	

The Plan covers hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and his or her family during the final stages of Illness.
Respite care: The Plan covers respite care 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 any Maximum Benefit limit on these services. Durable Medical Equipment associated with hospice care is covered under the Durable Medical Equipment benefit in this Booklet.

HOSPITAL CARE – INPATIENT AND OUTPATIENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers inpatient and outpatient services and supplies of a Hospital for Injury and Illness (including services of staff Providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. However, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact Customer Service for further information and guidance. See the Emergency Room benefit in this Medical Benefits Section for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

If benefits under the Plan change while You or a Beneficiary 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.

MATERNITY CARE
Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After $200 Copayment per pregnancy, the Plan pays 100% of the Allowed Amount. Copayment applies to professional global fee.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy, and related conditions. There is no limit for the mother's length of inpatient stay. Where the mother is attended by a Provider, the attending Provider will determine an appropriate discharge time, in consultation with the mother. See the Newborn Care benefit in this Booklet to see how the care of Your newborn is covered. Coverage also includes termination of pregnancy for all Claimants. When provided by an In-Network Provider, any Copayments, Coinsurance, and Deductible 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 under Your Preventive Care 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. Please also refer to the Subrogation and Right of Recovery Section of this Booklet for more information.

Definitions
In addition to the definitions in the Definitions Section, 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 (PKU)

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers medical foods for inborn errors of metabolism including, but not limited to, formulas for Phenylketonuria (PKU). 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
In addition to Covered Services for Mental Health or Substance Use Disorder by an In-Network Provider, Covered Services for Mental Health or Substance Use Disorder 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.

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Outpatient Office / Psychotherapy Visits

Provider: In-Network	Provider: Out-of-Network
Payment for BDTC Providers: After $12 Copayment per visit, the Plan pays 100% of the Allowed Amount. **Payment for all other Providers:** After $25 Copayment per visit, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Other Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers inpatient and outpatient Mental Health and Substance Use Disorder Services, including Applied Behavioral Analysis (ABA) therapy services and gender-affirmation services. Benefits include physical therapy, occupational therapy or speech therapy provided for treatment of a Mental Health Condition.

Definitions

In addition to the definitions in the Definitions Section, 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. Providers must submit individualized treatment plans and progress evaluations.

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 determined to be Medically Necessary). These

services include Habilitative services for Mental Health Conditions or Substance Use Disorders.

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.

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

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: The Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 30 outpatient visits per Claimant per Calendar Year for all therapies combined	

The Plan covers physical therapy, occupational therapy or speech therapy services 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 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 under the Mental Health or Substance Use Disorder Services benefit and are not subject to age or visit limits.) Outpatient

neurodevelopmental therapy visits that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services.

NEWBORN CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers services and supplies, under the newborn's own coverage, in connection with nursery care for the natural newborn or newly adoptive child. The newborn child must be eligible and enrolled as explained later in the Who Is Eligible, How to Enroll and When Coverage Begins Section. There is no limit for the newborn's length of inpatient stay. For the purpose of this benefit, "newborn care" means the medical services provided to a newborn child following birth including well-baby Hospital nursery charges, unless otherwise covered under the Preventive Care and Immunizations benefit.

NUTRITIONAL COUNSELING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: five visits per Claimant Lifetime (diabetic counseling is not subject to this limit). 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, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers benefits for the purchase of braces, splints, orthopedic shoes, orthopedic appliances and orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body.

Additionally, the Plan covers some orthotic devices that are obtained from an approved Commercial Seller. Benefits for eligible 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 orthotic devices, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, please visit the Claims Administrator's Web site or contact Customer Service.

Benefits under the Plan may be reduced for a less costly alternative item. The Plan does not cover off-the-shelf shoe inserts.

OSTEOPATHIC SPINAL MANIPULATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: After $25 Copayment per visit, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 30 osteopathic spinal manipulations per Claimant per Calendar Year	

The Plan covers osteopathic spinal manipulations.

PROSTHETIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers prosthetic devices for functional reasons to replace a missing body part, including artificial limbs, external or internal breast prostheses following a Mastectomy and maxillofacial prostheses. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility provision (Hospital inpatient care or Hospital outpatient and Ambulatory Surgical Center care) in this Medical Benefits Section. Repair or replacement of a prosthetic device due to normal use or growth of a child will be covered under the Plan.

REHABILITATION SERVICES
Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 30 inpatient days per Claimant per Calendar Year; up to 60 days per Claimant per condition for head and spinal cord injury	

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: The Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 30 outpatient visits combined per Claimant per Calendar Year	

The Plan covers inpatient and outpatient rehabilitation services (physical, occupational and speech therapy services only) and accommodations as appropriate and necessary to restore or improve lost function caused by Injury or Illness that is not a Mental Health Condition or Substance Use Disorder. (Rehabilitative services for mental diagnosis are not subject to a visit limit and are covered under the Mental Health or Substance Use Disorder Services benefit.) You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition. Rehabilitation services that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services.

REPAIR OF TEETH

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers services and supplies for treatment required as a result of damage to or loss of sound natural teeth when such damage or loss is due to an Injury.

ROUTINE HEARING EXAMINATIONS

Provider: In-Network	Provider: Out-of-Network
Payment: After $25 Copayment per visit, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: one routine hearing exam per Claimant per Calendar Year. Routine hearing exams that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.	

SKILLED NURSING FACILITY (SNF) CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 60 inpatient days per Claimant per Calendar Year	

The Plan covers the inpatient services and supplies of a Skilled Nursing Facility for Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is determined to be necessary. Skilled Nursing Facility days that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services. Ancillary services and supplies, such as physical therapy, 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.

TELEHEALTH

Provider: In-Network	Provider: Out-of-Network
Payment: The Plan pays 100% 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.

The Plan covers telehealth (live audio-only communication, audio and video communication and store and forward services, as permitted by law) between the patient and an In-Network Provider. The Plan does not cover telehealth office visits when provided by non-contracted telehealth Providers. Such office visits will be considered Out-of-Network. MDLIVE, a preferred Provider, has also been chosen by Your Plan Sponsor as an additional source for some telehealth services. To find an MDLIVE telehealth Provider or for additional information on Covered Services provided

by MDLIVE telehealth Providers, please visit MDLIVE Web site at **www.mdlive.com** or contact MDLIVE Customer Service at 1 (888) 725-3097.

For purposes of this benefit:

"Audio-only communication" is a secure telephonic communication. An audio-only communication must take the place of an in-person visit that would be billable by the Provider.

"Store and forward technology" is secure one-way electronic transmission (sending) of a patient's medical information from an originating site to a Provider at a distant site, which is later used by the Provider for diagnosis and medical management of the patient. Store and forward technology does not include telephone, fax or e-mail communication.

"Store and forward services" are the Provider's diagnosis and medical management of the patient that result from the use of store and forward technology. Coverage of store and forward services is limited to the services the Claims Administrator has specifically contracted with that Provider to provide.

TELEMEDICINE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers telemedicine (audio and video communication, including synchronous two-way interactive video conferencing) services between the patient at an originating site and a consulting Practitioner. The Plan also covers store and forward technology. For the purpose of this benefit, "store and forward technology" is a secure one-way electronic transmission (sending) of a patient's medical information from an originating site to a Provider at a distant site, which is later used by the Provider for diagnosis and medical management of the patient. Store and forward technology does not include telephone, fax or e-mail communication. Originating sites include facilities such as Hospitals, rural health clinics, Physician's offices and community mental health centers. This benefit includes Medically Necessary telemedicine health services provided in connection with diabetes.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

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

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

"Covered services" for the purpose of this TMJ benefit, mean those services that are:

- reasonable and appropriate for the treatment of a disorder of the TMJ, under all the factual circumstances of the case;
- effective for the control or elimination of one or more of the following, caused by a disorder of the TMJ: pain, infection, disease, difficulty in speaking or difficulty in chewing or swallowing food;
- recognized as effective, according to the professional standards of good medical practice; and
- not Investigational or primarily for Cosmetic purposes.

TOBACCO USE CESSATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Tobacco use cessation expenses not covered under the Preventive Care and Immunizations benefit are covered under this Tobacco Use Cessation benefit, as explained. For the purpose of this 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, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers transplants, including transplant-related services and supplies for covered transplants. A transplant recipient who is covered under this Plan and fulfills Medically Necessary criteria will be eligible for the following transplants: heart, lung, kidney, pancreas, liver, cornea, multivisceral, small bowel, islet cell and hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors, i.e., either autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor) or umbilical cord blood (only covered for certain conditions). This list of transplants is subject to change. Claimants can contact the Claims Administrator for a current list of covered transplants.

Donor Organ Benefits

The Plan covers donor organ procurement costs if the recipient is covered for the transplant under this Plan. Procurement benefits are limited to selection, removal of the organ, storage and transportation of the surgical harvesting team and the organ.

TRANSPLANT TRAVEL EXPENSES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment does not apply toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount does not apply toward the Out-of-Pocket Maximum.
Limit: $5,000 per Claimant per Calendar Year	

The Plan covers transportation and miscellaneous expenses (lodging, meals and parking).

Care Management and Wellness Programs

Because of Regence's involvement as the Claims Administrator, You have access to the following Group-sponsored care management and wellness programs. Your employer and SDIS have chosen to provide these benefits to You. To the extent any part of these programs (e.g., medications for smoking cessation) is also a benefit under the Medical Benefits or other benefit of the Plan, the Medical Benefits or other benefit applies first and until that benefit is exhausted.

CASE MANAGEMENT
Receive one-on-one help and support in the event You have a serious or sudden Illness or Injury. 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 make a referral to case management, please call 1 (866) 543-5765.

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

This program offers expectant mothers access to a nurse 24 hours a day, 7 days a week and educational materials tailored to their needs. Since BabyWise is most beneficial when a woman enrolls early in her pregnancy, call 1 (888) JOY-BABY (569-2229) or send an e-mail to BabyWise@regence.com right away to get started.

General Exclusions

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

SPECIFIC EXCLUSIONS
The Plan will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**. However, these exclusions will not apply with regard to an otherwise Covered Service for: 1) an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury , as required by federal law; 2) a preventive service as specified under the Preventive Care and Immunizations benefit in the Medical Benefits Section; or 3) services and supplies furnished in an emergency room for stabilization of a patient.

Activity Therapy
The Plan does not cover creative arts, play, dance, aroma, music, equine or other animal-assisted, recreational or similar therapy, sensory movement groups, and wilderness or adventure programs.

