VIGILANT GROUP BENEFITS TRUST

Coverage provided through
Regence BlueCross BlueShield of Oregon

Medical Plan ActiveCare

$500 DEDUCTIBLE

SUMMARY PLAN DESCRIPTION

January 1, 2016

VIGILANT
Group Benefits Trust

Regence

Regence BlueCross BlueShield of Oregon

Introduction

Regence BlueCross BlueShield of Oregon

Street Address:
100 SW Market Street
Portland, OR 97201

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

Customer Service/Correspondence Address:
P.O. Box 1271, M/S C7A
Portland, OR 97207-1271

Appeals Address:
P.O. Box 4208
Portland, OR 97208-4208

This Booklet provides the evidence and a description of the terms and benefits of coverage. The agreement between the Group and Regence BlueCross BlueShield of Oregon (called the "Contract") contains all the terms of coverage. Your plan administrator has a copy.

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 Us and makes it void.

As You read this Booklet, please keep in mind that references to "You" and "Your" refer to both the Enrolled Employee and Enrolled Dependents (except that in the eligibility and continuation of coverage sections, the terms "You" and "Your" mean the Enrolled Employee only). The terms "We," "Us" and "Our" refer to Regence BlueCross BlueShield of Oregon and the term "Group" means the trust through which Your employer has made arrangements for its employees to participate under this coverage. 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.

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 Members 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 Our 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) 367-2116
(TTY: 711)

And visit Our Web site at: **www.Regence.com**

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

Using Your Regence ActiveCare[SM] Booklet

YOUR PARTNER IN HEALTH CARE

Regence BlueCross BlueShield of Oregon is pleased that Your Group has chosen Us as Your partner in health care. It's important to have continued protection against unexpected health care costs. Thanks to the purchase of Regence ActiveCare, You have coverage that's comprehensive, affordable and provided by a partner You can trust in times when it matters most.

We have contracted with respected Providers to provide Our Members with the best health care possible. Regence ActiveCare provides You with great benefits that are quickly accessible and easy to understand, and valuable tools to assist You in navigating the health care system.

Selection of the Regence ActiveCare requires You, the Enrolled Employee, to choose a Provider network, for Yourself and Your Enrolled Dependents. Your Member card will identify the Provider network You chose.

You, the Enrolled Employee, are free to change the Provider network one time per Calendar Year. Beyond this, You may not change the Provider network that You choose until the next annual enrollment period. One exception is if You have a qualifying event according to the Special Enrollment provision of this Booklet, You may change Your Provider network outside of the annual enrollment period.

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

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

Note that, the Providers contracted under the Provider network You, the Enrolled Employee, selected at the time of enrollment under this plan, or later as explained in the exceptions above, will be considered the only In-Network Providers for purposes of payment of benefits in this Booklet.

- **In-Network.** You choose to see an In-Network Provider (Your chosen Provider network) and save the most in Your out-of-pocket expenses. Choosing this provider option means You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Out-of-Network.** You choose to see an Out-of-Network Provider that does not have a participating contract with Us, or is not in Your chosen Provider network and Your out-of-pocket expenses will generally be higher than seeing an In-Network Provider. Also, choosing this provider option means You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. This is sometimes referred to as balance billing.

For each benefit in this Booklet, We indicate the payment amount for each provider option You might use. See the Definitions Section of this Booklet for a complete description of In-Network and Out-of-Network. You can also go to **www.Regence.com** for further Provider network information.

ADDITIONAL MEMBERSHIP ADVANTAGES

When Your Group purchased Regence ActiveCare, You were provided with more than just great coverage. You also acquired Regence membership, which offers additional valuable services. The advantages of Regence membership include access 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 **www.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 www.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 Member card handy to log on. Use the secure Member Web site to:
  - view recent claims, benefits and coverage;
  - find a contracting Provider;
  - participate in online wellness programs and use tools to estimate upcoming healthcare costs;

- 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 Regence ActiveCare health care coverage and the rewards of Regence membership throughout this Booklet, some of which are highlighted here. We realize that You may still have some questions about Your Regence ActiveCare health care coverage, so please contact Us if You do.

- **Learn more and receive answers about Your coverage or any other plan that We offer.** Just call 1 (888) 367-2116 to talk with one of Our Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. - 6 p.m. You may also visit Our Web site at: **www.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.

TO PARTICIPANTS UNDER GROUP HEALTH PLANS

Your employer has elected to participate in the Group Health Plans made available through the Vigilant Group Benefits Trust to Member Employers engaged in certain approved industries in the western states of Washington, Oregon and Idaho. There is a board of Trustees who provides oversight of the benefits offered by the Trust.

This booklet is designed to provide You with a summary description of the Plan, including eligibility and benefit provisions. If there is any inconsistency between this description and the official Plan documents, the terms of the official Plan documents will govern.

Participants may receive from the Plan administrator upon written request, information about whether a particular Member Employer participates under the Plan, and if so, the Member Employer's address. The official Plan documents are available for review during regular business hours at the address shown below.

BOARD OF TRUSTEES

Rodger M. Glos, Trustee Chair

Jim Everett, Vanport International

Tom Jackman, IFA Nurseries, Inc.

This booklet contains a general description of the benefits and is not a contract.

Vigilant Group Benefits Trust
6825 SW Sandburg Street
Tigard, OR 97223
Phone: (503) 620-1710
www.vigilantcounsel.org

Table of Contents

Understanding Your Benefits

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

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

MAXIMUM BENEFITS

Some benefits for Covered Services may have a specific Maximum Benefit. For those Covered Services, We 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

Members can meet the Out-of-Pocket Maximum by payments of Deductibles, Copayments and Coinsurance for all categories as specifically indicated in the Medical Benefits and Prescription Medication Benefits Sections. There are two Out-of-Pocket Maximum amounts: one for In-Network benefits and another for Out-of-Network benefits. The Medical Benefits Section describes this more fully, but in this Booklet, the term is referred to simply as "the Out-of-Pocket Maximum." A Member's Deductible (if applicable), Copayment, and/or Coinsurance payment for emergency room services, Prescription Medication Benefits and benefits listed in the Medical Benefits Section that show under the Provider "All" will apply toward the In-Network Out-of-Pocket Maximum amount. 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 Booklet's Out-of-Pocket Maximum.

