CIS (CityCounty Insurance Services)

HDHP-1 w/HSA

with Alternative Care

Effective January 1, 2016

Employee Benefit Plan with Family Protection

Introduction

Regence BlueCross BlueShield of Oregon

100 SW Market Street
Portland, OR 97201

P.O. Box 30805
Salt Lake City, UT 84130-0805

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

EMPLOYER PAID BENEFITS

Your Plan is an employer-sponsored 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 CIS, not Regence BlueCross BlueShield of Oregon, pays for Your covered medical services and supplies. Your claims will be paid only after CIS 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, 2016, 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, and Other Continuation Options sections, the terms "You" and "Your" mean the Participant only). 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 Claim Administrator's risk-sharing arrangements is available upon request by calling Customer Service at the number listed below.

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

CONTACT INFORMATION

Customer Service: 1 (888) 370-6159
(TTY: 711)

And 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 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 three choices called: "Category 1," "Category 2" and "Category 3."

- **Category 1.** You choose to see a preferred Provider and save the most in Your out-of-pocket expenses. Choosing this category means You will not be billed for balances for Covered Services beyond any Deductible, Copayment and/or Coinsurance.
- **Category 2.** You choose to see a participating Provider and Your out-of-pocket expenses will generally be higher than if You choose Category 1 because larger discounts with preferred Providers may be negotiated that will result in lower out-of-pocket amounts for You. Choosing this category means You will not be billed for balances for Covered Services beyond any Deductible, Copayment and/or Coinsurance.
- **Category 3.** You choose to see a Provider that does not have a participating contract with the Claims Administrator and Your out-of-pocket expenses will generally be higher than Category 1. Also, choosing this category 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 Category is indicated. Categories 1, 2 and 3 are also in the Definitions Section of this Booklet. You can go to **regence.com** for further Provider network information. (From there, click on "Find a Doctor.")

ADDITIONAL PARTICIPATION ADVANTAGES

Your Plan offers You access to valuable services. The advantages of Regence involvement as the Claims Administrator include admission to personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to **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:
  - view recent claims, benefits and coverage;
  - find a contracting Provider;
  - participate in online wellness programs and use tools to estimate upcoming healthcare costs;
  - identify Participating Pharmacies;
  - find alternatives to expensive medicines;
  - learn about prescriptions for various illnesses; and
  - compare medications based upon performance and cost, as well as discover how to receive discounts on prescriptions.

GUIDANCE AND SERVICE ALONG THE WAY

This Booklet was designed to provide information and answers quickly and easily. Be sure to understand Your benefits before You need them. You can learn more about the unique advantages of Your health care coverage throughout this Booklet, some of which are highlighted here. If You have questions about Your health care coverage, please contact the Claims Administrator.

- **Learn more and receive answers about Your coverage.** Just call Customer Service: 1 (888) 370-6159 to talk with one of the Claims Administrator's Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. - 6 p.m. You may also visit the Claims Administrator's Web site at: **regence.com**.
- **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.** 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 serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world.

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, 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, the Plan will provide benefits 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 as a number of days, visits or services. Refer to the Medical Benefits Section in this Booklet to determine if a Covered Service has a specific Maximum Benefit.

OUT-OF-POCKET MAXIMUM

An important feature of this high deductible health plan is how the single and Family Out-of-Pocket Maximums work. The key is understanding the difference between "single" and "family" coverage. Single Coverage means only one person has coverage under the Plan. An employee who is the only one in his or her Family who has coverage under the Plan, a husband and wife who both work for the Plan Sponsor and have each filled out an application and are Participants on separate coverages, and a Beneficiary who is continuing insurance coverage on his or her own are all examples of Single Coverage. Family Coverage, on the other hand, means two or more members of the same Family have coverage under the Plan under a single application.

Claimants can meet the Out-of-Pocket Maximum by payments of Deductible and Coinsurance for all categories as specifically indicated in the Medical Benefits Section. 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 will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year. The Coinsurance for some benefits of the 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 Out-of-Pocket Maximum for a Calendar Year is satisfied when some or all Family Members' Deductibles and Coinsurance for Covered Services for that Calendar Year total and meet the Family's Out-of-Pocket Maximum amount.

COPAYMENTS

Copayments are the fixed dollar amount that You must pay directly to the Provider each time You receive a specified service (such as bariatric surgery). 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, 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. However, a Preferred or Participating Provider will not charge You for any balances for Covered Services beyond Your applicable

Deductible and Coinsurance amount if You choose Category 1 or Category 2. Nonparticipating Providers, however, may bill You for any balances over the Plan payment level in addition to any applicable Deductible and Coinsurance amount if You choose Category 3. 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 who is enrolled on Single Coverage satisfies the Single Coverage Deductible by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total and meet the Single Coverage Deductible.

The Family Coverage Deductible is satisfied when some or all covered Family Members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Coverage 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 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 include teaching doses of Self-Administrable Injectable Medication, and hospice respite care, and 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, including women's health care services. 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 and Professional Services benefits.

All covered benefits are subject to the limitations, exclusions and provisions of this plan. 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.

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

The maximum Out-of-Pocket for any Claimant on Family Coverage is not to exceed $6,850, including any Deductible. If a Claimant reaches this maximum amount prior to satisfying the Family Out-of-Pocket Maximum, including any Deductible, benefits will be paid at 100 percent of the Allowed Amount for that Claimant.

Single Coverage: $2,300
Family Coverage: $5,050

COPAYMENTS AND COINSURANCE

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

CALENDAR YEAR DEDUCTIBLES

Single Coverage Deductible: $1,500
Family Coverage Deductible: $3,000 (entire Deductible must be met before benefits begin for any Claimant of the Family.)

For Category 1 and Category 2 Providers, You do not need to meet any Deductible before receiving benefits for Preventive Care and Immunizations. Also, any Deductible does not need to be met when a prescription is filled for Medically Necessary Prescription Medications for management of a female Claimant’s diabetes from the date she conceives through six weeks postpartum for each pregnancy.

Furthermore, You do not need to meet any Deductible when You fill prescriptions for those Generic Medications or Formulary Brand-Name Medications specifically designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List found at **regence.com** (Sign in, from there, select "Resources," then "Pharmacy Benefits," then "Learn more about OmedaRx," then "Formularies and Other Drug Lists," then "Optimum Value Medications List.") or by calling the Claim Administrator’s Customer Service at 1 (888) 370-6159.

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 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 **regence.com** (From there, log into your account, go to the bottom of the page, click on "More Information", then "Benefits", then click "Preventive Care."), or contact Customer Service at 1 (888) 370-6159. NOTE: Covered Services that do not meet these criteria will be covered the same as any other Illness or Injury.

Preventive Care

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: The Plans pay 100% of the Allowed Amount.	**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. See the Prescription Medication Benefits Section in this Booklet for a description of how to obtain Generic Medications. Coverage for all such services is provided only for preventive care as designated above (which designation may be modified from time to time). Provider counseling for tobacco use cessation and Generic Medications prescribed for tobacco use cessation is provided separately by CIS Tobacco Cessation Program for all eligible members and meets the requirements of the federal Affordable Care Act. For details, go to **www.cisbenefits.org**. (From there, select "Healthy Benefits & Wellness," then "Tobacco Free Program.")