Assisted Reproductive Technologies
The Plan does not cover any assisted reproductive technologies (including, but not limited to, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception), or associated surgery, drugs, testing or supplies, regardless of underlying condition or circumstance.

Complementary Care
Except as provided under the Complementary Care benefit in this Booklet, the Plan does not cover complementary care.

Conditions Caused By Active Participation In a War or Insurrection
The treatment of any condition caused by or arising out of a Claimant's active participation in a war in the service of a non-United States nation-state or similar entity or in an insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services
The treatment of any Claimant's condition that the Secretary of Veterans Affairs determines either to be a service-connected disability incurred in performance of service in the uniformed services of the United States or to be aggravating such a service-connected disability.

Cosmetic/Reconstructive Services and Supplies
Cosmetic and/or reconstructive services and supplies, except in the treatment of the following:

- to treat a congenital anomaly for Claimants up to age 26;
- to restore a physical bodily function lost as a result of Injury or Illness; or

- related to breast reconstruction following a Medically Necessary Mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights provision.

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 provided in this Booklet or as required by law, the Plan does not cover counseling in the absence of Illness.

Custodial Care
The Plan does not cover non-skilled care and helping with activities of daily living.

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

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
The Plan does not cover family counseling unless the patient is a child or adolescent with a covered diagnosis, and the family counseling is part of the treatment.

Fees, Taxes, Interest
Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. The Plan also does not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.

Government Programs
Benefits that are covered, or would be covered in the absence of this Plan, by any federal, state or government program, except for facilities that contract with the Claims Administrator and except as required by law, such as for cases of medical emergency

or for coverage provided by Medicaid. Expenses from government facilities outside the service area are not covered (except for 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 under the Hearing Aids, Routine Hearing Examinations and Other Professional Services benefits in this Booklet, the Plan does not cover hearing care, routine hearing examinations, programs or treatment for hearing loss, including, but not limited to, hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them.

Hypnotherapy and Hypnosis Services
The Plan does not cover hypnotherapy and hypnosis services and associated expenses, including, but not limited to, use of such services for the treatment of painful physical conditions, mental health and substance use disorders, or for anesthesia purposes.

Illegal Services, Substances and Supplies
The Plan does not cover services, substances, and supplies that are illegal as defined under state or federal law.

Individualized Education Program (IEP)
The Plan does not cover services or supplies, including, but not limited to, supplementary aids, services and supports, provided under an individualized education plan developed and adopted pursuant to the Individuals with Disabilities Education Act.

Infertility
Except to the extent Covered Services are required to diagnose such condition, the Plan does not cover treatment of infertility, including, but not limited to, surgery, fertility drugs and medications.

Investigational Services
Except as provided under the Approved Clinical Trials benefit, the Plan does not cover Investigational treatments or procedures (Health Interventions), services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). Also excluded are any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section in this Booklet.

Motor Vehicle Coverage and Other Available Insurance
Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Claimant, whether or not the Claimant makes a claim under such coverage. Further, the Claimant is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or

considered to no longer be Injury-related under the no-fault provisions of the contract, benefits will be provided according to this Booklet.

Non-Direct Patient Care
Services that are not direct patient care, including charges for:

- appointments scheduled and not kept ("missed appointments");
- preparing or duplicating medical reports and chart notes;
- preparing itemized bills or claim forms (even at the Claims Administrator's request); and
- visits or consultations that are not in person, except as provided under the Telehealth and Telemedicine benefits.

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. In addition, if You are entitled to (that is, enrolled in) Medicare, You or Your Provider will not be paid for any part of expenses incurred if Your Provider has opted out of Medicare participation.

Obesity or Weight Reduction/Control
Except as required by law, the Plan does not cover medical treatment, medication, surgical treatment (including revisions, reversals, and treatment of complications), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions.

Orthognathic Surgery
Except for orthognathic surgery due to an Injury, temporomandibular joint disorder, sleep apnea or congenital anomaly (including craniofacial anomalies), the Plan does not cover services and supplies for orthognathic surgery. Orthognathic surgery means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones.

Over-the-Counter Contraceptives
The Plan does not cover over-the-counter contraceptive supplies unless approved by the FDA and prescribed by a Physician.

Personal Comfort Items
Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps, light boxes and therapy or service animals, including the cost of training and maintenance are not covered.

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

Prescription Medications
Prescription medications dispensed by a pharmacy. Prescription medication coverage is administered by CVS Caremark.

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

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

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

Routine Foot Care
Routine Foot Care is not considered medically necessary.

Self-Help, Self-Care, Training or Instructional Programs
Except as may be specifically provided in the Booklet, the Plan does not cover self-help, non-medical self-care, training programs, including:

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

This exclusion does not apply to services for training or educating a Claimant when provided without separate charge in connection with Covered Services or when specifically indicated as a Covered Service in the Medical Benefits Section (for example, nutritional counseling, diabetic education and teaching doses for self-administrable injectable medications).

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family. For purposes of this provision, "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
Except for preventive care benefits provided in this Booklet, the Plan does not cover services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Sexual Dysfunction
Except for Medically Necessary mental health services and supplies for a diagnosis of sexual dysfunction, the Plan does not cover services and supplies 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. For purpose of this exclusion, "maternity and related medical services" includes otherwise Covered Services for conception, prenatal, maternity, delivery and postpartum care. Please refer to the Maternity Care and/or Subrogation and Right of Recovery Sections of this Booklet for more information.

Therapies, Counseling, and Training
Except as provided in this Booklet, the Plan does not cover educational, vocational, social, image, 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.

Transplant Travel Expenses
Travel expenses other than covered transplant expenses provided in the Plan.

Travel and Transportation Expenses
Travel and transportation expenses other than covered ambulance services provided in the Plan.

Travel Immunizations
Immunizations for purposes of travel, occupation or residency in a foreign country.

Varicose Veins Treatment
Except when there is associated venous ulceration or persistent or recurrent bleeding from ruptured veins, the Plan does not cover treatment of varicose veins.

Vision Care
Routine eye exam and vision hardware. Refer to Vision Booklet for additional details.

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

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

exception is if You and Your Beneficiaries are exempt from state or federal workers' compensation law.

Claims Administration

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

PREAUTHORIZATION
Contracted Providers may be required to obtain preauthorization 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 under this Plan. The Plan does not require prior authorization of non-contracted Providers' services. That is, neither You nor Your non-contracted Provider is required to obtain prior authorization of any service or supply in order to be eligible for coverage of that service or supply and 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. However, 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 preauthorize services on Your behalf to determine Medical Necessity prior to the services being rendered.

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

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

PLAN IDENTIFICATION CARD
When Participants enroll in the Plan, they will receive Plan identification cards. The identification card will include important information such as the Participant's identification number, group number and name.

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

If You lose Your card, or if it gets destroyed, You can get a new one by contacting Customer Service. You can also view or print an image of Your Plan identification card by visiting the Claims Administrator's Web site on Your PC or mobile device. If the Agreement terminates, Your Plan identification card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims reimbursement is due, the Claims Administrator will decide whether to pay You, the Provider or You and the Provider jointly. Benefit payments may be made for a child covered by a legal National Medical Support Notice directly to the custodial parent or legal guardian of such child. If a person entitled to receive payment under the Plan has died, is a minor or is incompetent, benefits under the Plan 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 under this provision will fully discharge the Plan to the extent of the payment.

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. Please refer to Your Blue plan network where supplies were received for coverage of shipped Durable Medical Equipment.

Claims for independent clinical laboratory services will be submitted to the Blue plan in the locale in which the specimen was drawn or otherwise acquired, regardless of where the examination of the specimen occurred. Please refer to Your Blue plan network where the specimen was drawn for coverage of independent clinical laboratory services.

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

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.

Calendar Year and Plan Year

The Deductible and Out-of-Pocket Maximum provisions are calculated on a Calendar Year basis. The Agreement is renewed, with or without changes, 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. When the Agreement renews on other than January 1 of any year, any Deductible or Out-of-Pocket Maximum amounts You satisfied before the date the Agreement renews will be carried over into the next Plan Year. If the Deductible and/or Out-of-Pocket Maximum amount increases during the Calendar Year, You will need to meet the new requirement minus any amount You already satisfied under the previous Agreement during that same Calendar Year.

Timely Filing of Claims

Written proof of loss must be received within one year after the date of service for which a claim is made. If it can be shown that it was not reasonably possible to furnish such

proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof within the time required will not invalidate or reduce any claim. A claim that is 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. You may, however, appeal the denial in accordance with the appeal process to demonstrate that the claim could not have been filed in a timely manner.

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

In-Network Provider Claims
You must present Your Plan identification card when obtaining Covered Services from an In-Network Provider. You must also furnish any additional information requested. The Provider will furnish the Claims Administrator with the forms and information needed to process Your claim.

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

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

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

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

Out-of-Network Provider Reimbursement
In most cases, the Plan will pay You directly for Covered Services provided by an Out-of-Network Provider.

Out-of-Network Providers have not agreed to accept the Allowed Amount as full compensation for Covered Services. So, You are responsible for paying any difference between the amount billed by the Out-of-Network Provider and the Allowed Amount in addition to any amount You must pay due to Deductible, Copayment and/or Coinsurance. 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 is an example of how Your selection of In-Network or Out-of-Network Providers affects payment to Providers and Your cost sharing amount. For purposes of this example, 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 from the Medical Benefits Section (or other benefits section) would appear as follows:

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Now, let's assume that 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. Finally, let's assume that You have met the Deductible and that You have not met the Out-of-Pocket Maximum. Here's how that Covered Service would be paid:

- 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 of the Plan may vary, so please read the benefits sections thoroughly to determine how Your benefits are paid. For example, as explained in the Definitions Section, the Allowed Amount may vary for a Covered Service depending upon Your selected Provider.

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

group and identification numbers. Payment for Covered Services will be paid directly to the ambulance service Provider.

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

- When action cannot be taken on the claim due to circumstances beyond the Claims Administrator's control, they will notify You within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when the Claims Administrator expects to act on the claim.
- When action cannot be taken on the claim due to lack of information, the Claims Administrator will notify You within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

If the Claims Administrator seeks additional information from You, You will be allowed at least 45 days to provide the additional information. If the Claims Administrator does not receive the requested information to process the claim within the time allowed, the claim will be denied.