Once You reach the Out-of-Pocket Maximum, benefits subject to the Out-of-Pocket Maximum will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year. The Coinsurance for some benefits of this Booklet 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.

There are two Family Out-of-Pocket Maximum amounts: one for In-Network benefits and another for Out-of-Network benefits. The Family Out-of-Pocket Maximum for a Calendar Year is satisfied when two or more Family Members' Deductibles, Copayments and Coinsurance for Covered Services for that Calendar Year total and meet the Family's Out-of-Pocket Maximum amount. One Member may not contribute more than the individual Out-of-Pocket Maximum amount.

COPAYMENTS

A Copayment means a fixed dollar amount that You must pay directly to a provider of services or supplies, including medications, at the time the service or supply is furnished. The Copayment will be the lesser of the fixed dollar amount or the Allowed Amount for the service or medication. Refer to the Medical Benefits Section to understand what Copayments You are responsible for.

Copayments applicable to Prescription Medications are located in the Prescription Medication Benefits Section of this Booklet.

PERCENTAGE PAID UNDER THE CONTRACT (COINSURANCE)

Once You have satisfied any applicable Deductible and any applicable Copayment, We pay a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When Our 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 We pay varies, depending on the kind of service or supply You received and who rendered it.

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

Coinsurance amounts applicable to Prescription Medications are located in the Prescription Medication Benefits Section of this Booklet.

DEDUCTIBLES

We will begin to pay benefits for Covered Services in any Calendar Year only after a Member satisfies the Calendar Year Deductible. There are two Deductible amounts: one for In-Network benefits and another for Out-of-Network benefits. The Medical Benefits Section describes this more fully, but in this Booklet, the term is referred to simply as "the Deductible." A Member satisfies the Deductible by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible. A Member's Deductible amount paid toward Covered Services listed in the Medical Benefits Section for emergency room services and Covered Services that show under the Provider "All" will apply toward the In-Network Deductible amount.

There are two Family Calendar Year Deductible amounts: one for In-Network benefits and another for Out-of-Network benefits. The Family Calendar Year Deductible is satisfied when two or more covered Family Members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Deductible amount. One Member may not contribute more than the individual Deductible amount.

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

HOW CALENDAR YEAR BENEFITS RENEW

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

Medical Benefits

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

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

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

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

In-Network
Per Member: $2,500
Per Family: $5,000

Out-of-Network
Per Member: $5,000
Per Family: $10,000

COPAYMENTS AND COINSURANCE

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

CALENDAR YEAR DEDUCTIBLES

In-Network
Per Member: $500
Per Family: $1,000

Out-of-Network
Per Member: $1,000
Per Family: $2,000

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

- Upfront Benefits for Outpatient Radiology and Laboratory Services;
- In-Network Preventive Care and Immunizations;
- In-Network Office Visits;
- In-Network Diabetes Management Associated with Pregnancy;
- Complementary Care;
- In-Network outpatient Mental Health or Substance Use Disorder Services; and
- In-Network Telehealth.

UPFRONT BENEFITS

We cover the following Upfront Benefits as described in the tables that follow:

- outpatient radiology and laboratory services up to $400 per Member per Calendar Year.

You have multiple ways of tracking Your benefits, including access to **www.Regence.com**, and by calling Our Customer Service department.

Upfront Benefits for Outpatient Laboratory and Radiology Services

Provider: In-Network	Provider: Out-of-Network
Payment: We pay 100% of the Allowed Amount.	**Payment:** We pay 100% of the Allowed Amount and You pay balance of billed charges.
Limit: $400 per Member per Calendar Year. Once this limit is reached, We cover laboratory and radiology services, including mammography, under the Professional Services benefit in this Medical Benefits Section.	

BENEFITS COVERED AFTER DEDUCTIBLE

For Your ease in finding the information regarding benefits most important to You, We have listed these benefits alphabetically, with the exception of the Preventive Care, including immunizations, Office Visits and Other Professional Services benefits.

PREVENTIVE CARE AND IMMUNIZATIONS

Benefits will be covered under this Preventive Care and Immunizations benefit, not any other provision in this Booklet, if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA), or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC). In the event any of these bodies adopts a new or revised recommendation, this plan has up to one year before coverage of the related services must be available and effective under this benefit. For a list of services covered under this benefit, please visit **www.Regence.com** or contact Customer Service at 1 (888) 367-2116. You can also visit the HRSA Web site at: **http://www.hrsa.gov/womensguidelines/** for women's preventive services guidelines, and the USPSTF Web site at: **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations** for a list of A and B preventive services. NOTE: Covered Services that do not meet these criteria will be covered the same as any other Illness or Injury.

Provider: In-Network	Provider: Out-of-Network
Payment: We pay 100% of the Allowed Amount.	**Payment:** After Deductible,* We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
*Out-of-Network outpatient laboratory and radiology services may otherwise be covered under the Upfront Benefits For Outpatient Laboratory and Radiology Services benefit. Once any applicable Upfront limit is reached, outpatient laboratory and radiology services will be covered as specified here.	

We cover preventive care services provided by a professional Provider or facility. Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care, routine immunizations and routine health screenings. Also included is Provider counseling for tobacco use cessation and Generic Medications prescribed for tobacco use cessation. 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).

Additionally, We cover 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 Our Web site at **www.Regence.com** for Our preferred contraceptive products covered under the Prescription Medication Benefits Section.