Additionally, the Plan covers all United States Food and Drug Administration (FDA) approved contraceptive and sterilization methods for women in accordance with HRSA recommendations. These include female condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill, and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection, emergency contraceptives (both levonorgestrel and ulipristal acetate-containing products), intrauterine devices (both copper and those with progestin), implantable contraceptive rod, surgical implants and surgical sterilization. Please visit the Claims Administrator's Web site at **regence.com** for the Plan's preferred contraceptive products covered under the Prescription Medications benefit.

Immunizations - Adult

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: The Plan pays 100% of the Allowed Amount.	**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.

Immunizations -Childhood

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: The Plan pays 100% of the Allowed Amount.	**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.

PROFESSIONAL SERVICES

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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 provided by a professional Provider subject to the Deductible and Coinsurance and any specified limits as explained in the following paragraphs:

Medical Services

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. 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.

Diabetic Management Associated with Pregnancy

Management of a female Claimant's diabetes from the date she conceives through six weeks postpartum (for each pregnancy) that is Medically Necessary and a Covered Service is not subject to any Coinsurance or Deductible.

Office Visits

The Plan covers office visits for treatment of Illness or Injury.

Professional Inpatient

The Plan covers professional inpatient visits for Illness or Injury. If pre-arranged procedures are performed by a preferred Provider and You are admitted to a preferred Hospital, the Plan will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by participating and nonparticipating Providers at the Category 1 benefit level. However, a nonparticipating Provider may bill You for balances beyond any Deductible, 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.

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

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.

A selected list of Self-Administrable Injectable Medications is covered under the Prescription Medications benefit in this Booklet. Teaching doses (by which a Provider educates the Claimant to self-inject) are covered for this list of Self-Administrable Injectable Medications up to a limit of three doses per medication per Claimant Lifetime. Teaching doses that are applied toward the Deductible will be applied against the Maximum Benefit limit on these services.

Women's Examinations
The Plan covers women's breast, pelvic and Pap smear examinations not covered under the Preventive Care and Immunizations benefit.

ALTERNATIVE CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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 billed charges and You pay balance of billed charges. Your 40% payment will be applied toward the Out-of-Pocket Maximum.
Limit: $1,000 for all alternative care combined per Claimant per Calendar Year		

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

AMBULANCE SERVICES

Category: All
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 ambulance services to the nearest Hospital equipped to provide treatment, when any other form of transportation would endanger Your health and the purpose of the transportation is not for personal or convenience purposes. Covered ambulance services include licensed ground and air ambulance Providers.

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 Maximum Benefits as specified in the Medical Benefits and Prescription Medication benefits in this Booklet. Additional specified limits are as further defined. If a preferred Provider is participating in the Approved Clinical Trial and will accept You as a trial participant, these benefits will be provided only if You participate in the Approved Clinical Trial

through that Provider. If the Approved Clinical Trial is conducted outside Your state of residence, You may participate and benefits will be provided in accordance with the terms for other covered out-of-state care.

Definitions

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

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

- Approved or funded by one or more of:
  - The National Institutes of Health (NIH), the CDC, The Agency for Health Care Research and Quality, The Centers for Medicare & Medicaid, or a cooperative group or center of any of those entities or of the Department of Defense (DOD) or the Department of Veteran's Affairs (VA);
  - A qualified non-governmental research entity identified in guidelines issued by the NIH for center approval grants; or
  - The VA, DOD, or Department of Energy, provided it is reviewed and approved through a peer review system that the Department of Health and Human Services has determined both is comparable to that of the NIH and assures unbiased review of the highest scientific standards by qualified individuals without an interest in the outcome of the review; or
- Conducted under an investigational new drug application reviewed by the Food and Drug Administration or that is a drug trial exempt from having an investigational new drug application.

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

Routine Patient Costs means items and services that typically are Covered Services for 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;
- A service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis; or
- Services, supplies or accommodations for direct complications or consequences of the Approved Clinical Trial.

BARIATRIC SERVICES

Bariatric Office Visits

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: The Plan pays 100% of the Allowed Amount.	**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.
Limit: four visits per Claimant per Calendar Year		

Bariatric Surgery

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible and a $1,000 Copayment, the Plan pays 80% and You pay 20% of the Allowed Amount. Your Copayment and 20% payment do not apply toward the Out-of-Pocket Maximum.	**Payment:** After Deductible and a $1,000 Copayment, the Plan pays 60% and You pay 40% of the Allowed Amount. Your Copayment and 40% payment do not apply toward the Out-of-Pocket Maximum.	**Payment:** After Deductible and a $1,000 Copayment, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your Copayment and 40% payment of the Allowed Amount do not apply toward the Out-of-Pocket Maximum.
Limit: one surgery per Claimant Lifetime		

The Plan covers bariatric surgery to treat morbid obesity. Before You proceed with bariatric surgery, the Claims Administrator must evaluate and approve the surgery as meeting its published medical policy. For the purpose of this benefit, "morbid obesity" means a severe state of obesity, as defined in the Claims Administrator's published medical policies.

In addition to the exclusions listed in the General Exclusions section, the Plan will not cover the following, unless the previous bariatric surgery was approved by the Claims Administrator and covered by the Plan:

- complications;
- revisions of the same bariatric surgery;
- reversals.

BLOOD BANK

Category: All
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 a Community Assessment Center in conducting a Child Abuse Medical Assessment of a child enrolled on this plan subject to the Deductible and/or Coinsurance 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.

DENTAL HOSPITALIZATION

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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. Benefits are not available for services received in a dentist's office.

DETOXIFICATION

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Maximum Coinsurance.	**Payment:** After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Maximum Coinsurance.	**Payment:** After 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 Maximum Coinsurance.

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 Professional Services, Diabetic Education, Durable Medical Equipment, Nutritional Counseling, Orthotic Devices or Prescription Medications benefits in this Booklet for coverage details of such covered supplies and equipment.

DIABETIC EDUCATION

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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, including nutritional therapy if provided by Providers with expertise in diabetes.

DURABLE MEDICAL EQUIPMENT

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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 80% of the Allowed Amount and You pay balance of billed charges. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

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 female Claimant, whom is pregnant, to perform the delivery (including the placenta). Emergency room services do not need to be preauthorized. If admitted to a participating or nonparticipating Hospital directly from the emergency room, services will be covered at the Category 1 benefit level. However, a nonparticipating 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

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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. See the Prescription Medication Benefits Section for coverage of prescription contraceptives.

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

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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 hearing aids only for Claimants 18 years of age or younger, or for enrolled children 19 years of age or older and enrolled in a secondary school or an accredited educational institution, 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

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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 homebound patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility. Home health care visits that are applied toward 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 of this Booklet.

HOSPICE CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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: 14 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. In order to qualify for hospice care, the patient's Physician must certify that the patient is terminally ill and is eligible for hospice services. 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 the 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 of this Booklet.

HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER
Inpatient and Outpatient

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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.