Claims Processing Report
You will be told how a claim has been acted on via a form called a claims processing report. Claims under the Plan may be denied or accumulated toward satisfying any Deductible. If all or part of a claim is denied, the reason for the denial will be stated on the claims processing report. The claims processing report 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 will receive it from one of two kinds of Providers. Most Providers ("In-Network Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Out-of-Network Providers") don't contract with the Host Blue. The Claims Administrator explains below how both 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.

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.

CLAIMS RECOVERY
If a benefit to which You were not entitled is paid under the Plan, or if a person who is not eligible for benefits at all is paid under the Plan, the Plan reserves the right to recover the payment from the person 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 that would have been provided the Participant or any of his or her 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.). All recovered amounts will be credited to the Plan.

This Claims Recovery provision in no way reduces the Plan's right to reimbursement or subrogation. Refer to the other-party liability provision in the Claims Administration Section for additional information.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS
It is important to understand that Your personal health information may be requested or disclosed by 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. Please contact the Claims Administrator's Customer Service department to make this request.

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

LIMITATIONS ON LIABILITY

In all cases, You have the exclusive right to choose a health care Provider. Neither the Plan nor the Claims Administrator is responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since neither the Plan nor the Claims Administrator provides 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 of the Plan by reason of epidemic, disaster or other cause or condition beyond the Claims Administrator's control.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former Claimants who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of Your estate, Your decedents, minors, and incompetent or disabled persons. No adult Claimant hereunder, may assign any rights that it 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.

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.

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 preauthorization 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 benefits would normally be provided. However, the amount of any Covered Services excluded under 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 under any other individual or group medical contract or plan (referred to as "Other Plan" and defined below), the benefits under this Plan and those of the Other Plan will be coordinated in accordance with the provisions of this section.

Benefits Subject to this Provision
All of the benefits described in this Booklet are subject to this Coordination of Benefits provision.

Definitions
In addition to the definitions in the Definitions Section, the following are definitions that apply to this Coordination of Benefits Section:

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, except that 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.
- When this Plan restricts coordination of benefits to certain types of coverage or benefits, any expenses for other types of coverage or benefits. See the Benefits Subject to this Provision paragraph, above, for restrictions on the types of coverage or benefits to which coordination applies.
- 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, for purposes of these coordination of benefits provisions, means only the day and month of birth, regardless of the year.

Claim Determination Period means a Calendar Year. However, 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.
- 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 state plan under Medicaid, 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 under 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 under 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, for purposes of this Coordination of Benefits provision, 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 applies:

Non-dependent Coverage: A plan that covers You other than as a dependent will be primary to a plan under 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 his or her plan longer shall be primary to the plan of the parent who has been covered by his or her 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 his or her 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; and
- The plan of Your noncustodial parent shall be primary to the plan of Your noncustodial parent's spouse.

If You are covered under 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 under 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 under 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 over 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 under a plan, two plans will be treated as one if You were eligible under 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 under a plan is measured from Your first date of coverage under 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 under 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 under 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 under 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; and
- 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 under 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 under any Other Plan(s) may include an amount that should have been paid under 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 under 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 under this Plan were provided to or on behalf of You in excess of the amount that would have been payable under this Plan by reason of Your coverage under any Other Plan(s), this Plan will be entitled to a recovery 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, please 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 department 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. Please 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 (or, in the case of a first level appeal, within 180 days of Your receipt of the Claims Administrator's original adverse decision that You are appealing). 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 under the regular appeal process, You or Your Provider may specifically request an expedited appeal. Please see Expedited Appeals later in this section for more information.

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, Regence BlueCross BlueShield of Oregon, P.O. Box 2998, Tacoma, WA 98401-2998 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 Independent Review Organization (IRO). An appeal to an IRO is available only after You have exhausted the Internal Appeal process (or You and the Claims Administrator have mutually agreed to waive exhaustion, You are deemed to have exhausted the Internal Appeal process because 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 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 Formulary should be granted.

The Claims Administrator coordinates external appeals, but the decision is made by an IRO at no cost to You. The Claims Administrator will provide the IRO with the appeal documentation. You may submit additional information to the IRO within five business days after You receive notice of the IRO's appointment. The IRO will make its decision within 30 days after You apply for external review. Written notice of the IRO decision will be sent to You by the IRO within five days of the decision. The Claims Administrator is bound by the decision made by the IRO, even if it conflicts with the Plan's definition of Medical Necessity.

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, Regence BlueCross BlueShield of Oregon, P.O. Box 2998, Tacoma, WA 98401-2998. 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 initiate an external appeal by submitting Your request to the Oregon Division of Financial Regulation at P.O. Box 14480, Salem, OR 97309-0405.

In order to have the appeal decided by an IRO, You must sign a waiver granting the IRO access to medical records that may be required to be reviewed for the purpose of reaching a decision on the external appeal.

If You want more information regarding IRO review, please 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; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: **http://dfr.oregon.gov/gethelp/Pages/file-a-complaint.aspx**; or by E-mail at: **cp.ins@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, Regence BlueCross BlueShield of Oregon, P.O. Box 2998, Tacoma, WA 98401-2998. 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 appeals time frame) to provide written materials, including written testimony on Your behalf. Verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but 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, Regence BlueCross BlueShield of Oregon, P.O. Box 2998, Tacoma, WA 98401-2998. 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. In order to have the expedited appeal decided by an IRO, You must sign a waiver granting 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 outlined here, You may contact Customer Service or You can write to Customer Service at the following address: Attn: ASO Appeals, 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; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: **http://dfr.oregon.gov/gethelp/Pages/file-a-complaint.aspx**; or by E-mail at: **cp.ins@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 SPECIFIC TO THE GRIEVANCE AND APPEAL PROCESS

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 which acts as the decision-maker for external appeals and external expedited appeals, through an independent contractor relationship with the Claims Administrator and/or through assignment to the Claims Administrator via state regulatory requirements. The IRO is unbiased and 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 under the Plan that is not considered Pre-Service.

Pre-Service means any claim for benefits under the Plan 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 purpose of a 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 purpose of 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.

Who Is Eligible, How to Enroll and When Coverage Begins

This section explains how to enroll Yourself and/or Your eligible dependents when first eligible, during a period of special enrollment or during an annual enrollment period. It also describes when coverage under the Plan begins for You and/or Your eligible dependents. Of course, 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 the same terms and conditions of the Plan will be applied to an Eligible Domestic Partner.

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

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

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

Retiree Eligibility
A retiree of a Member Employer can enroll as an eligible employee under this Plan, if the individual:

- retires from employment with a Member Employer; and
- is classified by a Member Employer as a retiree for the purposes of eligibility for coverage under the group health plan.

Dependents
Your Beneficiaries are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and the Plan Sponsor has enrolled them in coverage under the Plan. Your newly Eligible Domestic Partner who is not an Oregon-Certified Domestic Partner is eligible for coverage when a domestic partnership is established and an enrollment form or a subsequent change form is submitted to the Plan Sponsor along with an affidavit of qualifying domestic partnership. "Established," means the date on which the conditions described below are met. Dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your Oregon-Certified Domestic Partner. Oregon-Certified 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 domestic partner who is not an Oregon-Certified Domestic Partner, provided that all of the following conditions are met:

  - You have completed, executed and submitted an affidavit of qualifying domestic partnership form with regard to Your domestic partner;
  - both You and Your domestic partner are age 18 or older;
  - You and Your domestic partner share a close, personal relationship and are responsible for each other's common welfare;
  - neither You nor Your domestic partner is legally married to anyone else or has had another domestic partner within the 30 days immediately before enrollment of Your domestic partner;
  - You and Your domestic partner share the same regular and permanent residence and intend to continue doing so indefinitely;
  - You and Your domestic partner share joint financial responsibility for Your basic living expenses, including food, shelter and medical expenses; and
  - You and Your domestic partner are not more closely related by blood than would bar marriage in Your state of residence.

- 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, step child, 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; and
  - a child for whom You (or Your spouse or Your Eligible Domestic Partner) are required to provide coverage by a legal National Medical Support Notice.

- Your (or Your spouse's or Your Eligible Domestic Partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of developmental disability or physical handicap that began before his or her 26th birthday, if You complete and submit 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:

  - he or she is a Beneficiary immediately before his or her 26th birthday; or
  - his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on group coverage since that birthday.

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-Certified Domestic Partner, an affidavit of qualifying domestic partnership form) to the Plan Sponsor. Request for enrollment of a new child by birth, adoption or placement for adoption must be made within 60 days of the date of

birth, adoption or placement for adoption. Request for enrollment of all other newly eligible dependents must be made within 30 days of the dependent's attaining eligibility. Coverage for such dependents will begin on their Effective Dates (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 enrollment period.

Note that loss of eligibility does not include a loss because You failed to timely pay Your portion of the cost of coverage or when termination of coverage was because of fraud. It also doesn't include Your decision to terminate coverage, though it may include Your decision to take another action (e.g., terminating employment) that results in a loss of eligibility.

If You are already enrolled or if You declined coverage when first eligible and subsequently have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your Eligible Domestic Partner) and any eligible children are eligible to enroll for coverage under the Plan within 30 days from the date of the qualifying event (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 dependents 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, for instance, due to 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 the Children's Health Insurance Program (CHIP), see below).
- You lose coverage under Medicaid or the Children's Health Insurance Program (CHIP).

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

If You are already enrolled or if You declined coverage when first eligible and subsequently have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your Eligible Domestic Partner, except as noted) and any eligible children are eligible to enroll for coverage under the Plan within 30 days from the date of the qualifying event:

- 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 are already enrolled or if You declined coverage when first eligible and subsequently have the following qualifying event, You (unless already enrolled), Your spouse (or Your Eligible Domestic Partner) and any eligible children are eligible to enroll for coverage under the Plan within 60 days from the date of the qualifying event:

- You and/or Your dependent(s) become eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP).

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

ANNUAL ENROLLMENT PERIOD

The annual 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 (and, for an Eligible Domestic Partner who is not an Oregon-Certified Domestic Partner, an affidavit of qualifying domestic partnership form) on behalf of all individuals You want enrolled. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

DOCUMENTATION OF ELIGIBILITY

You must promptly furnish or cause to be furnished any information necessary and appropriate to determine the eligibility of a dependent. Such information must be received 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 Plan Sponsor within 30 days of the date on which a Beneficiary is no longer eligible for coverage.

No person will have a right to receive benefits after the Plan terminates. Termination of Your or Your Beneficiary's coverage under the Plan for any reason will completely end all 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, provided, 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, claims administration by Regence ends for You and Your Beneficiaries on the date the Agreement is terminated or not renewed (except, if agreed between the Plan Sponsor and Regence, Regence may administer certain claims for services that Claimants received before that termination or nonrenewal).