OFFICE VISITS – ILLNESS OR INJURY

	Provider: In-Network	Provider: Out-of-Network
Primary Physician or Practitioner	**Payment:** After $25 Copayment per visit, We pay 100% of the Allowed Amount.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Specialist	**Payment:** After $45 Copayment per visit, We pay 100% of the Allowed Amount.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

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

OTHER PROFESSIONAL SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover services and supplies provided by a professional Provider subject to any Deductible and Coinsurance and any specified limits as explained in the following paragraphs:

Medical Services

We cover 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 Members 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.

Diabetes Management Associated with Pregnancy

Management of a female Member'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 Copayments, Coinsurance, or Deductible when provided by an In-Network Provider.

Professional Inpatient

We cover professional inpatient visits for Illness or Injury. If pre-arranged procedures are performed by an In-Network Provider and You are admitted to an In-Network Hospital, We will cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by an Out-of-Network Provider at the In-Network benefit level. However, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact Customer Service for further information and guidance.

Radiology and Laboratory
We cover services for treatment of Illness or Injury after any limit for Upfront laboratory and radiology is exhausted. This includes, but is not limited to, Medically Necessary mammography services not covered under the Preventive Care and Immunizations benefit.

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

Surgical Services
We cover surgical services and supplies including cochlear implants and the services of a surgeon, an assistant surgeon and an anesthesiologist.

Therapeutic Injections
We cover 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 Medication Benefits Section in this Booklet. Teaching doses (by which a Provider educates the Member to self-inject) are covered for this list of Self-Administrable Injectable Medications.

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

AMBULANCE SERVICES

Provider: All
Payment: After Deductible, We pay 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.

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

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

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

- Approved or funded by one or more of:
    - The National Institutes of Health (NIH), the CDC, The Agency for Health Care Research and Quality, The Centers for Medicare & Medicaid, or a cooperative group or center of any of those entities or of the Department of Defense (DOD) or the Department of Veteran's Affairs (VA);
    - A qualified non-governmental research entity identified in guidelines issued by the NIH for center approval grants; or

- The VA, DOD, or Department of Energy, provided it is reviewed and approved through a peer review system that the Department of Health and Human Services has determined both is comparable to that of the NIH and assures unbiased review of the highest scientific standards by qualified individuals without an interest in the outcome of the review; or

- Conducted under an investigational new drug application reviewed by the Food and Drug Administration or that is a drug trial exempt from having an investigational new drug application.

Routine Patient Costs means items and services that typically are Covered Services for a Member 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 Member;
- 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.

BLOOD BANK

Provider: All
Payment: After Deductible, We pay 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.

We cover the services and supplies of a blood bank, excluding storage costs.

CHILD ABUSE MEDICAL ASSESSMENT

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

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Child Abuse Medical Assessment benefit:

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

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

CLOTTING FACTOR PRODUCTS – OUTPATIENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover plasma-derived and recombinant clotting factor products used in outpatient replacement therapy for hemophilia, Von Willebrand disease, and similar clotting disorders when received from a home infusion provider. This benefit does not cover these products when provided by a retail Pharmacy.

COMPLEMENTARY CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After $25 Copayment per visit, We pay 100% of the Allowed Amount.	**Payment:** After $25 Copayment per visit, We pay 100% of the Allowed Amount and You pay balance of billed charges. Your Copayment does not apply toward the Out-of-Pocket Maximum.
Limit: 24 visits for all complementary care combined per Member per Calendar Year	

We cover acupuncture and spinal manipulations under this benefit when performed by any Provider.

DENTAL HOSPITALIZATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover 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

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

We cover Medically Necessary detoxification.

DIABETES SUPPLIES AND EQUIPMENT

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

DIABETIC EDUCATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover services and supplies for diabetic self-management training and education, including nutritional therapy if provided by Providers with expertise in diabetes.

DISCRETIONARY SURGERIES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After $500 Copayment per surgery and Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover services and supplies for discretionary surgery, including, but not limited to the following services: breast reductions, eyelid surgery, hammer toe and bunion surgeries, joint replacement for hips or knees, lumbar surgery for low back pain, nasal surgery (rhinoplasty, septoplasty and turbinates), Transurethral Resection of the Prostate (TURP) and varicose vein surgery. This benefit does not apply to breast reductions following a Medically Necessary mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice in this Booklet.

DURABLE MEDICAL EQUIPMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% 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 Member'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)

Provider: In-Network	Provider: Out-of-Network
Payment: After $250 Copayment per visit and Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum. This Copayment applies to the facility charge, whether or not You have met the Deductible. However, this Copayment is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	**Payment:** After $250 Copayment per visit and In-Network Deductible, We pay 80% of the Allowed Amount and You pay balance of billed charges. Your 20% payment of the Allowed Amount will be applied toward the In-Network Out-of-Pocket Maximum. This Copayment applies to the facility charge, whether or not You have met the Deductible. However, this Copayment is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.

We cover 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 Member from a facility; and 2) in the case of a covered female Member, whom is pregnant, to perform the delivery (including the placenta). Emergency room services do not need to be preauthorized. If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. However, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact Customer Service for further information and guidance. See the Hospital Care benefit in this Medical Benefits Section for coverage of inpatient Hospital admissions.

FAMILY PLANNING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover 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

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

NOTE: Genetic testing services may otherwise be covered under the Upfront Benefits For Outpatient Laboratory and Radiology Services benefit. Once any applicable Upfront limit is reached, genetic testing services will be covered as specified here.

HEARING AIDS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: two devices per Member every four Calendar Years	

We cover hearing aids only for Members 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. Hearing aids that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services.