Ambulatory Surgical Center

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**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 the inpatient and outpatient services and supplies of a Hospital or the outpatient services and supplies of an Ambulatory Surgical Center 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. 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.

KIDNEY DIALYSIS – OUTPATIENT

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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: 42 treatments per Treatment Period 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 prior to Medicare coverage enrollment, the Claims Administrator must be contacted to approve the additional treatment and document Your progress. See the Supplemental Kidney Dialysis in this benefit for coverage after the first 42 treatments in the first treatment period.

When Your Physician recommends kidney dialysis, You should first contact the Claims Administrator to begin Case Management and activate Your enrollment in the Supplemental Kidney Dialysis program described below. Enrollment in the Supplemental Kidney Dialysis program is voluntary and if You do not enroll in the program, You will not have access to the expanded benefits provided through the program.

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 Kidney Dialysis – Outpatient

For any subsequent outpatient kidney dialysis beyond the first Treatment Period, until Your 34th month after beginning dialysis, the Plan will provide additional supplemental coverage as described here if You have enrolled in this program. Supplemental dialysis benefits will not be retroactively covered if You choose to enroll after the first treatment period. This Supplemental Kidney Dialysis benefit covers 150 percent of the current Medicare reimbursement amount, after any Deductible, for the same or similar services as provided under the Kidney Dialysis benefit above.

In addition, a Claimant with end stage renal disease (ESRD) is eligible to have Medicare Part B premiums reimbursed by the Plan as an eligible Plan expense for the duration of the Claimant's ESRD 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.

Notwithstanding the above, in the event a Provider accepts Medicare assignment as payment in full, the eligible expenses are the lesser of the total amount of charges allowable by Medicare and the total eligible expenses allowable under this Plan, exclusive of Coinsurance and regardless of Your Medicare enrollment. This Supplemental Kidney Dialysis benefit applies to all Providers providing kidney dialysis related services.

MATERNITY CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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 prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy, and related conditions for all female Claimants. There is no limit for the mother 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 female Claimants. Any Coinsurance and Deductible do not apply to Medically Necessary Covered Services for management of a female Claimant's diabetes from the date she conceives 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.

MEDICAL FOODS (PKU)

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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 for outpatient treatment for Mental Health Conditions or Substance Use Disorder. 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 Behavior 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.

Habilitative means health care services that help a person keep, learn or improve skills and functioning for daily living such as therapy for a child who is not walking or talking at the expected age. These services may include physical therapy, occupational therapy or speech therapy.

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 by the Claims Administrator 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 disorders 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.

NEWBORN CARE

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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, the initial physical examination and a PKU test.

NUTRITIONAL COUNSELING

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 100% of the Allowed Amount.	**Payment:** After Deductible, the Plan pays 100% of the Allowed Amount and You pay balance of billed charges.
Limit: four visits per Claimant per Calendar Year (diabetic education and 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

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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 appliances and orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body. Benefits under the Plan may be reduced for a less costly alternative item. The Plan does not cover off-the-shelf shoe inserts.

PRESCRIPTION MEDICATIONS

For Prescription Medications from a Pharmacy

- After Deductible, the Plan pays 80% and You pay 20% of the Covered Prescription Medication Expense for each Generic Medication, Brand-Name Medication or Self-Administrable Cancer Chemotherapy Medication. Your 20% payment will be applied toward the Out-of-Pocket Maximum.

Any Coinsurance and Deductible do not apply to Medically Necessary Covered Services for management of a female Claimant's diabetes from the date she conceives through six weeks postpartum for each pregnancy.

For Prescription Medications from a Mail-Order Supplier

- After Deductible, the Plan pays 80% and You pay 20% of the Covered Prescription Medication Expense for each Generic Medication or Brand-Name Medication. Your 20% payment will be applied toward the Out-of-Pocket Maximum.

Any Coinsurance and Deductible do not apply to Medically Necessary Covered Services for management of a female Claimant's diabetes from the date she conceives through six weeks postpartum for each pregnancy.

Brand-Name Prescription Medication Instead of Generic

If an equivalent Generic Medication is available and You choose to fill a Prescription Order with a Brand-Name Medication, You will be responsible for paying the difference in cost (which does not count toward Your Deductible (if applicable) or any Out-of-Pocket Maximum). The difference is calculated at the time of purchase based upon the difference in price between the equivalent Generic Medication and the applicable Brand-Name Medication, in addition to the Copayment and/or Coinsurance (as applicable).

The exception is when the prescribing Provider specifies that the Brand-Name Medication must be dispensed, in which case You will not be responsible for payment of the difference in cost.

Covered Prescription Medications

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

- diabetic supplies as defined by the Claims Administrator (including glucometers, lancets, serum, needles, test strips, glucagon emergency kits, insulin and insulin syringes, but not insulin pumps and their supplies), when obtained with a Prescription Order (insulin pumps and their supplies are covered under the Durable Medical Equipment benefit);
- Prescription Medications;
- certain preventive medications (including, but not limited to, aspirin, fluoride, and iron) according to, and as recommended by, the USPSTF, when obtained with a Prescription Order;
- FDA-approved women's prescription and over-the-counter (if presented with a prescription) contraception methods as recommended by the HRSA. These include female condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill, and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection, and emergency contraceptives (both levonorgestrel and ulipristal acetate-containing products);
- immunizations for adults and children according to, and as recommended by, the CDC;
- Specialty Medications;
- Self-Administrable Cancer Chemotherapy Medication; and
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Compound and Injectable Medications).

You are not responsible for any applicable Deductible, and/or Coinsurance when You fill prescriptions at a Participating Pharmacy, for specific strengths or quantities of medications that are specifically designated as preventive medications, women's contraceptives, or for immunizations, as specified above. For a list of such medications, please visit the Claim Administrator's Web site at **regence.com**, or contact Customer Service at 1 (888) 370-6159. Also, if Your Provider believes that the Plan's covered preventive medications, including women's contraceptives, are medically inappropriate for You, You may request a coverage exception for a different preventive medication by contacting Customer Service. NOTE: The applicable Deductible, Copayment and/or Coinsurance as listed in this Prescription Medication Benefits Section will apply when You fill preventive medications and immunizations that meet the above criteria, at a Nonparticipating Pharmacy.

Pharmacy Network Information

A nationwide network of Participating Pharmacies is available to You. Pharmacies that participate in this network submit claims electronically.

Your Plan identification card enables You to participate in this Prescription Medication program, so You must use it to identify Yourself at any Pharmacy. If You do not identify Yourself as a Claimant through Regence BlueCross BlueShield of Oregon, a Participating Pharmacy, Specialty Pharmacy or Mail-Order Supplier may charge You more than the Covered Prescription Medication Expense. You can find Participating Pharmacies and a Pharmacy locator on the Claims Administrator's Web site at **regence.com**, or by contacting Customer Service at 1 (888) 370-6159.

Preauthorization

Preauthorization may be required before a Prescription Medication can be dispensed to determine Medical Necessity. The Claims Administrator publishes a list of those medications that currently require preauthorization. You can see the list on their Web site at **regence.com** or call Customer Service at 1 (888) 370-6159. In addition, participating Providers, including Pharmacies, are notified which Prescription Medications require preauthorization. The prescribing Provider must provide the medical information necessary to determine Medical Necessity of Prescription Medications that require preauthorization.