MEMBER EMPLOYMENT 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, Your and Your Beneficiaries' coverage ends 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 continuation of coverage provisions of this Booklet.

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE
If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Plan, Your coverage will end for You and all Beneficiaries on the last day of the monthly period following the date on which eligibility ends.

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

FAMILY AND MEDICAL LEAVE

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

- You and Your 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:

  - in order to care for Your newly born child;
  - in order to care for Your spouse, child or parent, if such spouse, child or parent has 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 just 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.

Persons entitled to coverage under this provision will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this provision. Entitlement to FMLA leave does not constitute a qualifying event for the purpose of 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 period off work granted by Your employer at Your request during which You are still considered to be employed and are carried on the employment records of the Plan Sponsor. 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 under 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 enrollment period.

WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE
If Your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), his or her coverage will end on the last day of the monthly period in which his or her eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Plan according to the continuation of coverage provisions of this Booklet.

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.

If You Die
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-Certified Domestic Partnership
If the contract with Your Oregon-Certified 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.

Termination of Domestic Partnership
If Your domestic partnership other than an Oregon-Certified Domestic Partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet any of the requirements outlined in the definition of a dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the monthly period following the date of termination of the domestic partnership. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence. You may not file another affidavit

of qualifying domestic partnership within 90 days after a request for termination of a domestic partnership has been received.

Loss of Dependent Status

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

OTHER CAUSES OF TERMINATION

Claimants may be terminated for either of the following reasons. However, it may be possible for them to continue coverage under the Plan according to the continuation of coverage provisions of this Booklet.

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

Coverage under the Plan is based upon all information furnished to the Plan Sponsor, for the benefit of the Plan 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.

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 under 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
Generally, You or Your Beneficiaries are responsible for payment of the full cost for COBRA continuation coverage, plus an administration fee, even if the Member Employer contributes toward the cost of those not on COBRA continuation. The administration fee is 2 percent or, during any period of extension for disability, 50 percent.

In order to preserve Your and Your Beneficiary's rights under 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 was disabled for Social Security purposes at the time of a termination of employment or reduction in working hours or within the first 60 days of COBRA continuation following that event. (If a final determination is later made that You or Your Beneficiary is no longer disabled for Social Security purposes, 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 therefore 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 described in the Booklet and claims under the Plan for services provided on and after the date coverage ends will not be paid. Further, this may jeopardize Your or Your Beneficiaries' future eligibility for an individual plan.

Notice
The complete details on the COBRA Continuation provisions outlined here 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.

Reenrolling After Layoff
If You are rehired and return to active work within nine months of being laid off, You and any previously enrolled Beneficiaries may reenroll under the Plan on the date You are rehired, regardless of any lapse in coverage. The Your employer must notify the Claims Administrator that You are being rehired following a layoff and the necessary payment for Your coverage must be made. All Plan provisions will resume at the time You reenroll whether or not there was a lapse in Your coverage. Any exclusion period You did not complete at the time You were laid off must be satisfied. However, the period of Your layoff will be counted toward the exclusion period. At the time You are rehired, You do not have to re-satisfy any eligibility waiting period required under the Plan.

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 due, including any part usually paid by Your employer or the Plan Sponsor, directly to the union or trust that represents You. And 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 his or her marriage or terminates his or her 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 his or her 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

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

CHOICE OF FORUM
Any legal action arising out of the Plan benefit option described herein 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.

PLAN SPONSOR IS AGENT
The Plan Sponsor is Your agent for all purposes under the Plan and not the agent of Regence BlueCross BlueShield of Oregon. You are entitled to health care benefits pursuant to the Plan. 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.

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.

NOTICES
Any notice to Claimants required in the Plan will be considered to be 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 Participant or to the Plan Sponsor at the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address form (COA) for a Participant, it will update its records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the Plan Sponsor if it becomes aware that it doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required in the Agreement may be given by mail addressed to: Regence BlueCross BlueShield of Oregon, P.O. Box 2998, Tacoma, WA 98401-2998; provided, however that any notice to the Claims Administrator will not be considered to have been given to and received by it until physically received.

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, 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 Regence 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 Regence 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 and that no person or entity other than Regence will be held accountable or liable to the Plan Sponsor, its Member Employers or the Claimants for any of Regence'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 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 the purpose of obtaining coverage will void such coverage or reduce benefits unless contained in a written document signed by You, a copy of which is furnished to You.

WHEN BENEFITS ARE AVAILABLE
In order for health expenses to be covered under the Plan, 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 described in the Plan Document; and
- the person has enrolled in coverage and has been enrolled by the Plan Sponsor.

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, provided, 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, coverage under the Plan will be provided (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.

Definitions

The following are definitions of important terms used in this Booklet. 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 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 (see definition of "In-Network" below), the amount that they have contractually agreed to accept as payment in full for a service or supply.
- For Out-of-Network Providers (see definition of "Out-of-Network" below) who are not accessed through the BlueCard Program, the amount the Claims Administrator has determined to be Reasonable Charges for Covered Services or supplies. The Allowed Amount may be based upon the billed charges for some services, as determined by 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, please contact the Claims Administrator.

Ambulatory Surgical Center means a facility or that portion of a facility licensed by the state in which it is located, that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission. Ambulatory Surgical Center does not mean: 1) individual or group practice offices of private Physicians or dentists that do not contain a distinct area used for 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 2) 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.

Blue Distinction Total Care (BDTC) Providers means a select group of In-Network Providers that have entered into an additional contract with the Claims Administrator to take extra measures aimed at improving the quality of care for Claimants through

improved data sharing and care coordination, while controlling costs. Obtaining care from a BDTC Provider will result in a lower Claimant cost share for most office visits.

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.

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 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 benefits sections in this Booklet.

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

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

Effective Date means the 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 Who Is Eligible, How to Enroll and When Coverage Begins 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, her health or the health of her unborn child, in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part; or
- a behavioral health crisis.

Family means a Participant and his or her 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, Injury, genetic or congenital anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or to maintain or restore functional ability. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

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.

Healthcare Facility means a Hospital, an Ambulatory Surgical Center, a freestanding birthing center, or an outpatient renal dialysis center. A Healthcare Facility does not mean: 1) a residential facility licensed by the Department of Human Services or the Oregon Health Authority under Oregon law; 2) an establishment furnishing primarily domiciliary care as described under Oregon law; 3) a residential facility licensed or approved under the rules of the Department of Corrections; 4) facilities established through the Oregon Health Authority for the treatment of substance abuse disorders; 5) community mental health programs or community developmental disabilities programs established under Oregon law; or 6) a long-term care facility.

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

Illness means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an Injury; and pregnancy. Illness does not include any state of mental health or mental disorder which is otherwise defined in the Mental Health or Substance Use Disorder Services Section.

Injury means physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical or that is the direct result of an accident, independent of Illness or any other cause. An Injury does not mean 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 him, her or it as a network Provider, who is a member of the Plan Sponsor's chosen Provider network, to provide services and supplies to Claimants in accordance with the provisions of this coverage. In-Network also means a Provider that has an effective participating contract with one of the Claims Administrator's Affiliates or a Provider outside the area that the Claims Administrator or one of its Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program (designated as a Provider in the "In-Network") to provide services and supplies to Claimants in accordance with the provisions of this coverage. 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:

- If a medication or device, the Health Intervention must have final approval from the United States Food and Drug Administration as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the use for 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, Injury or Illness, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- Medications approved under the FDA's Accelerated Approval Pathway must show improved Health Outcomes.
- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

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 for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

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

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible Scientific Evidence published in Peer-Reviewed Medical Literature generally recognized by the relevant medical community, Physician

Specialty Society recommendations and the views of Physicians and other health care Providers practicing in relevant clinical areas and any other relevant factors.

Member Employer means a business entity qualifying for membership or participation under 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 refers to Providers that are not In-Network. For reimbursement of these Out-of-Network Provider services, You may be billed for balances over the Claims Administrator'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 Administer or one of its Affiliates serves.

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

Physician means an individual who is duly licensed to practice medicine and surgery in all of its branches or to practice as an osteopathic Physician and 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 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, Skilled Nursing Facility, Ambulatory Surgical Center, Physician, 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.

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

Regence refers to Regence BlueCross BlueShield of Oregon.

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.

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; the 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. You also have the right to 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 a Plan 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 preauthorized 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 a Plan 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 he or she is 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 his or her 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 a preferred or participating Provider and benefits for that Provider would be denied (or paid at a level below the benefit for a nonparticipating 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 Independent Review Organization 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; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: **http://dfr.oregon.gov/gethelp/Pages/file-a-complaint.aspx**; or by E-mail at: **cp.ins@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, Plan 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 over the internet at: **regence.com**.

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, also known as preauthorization, 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 Plan identification card, or ask Your Provider for a list of services that need to be preauthorized. Many types of treatment may be available for certain conditions; the preauthorization 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. And, preauthorization 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 of this Booklet.

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 Customer Service phone number on the back of Your Plan 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 his or her 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 THE POLICY THAT HE HAS WITH YOU AND DOESN'T SPEAK ENGLISH VERY WELL. CAN YOU HELP?

Yes. Simply have Your neighbor call Customer Service at the number on his or her Plan 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 Customer Service representative:

- Rules related to the Claims Administrator's medication Formulary, including information on whether a particular medication is included or excluded from the Formulary.

- 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, You can call the Oregon Division of Financial Regulation at (503) 947-7984 or the toll free message line at 1 (888) 877-4894; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: **http://dfr.oregon.gov/gethelp/Pages/file-a-complaint.aspx**; or by E-mail at: **cp.ins@oregon.gov**. You can also contact the Claims Administrator's Customer Service.

Your Prescription Medication Benefits Administered By RxBenefits Inc.

Beginning 1/1/2017, your prescription benefits through CVS/caremark will be administered by RxBenefits Inc. Please contact the RxBenefits Inc. member services team at 800-334-8134 for all of your prescription benefit questions. Regence BlueCross BlueShield of Oregon assumes no liability for the accuracy of your prescription benefits information.

Prescription Medication Benefits

In this section, you will learn how Your Prescription Medication coverage works, including information about Out of pocket Maximums, Deductibles (if any), Copayments, Coinsurance, Covered Services and payment, as well as definitions of terms specific to this Prescription Medication Benefits Section.

All terms and conditions of the Plan apply to this Prescription Medication Benefits Section, except as otherwise noted. Benefits will be paid under this Prescription Medication Benefits Section, not any other provision in this Booklet, if a medication or supply is covered under both.