HOME HEALTH CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 130 visits per Member per Calendar Year	

We cover 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

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 14 inpatient or outpatient respite care days per Member Lifetime	

We cover hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and any family members who are caring for a patient, who is experiencing a life threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and his or her family during the final stages of Illness. Respite care: We cover respite care to provide continuous care of the Member and allow temporary relief to family members from the duties of caring for the Member. Respite days that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services. Durable Medical Equipment associated with hospice care is covered under the Durable Medical Equipment benefit in this Booklet.

HOSPITAL CARE – INPATIENT, OUTPATIENT AND AMBULATORY SURGICAL CENTER

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover 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 in this Booklet change while You or an Enrolled Dependent is in the Hospital (or any other facility as an inpatient), coverage will be provided based upon the benefit in effect when the stay began.

NOTE: Ambulatory Surgical Center services may otherwise be covered under the Upfront Benefits. Once any applicable Upfront limit is reached, Ambulatory Surgical Center services will be covered as specified here.

MATERNITY CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy, and related conditions for all female Members. There is no limit for the mother's length of inpatient stay. Where the mother is attended by a Provider, the attending Provider will determine an appropriate discharge time, in consultation with the mother. See the Newborn Care benefit in this Medical Benefits Section to see how the care of Your newborn is covered. Coverage also includes termination of pregnancy for all female Members. When provided by an In-Network Provider, any Copayments, Coinsurance, and Deductible do not apply to Medically Necessary Covered Services for management of a female Member'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)

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover 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

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After $25 Copayment* per visit, We pay 100% of the Allowed Amount. *Copayment applies to therapy visit only.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover 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 Us to be Medically Necessary). These services include Habilitative services for Mental Health Conditions or Substance Use Disorders.

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

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

NEURODEVELOPMENTAL THERAPY

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Inpatient limit: unlimited **Outpatient limit:** 25 visits per Member per Calendar Year for all therapies combined	

We cover physical therapy, occupational therapy or speech therapy services for neurological conditions that are not a Mental Health Condition or Substance Use Disorder (e.g. failure to thrive in newborn, lack of physiological development in childhood) to restore or improve function for a Member age 17 and under. Covered Services include maintenance services if significant deterioration of a Member's condition would result without the service. (Services for Mental Health Conditions or Substance Use Disorders are covered under the Mental Health or Substance Use Disorder Services benefit and are not subject to age or visit limits.) Outpatient neurodevelopmental therapy visits that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services.

NEWBORN CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover 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

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: three visits per Member 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

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover 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. We may elect to provide benefits for a less costly alternative item. We do not cover off-the-shelf shoe inserts.

OUTPATIENT KIDNEY DIALYSIS

Initial Outpatient Treatment Period

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

When Your Physician prescribes outpatient kidney dialysis, regardless of Your diagnosis, We cover hemodialysis, peritoneal dialysis and hemofiltration services during an initial treatment period of 120 days, measured from the first day You receive dialysis treatment. This initial treatment period benefit is available once for each course of continuous or related dialysis care, even if that course of treatment spans two or more Calendar Years.

Supplemental Outpatient Treatment Period (Following Initial Outpatient Treatment Period)

Provider: In-Network	Provider: Out-of-Network
Payment: We pay 125% of the Medicare allowed amount at the time of service, not subject to Deductible or Coinsurance.	**Payment:** We pay 125% of the Medicare allowed amount at the time of service, not subject to Deductible or Coinsurance. If You are not enrolled in Medicare Part B: **Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

When Your Physician prescribes outpatient kidney dialysis, regardless of Your diagnosis, for a period that is longer than the initial treatment period, then beginning the first day following completion of the initial treatment period, We cover outpatient hemodialysis, peritoneal dialysis, and hemofiltration services. Your kidney diagnosis may make You Medicare-eligible and, if You are enrolled in additional Medicare Part B on any basis and receive dialysis from a Medicare-participating Provider, You may not be responsible for additional out-of-pocket expenses. For the purpose of this benefit, "Medicare allowed amount" is the amount that a Medicare-contracted provider agrees to accept as full payment for a covered service. This is also referred to as the provider accepting Medicare assignment.

PALLIATIVE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 30 visits per Member per Calendar Year	

We cover palliative care when a Provider has assessed that a Member is in need of palliative services. For the purpose of this benefit, "palliative care" means specialized services received from a Provider in a home setting for counseling and home health aide services for activities of daily living. Palliative care visits that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

PROSTHETIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover 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. We will cover repair or replacement of a prosthetic device due to normal use or growth of a child.

REHABILITATION SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Inpatient limit: 30 days per Member per Calendar Year **Outpatient limit:** 25 visits combined per Member per Calendar Year	

We cover 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. (Services for mental diagnosis will be covered under the Mental Health or Substance Use Disorder Services benefit and are not subject to a visit limit.) You will not be eligible for both the Neurodevelopmental Therapy benefit

and this benefit for the same services for the same condition. Rehabilitation services that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.

SKILLED NURSING FACILITY (SNF) CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 60 inpatient days per Member per Calendar Year	

We cover the inpatient services and supplies of a Skilled Nursing Facility for Illness, Injury or physical disability. Room and board is limited to the Skilled Nursing Facility's average semiprivate room rate, except where a private room is determined to be necessary. Skilled Nursing Facility days that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services. Ancillary services and supplies, such as physical therapy, 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: In-Network	Provider: Out-of-Network
Payment: After $25 Copayment per visit, We pay 100% of the Allowed Amount.	**Payment:** You pay 100% of billed charges. Your payment will not be applied toward the Deductible or the Out-of-Pocket Maximum.