Coverage for preauthorized Prescribed Medications begins on the date the Claims Administrator preauthorizes them. If Your Prescription Medication requires preauthorization and You purchase it before

the Claims Administrator preauthorizes it or without obtaining the preauthorization, the Prescription Medication may not be covered, even if purchased from a Participating Pharmacy.

LIMITATIONS

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

Maximum 34-Day or Greater Supply Limit

- **Injectable Medications and 90-Day Supply.** The largest allowable quantity for Self-Administrable Injectable Medications purchased from a Pharmacy or Mail-Order Supplier, is a 90-day supply. The Copayment and/or Coinsurance for Self-Administrable Injectable Medications purchased from a Mail-Order Supplier will be the same as if the medication was purchased from and the claim was submitted electronically by a Pharmacy.
- **Specialty Medications and 34-Day Supply.** The largest allowable quantity for a Specialty Medication purchased from a Specialty Pharmacy, is a 34 day supply. The first fill is allowed at a retail Pharmacy. Additional fills must be provided at a Specialty Pharmacy.
- **Prescription Contraceptives and 3-Month Supply.** The largest allowable quantity for the first fill of a prescription contraceptive purchased from a Pharmacy or Mail Order Supplier, is a three-month supply. After the first fill, a 12-month supply is allowed for subsequent fills of the same contraceptive. The Copayment and/or Coinsurance is based on each 34-day supply from a Pharmacy and each 90-day supply from a Mail Order Supplier.
- **Mail-Order and 90-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Mail-Order Supplier is a 90-day supply. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities. Self-Administrable Injectable Medications are limited to a 90-day supply as indicated above.
- **Pharmacy and 90-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Pharmacy is a 90-day supply. A Provider may choose to prescribe, or You may choose to purchase, some medications in smaller quantities. The Coinsurance is based on each 34-day supply.
- **Pharmacy and 90-Day Multiple – Month Supply.** Except for prescription contraceptives, the largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Pharmacy is the smallest multiple-month supply packaged by the manufacturer for dispensing by Pharmacies. The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The maximum supply covered for these products is a 90-day supply (even if the packaging includes a larger supply). The Coinsurance is based on each 34-day supply within that multiple-month supply.

Maximum Quantity Limit

For certain Prescription Medications, the Claims Administrator establishes maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. The Claims Administrator uses information from the United States Food and Drug Administration (FDA) and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your Plan identification card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by checking the Claims Administrator's pharmacy services Web site at **regence.com** (From there, go to the bottom of the page under “Quick Links”, click on “RegenceRx Pharmacy Benefits”, then click “Learn more about RegenceRx”, then click “Learn about Medications”, then click “Prior Auth/Medication Quantities.") or contacting Customer Service at 1 (888) 370-6159. The Plan does not cover any amount over the established maximum quantity, except if it is determined the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

Refills

The Plan will cover refills from a Pharmacy when You have taken 75 percent of the previous prescription. Refills obtained from a Mail-Order Supplier are allowed after You have taken all but 20 days of the

previous Prescription Order. If You choose to refill Your Prescription Medications sooner, You will be responsible for the full costs of these Prescription Medications and these costs will not count toward Your Deductible (if applicable) or any Out-of-Pocket Maximum. If You feel You need a refill sooner than allowed, a refill exception will be considered at the Claims Administrator's discretion on a case-by-case basis. You may request an exception by calling Customer Service at 1 (888) 370-6159.

If You receive maintenance medications for chronic conditions, You may qualify for the Claims Administrator's prescription refill synchronization which allows refilling Prescription Medications from a Pharmacy on the same day of the month. For further information on prescription refill synchronization, please call Customer Service at 1 (888) 370-6159.

Prescription Medications Dispensed by Excluded Pharmacies

A Pharmacy may be excluded if it has been investigated by the Office of the Inspector General (OIG) and appears on the OIG's exclusion list. If You are receiving medications from a Pharmacy that is later determined by the OIG to be an excluded Pharmacy, You will be notified, after Your claim has been processed, that the Pharmacy has been excluded, so that You may obtain future Prescription Medications from a non-excluded Pharmacy. Excluded Pharmacies are not permitted to submit claims after the excluded Pharmacies have been added to the OIG list.

Exclusions

In addition to the exclusions in the General Exclusions Section, the following exclusions apply to this Prescription Medications benefit:

Acne Medication: Prescription Medications for the treatment of acne in Claimants over age 26.

Biological Sera, Blood or Blood Plasma.

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

Devices or Appliances: Devices or appliances of any type, even if they require a Prescription Order (coverage for devices and appliances may otherwise be provided under the Medical Benefits Section). However glucometers, needles, syringes, testing supplies, lancets and serum used for treatment of diabetes are covered.

Foreign Prescription Medications: Except for Prescription Medications associated with an Emergency Medical Condition while You are traveling outside the United States, or those You purchase while residing outside the United States, the Plan does not cover foreign Prescription Medications. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this section if obtained in the United States, except as may be provided under the Investigational definition in the Definitions Section found at the back of this Booklet.

Insulin Pumps and Pump Administration Supplies: Coverage for insulin pumps and supplies is provided under the Medical Benefits Section.

Medications That Are Not Self-Administrable: Coverage for these medications may otherwise be provided under the Medical Benefits Section.

Nonprescription Medications: Medications that by law do not require a Prescription Order and which are not included in the Claims Administrator's definition of Prescription Medications, shown below, unless included on the Formulary, approved by the FDA and prescribed by a Physician.

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

Prescription Medications for Treatment of Infertility

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

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

Prescription Medications without Examination: Except as provided under the Telehealth and Telemedicine benefits in the Medical Benefits Section, and except for hormonal contraceptive patches or self-administered oral hormonal contraceptives prescribed by a Pharmacist, the Plan does not cover prescriptions made by a Provider without recent and relevant in-person examination of the patient, whether the Prescription Order is provided by mail, telephone, internet or some other means. For purposes of this exclusion, an examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.

Professional Charges for Administration of Any Medication

Definitions

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

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

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

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

Formulary means the Claims Administrator's list of selected Prescription Medications. The Claims Administrator established and routinely reviews and updates the Formulary. It is available on the Claims Administrator's Web site at **regence.com** (From there, go to the bottom of the page under “quick links” click “RegenceRx Pharmacy Benefits”, then select “Learn more about RegenceRx”, then select “Learn about Medications”, then select “What’s covered/Formulary.”), or by calling Customer Service at 1 (888) 370-6159. Medications are reviewed and selected for inclusion in the Formulary by an outside committee of providers, including Physicians and Pharmacists.

Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references (or specified by the Claims Administrator) as a Generic Medication. For the purpose of this definition, "equivalent" means the FDA ensures that the Generic Medication has the same active ingredients, meets the same manufacturing and testing standards, and is as safe and as effective as the Brand-Name Medication. If listings in widely accepted references are conflicting or indefinite about whether a Prescription Medication is a generic or Brand-Name Medication, the Claims Administrator will decide.