Copayments and/or any Coinsurance You pay to Participating and Nonparticipating Pharmacies as well as to Mail-Order Suppliers count toward the medical Out-of-Pocket Maximum. Any additional charges, such as costs in excess of the Covered Prescription Medication Expense charged by a Nonparticipating Pharmacy, do not count toward any Out-of-Pocket Maximum and you will continue to be responsible for these amounts, even after you reach the Out-of-Pocket Maximum.

COPAYMENTS AND 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). (See below for information on claims that are not submitted electronically and for information on maximum quantities.)

Medications purchased at CVS Caremark participating pharmacies The maximum quantity is a 30-day supply for each prescription filled.	
Generic medications	100% after $10 copayment
Preferred brand medications	100% after $30 copayment
Non-Preferred brand medications	100% after $50 copayment

Medications purchased through CVS Caremark mail order

The maximum quantity is a 90-day supply for each prescription filled.

Generic medications	100% after $10 copayment
Preferred brand medications	100% after $60 copayment
Non-Preferred brand medications	100% after $100 copayment

Specialty medications purchased through CVS Specialty Pharmacy

The maximum quantity is a 30-day supply for each prescription filled.

Specialty medications	Lesser of $200 copayment per prescription or 30% coinsurance per prescription

GENERIC SUBSTITUTION

Over 400 commonly prescribed drug products are now available in a generic form at an average cost of 50% less than the brand name products. This plan encourages the use of generic prescription drugs. By law, generic and brand name drugs must meet the same standards of safety, purity, strength, and effectiveness. At the same time, brand name drugs are often 2 to 3 times more expensive than generic drugs. Use of generics with this benefit will save you money and we encourage you to ask your provider to prescribe them whenever possible.

BRAND NAME DRUGS

An important element of your CVS Caremark Prescription Drug Card Program is the opportunity to select drugs from the Preferred Drug List. The Preferred Drug List is a guide to the best values within select therapeutic categories which helps the provider identify products that will provide optimal clinical results at a lower cost. The Preferred Drug List undergoes a thorough review and/or revision annually. Interim changes could occur to reflect changes in the market. These changes could include: entry of new products, entry of a generic option to a brand drug, or other events that alter the clinical or economic value of the products on the Preferred Drug List. Please see your Group's Human Resources Department for a copy of this list or visit www.caremark.com.

DRUGS COVERED

- Legend Drugs (those medications that REQUIRE a prescription) Exceptions: See Exclusion list below.
- Compounded medication of which at least one ingredient is a legend drug.
- Insulin/Insulin prefilled syringe.
- Emergency allergic kits (e.g., Bee Sting Kits, Epi-pen, Epinephrine Inj)
- Diabetic Care: Agents/Strips for testing, Disposable insulin needles/syringes and Lancets.
- Tretinoin, Differin, Tazorac (e.g. Retin-A), for individuals through the age of 34 years.
- Fluoride (Topical Fluoride dental products – requiring a prescription)
- Folic Acid and Iron supplements when prescribed by a physician.
- Drugs used for the treatment of ADHD and Narcolepsy

- Anti-Smoking Aids (Requiring a prescription)
- Migraine Medicines (kit, nasal spray, tablet, injectables)
- Immunizations as required by Health Care Reform.
- Any other drug which under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

DRUGS EXCLUDED AND LIMITED

- Anti-obesity drugs and anorectics (any drug used for the purpose of weight loss, e.g., Didrex®, Meridia® , Xenical®).
- Anti-wrinkle agents (e.g. Renova®, Avage®).
- Dietary supplements and health and beauty aids.
- Drugs used for cosmetic purposes (e.g., Botox®, Myobloc, Renova®, Eldoquin, Solage, Vaniqua®).
- Drugs used for the treatment of impotency (e.g., Viagra®, Caverject®, Muse®, Levitra®, Yocon®, Edex®).
- Drugs used for the treatment of hair loss (e.g., Propecia®, Rogaine®).
- Biological sera, blood, or blood plasma.
- Fertility medications, all dosage forms (e.g., Clomid®, Pergonal®, Metrodin®).
- Non-legend drugs other than insulin.
- Pigmenting and depigmenting agents.
- Tretinoin, Differin, Tazorac, all dosage forms (e.g. Retin-A), for individuals 35 years of age or older. Prior authorization required for age 35 or over.
- Therapeutic devices or appliances, including support garments and other nonmedical substances, regardless of intended use, except those listed above.
- Charges for the administration or injection of any drug.
- Prescriptions which an eligible individual is entitled to receive without charge from any Worker's Compensation Laws.
- Drugs labeled Caution-limited by federal law to investigational use or experimental drugs, even though a charge is made to the individual.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed medical facility, rest home, sanitarium, extended care facility, convalescent medical facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises or a facility for dispensing pharmaceuticals. **Nursing Home Claims are set to be reimbursed.**
- Any prescription refilled in excess of the number specified by the provider, or any refill dispensed after one year from the provider's original order.
- Prescription drugs which may be obtained without charge under local, state, or federal programs.
- Drugs purchased outside the U.S. that are not legal inside the U.S.
- Anabolic steroids.
- Compounds over $300 will require prior authorization. Bulk powders and high cost bases are excluded.

PRESCRIPTION DRUG PREAUTHORIZATION
Some medications may require clinical information from your physician which must be received and approved by CVS/caremark before your prescription can be dispensed. For information about receiving prior authorization, please contact RxBenefits member services at 800-334-8134 or have your physician contact the CVS/caremark Prior Authorization department at 800-294-5979.

SPECIALTY PHARMACY
CVS Caremark Specialty Pharmacy is designed for individuals with rare, complex or genetic conditions. Specialty pharmacies dispense high-cost medications that can be safely administered at home. This program supports safe, clinically appropriate and cost-effective use of specialty medicines. Through this pharmacy you have the ability to receive specialty medications delivered to your home or other specified location. In addition, all supplies required for administration will be included at no cost to you.

To sign up for the CVS/caremark Specialty pharmacy please call them at 800-237-2767 or call the RxBenefits member services team at 800-334-8134.

MAIL ORDER PRESCRIPTION DRUG PROGRAM
CVS Caremark Mail Service Pharmacy is a cost-effective choice for long-term medications because you can get up to a 90-day supply for less than what you would pay for the same supply at retail. For new prescriptions, complete a mail service form and send it to CVS Caremark, along with our original prescription(s) and the appropriate copayment for each prescription. Be sure to include your original prescription (photocopies are not accepted). When a refill is due, the mail-order services do not automatically fill the prescription and mail it unless requested. You should submit your request for refill 2 weeks before your current prescription ends to allow for mailing and processing time. Refills can be ordered by Web, phone, or by completing a mail service form. Mail order forms can be obtained from www.caremark.com or through your Group's Human Resources Department.

Dispensing Limitations
The amount normally prescribed by a physician or other lawful prescriber, but not to exceed a 90 day supply.

Paper Claims Reimbursement
If you use a network pharmacy but do not present your identification card at the time of service, if the network pharmacy is unable to process the pharmacy claim electronically for any reason or if you use a non-network pharmacy, payment may be required for the full charge for the medication(s) received. You may request reimbursement of any such payments by obtaining a pharmacy claim form from your employer or visit www.caremark.com and completing the necessary information. Your prescription medication plan does not coordinate benefits with any other pharmacy or medical plans.

Reimbursement will be made only if the prescription medication would otherwise be covered under this plan, and reimbursement will be based upon the billed charges from

a network pharmacy, or, if charges are from a non-network pharmacy, the amount the plan would have paid, less your applicable co-payment.

Claim forms should be sent to:
Caremark
Attn: Claims Department
PO Box 52196
Phoenix, AZ 85072-2196

Any reimbursement will be sent directly to you and made according to the plan's prescription medication benefit as outlined on the Schedule of Benefits.

If you would like to know more information about the drug coverage policies under this program, or if you have a question or concern about your pharmacy benefit, please contact RxBenefits Inc. at 800-334-8134.

Appeal Process
If CVS Caremark determines that your request for pre-authorization cannot be approved, that determination will constitute an Adverse Benefit Determination. If an Adverse Benefit Determination is rendered on your Claim, you may file an appeal of that determination. Your appeal of the Adverse Benefit Determination must be made in writing and submitted to CVS Caremark within 180 days after you receive notice of the Adverse Benefit Determination.

Your appeal and supporting documentation may be mailed or faxed to CVS Caremark:

CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-689-3092

Physicians may submit urgent appeal requests by calling the physician-only toll free number: 1-866-443-1183

Review of Adverse Benefit Determinations of Pre-Service Clinical Claims
CVS Caremark will provide the first-level review of appeals of Pre-Service clinical Claims. Such Claims will be reviewed against pre-determined medical criteria relevant to the drug or benefit being requested. If your first-level appeal is denied, you may appeal CVS Caremark's decision and request an additional second-level Medical Necessity review. The review of whether the requested drug or benefit is Medically Necessary will be conducted by an Independent Review Organization ("IRO").

Review of Administrative Denials
CVS Caremark provides a single level of appeal for Administrative Denials. Upon receipt of such an appeal, CVS Caremark will review your request for a particular drug or benefit against the terms of the Plan, including preferred drug lists or formularies.

Timing of Review:
Pre-Authorization Review – CVS Caremark will make a decision on a Pre-Authorization request for a Plan benefit within 15 days after it receives the request. If the request relates to an Urgent Care Claim, CVS Caremark will make a decision on the Claim within 72 hours.

Pre-Service Clinical Claim Appeal – CVS Caremark will make a decision on a first-level appeal of an Adverse Benefit Determination rendered on a Pre-Service clinical Claim within 15 days after it receives your appeal. If CVS Caremark renders an Adverse Benefit Determination on the first-level appeal of the Pre-Service Claim, you may appeal that decision by providing the information described above. A decision on your second-level appeal of the Adverse Benefit Determination will be made (by the IRO) within 15 days after the new appeal is received. If you are appealing an Adverse Benefit Determination of an Urgent Care Claim, a decision on such appeal will be made not more than 72 hours after the request for appeal(s) is received (for both the first-and second-level appeals, combined).

Administrative Denial or Post-Service Claim Appeal – CVS Caremark will make a decision on an appeal of an Adverse Benefit Determination rendered on a Post-Service Claim or on an Administrative Denial within 60 days after it receives such appeal.