We cover telehealth (audio and video communication) office visits for primary care services and equivalent behavioral health services between the patient and an In-Network Provider. We do not cover telehealth office visits when provided by a Provider who is not contracted with Us. Such office visits will be considered Out-of-Network. For additional information on Covered Services, please visit Our Web site at **www.Regence.com** or contact Customer Service at 1 (888) 367-2116. NOTE: Telehealth services are prohibited in some states and therefore You will not be covered for these services if You attempt to access them while in one of those states. Please contact Customer Service for further information and guidance. 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

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover 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

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

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

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

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

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

TOBACCO USE CESSATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

Tobacco use cessation expenses not covered under the Preventive Care and Immunizations benefit are covered under this Tobacco Use Cessation benefit, as explained. For the purpose of this benefit, a tobacco use cessation service means a service that follows the United States Public Health Service guidelines for tobacco use cessation, including education and medical treatment components designed to assist a person in ceasing the use of tobacco products. See the Preventive Care and Immunizations benefit and the Prescription Medication Benefits Section to see how tobacco use cessation Prescription Medications are covered.

TRANSPLANTS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After Deductible, We pay 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

We cover 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. Members can contact Us for a current list of covered transplants.

Donor Organ Benefits

We cover 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.

We will reduce the duration of the transplant waiting period 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 Contract 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 Member.

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 Contract; 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 Us 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. We 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.

Prescription Medication Benefits

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

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

PRESCRIPTION MEDICATION CALENDAR YEAR DEDUCTIBLES

Per Member: $250

You do not need to meet the Prescription Medication Deductible when You fill a prescription for a Generic Medication. You also do not need to meet the Prescription Medication Deductible when You fill a prescription for a Self-Administrable Cancer Chemotherapy Medication or for Medically Necessary Prescription Medications for management of a female Member's diabetes from the date she conceives through six weeks postpartum for each pregnancy.

Additionally, You do not need to meet any Prescription Medication 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 **www.Regence.com** or by calling Customer Service at 1 (888) 367-2116.

This Prescription Medication Deductible is calculated separately from any other Deductible in this Booklet. However, this Prescription Medication Deductible will be applied toward the In-Network Out-of-Pocket Maximum as further specified in the Understanding Your Benefits Section in this Booklet. Any costs in excess of the Covered Prescription Medication Expense that are charged by a Nonparticipating Pharmacy do not count toward the Prescription Medication Deductible. In addition, the difference between the price of a Brand-Name Medication and its generic equivalent do not count toward the Prescription Medication Deductible.

COPAYMENTS AND COINSURANCE

After You meet any applicable Deductible, You are responsible for paying the following Copayment and/or Coinsurance amounts (at the time of purchase, if the Pharmacy submits the claim electronically). (See below for information on claims that are not submitted electronically and for information on maximum quantities.) Copayments and/or Coinsurance do not apply to Medically Necessary Prescription Medications for management of a female Member's diabetes from the date she conceives through six weeks postpartum for each pregnancy.

For Prescription Medications from a Pharmacy

• $4 for each Generic and Brand-Name Prescription Medication on the Formulary specifically designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List.
• $7 for each Generic Medication
• 25% for each Brand-Name Medication on the Formulary
• 50% for each Brand-Name Medication not on the Formulary

For Prescription Medications from a Mail-Order Supplier

• $10 for each Generic and Brand-Name Prescription Medication on the Formulary specifically designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List.
• $17.50 for each Generic Medication
• 20% for each Brand-Name Medication on the Formulary
• 50% for each Brand-Name Medication not on the Formulary

For Prescription Medications from a Specialty Pharmacy

• $7 for each Generic Specialty Medication; $10 for each Self-Administrable Cancer Chemotherapy Medication*. The first fill is allowed at a retail Pharmacy. Additional fills must be provided at a Specialty Pharmacy.
• 25% for each Brand-Name Specialty Medication on the Formulary; $50 for each Self-Administrable Cancer Chemotherapy Medication*. The first fill is allowed at a retail Pharmacy. Additional fills must be provided at a Specialty Pharmacy.
• 50% for each Brand-Name Specialty Medication not on the Formulary; $100 for each Self-Administrable Cancer Chemotherapy Medication*. The first fill is allowed at a retail Pharmacy. Additional fills must be provided at a Specialty Pharmacy.
*****All covered Self-Administrable Cancer Chemotherapy Medications must be filled at a Specialty Pharmacy. The first fill is not allowed at a retail Pharmacy.

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, even if the prescribing Provider specifies that the Brand-Name Medication must be dispensed, 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). NOTE: See the Covered Prescription Medications provision below for an exception that applies to covered preventive medications, including women's contraceptives.

PRESCRIPTION MEDICATION CALENDAR YEAR OUT-OF-POCKET MAXIMUM

Not applicable

COVERED PRESCRIPTION MEDICATIONS

Benefits under this Prescription Medication Benefits Section are available for the following:

- diabetic supplies (including 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);
- Brand-Name Medications for tobacco use cessation when obtained with a Prescription Order;
- Prescription Medications;
- certain preventive medications (including, but not limited to, aspirin, fluoride, iron and Generic Medications for tobacco use cessation) 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, Copayment 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 **www.Regence.com** or contact Customer Service at 1 (888) 367-2116. Also, if Your Provider believes that Our 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.

GENERAL PRESCRIPTION MEDICATION BENEFITS INFORMATION (NETWORK, SUBMISSION OF CLAIMS AND MAIL-ORDER)

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

Your Member 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 Member of 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 Our Web site at **www.Regence.com** or by contacting Customer Service at 1 (888) 367-2116.

Claims Submitted Electronically

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

Claims Not Submitted Electronically

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 Us. We will reimburse You based on the Covered Prescription Medication Expense, less the applicable Deductible, Copayment and/or Coinsurance that would have been required had the medication been purchased from and submitted electronically by a Participating Pharmacy. We will send payment 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, Copayment and/or Coinsurance.