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

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

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed. A Participating Pharmacy means either a Pharmacy with which the Claims Administrator has a contract or a Pharmacy that participates in a network for which the Claims Administrator has contracted to have access. Participating Pharmacies have the capability of submitting claims electronically. A

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

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

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

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

Specialty Medications means medications used for patients with complex disease states, such as, but not limited to, multiple sclerosis, rheumatoid arthritis, cancer and hepatitis C. For a list of some of these medications, please visit the Claims Administrator's Web site at **regence.com** or contact Customer Service at 1 (888) 370-6159.

Specialty Pharmacy means a Pharmacy that specializes in the distribution and medication management services of high cost injectables and Specialty Medications. To find a Specialty Pharmacy, please visit the Claims Administrator's Web site at **regence.com** or contact Customer Service at 1 (888) 370-6159.

PROSTHETIC DEVICES

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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: 77 visits for all therapies 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 include neurodevelopmental therapy 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 rehabilitation services that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

REPAIR OF TEETH

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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.

SKILLED NURSING FACILITY (SNF) CARE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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: 120 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 the Deductible will be applied against any Maximum Benefit limit on these services.

Ancillary services and supplies, such as physical therapy, Prescription Medications, and radiology and laboratory services, billed as part of a Skilled Nursing Facility admission also apply toward any Maximum Benefit limit on Skilled Nursing Facility care.

TELEHEALTH

Provider: MDLIVE
Payment: After Deductible, the Plan pays 100% of the Allowed Amount.

The Plan has chosen MDLIVE to provide telehealth. The Plan covers telehealth (audio and video communication) office visits for primary care services and equivalent behavioral health services between the patient and an MDLIVE Provider. The Plan does not cover telehealth office visits when not provided by MDLIVE Providers.

To find an MDLIVE telehealth Provider or for additional information on Covered Services, please visit the MDLIVE Web site at **www.mdlive.com** or contact Customer Service at 1 (888) 725-3097. Coverage is not provided under this benefit for all non-real-time delivery methods, including, but not limited to, store and forward solutions, e-mail or secure message exchange.

TELEMEDICINE

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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. 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

Category: 1	Category: 2	Category: 3
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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 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.

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.

TRANSPLANTS

Category: 1	Category: 2	Category: 3
Provider: Center of Excellence	**Provider: Participating**	**Provider: Nonparticipating**
Payment: After Deductible, the Plan pays 100% of the Allowed Amount.	**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 Waiting Period

You will not be eligible for any benefits related to a transplant until the first day of the 25th month of continuous coverage under this or any previous medical plan, whether or not the condition is preexisting.

The duration of the transplant waiting period will be reduced by the amount of Your combined periods of creditable coverage if You have been covered by creditable coverage. For crediting to apply, there must have been no break in creditable coverage greater than 63 days immediately preceding Your enrollment date of coverage under the Plan or between any two successive creditable coverages for which You seek credit. Creditable coverage may still be in force at the time credit for it is sought on this coverage.

You will be allowed a credit against this transplant waiting period for the combined amount of prior creditable coverages that You have had. If You have had more than one creditable coverage in effect at the same time, credit is given only for one (that is, a day on which You have creditable coverage in force under two coverages is not counted as two days of creditable coverage). In calculating Your creditable coverage credit, if You have had a break in coverage (that is, a period between the termination date of one creditable coverage and the enrollment date on next creditable coverage) of 63 days or more, no credit will be given for any creditable coverages prior to that break in coverage.

Creditable coverage means any of the following: group coverage (including self-funded plans); individual insurance coverage; S-CHIP; Medicaid; Medicare; CHAMPUS/Tricare; Indian Health Service or tribal organization coverage; state high-risk pool coverage; Federal Employee Health Benefit Plan coverage; and public health plans (including foreign government and US government plans).

Creditable coverage is determined separately for each Claimant.

The following periods do not count in the calculation of the length of a break in coverage:

- days in a waiting period for eligibility for coverage under the Plan; and
- for an individual who elects COBRA continuation coverage during the second election period offered under the Trade Act of 2002, days between the loss of coverage and the first day of that second election period.

You have the right to demonstrate the existence of creditable coverage by providing the Claims Administrator with one or more certificates of creditable coverage from a prior group or individual plan or with other documentation. You may obtain a certificate of creditable coverage from a prior group health plan or insurer by requesting it within 24 months of coverage termination. The Claims Administrator can help You obtain a certificate from a prior plan or insurer or suggest other documents that will serve as alternatives to a certificate of creditable coverage as provided by federal law.

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 CIS 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.

CASE MANAGED KIDNEY DIALYSIS AND SUPPLEMENTAL KIDNEY DIALYSIS

Receive one-on-one help and support in the event Your Physician recommends kidney 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 (888) 370-6159.

REGENCE CONDITION MANAGER

Regence Condition Manager is a support and education program for people with chronic conditions such as diabetes, heart disease, asthma and/or depression. The Claims Administrator's nurses and behavioral health care coordinators provide tailored educational materials, tools and other services to help You get on track with Your care--and stay there. They can help You understand the care plan You've developed with Your Physician, and make smarter choices for better health.

To learn more, 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 in the Prescription Medication Benefits provision; or 3) services and supplies furnished in an emergency room for stabilization of a patient.

Alternative Care

Except as provided under the Alternative Care benefit in this Booklet, the Plan does not cover alternative care, including, but not limited to, acupuncture and spinal manipulations.

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 drugs, testing or supplies, regardless of underlying condition or circumstance.

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 or 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 to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

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 for as provided in this Booklet or as required by law, the Plan does not cover counseling in the absence of Illness, for example; educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; Employee Assistance Program ("EAP") services, except as provided under the EAP Section, if applicable; wilderness programs; premarital or marital counseling; and family counseling (however family counseling will be covered when the identified

patient is a child or an adolescent with a covered diagnosis and the family counseling is part of the treatment when Mental Health Services are covered benefits under the Plan).

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 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.)

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 and the 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.

Infertility
Treatment of infertility, including, but not limited to fertility drugs and medications, except to the extent Covered Services are required to diagnose such condition.

Investigational Services
Except as provided under the Approved Clinical Trials benefit, the Plan does not cover Investigational treatments or procedures (Health Interventions) and 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 had You properly enrolled in Medicare when first eligible, benefits will be reduced to the extent that those benefits are or would have been provided by any part of Medicare (for example, Part A, B, C or D), regardless of whether or not You choose to accept those benefits. In addition, if You are eligible for 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 may be specifically provided in this Booklet, the Plan does not cover medical treatment, medication, surgical treatment (including reversals), 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, a 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
Except as provided under the Prescription Medications benefit in this Booklet, the Plan does not cover over-the-counter contraceptive supplies and oral contraceptives 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 and light boxes 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.

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

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:

- diet and weight monitoring services;
- childbirth-related classes including infant care; and
- instruction programs including those to learn how to stop smoking and programs that teach a person how to use Durable Medical Equipment or how to care for a family member.

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, marriage or 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.

Services Required As A Condition Of Employment
Including but not limited to physical examinations required to maintain a commercial drivers license, other employment related physical examinations and work related substance abuse testing.