2018 BOOKLET FOR:

SPECIAL DISTRICTS INSURANCE SERVICES

SDIS Special Districts Insurance Services

Group Number: 800000031

Regence Choice Vision Plan $25/$300

Regence

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

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

Welcome to participation in the self-funded group vision plan (hereafter referred to as "Plan") provided for You by Your employer and Special Districts Insurance Services (SDIS). SDIS has chosen Regence BlueCross BlueShield of Oregon to administer claims for Your group vision plan. Throughout this Booklet, Your employer may be referred to as the "Plan Sponsor" or "Plan Administrator."

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

Because of their extensive experience and reputation of service, Regence BlueCross BlueShield of Oregon has been chosen as the Claims Administrator of Your Plan. As Claims Administrator, Regence BlueCross BlueShield of Oregon has selected Vision Service Plan (VSP) to coordinate the provision of benefits and claims processing.

The following pages are the Booklet, the written description of the terms and benefits of coverage available under the Plan. This Booklet describes benefits effective July 1, 2018, or the date after that on which 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.

As You read this Booklet, please keep in mind that references to "You" and "Your" refer to both the Participant and Beneficiaries (except that in the Who Is Eligible, How To Enroll And When Coverage Begins, When Coverage Ends and COBRA Continuation of Coverage sections, the terms "You" and "Your" mean the Participant only). The term "Claims Administrator" refers to 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. The term "Agreement" refers to the administrative services contract between the Plan Sponsor and the Claims Administrator. Other terms are defined in the Definitions Section at the back of this Booklet or where they are first used and are designated by the first letter being capitalized.

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
If You have Provider or benefit questions specific to Your vision coverage, call VSP at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance),

Monday-Friday 5 a.m. - 8 p.m.; Saturday 7 a.m. - 8 p.m.; and Sunday 7 a.m. - 7 p.m. You may also visit VSP's Web site at **www.vsp.com**.

If You have membership questions, talk with one of the Claims Administrator's Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. - 6 p.m. Pacific Time.

Customer Service: 1 (866) 240-9580
(TTY: 711)

Or visit the Claims Administrator's Web site at: **regence.com.**

For assistance in a language other than English, please call the Customer Service telephone number.

Using Your Booklet

YOUR PARTNER IN VISION CARE

This Plan provides You with great benefits that are quickly accessible and easy to understand, thanks to broad access to Providers and innovative tools. With this vision care coverage, You will discover the personal freedom to make informed health care decisions, as well as the assistance You need to navigate the vision care system.

ACCESS TO PROVIDERS

Your Plan allows You to control Your out-of-pocket expenses, such as Copayments and/or Coinsurance, for each Covered Service. Here's how it works - You control Your out-of-pocket expenses by choosing Your Provider under two choices called: "VSP Doctor" and "Out-of-Network Provider."

- **VSP Doctor.** You choose to see a VSP Doctor and save the most in Your out-of-pocket expenses. Choosing this provider option means You will not be billed for balances beyond the Allowed Amount.
- **Out-of-Network Provider.** You choose to see an Out-of-Network Provider that does not have a contract with VSP and Your out-of-pocket expenses will generally be higher than a VSP Doctor. Also, choosing this provider option means You may be billed for balances beyond the Allowed Amount: this is sometimes referred to as balance billing.

For each benefit in this Booklet, the Provider You may choose and Your payment amount for each provider option is indicated. See the Definitions Section of this Booklet for a complete description of VSP Doctor and Out-of-Network Provider. You can go to **www.vsp.com** for further Provider network information.

Table of Contents

Understanding Your Benefits

In this section, You will discover information to help You understand what is meant by Your Maximum Benefits, Copayments and Coinsurance. Other terms are defined in the Definitions Section at the back of this Booklet or where they are first used and are designated by the first letter being capitalized.

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

MAXIMUM BENEFITS
Vision benefits for Covered Services may have a specific Maximum Benefit. For those Covered Services, benefits will be provided until the specified Maximum Benefit (which may be a number of visits, supplies or a dollar amount) has been reached. Allowed Amounts for Covered Services provided are applied against any specific Maximum Benefit that is expressed in this Booklet. Refer to the Vision Benefits Section in this Booklet to determine if a Covered Service has a specific Maximum Benefit.

COPAYMENTS
Copayments are the fixed dollar amount that You must pay directly to the Provider each time You receive a specified service. Refer to the Vision Benefits Section to understand what Copayments (if any) You are responsible for.

PERCENTAGE PAID UNDER THE PLAN (COINSURANCE)
Once You have satisfied any applicable Copayment, the Plan pays a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). Your Coinsurance will be based upon the lesser of the billed charges or the Allowed Amount. The percentage the Plan pays varies, depending on the kind of service or supply You received and who rendered it.

The Plan does not reimburse Providers for charges above the Allowed Amount. A VSP Doctor will not charge You for any balances for Covered Services beyond any Copayment and/or Coinsurance amount. Out-of-Network Providers, however, may bill You for any balances over Claims Administrator's payment level in addition to any Copayment and/or Coinsurance amount. See the Definitions Section for descriptions of Providers.

HOW CALENDAR YEAR BENEFITS RENEW
Provisions in this Booklet (for example, certain benefit maximums) are calculated on a Calendar Year basis, except as otherwise noted. Each January 1, those Calendar Year maximums begin again.

Vision Benefits

In this section, You will learn how Your vision coverage works. The explanation includes information about Covered Services, specific limitations and payment. Covered Services are those Medically Necessary services required for the diagnosis or correction of visual acuity and must be rendered by a Physician or optometrist practicing within the scope of his or her license.

All terms and conditions in this Booklet apply to this Vision Benefits Section, except as otherwise noted. Please see the Definitions Section in the back of this Booklet for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

There is no deductible applicable for Vision Benefits.

COPAYMENT
You are responsible for paying the following Copayment when You receive vision benefits. The Copayment is due at the time of service:

Examinations, Lenses and Frames

• $25 for each examination, lenses and/or frames during the Frequency Period.
• None for each contact lens evaluation and fitting examination during the Frequency Period from a VSP Doctor. For contact lens evaluation and fitting examination from an Out-of-Network Provider, covered expenses are included in the $105 elective contact lens or the $210 Necessary Contact Lenses allowances.

VISION EXAMINATION

Provider: VSP Doctor	Provider: Out-of-Network
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.
Frequency Period: every Calendar Year	
Limit: $45 allowance for Out-of-Network Provider	

The Plan covers professional complete medical eye examination or visual analysis, including:

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

CONTACT LENS EVALUATION AND FITTING EXAMINATION

Provider: VSP Doctor	Provider: Out-of-Network
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.
Frequency Period: every Calendar Year	

The Plan covers services and supplies for contact lens evaluation and fitting examinations. For an Out-of-Network Provider, the Contact Lens Evaluation and Fitting Examination benefit and elective or Necessary Contact Lenses combined, will not exceed the limit indicated below in the Lenses benefit.

LENSES

Provider: VSP Doctor	Provider: Out-of-Network
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.
Frequency Period: every Calendar Year	

Lenses limit: one pair of standard lenses which include the following in either glass or plastic:

VSP Doctor:

- single vision lenses
- lined bifocal lenses
- lined trifocal lenses
- lenticular lenses
- standard progressive lenses
- $300 elective contacts*
- Necessary Contact Lenses**

Out-of-Network Provider Limits:

- $30 single vision lenses
- $50 lined bifocal / standard progressive lenses
- $65 lined trifocal lenses
- $100 lenticular lenses
- $105 elective contacts including any fitting/evaluation services*
- $210 Necessary Contact Lenses including any fitting/evaluation services**

*Contact lenses are available once every Calendar Year in lieu of all other lenses and frame benefits. When You receive contact lenses, You will not be eligible for any lenses and/or frames again until the next Calendar Year.

**Necessary Contact Lenses are covered without frequency limitations if You have a specific condition for which contact lenses provide better visual correction.

FRAMES

Provider: VSP Doctor	Provider: Out-of-Network
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.
Frequency Period: every Calendar Year	
Limit: $300 for a VSP Doctor; $165 for a VSP approved wholesale/retail vendor; $70 for an Out-of-Network Provider.	

LOW VISION BENEFIT
Supplemental Testing

Provider: VSP Doctor	Provider: Out-of-Network
Payment: The Plan pays 100% of the Allowed Amount.	**Payment:** The Plan pays 100% of the Allowed Amount up to $125 and You pay balance of billed charges.
Frequency Period: every two Calendar Years	
Limit: $1,000 for all Supplemental Testing and Supplemental Aids combined.	

The Plan covers complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.

Supplemental Aids

Provider: VSP Doctor	Provider: Out-of-Network
Payment: The Plan pays 75% and You pay 25% of the Allowed Amount.	**Payment:** The Plan pays 75% of a VSP Doctor's Allowed Amount and You pay balance of billed charges.
Frequency Period: every two Calendar Years	
Limit: $1,000 for all Supplemental Testing and Supplemental Aids combined.	

In addition to the vision benefits described above, the Plan covers special aid for Claimants if vision loss is sufficient enough to prevent reading and performing daily activities. If You fall within this category (check with Your Provider), You will be entitled to professional services as well as ophthalmic materials, including, but not limited to: supplemental testing (complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated); evaluations; visual training; low vision prescription services; plus optical and non-optical aids, subject to the frequency and benefit limitations of these vision benefits. Consult Your VSP Doctor for more details.

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

- optional cosmetic processes;
- anti-reflective coating;
- color coating;
- mirror coating;
- scratch coating;
- blended lenses;
- cosmetic lenses;
- laminated lenses;
- oversize lenses;
- premium and custom progressive multifocal lenses;
- photochromic lenses; tinted lenses except Pink #1 and Pink #2;
- UV (ultraviolet) protected lenses;
- certain limitations on low vision care;
- a frame that costs more than the limit in this Booklet; and
- contact lenses not previously described as covered.

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

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

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

General Exclusions

The Plan will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**. However, these exclusions will not apply with regard to an otherwise Covered Service for an Injury, if the Injury results from an act of domestic violence regardless of whether such condition was diagnosed before the Injury, as required by law.

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

Conditions Caused By Active Participation In a War or Insurrection
The treatment of any condition caused by or arising out of a Claimant's active participation in a war in the service of a non-United States nation-state or similar entity or in an insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services
The treatment of any Claimant's condition that the Secretary of Veterans Affairs determines either to be a service-connected disability incurred in performance of service in the uniformed services of the United States or to be aggravating such a service-connected disability.