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 Medications 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 Our Web site at **www.Regence.com** or from Your Group (which also includes refill instructions):

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

PREAUTHORIZATION

Preauthorization may be required so that We can determine that a Prescription Medication is Medically Necessary before it is dispensed. We publish a list of those medications that currently require preauthorization. You can see the list on Our Web site at **www.Regence.com** or call Customer Service at 1 (888) 367-2116. In addition, We notify participating Providers, including Pharmacies, 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 We preauthorize them. If Your Prescription Medication requires preauthorization and You purchase it before We preauthorize 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 Medication Benefits Section, except for certain preventive medications as specified in the Covered Prescription Medications section:

Maximum 30-Day or Greater Supply Limit

- **Injectable Medications and 30-Day Supply.** The largest allowable quantity for Self-Administrable Injectable Medications purchased from a Pharmacy or Mail-Order Supplier, is a 30-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 30-Day Supply.** The largest allowable quantity for a Specialty Medication purchased from a Specialty Pharmacy, is a 30-day supply. The first fill is allowed at a 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 30-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 30-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 Copayment and/or Coinsurance is based on each 30-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 Copayment and/or Coinsurance is based on each 30-day supply within that multiple-month supply.

Maximum Quantity Limit
For certain Prescription Medications, We establish 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. We use 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 Member card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service at 1 (888) 367-2116. We do not cover any amount over the established maximum quantity, except if We determine 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
We 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 Our discretion on a case-by-case basis. You may request an exception by calling Customer Service at 1 (888) 367-2116.

If You receive maintenance medications for chronic conditions, You may qualify for Our 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) 367-2116.

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. We do not permit excluded Pharmacies 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 Medication Benefits Section:

Acne Medication
Prescription Medications for the treatment of acne in Members over age 39.

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).

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, We do 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 Our definition of Prescription Medications, shown below, unless included on Our 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, We do 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 Medication Benefits Section:

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 Us) 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 Our list of selected Prescription Medications. We established Our Formulary and We review and update it routinely. It is available on Our Web site at **www.Regence.com**, or by calling Customer Service at 1 (888) 367-2116. Medications are reviewed and selected for inclusion in Our 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 Us) 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, We will decide.

Mail-Order Supplier means a mail-order Pharmacy with which We have 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 We have a contract or a Pharmacy that participates in a network for which We have contracted to have access. Participating Pharmacies have the capability of submitting claims electronically. A Nonparticipating Pharmacy means a Pharmacy with which We neither have a contract nor have 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 Medications) 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 Our 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 We consider Self-Administrable Medications, We refer to information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that We consider a relevant and reliable indication of safety and acceptability. We do not consider Your status, such as Your ability to administer the medication, 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 Our Web site at **www.Regence.com** or contact Customer Service at 1 (888) 367-2116.

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 Our Web site at **www.Regence.com** or contact Customer Service at 1 (888) 367-2116.

General Exclusions

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

SPECIFIC EXCLUSIONS

We 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 Section; or 3) services and supplies furnished in an emergency room for stabilization of a patient.

Assisted Reproductive Technologies

We do 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.

Complementary Care

Except as provided under the Complementary Care benefit in this Booklet, We do not cover complementary care, including, but not limited to, acupuncture and spinal manipulations.

Conditions Caused By Active Participation In a War or Insurrection

The treatment of any condition caused by or arising out of a Member's active participation in a war or insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

The treatment of any Member'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 Members 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 notice in this Booklet.

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

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

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

Counseling in the Absence of Illness

Except as provided in this Booklet or as required by law, We do 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 in this Booklet).

Custodial Care
Except as provided under the Palliative Care benefit, We do not cover non-skilled care and helping with activities of daily living.

Dental Services
Except as provided under the Professional Services benefit in this Booklet, We do 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 Contract or after Your termination under the Contract. However, when the Contract is terminated and coverage for the entire Group is immediately replaced by another group contract and You are in the Hospital on the day this coverage ends, We 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. We also do 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 Us and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. We do not cover government facilities outside the service area (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 Other Professional Services benefits in this Booklet, We do 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, We do not cover Investigational treatments or procedures (Health Interventions) and services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). We also exclude 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 Member, whether or not the Member makes a claim under such coverage. Further, the Member 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, We will provide benefits 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 Our 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, We will not pay You or Your Provider for any part of expenses incurred if Your Provider has opted out of Medicare participation.

Obesity or Weight Reduction/Control
Except as provided under the Nutritional Counseling benefit in this Booklet, We do 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, temporomandibular joint disorder, sleep apnea or congenital anomaly (including craniofacial anomalies), We do not cover services and supplies for orthognathic surgery. By "orthognathic surgery," We mean 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 Medication Benefits Section in this Booklet, We do 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, We do not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps and light boxes.

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 Member'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 Member's **voluntary participation in** a riot, armed invasion or aggression, insurrection or rebellion or sustained by a Member 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
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 Member 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, We do not cover services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Sexual Dysfunction
Except for Medically Necessary mental health services and supplies for a diagnosis of sexual dysfunction, We do not cover services and supplies for or in connection with sexual dysfunction.

Sexual Reassignment Surgery
Surgical services for sexual reassignment are excluded, except a surgical service that is Medically Necessary to treat a Member's diagnosis of gender identity disorder or gender dysphoria if that same surgical service is a Covered Service when it is Medically Necessary treatment of any other diagnosis in any Member.

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
Except as specifically provided in this Booklet, We do not cover treatment of tobacco addiction and supportive items for addiction to tobacco, tobacco products or nicotine substitutes.

Travel and Transportation Expenses
Travel and transportation expenses other than covered ambulance services provided in this Booklet.

Travel Immunizations
Immunizations if received only for purposes of travel, occupation or residence in a foreign country.

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.

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, We do 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, We do not cover services and supplies received for work-related Injuries or Illnesses where You and Your Enrolled Dependent(s) fail to file a claim for workers' compensation benefits. The only exception is if You and Your Enrolled Dependent(s) are exempt from state or federal workers' compensation law.