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.

Sexual Reassignment Treatment and Surgery
As permitted by law treatment, surgery or counseling services for sexual reassignment, unless they are Medically Necessary in connection with sexual reassignment and are covered when provided for diagnoses other than gender identity disorder or gender dysphoria.

Surrogacy
"Surrogacy," "surrogate," "surrogate mother" or "surrogate parent" with respect to a Claimant means a person whose pregnancy is commissioned by an individual or couple, regardless of whether or not such commission is as a commercial surrogate, compensated by the commissioner or is an altruistic surrogate, obliged to carry the child for reasons other than financial gain through a surrogate parent agreement either written or oral.

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

Tobacco Addiction Treatment
The Plan does not cover treatment of tobacco addiction and supportive items for addiction to tobacco, tobacco products or nicotine substitutes. However, a tobacco cessation program is offered through CIS

for all eligible Claimants. Details at **www.cisbenefits.org**. (From there, select “Healthy Benefits & Wellness,” then “Enroll in a Tobacco Cessation Program.”)

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

Vision Care
Routine eye exam and vision hardware.

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.

Your employer and CIS may provide vision care through VSP. Please check with your benefits department.

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 from the Claims Administrator in advance for certain services provided to You. You will not be penalized if the contracted Provider does not obtain those approvals from the Claims Administrator in advance and the service is determined to be not covered under this Booklet. The Claims Administrator does not require prior authorization of non-contracted Providers' services under the Contract. 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 Contract will not be denied solely for lack of prior authorization. However, benefits will be paid for services and supplies covered under the Contract only if all terms and conditions of the Contract 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 the Claims Administrator does preauthorize a service or supply (from a contracted or non-contracted Provider), the Claims Administrator is bound to cover it as follows:

- If Your coverage terminates within five business days of the preauthorization date, the Claims Administrator 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 their written preauthorization. In that case, the Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 service or supply is preauthorized by the Claims Administrator.

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 simply calling the Claims Administrator's Customer Service department at: 1 (888) 370-6159. You can also view or print an image of Your Plan identification card by visiting the Claims Administrator's Web site at **regence.com** on Your PC or mobile device. (From there you will need to sign into your Regence.com account, click on “Member Dashboard”, then click on “My Account”, then click on “Member ID Cards.”) 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 is renewed 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.

Category 1 and Category 2 Claims

You must present Your Plan identification card when obtaining Covered Services from a preferred or participating 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.

Category 1 and Category 2 Reimbursement

A preferred or participating 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 and/or Coinsurance. These Providers may require You to pay Your share at the time You receive care or treatment.

Category 3 Claims

In order for Covered Services to be paid, You or the nonparticipating 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.

Category 3 Reimbursement

In most cases, You will be paid directly for Covered Services provided by a nonparticipating Provider.

Nonparticipating 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 nonparticipating Provider and the Allowed Amount in addition to any amount You must pay due to Deductible, Copayment and/or Coinsurance. For nonparticipating 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. The Claims Administrator has up to 24 months from the date a claim is paid to make any adjustments, including requesting a refund in writing.

Reimbursement Examples by Category

Here is an example of how Your selection of Category 1, 2 or 3 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 Category 1 and 60 percent of the Allowed Amount for Categories 2 and 3. The benefit table from the Medical Benefits Section (or other benefits section) would appear as follows:

Category: 1	**Category: 2**	**Category: 3**
Provider: Preferred	**Provider: Participating**	**Provider: Nonparticipating**
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% and You pay 40% of the Allowed Amount. Your 40% 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 Category 1. 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:

- Category 1: the Plan would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:

  - Amount preferred 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

- Category 2: the Plan would pay 60 percent of the Allowed Amount and You would pay 40 percent of the Allowed Amount, as follows:

  - Amount participating Provider must "write-off" (that is, cannot charge You for): $1,000
  - Amount the Plan pays (60% of the $4,000 Allowed Amount): $2,400
  - **Amount You pay** (40% of the $4,000 Allowed Amount): $**1,600**
  - Total: $5,000

- Category 3: the Plan would pay 60 percent of the Allowed Amount. Because the nonparticipating Provider does not accept the Allowed Amount, You would pay 40 percent of the Allowed Amount, plus

the $1,000 difference between the nonparticipating 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.

Prescription Medication Claims Submitted Electronically

You must present Your Plan identification card at a Pharmacy for the claim to be submitted electronically. You must pay any required Deductible and/or Coinsurance at the time of purchase. If a Nonparticipating Pharmacy provides Your Prescription Medication and submits the claim electronically, the Nonparticipating Pharmacy will be paid directly. Nonparticipating Pharmacies, however, may charge amounts in excess of Covered Prescription Medication Expenses. If that happens, You will be responsible for the excess amounts, as well as any Deductible and/or Coinsurance shown electronically to the Nonparticipating Pharmacy at the time of purchase.

Prescription Medication Claims Not Submitted Electronically

When a claim is not submitted electronically, You must pay for the Prescription Medication in full at the time of purchase. For reimbursement, simply complete a Prescription Medication claim form and mail the form and receipt to the Claims Administrator. You will be reimbursed based on the Covered Prescription Medication Expense, less the applicable Deductible and/or Coinsurance that would have been required had the medication been purchased from and submitted electronically by a Participating Pharmacy. Payment will be sent directly to You.

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

Prescription Medication Mail-Order

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

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

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

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 Programs.” Whenever You obtain health care services outside of the Claims Administrator’s service area the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between the Claims Administrator and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the Claims Administrator's service area You will obtain care from health care Providers that have a contractual agreement (i.e., are “participating Providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, You may obtain care from nonparticipating Providers. The Claims Administrator’s payment practices in both instances are described below.

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 fulfilling contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

Whenever You access 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 for the types of transaction modifications noted above. However, such adjustments will not affect the price the Claims Administrator uses for Your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to Your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, the Claims Administrator would then calculate Your liability for any Covered Services according to applicable law.

Negotiated National Account Arrangements

As an alternative to the BlueCard Program, Your claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount You pay for Covered Services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price above) made available to the Claims Administrator by the Host Blue.

Nonparticipating Providers Outside the Claims Administrator's Service Area

- Member Liability Calculation. When Covered Services are provided outside of the Claims Administrator's service area by nonparticipating Providers, the amount You pay for such services will generally be based on either the Host Blue's nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.
- Exceptions. In certain situations, the Claims Administrator may use other payment bases, 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, as permitted under Inter-Plan Programs Policies, to determine the amount the Claims Administrator will pay for services rendered by nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

BLUECARD WORLDWIDE®

BlueCard Worldwide coverage is also accessible to You. With BlueCard Worldwide, You have access to inpatient and outpatient Hospital care and Physician services when You're traveling or living outside the United States or any other areas covered by the domestic BlueCard Program, as well as medical assistance and claims support services.