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

Corrective Vision Treatment of an Experimental Nature

Cosmetic Services and Supplies
Services and supplies for beautification, cosmetic, or aesthetic purposes.

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

Costs For Services and/or Supplies Exceeding Benefit Limits in this Booklet

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.

Facility Charges
Services and supplies provided in connection with facility services.

Fees, Taxes, Interest
Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. The Plan also does not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.

Government Programs
Benefits that are covered, or would be covered in the absence of this Plan, by any federal, state or government program, except for facilities that contract with the Claims Administrator and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. Expenses from government facilities outside the service area are not covered under the Plan (except for facilities contracting with the local Blue Cross and/or Blue Shield plan or as required by law for emergency services).

Investigational Services
Investigational treatments or procedures (Health Interventions), services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). Also excluded are any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section in this Booklet.

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

Motor Vehicle Coverage and Other Available Insurance
Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Claimant, whether or not the Claimant makes a claim under such coverage. Further, the Claimant is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, benefits will be provided according to this Booklet.

Non-Direct Patient Care
Services that are not direct patient care, including charges for:

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

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. In addition, if You are entitled to (that is, enrolled in) Medicare, You or Your Provider will not be paid for any part of expenses incurred if Your Provider has opted out of Medicare participation.

Orthoptics or Vision Training
Orthoptics or vision training and any associated supplemental testing.

Personal Comfort Items
Items that are primarily for comfort or convenience, contentment, personal hygiene, aesthetics or other nontherapeutic purposes.

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

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

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

Self-Help, Self-Care, Training or Instructional Programs
Self-help, non-vision self-care, and training programs. This exclusion does not apply to services for training or educating a Claimant, when provided without separate charge in connection with Covered Services.

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family. For purposes of this provision, "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 the diagnosis or correction of visual acuity.

Services And/Or Supplies Not Described As Covered Under This Vision Benefit

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
Travel and transportation expenses.

Two Pair of Glasses in Lieu of Bifocals

Work-Related Conditions
Expenses for services and supplies incurred as a result of any work-related Injury or Illness, including any claims that are resolved related to a disputed claim settlement. The Claims Administrator may require the Claimant to file a claim for workers' compensation benefits before providing any benefits under the Plan. The Plan does not cover services and supplies received for work-related Injuries or Illnesses even if the service or supply is not a covered workers' compensation benefit. The only exception is if You and Your Beneficiaries are exempt from state or federal workers' compensation law.

Claims Administration

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

PLAN IDENTIFICATION CARD
When Participants enroll in the Plan, they will receive Plan identification cards. The identification card will include important information such as the Participant's identification number, group number and name.

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

If You lose Your card, or if it gets destroyed, You can get a new one by contacting Customer Service. You can also view or print an image of Your Plan identification card by visiting the Claims Administrator's Web site on Your PC or mobile device. If the Agreement terminates, Your Plan identification card will no longer be valid.

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

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

Send to:

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

Calendar Year and Plan Year
This Agreement is renewed, with or without changes, 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.

Timely Filing of Claims
Written proof of loss must be received within one year after the date of service for which a claim is made. If it can be shown that it was not reasonably possible to furnish such

proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof within the time required will not invalidate or reduce any claim. A claim that is 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. You may, however, appeal the denial in accordance with the appeal process to demonstrate that the claim could not have been filed in a timely manner.

Freedom of Choice of Provider
Nothing contained in this Booklet is designed to restrict You in selecting the Provider of Your choice for vision care.

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

- When action cannot be taken on the claim due to circumstances beyond the Claims Administrator's control, they will notify You within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when the Claims Administrator expects to act on the claim.
- When action cannot be taken on the claim due to lack of information, the Claims Administrator will notify You within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

If the Claims Administrator seeks additional information from You, You will be allowed at least 45 days to provide the additional information. If the Claims Administrator does not receive the requested information to process the claim within the time allowed, the claim will be denied.

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.

CLAIMS RECOVERY
If a benefit to which You were not entitled is paid under the Plan, or if a person who is not eligible for benefits at all is paid under the Plan, the Plan reserves the right to recover the payment from the person 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 that would have been provided the Participant or any of his or her 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.). All recovered amounts will be credited to the Plan.

This Claims Recovery provision in no way reduces the Plan's right to reimbursement or subrogation. Refer to the other-party liability provision in the Claims Administration Section for additional information.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by 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 their 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. Please contact the Claims Administrator's Customer Service department to make this request.

NOTE: This provision does not apply to information regarding HIV/AIDS, psychotherapy notes, alcohol/drug services and genetic testing. A specific

authorization will be obtained from You in order for the Claims Administrator to receive information related to these health conditions.

LIMITATIONS ON LIABILITY

In all cases, You have the exclusive right to choose a Provider. Neither the Plan nor the Claims Administrator is responsible for the quality of care You receive, since all those who provide care do so as independent contractors. Since neither the Plan nor the Claims Administrator provides any services, neither can be held liable for any claim or damages connected with Injuries You suffer while receiving 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 any applicable 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 of the Plan by reason of epidemic, disaster or other cause or condition beyond the Claims Administrator's control.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former Claimants who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of Your estate, Your decedents, minors, and incompetent or disabled persons. No adult Claimant hereunder, may assign any rights that it 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.

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.

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
If the entity providing workers' compensation coverage denies Your 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 Vision 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 benefits would normally be provided. However, the amount of any Covered Services excluded under 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 under any other individual or group medical contract or plan (referred to as "Other Plan" and defined below), the benefits under this Plan and those of the Other Plan will be coordinated in accordance with the provisions of this section. NOTE: This Section refers to a broad range of benefits, even though this plan is a Vision only plan.

Benefits Subject to this Provision
All of the benefits described in this Booklet are subject to this Coordination of Benefits provision.

Definitions
In addition to the definitions in the Definitions Section, the following are definitions that apply to this Coordination of Benefits Section:

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, except that 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.

- When this Plan restricts coordination of benefits to certain types of coverage or benefits, any expenses for other types of coverage or benefits. See the Benefits Subject to this Provision paragraph, above, for restrictions on the types of coverage or benefits to which coordination applies.
- 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, for purposes of these coordination of benefits provisions, means only the day and month of birth, regardless of the year.

Claim Determination Period means a Calendar Year. However, 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.

- 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 state plan under Medicaid, 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 under 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 under 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, for purposes of this Coordination of Benefits provision, 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 applies:

Non-dependent Coverage: A plan that covers You other than as a dependent will be primary to a plan under 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 his or her plan longer shall be primary to the plan of the parent who has been covered by his or her 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 his or her 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; and
- The plan of Your noncustodial parent shall be primary to the plan of Your noncustodial parent's spouse.

If You are covered under 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 under 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 under 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 over 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 under a plan, two plans will be treated as one if You were eligible under 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 under a plan is measured from Your first date of coverage under 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 under 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 under 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 in this Plan will be calculated as follows:

The benefits that would have been paid under this Plan for a service if this coverage 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 under 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; and

- 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 under 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 under any Other Plan(s) may include an amount that should have been paid under 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 under 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 under this Plan were provided to or on behalf of You in excess of the amount that would have been payable under this Plan by reason of Your coverage under any Other Plan(s), this Plan will be entitled to a recovery 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 of VSP is incorrect, please contact the VSP Customer Service department. If Your concern cannot be resolved to Your satisfaction, You or Your Representative (any Representative authorized by You) may Appeal -- that is, ask for Your case to be reviewed again.

If You have concerns regarding a decision, action or statement by Your Provider, You are encouraged to discuss these concerns with the Provider. If You remain dissatisfied after discussing Your concern with Your Provider, You may file a Grievance. However, if You would prefer to discuss Your concern with VSP rather than Your Provider, please contact VSP's Customer Service department at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance).

Grievances and Appeals can be initiated through either written or verbal request. A written request can be made by completing the form available on **www.vsp.com** or by sending the written request by mail to VSP at: Vision Service Plan, Attention: Complaint and Grievance Unit, P.O. Box 997100, Sacramento, CA 95899-7100. Verbal requests can be made by calling VSP's Customer Service department at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance).

Each Grievance or Appeal, including Expedited Appeals, must be pursued within 180 days of Your receipt of the determination (or, in the case of a Grievance, within 180 days of Your receipt of the original adverse decision that You are Appealing). If You don't act within this time period, You will not be able to continue to pursue the Grievance and Appeal process and may jeopardize Your ability to pursue the matter in any forum.

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

Filing A Grievance

The first step in the process to resolving Your concern is filing a Grievance. Within five business days of receiving Your Grievance, a written acknowledgement and information describing the entire Grievance and Appeal process and Your rights will be sent to You. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Grievance. For a Grievance involving a Pre-Service preauthorization of a procedure, a written notice of the decision will be sent within 14 days of receipt of the Grievance.

Filing Appeals (First and Second Level)

If You don't agree with the decision after filing a Grievance, You may file an Appeal. You have the right to file up to two Appeals. Appeals are reviewed by a panel who were not involved in, or subordinate to anyone involved in, the prior decision. You or Your Representative, on Your behalf, will be given a reasonable opportunity to personally appear or to provide written materials. 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 preauthorization of a procedure, a written notice of the decision will be sent within 14 days of receipt of the Appeal.

EXPEDITED APPEALS
An Expedited Appeal is available as described here:

Panel-Level (First-Level) Expedited Appeal
The first-level Expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Grievance or Appeal decision. First-level Expedited Appeals are reviewed by a panel who were not involved in, or subordinate to anyone involved in, any initial denial determination. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the Expedited Appeals time frame) to provide written materials. A verbal and written notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Expedited Appeal.

INFORMATION
If You have any questions about the Grievance and Appeal process outlined here, You may contact VSP's Customer Service department at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance Monday-Friday 5 a.m. - 8 p.m., Saturday 7 a.m. - 8 p.m., and Sunday 7 a.m. - 7 p.m.

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; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit; P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: **http://dfr.oregon.gov/gethelp/Pages/file-a-complaint.aspx**; or by Email at: **cp.ins@oregon.gov**.

DEFINITIONS SPECIFIC TO THE GRIEVANCE AND APPEAL PROCESS
Appeal means a written or verbal request from a Claimant or, if authorized by the Claimant, the Claimant's Representative, to change a previous decision made concerning:

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

Expedited Appeal means a Grievance or Appeal where the application of regular Grievance or Appeal time frames:

- could, on a Pre-Service or concurrent care claim, jeopardize Your life, health or ability to regain maximum function, or

- would, according to a physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

Grievance means the initial complaint, verbal or written, submitted by or on behalf of a Claimant regarding the availability, delivery or quality of the health care (including preauthorization determinations), claims payments or matter related to the relationship between the Claimant and the Claims Administrator.