Contract and 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 Us.

PREAUTHORIZATION

Contracted Providers may be required to obtain preauthorization from Us in advance for certain services provided to You. You will not be penalized if the contracted Provider does not obtain those approvals from Us in advance and the service is determined to be not covered under this Booklet. We do 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 We do preauthorize a service or supply (from a contracted or non-contracted Provider), We are bound to cover it as follows:

- If Your coverage terminates within five business days of the preauthorization date, We 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 We are aware the coverage is about to terminate and We disclose this information in Our written preauthorization. In that case, We 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, We 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, We 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 We preauthorize the service or supply.

CASE MANAGEMENT

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

ALTERNATIVE BENEFITS

Alternative benefits means benefits for services or supplies that are not otherwise covered under the Contract, but for which We may approve coverage after case management evaluation and analysis. We may cover alternative benefits through case management if We determine that alternative benefits are Medically Necessary and will result in overall reduced covered costs and improved quality of care. Before coverage of alternative benefits and before the processing of claims for alternative benefits, We, You or Your legal representative and, if required by Us, Your Physician or other Provider must agree in writing to the specific terms and conditions for payment. Alternative benefits are approved on a case-specific basis only. The fact that We may cover alternative benefits for You does not set any precedent for coverage of continued or additional alternative benefits for You, or anyone else covered under the Contract.

MEMBER CARD

When You, the Enrolled Employee, enroll with Regence BlueCross BlueShield of Oregon, You will receive a Member card. It will include important information such as Your identification number, the network You, the Enrolled Employee selected, Your Group number and Your name.

It is important to keep Your Member 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 Our Customer Service department at 1 (888) 367-2116. You can also view or print an image of Your Member card by visiting Our Web site at **www.Regence.com** on Your PC or mobile device. If coverage under the Contract terminates, Your Member card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims reimbursement is due, We decide whether to pay You, the Provider or You and the Provider jointly. We may make benefit payments for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child. If a person entitled to receive payment under the Contract has died, is a minor or is incompetent, We may pay the benefits up to $1,000 to a relative by blood or marriage of that person when We believe that person is equitably entitled to the payment. A payment made in good faith under this provision will fully discharge Us 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 We receive an inquiry regarding a properly submitted claim and We believe that You expect a response to that inquiry, We will respond to the inquiry within 30 days of the date We first received it.

Calendar Year and Contract Year

The Deductible and Out-of-Pocket Maximum provisions are calculated on a Calendar Year basis. This Contract is renewed, with or without changes, each Contract Year. A Contract Year is the 12-month period following either the Contract's original Effective Date or subsequent renewal date. A Contract Year may or may not be the same as a Calendar Year. When Your Contract renews on other than January 1 of any year, any Deductible or Out-of-Pocket Maximum amounts You satisfied before the date the Contract renews will be carried over into the next Contract 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 Contract 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. We will deny a claim that is not filed in a timely manner unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. You may, however, appeal the denial in accordance with the appeal process to demonstrate that the claim could not have been filed in a timely manner.

Freedom of Choice of Provider

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

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

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

Out-of-Network Provider Claims
In order for Us to pay for Covered Services, You or the Out-of-Network Provider must first send Us 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 Us the claim.

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

Out-of-Network Providers have not agreed to accept the Allowed Amount as full compensation for Covered Services. So, You are responsible for paying any difference between the amount billed by the Out-of-Network Provider and the Allowed Amount in addition to any amount You must pay due to Deductible, Copayment and/or Coinsurance. For Out-of-Network Providers, the Allowed Amount may be based upon the billed charges for some services, as determined by Us or as otherwise required by law.

Reimbursement Examples by Provider
Here is an example of how Your selection of In-Network or Out-of-Network Providers affects Our payment to Providers and Your cost sharing amount. For purposes of this example, let's assume We pay 80 percent of the Allowed Amount for In-Network Providers and 60 percent of the Allowed Amount for Out-of-Network Providers. The benefit table from the Medical Benefits Section (or other benefits section) would appear as follows:

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

Now, let's assume that the Provider's charge for a service is $5,000 and the Allowed Amount for that charge is $4,000 for an In-Network Provider. Finally, We will assume that You have met the Deductible and that You have not met the Out-of-Pocket Maximum. Here's how that Covered Service would be paid:

- In-Network Provider: We would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:

  - Amount In-Network Provider must "write-off" (that is, cannot charge You for): $1,000
  - Amount We pay (80% of the $4,000 Allowed Amount): $3,200
  - **Amount You pay** (20% of the $4,000 Allowed Amount): **$800**
  - Total: $5,000

- Out-of-Network Provider: We would pay 60 percent of the Allowed Amount. Because the Out-of-Network Provider does not accept the Allowed Amount, You would pay 40 percent of the Allowed

Amount, plus the $1,000 difference between the Out-of-Network Provider's billed charges and the Allowed Amount, as follows:

- Amount We pay (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 in this Booklet 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 Us, 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. We will send Our payment for Covered Services directly to the ambulance service Provider.

Claims Determinations

Within 30 days of Our receipt of a claim, We will notify You of the action We have taken on it. However, this 30-day period may be extended by an additional 15 days in the following situations:

- When We cannot take action on the claim due to circumstances beyond Our control, We 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 We expect to act on the claim.
- When We cannot take action on the claim due to lack of information, We 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.

We must allow You at least 45 days to provide Us with the additional information if We are seeking it from You. If We do not receive the requested information to process the claim within the time We have allowed, We will deny the claim.

Claims Processing Report

We will tell You how We have acted on a claim. We use a form called a claims processing report. We may pay claims, deny them or accumulate them toward satisfying any Deductible. If We deny all or part of a claim, the reason for Our action will be stated on the claims processing report. The claims processing report will also include instructions for filing an appeal or Grievance if You disagree with the action.