When You need health care outside of the United States or its territories, follow these simple steps:

- Always carry Your current Plan identification card.
- If You need emergency medical care outside the United States, go to the nearest Hospital.
- If You are admitted, call the BlueCard Worldwide Service Center at 1 (800) 810-BLUE (2583) or call collect at 1 (804) 673-1177.
- For non-emergency medical care, call the BlueCard Worldwide Service Center. The Service Center will facilitate hospitalization if necessary at a BlueCard Worldwide Hospital or make an appointment with a Physician. BlueCard Worldwide Service Center staff are available to assist You 24 hours a day, 7 days a week.
- You will only be responsible for out-of-pocket expenses such as any applicable Deductible, Copayment, Coinsurance and non-covered services for Your inpatient care. For outpatient, Hospital care or Physician services, You will be responsible for paying the Hospital or Physician at the time of service and then must complete an international claim form and send it to the BlueCard Worldwide Service Center for reimbursement of Covered Services.

You can obtain an international claim form and find additional information about the BlueCard Worldwide program at **www.bcbs.com**.

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 calling the Claims Administrator's Customer Service department or visiting their Web site **regence.com**.

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, and 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.

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

Advancement of Benefits

If You have a potential right of recovery for Illnesses or Injuries from a third-party who may have legal responsibility or from any other source, benefits may be advanced pending the resolution of a claim to the right of recovery if all the following conditions apply:

- By accepting or claiming benefits, You agree that the Plan is entitled to reimbursement of the full amount of benefits paid out of any settlement or recovery from any source. This includes any judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which benefits under the Plan have been provided.
- In addition to the Plan's right of reimbursement, the Claims Administrator may choose instead to achieve the Plan's rights through subrogation. The Claims Administrator is authorized, but not obligated, to recover any benefits paid under the Plan directly from any party liable to You, upon mailing of a written notice to the potential payer, to You or to Your representative.
- The Plan's rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration award or judgment or other characterization of the recovery by the Claimant and/or any third-party or the recovery source. The Plan is entitled to reimbursement from the first dollars received from any recovery. This applies regardless of whether:
    - the third-party or third-party's insurer admits liability;
    - the health care expenses are itemized or expressly excluded in the recovery; or
    - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered under the Plan.
- Reimbursement or subrogation under the Plan will not be reduced due to Your not being made whole.
- You may be required to sign and deliver all legal papers and take any other actions requested to secure the Plan's rights (including an assignment of rights to pursue Your claim if You fail to pursue Your claim of recovery from the third-party or other source). If You are asked to sign a trust agreement or other document to reimburse the Plan from the proceeds of any recovery, You will be required to do so as a condition to advancement of any benefits.
- You must agree that nothing will be done to prejudice the Plan's rights and that You will cooperate fully with the Claims Administrator, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify the Claims Administrator of any facts that may impact the right to reimbursement or subrogation, including, but not necessarily limited to, the following:
    - the filing of a lawsuit;
    - the making of a claim against any third-party;
    - scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
    - intent of a third-party to make payment of any kind to Your benefit or on Your behalf and that in any manner relates to the Injury or Illness that gives rise to the Plan's right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).

- You and/or Your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to Your benefit or on Your behalf that in any manner relates to the Injury or Illness giving rise to the Plan's right of reimbursement or subrogation, until the Plan's right is satisfied or released.
- In the event You and/or Your agent or attorney fails to comply with any of these conditions, any such benefits advanced for any Illness or Injury may be recovered through legal action.
- Any benefits provided or advanced under the Plan are provided solely to assist You. By paying such benefits, neither the Plan nor the Claims Administrator is acting as a volunteer and is not waiving any right to reimbursement or subrogation.

Motor Vehicle Coverage

If You are involved in a motor vehicle accident, You may have rights both under motor vehicle insurance coverage and against a third-party who may be responsible for the accident. In that case, this right of reimbursement and subrogation provision still applies.

Workers' Compensation

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

- You must notify the Claims Administrator in writing within five days of any of the following:
  - filing a claim;
  - having the claim accepted or rejected;
  - appealing any decision;
  - settling or otherwise resolving the claim; or
  - any other change in status of Your claim.
- 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.

Fees and Expenses

Neither the Plan nor the Claims Administrator is liable for any expenses or fees incurred by You in connection with obtaining a recovery. However, You may request that a proportional share of attorney's fees and costs be paid at the time of any settlement or recovery to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid under the Plan. The Claims Administrator has discretion whether to grant such requests.

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.

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.

Coordination of Benefits Under an HSA Plan

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

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 child of Your parents who are separated or divorced and/or those parents' spouses, a plan that covers You as the child of Your parent whose Birthday occurs earlier in the Year will be primary over a plan that covers You as the child of Your parent whose Birthday occurs later in the Year. If both parents covering You as a child 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 child of Your parent

whose Birthday occurs earlier in the Year will be primary over a plan that covers You as the child 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 child 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 Child 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 and Coinsurance, 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 at 1 (888) 370-6159 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 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. When an appeal request is received, the Claims Administrator will acknowledge it in writing.

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 Post-Service Investigational issue, a written notice of the decision will be sent within 20 working 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 14 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 Claims Administrator 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: Appeals and Correspondence, 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 the Claims Administrator at 1 (888) 370-6159. The Claims Administrator will acknowledge receipt of a Grievance or an appeal within seven days of receiving it.

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 the Claims Administrator has 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 Department of Consumer and Business Services 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; or
- delivered in an appropriate health care setting at the appropriate level of care.

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: Appeals and Correspondence, 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 the Claims Administrator at 1 (888) 370-6164. The Claims Administrator must notify the Department of Consumer and Business Services 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 Director of the Department of Consumer and Business Services 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 at 1 (888) 370-6159. You can also contact the Oregon Insurance Division by calling (503) 947-7984 or the toll free message line at 1 (888) 877-4894; by writing to the Oregon Insurance Division, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: **http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx**; or by E-mail at: **cp.ins@state.or.us**.

Exercise of Your right to IRO review is at Your option. Alternatively, You may use another forum as the final level of appeal, including, but not limited to, civil action under Section 502(a) of ERISA, where applicable, or 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 timeframe 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: Appeals and Correspondence, 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 the Claims Administrator at 1 (888) 370-6159.

The internal expedited appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the appeal decision. Internal expedited appeals are reviewed by a panel, the members of which were not involved in, or subordinate to anyone involved in, any initial denial determination. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the expedited appeals timeframe) to provide written materials, including written testimony on Your behalf. Verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but 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 timeframe 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: Appeals and Correspondence, 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 the Claims Administrator at 1 (888) 370-6159. The Claims Administrator must notify the Department of Consumer and Business Services 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 Director of the Department of Consumer and Business Services 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, including, but not limited to, civil action under Section 502(a) of ERISA, where applicable.

INFORMATION

If You have any questions about the appeal process outlined here, You may contact the Claims Administrator's Customer Service department at 1 (888) 370-6159 or You can write to the Claims Administrator's Customer Service department at the following address: Appeals and Correspondence, 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 Insurance Division. Assistance is available by calling: (503) 947-7984 or the toll free message line at 1 (888) 877-4894; by writing to the Oregon Insurance Division, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: **http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx**; or by E-mail at: **cp.ins@state.or.us**.

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:

- 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 Claims Administrator.