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

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

Representative means someone who represents You for the purpose of the Grievance or Appeal. The Representative may be Your personal Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the purpose of the Grievance or Appeal. 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 each Grievance and Appeal level). If no authorization exists and is not received in the course of the Grievance or Appeal, the determination and any personal information will be disclosed to You, Your personal Representative or treating Provider only.

Who Is Eligible, How to Enroll and When Coverage Begins

This section explains how to enroll Yourself and/or Your eligible dependents when first eligible, or during an annual enrollment period. It also describes when coverage under the Plan begins for You and/or Your eligible dependents. Of course, 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 the same terms and conditions of the Plan will be applied to an Eligible Domestic Partner.

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS
You will be entitled to enroll in coverage for Yourself and Your eligible dependents within 30 days of Your first becoming eligible for coverage under the eligibility requirements in effect with the 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 enrollment period to enroll.

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

Retiree Eligibility
A retiree of a Member Employer can enroll as an eligible employee under this Plan, if the individual:

- retires from employment with a Member Employer; and
- is classified by a Member Employer as a retiree for the purposes of eligibility for coverage under the group health plan.

Dependents
Your Beneficiaries are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and the Plan Sponsor has enrolled them in coverage under the Plan. Your newly Eligible Domestic Partner who is not an Oregon-Certified Domestic Partner is eligible for coverage when a domestic partnership is established and an enrollment form or a subsequent change form is submitted to the Plan Sponsor along with an affidavit of qualifying domestic partnership. "Established," means the date on which the conditions described below are met. Dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your Oregon-Certified Domestic Partner. Oregon-Certified 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 domestic partner who is not an Oregon-Certified Domestic Partner, provided that all of the following conditions are met:

- You have completed, executed and submitted an affidavit of qualifying domestic partnership form with regard to Your domestic partner;
- both You and Your domestic partner are age 18 or older;
- You and Your domestic partner share a close, personal relationship and are responsible for each other's common welfare;
- neither You nor Your domestic partner is legally married to anyone else or has had another domestic partner within the 30 days immediately before enrollment of Your domestic partner;
- You and Your domestic partner share the same regular and permanent residence and intend to continue doing so indefinitely;
- You and Your domestic partner share joint financial responsibility for Your basic living expenses, including food, shelter and medical expenses; and
- You and Your domestic partner are not more closely related by blood than would bar marriage in Your state of residence.

- 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, step child, 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; and
  - a child for whom You (or Your spouse or Your Eligible Domestic Partner) are required to provide coverage by a legal National Medical Support Notice.

- Your (or Your spouse's or Your Eligible Domestic Partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of developmental disability or physical handicap that began before his or her 26th birthday, if You complete and submit 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:

  - he or she is a Beneficiary immediately before his or her 26th birthday; or
  - his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on group coverage since that birthday.

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-Certified Domestic Partner, an affidavit of qualifying domestic partnership form) to the Plan Sponsor. Request for enrollment of a new child by birth, adoption or placement for adoption must be made within 60 days of the date of birth, adoption or placement for adoption. Request for enrollment of all other newly eligible dependents must be made within 30 days of the dependent's attaining eligibility. Coverage for such dependents will begin on their Effective Dates (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).

ANNUAL ENROLLMENT PERIOD

The annual enrollment period is the period of time before the Plan Sponsor's Renewal Date and is the only time, other than initial eligibility, during which You and/or Your eligible dependents may enroll. You must submit an enrollment form (and, for an Eligible Domestic Partner who is not an Oregon-Certified Domestic Partner, an affidavit of qualifying domestic partnership form) on behalf of all individuals You want enrolled. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

DOCUMENTATION OF ELIGIBILITY

You must promptly furnish or cause to be furnished any information necessary and appropriate to determine the eligibility of a dependent. Such information must be received 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 Plan Sponsor within 30 days of the date on which a Beneficiary is no longer eligible for coverage.

No person will have a right to receive benefits after the Plan terminates. Termination of Your or Your Beneficiary's coverage under the Plan for any reason will completely end all 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.

AGREEMENT TERMINATION
If the Agreement is terminated or not renewed, claims administration by Regence ends for You and Your Beneficiaries on the date the Agreement is terminated or not renewed (except, if agreed between the Plan Sponsor and Regence, Regence may administer certain claims for services that Claimants received before that termination or nonrenewal).

MEMBER EMPLOYMENT 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, Your and Your Beneficiaries' coverage ends 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 continuation of coverage provisions of this Booklet.

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE
If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Plan, Your coverage will end for You and all Beneficiaries on the last day of the monthly period following the date on which eligibility ends.

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

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

- You and Your 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:

  - in order to care for Your newly born child;
  - in order to care for Your spouse, child or parent, if such spouse, child or parent has 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 just 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.

Persons entitled to coverage under this provision will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this provision. Entitlement to FMLA leave does not constitute a qualifying event for the purpose of 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 period off work granted by Your employer at Your request during which You are still considered to be employed and are carried on the employment records of the Plan Sponsor. 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 under 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 enrollment period.

WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE
If Your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), his or her coverage will end on the last day of the monthly period in which his or her eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Plan according to the continuation of coverage provisions of this Booklet.

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.

If You Die
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-Certified Domestic Partnership
If the contract with Your Oregon-Certified 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.

Termination of Domestic Partnership
If Your domestic partnership other than an Oregon-Certified Domestic Partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet any of the requirements outlined in the definition of a dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the monthly period following the date of termination of the domestic partnership. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence. You may not file another affidavit of qualifying domestic partnership within 90 days after a request for termination of a domestic partnership has been received.

Loss of Dependent Status
- For an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the last day of the monthly period in which the child exceeds the dependent age limit.

- For an enrolled child who is no longer eligible due to disruption of placement before legal adoption and who is removed from placement, eligibility ends on the date the child is removed from placement.
- For an enrolled child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the last day of the monthly period in which the child is no longer a dependent.

OTHER CAUSES OF TERMINATION
Claimants may be terminated for either of the following reasons. However, it may be possible for them to continue coverage under the Plan according to the continuation of coverage provisions of this Booklet.

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
Coverage under the Plan is based upon all information furnished to the Plan Sponsor, for the benefit of the Plan 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.

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 under 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
Generally, You or Your Beneficiaries are responsible for payment of the full cost for COBRA continuation coverage, plus an administration fee, even if the Member Employer contributes toward the cost of those not on COBRA continuation. The administration fee is 2 percent or, during any period of extension for disability, 50 percent.

In order to preserve Your and Your Beneficiary's rights under 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 was disabled for Social Security purposes at the time of a termination of employment or reduction in working hours or within the first 60 days of COBRA continuation following that event. (If a final determination is later made that You or Your Beneficiary is no longer disabled for Social Security purposes, 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 therefore 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 described in the Booklet and claims under the Plan for services provided on and after the date coverage ends will not be paid. Further, this may jeopardize Your or Your Beneficiaries' future eligibility for an individual plan.

Notice
The complete details on the COBRA Continuation provisions outlined here 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.

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 his or her marriage or terminates his or her 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 his or her 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

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

CHOICE OF FORUM
Any legal action arising out of the Plan benefit option described herein 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.

PLAN SPONSOR IS AGENT
The Plan Sponsor is Your agent for all purposes under the Plan and not the agent of Regence BlueCross BlueShield of Oregon. You are entitled to health care benefits pursuant to the Plan. 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 this 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.

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.

NOTICES
Any notice to Claimants required in the Plan will be considered to be 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 Participant or to the Plan Sponsor at the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address form (COA) for a Participant, it will update its records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the Plan Sponsor if it becomes aware that it doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required in the Agreement may be given by mail addressed to: Regence BlueCross BlueShield of Oregon, P.O. Box 2998, Tacoma, WA 98401-2998; provided, however that any notice to the Claims Administrator will not be considered to have been given to and received by it until physically received.

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, 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 Regence 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 Regence 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 and that no person or entity other than Regence will be held accountable or liable to the Plan Sponsor, its Member Employers or the Claimants for any of Regence'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 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 the purpose of obtaining coverage will void such coverage or reduce benefits unless contained in a written document signed by You, a copy of which is furnished to You.

WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered under the Plan, 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 described in the Plan Document; and
- the person has enrolled in coverage and has been enrolled by the Plan Sponsor.

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.

Definitions

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

Allowed Amount means:

- For VSP Doctors (see definition of "VSP Doctor" below), the amount that these Providers have contractually agreed to accept as payment in full for a service or supply.
- For Out-of-Network Providers (see definition of "Out-of-Network Provider" below), the billed amount for listed services and supplies up to any described limit.

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

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

Benefit Authorization means VSP has approved benefits for You.

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.

Claimant means a Participant or a Beneficiary.

Covered Service means a service, supply, treatment or accommodation that is listed in the Vision Benefits Section in this Booklet.

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 Who Is Eligible, How to Enroll and When Coverage Begins Section.

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

Family means a Participant and his or her Beneficiaries.

Frequency Period is the number of Calendar Years, usually one or two, that must pass before benefits renew.

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, Injury, genetic or congenital anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or to maintain or restore functional ability. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

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.

Illness means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an Injury; and pregnancy. Illness does not include any state of mental health or mental disorder.

Injury means physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical or that is the direct result of an accident, independent of Illness or any other cause. An Injury does not mean Injury to teeth due to chewing and does not include any condition related to pregnancy.

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

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

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.

Medically Necessary or Medical Necessity means health care services or supplies that a Physician or other health care Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are:

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

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible Scientific Evidence published in Peer-Reviewed Medical Literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians and other health care Providers practicing in relevant clinical areas and any other relevant factors.

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.

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

Out-of-Network Provider means any optometrist, optician, ophthalmologist or other licensed and qualified vision care Provider who has not contracted with VSP to provide vision care services and/or vision care materials.

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

Physician means an individual who is duly licensed to practice medicine and surgery in all of its branches or to practice as an osteopathic Physician and 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 (for example, an optometrist). Practitioners include podiatrists who do not meet the definition of Physician.

Provider means a Physician, Practitioner or other individual or organization which is duly licensed to provide the services covered in this Booklet.

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.

VSP Doctor means an optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials to Claimants in accordance with the provisions of this coverage.

For more information contact the Claims Administrator at
1 (866) 240-9580 or 100 SW Market Street, Portland, OR 97201

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