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 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

The eligibility guidelines and enrollment requirements for the CIS Benefits Program are set forth in the Benefits Rules and the Benefits Enrollment & Eligibility Guide. Employees can access these documents on the CIS Benefits website at **www.cisbenefits.org**.

ADMINISTRATIVE AND ELIGIBILITY APPEALS

Administrative appeals relate to decisions made by Your employer. Eligibility appeals relate to employees missing enrollment timelines. Employees may appeal an administrative or eligibility decision by appealing in writing to the CIS Benefits Director within 45 days of the date of denial. The Benefits Director will make a determination and send a written response and explanation within 15 days. If the employee is dissatisfied with the decision, he/she may make a written request for reconsideration to the Executive Director within 45 days of the Benefits Director's denial. The Executive Director may, at his or her discretion, consult with the Board of Trustees and will respond with a notification of status of the request for consideration within 15 days. A final determination response will be sent in writing not later than 30 days from the date the request is received by the Executive Director. The Executive Director's determination is final, and there are no further appeal rights.

When Coverage Ends

The situations that will cause You and/or Your Beneficiaries to lose coverage are described in the CIS Benefits Rules and the Benefits Enrollment & Eligibility Guide. Employees can access these documents on the CIS Benefits website at **www.cisbenefits.org**.

OTHER CAUSES OF TERMINATION

Eligibility for Medicare

Enrolled retirees or enrolled dependents of retirees who become eligible for Medicare due to age or disability, are not eligible to continue health coverage through CIS. Coverage will end on the last day of the month prior to becoming eligible for Medicare. Even if You don't notify CIS of Your eligibility for Medicare, coverage will be terminated retroactive to the date You became eligible for Medicare when CIS is notified by any other party. If You have any questions, please contact the CIS Retiree Coordinator at 503-763-3823.

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 You and Your Beneficiaries.

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 Plan Sponsor), any action allowed by law or contract may be taken, including denial of benefits, termination of coverage and/or pursuit of criminal charges and 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.

CERTIFICATES OF CREDITABLE COVERAGE

Requests for and inquiries about required certificates relating to period(s) of creditable coverage under the Plan should be directed to the Claims Administrator at Regence BlueCross BlueShield of Oregon, P.O. Box 2998, Tacoma, WA 98401-2998, or call Customer Service at 1 (888) 370-6159.

COBRA Continuation of Coverage

The eligibility guidelines and enrollment requirements for the CIS Benefits Program are set forth in the Benefits Rules and the Benefits Enrollment & Eligibility Guide. Employees can access these documents on the CIS Benefits website at **www.cisbenefits.org**.

Other Continuation Options

This section describes situations when coverage may also be extended for You and/or Your Beneficiaries beyond the date of termination. For additional information about continuation options refer to the CIS Benefits website at **www.cisbenefits.org**.

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 within its established timeframe in order to maintain coverage during this period. This six months of continued coverage is in lieu of and not in addition to any continuation of coverage provisions of the Plan.

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 request 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 or to the Plan Sponsor 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 or to the Plan Sponsor 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 Administrator or 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 BlueCross BlueShield of Oregon, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association), permitting 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 or the Claimants for any of Regence's obligations to the Plan Sponsor, its Member Employers 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 request 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.

CLAIMS ADMINISTRATOR IS NOT RESPONSIBLE FOR HEALTH SAVINGS ACCOUNT FINANCIAL OR TAX ARRANGEMENTS

While this high deductible health plan was designed for use in conjunction with a health savings account (HSA), the Claims Administrator does not assume any liability associated with Your contribution to an HSA during any period that this high deductible health plan does not qualify for use with an HSA. An HSA is a tax-exempt account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions to such an account are tax deductible but in order to qualify for and make contributions to an HSA, You must be enrolled in a qualified high deductible health plan (and generally not be enrolled in other coverage). You are solely responsible to ensure that this plan qualifies, and continues to qualify, for use with any HSA that You choose to establish and maintain. Please note that the tax references contained in this Booklet relate to federal income tax only. The tax treatment of HSA contributions and distributions under Your state's income tax laws may differ from the federal tax treatment, and differs from state to state.

The Claims Administrator does not provide tax advice and assume no responsibility for reimbursement from the custodial financial institution under any HSA with which this high deductible health plan is used. Consult with Your financial or tax advisor for tax advice or for more information about Your eligibility for an HSA.

WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered under 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 preferred and participating Providers (see definitions of "Category 1" and "Category 2" below), the amount that they have contractually agreed to accept as payment in full for a service or supply.
- For nonparticipating Providers (see definition of "Category 3" 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 nonparticipating Providers (see definition of "Category 3" below) 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.

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.

Agreement means the administrative services contract between the Plan Sponsor and 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 request and who is enrolled under the Plan.

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

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

Category 1 means the benefit reimbursement level for services that are received from a Provider who has an effective participating contract with the Claims Administrator or one of the Claims Administrator's Affiliates which designates him, her or it as a preferred Provider. It also includes Providers outside the area that the Claims Administrator, or one of the Claims Administrator's Affiliates serves, but who have contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program. The Provider must be designated as a Provider in the “Preferred Provider Organization (“PPO”) Network” to provide services and supplies to Claimants in accordance with the provisions of this coverage. Category 1 reimbursement is generally at the highest payment level and You will not be charged for balances beyond any Deductible, Copayments and/or Coinsurance for Covered Services.

Category 2 means the benefit reimbursement level for services that are received from a Provider who has an effective participating contract with the Claims Administrator or one of the Claims Administrator's Affiliates which designates him, her or it as a participating Provider. It also includes Providers outside the area that the Claims Administrator, or one of the Claims Administrator's Affiliates serves, but who have contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program. The Provider must be designated as a Provider in the "Participating Network" to provide services and supplies to Claimants in accordance with the provisions of this coverage. Category 2 reimbursement is generally a lower payment level than Category 1, but You will not be charged for balances beyond any Deductible and/or Coinsurance for Covered Services.

Category 3 means the benefit reimbursement level for services that are received from a Provider who does not have an effective participating contract with the Claims Administrator or one of the Claims Administrator's Affiliates to provide services and supplies to Claimants. Category 3 reimbursement is generally the lowest payment level of all categories, and You may be billed for balances beyond any Deductible, Copayments and/or Coinsurance for Covered Services.

Center of Excellence means a contracting transplant facility which has contracted or arranged to provide facility transplant services for the Claimant or Beneficiary under this Plan. The Claims Administrator preauthorizes transplants, in part, based on where the transplant will be performed and reserves the right to contract with specific facilities to perform facility transplant services and to base payment on such third-party contracts.

Claims Administrator means Regence BlueCross BlueShield of Oregon, the claims processor for the Plan.

Claimant means a Participant or a Beneficiary.

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; or
- serious dysfunction of any bodily organ or part.

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.

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.

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 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.
- 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.

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.

Participant means an employee of the Plan Sponsor who is eligible under the terms described in this Booklet, has completed an enrollment request 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.

Plan Administrator means CIS.

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.

For more information contact the Claims Administrator at
1 (888) 370-6159 or 100 SW Market Street, Portland, OR 97201

regence.com