OUT-OF-AREA SERVICES

We have 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 Our 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 Us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Our 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. Our 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, We will remain responsible for fulfilling Our 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 Our 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 Us.

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 We use 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, We 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 Us by the Host Blue.

Nonparticipating Providers Outside Our Service Area

- Member Liability Calculation. When Covered Services are provided outside of Our 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 We will make for the Covered Services as set forth in this paragraph.
- Exceptions. In certain situations, We may use other payment bases, such as billed covered charges, the payment We would make if the health care services had been obtained within Our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount We 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 We will make for the Covered Services as set forth in this paragraph.

BLUECARD WORLDWIDE®

We provide BlueCard Worldwide coverage for You. With BlueCard Worldwide, You have more access to inpatient and outpatient Hospital care and Physician services when You're traveling or living outside the United States, 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 Member 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 Contract. 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 Us. 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 We pay a benefit to which You or Your Enrolled Dependent was not entitled, or if We pay a person who is not eligible for benefits at all, We reserve the right to recover the payment from the person We paid or anyone else who benefited from it, including a Provider of services. Our right to recovery includes the right to deduct the mistakenly paid amount from future benefits We would provide the Enrolled Employee or any of his or her Enrolled Dependents, even if the mistaken payment was not made on that person's behalf.

We regularly work 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.). We will credit all amounts that We recover, less Our reasonable expenses for obtaining the recoveries, to Your Group's experience or the experience of the pool under which You or Your Group is rated. Crediting reduces claims expense and helps reduce future premium rate increases.

This claims recovery provision in no way reduces Our right to reimbursement or subrogation. Refer to the other-party liability provision in the Contract and 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 Us. 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 Us 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.

We are 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 Our Customer Service department or visiting Our Web site **www.Regence.com**.

You have the right to request, inspect and amend any records that We have that contain Your personal health information. Please contact Our 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 Us 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. We are not responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since We do not provide any health care services, We cannot 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 Our employees nor agents.

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

In addition, We will not be liable to any person or entity for the inability or failure to procure or provide the benefits in this Booklet by reason of epidemic, disaster or other cause or condition beyond Our 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, We may advance benefits 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 We are entitled to reimbursement of the full amount of benefits that We have 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 We have provided benefits.
- In addition to Our right of reimbursement, We may choose instead to achieve Our rights through subrogation. We are authorized, but not obligated, to recover any benefits We have paid directly from any party liable to You, upon mailing of a written notice to the potential payer, to You or to Your representative.
- Our 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 Member and/or any third-party or the recovery source. We are 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 in this Booklet.
- We will not reduce Our reimbursement or subrogation due to Your not being made whole, unless applicable state law requires otherwise. Our right to reimbursement or subrogation, however, will not exceed the amount of recovery.
- We may require You to sign and deliver all legal papers and take any other actions requested to secure Our 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 We ask You to sign a trust agreement or other document to reimburse Us 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 Our rights and that You will cooperate fully with Us, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify Us of any facts that may impact Our 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 Our 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 Our right of reimbursement or subrogation, until Our right is satisfied or released.
- In the event You and/or Your agent or attorney fails to comply with any of these conditions, We may recover any such benefits advanced for any Illness or Injury through legal action.
- Any benefits We have provided or advanced are provided solely to assist You. By paying such benefits, We are not acting as a volunteer and are 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 Us 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.

- We 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, We may advance benefits for Covered Services if You agree to hold any recovery obtained in a segregated account for Us.

Fees and Expenses

We are not liable for any expenses or fees incurred by You in connection with obtaining a recovery. However, You may request that We pay a proportional share of attorney's fees and costs at the time of any settlement or recovery to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid by Us. We have 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 We would normally provide benefits. 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 in this Booklet and those of the Other Plan will be coordinated in accordance with the provisions of this section.

Benefits Subject to this Provision

All of the benefits provided 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 in this Booklet 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 coverage 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 We are 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 the Contract.

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 another plan and without taking the existence of that Other Plan into consideration. (This is also referred to as that plan being "primary" to that Other Plan.) There may be more than one Primary Plan. A plan is a Primary Plan with regard to another plan in any of the following circumstances:

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

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

Year, for purposes of this Coordination of Benefits provision, means calendar year (January 1 through December 31).

Order of Benefit Determination

The order of benefit determination is identified by using the first of the following rules that applies:

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

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

If a court decree specifies that Your parent is responsible for Your health care expenses or health care coverage and that parent's plan has actual knowledge of that term of the decree, the plan of that parent is primary to the plan of Your other parent. If the parent with that responsibility has no coverage for You, but that parent's spouse does and the spouse's plan has actual knowledge of that term in the decree, the plan of the spouse shall be primary to the plan of Your other parent. If benefits have been paid or provided by

a plan before it has actual knowledge of the term in the court decree, these rules do not apply until that plan's next Contract Year.

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

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

- The plan of Your custodial parent shall be primary to the plan of Your custodial parent's spouse;
- The plan of Your custodial parent's spouse shall be primary to the plan of Your noncustodial parent; and
- The plan of Your noncustodial parent shall be primary to the plan of Your noncustodial parent's spouse.

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

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

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

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

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

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

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

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

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

Primary Health Plan Benefits

When, in accordance with the order of benefit determination, this coverage is the Primary Plan, We will pay the benefits in this Booklet 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 coverage, the benefits in this Booklet will be calculated as follows:

We will calculate the benefits that We would have paid for a service if this coverage were the Primary Plan. We will compare the Allowable Expense in this Booklet for that service to the Allowable Expense for it under the Other Plan(s) by which You are covered. We 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 We would have paid for the service if this coverage were the Primary Plan.

Deductibles, Coinsurance and Copayments, if any, in this Booklet will be used in the calculation of the benefits that We would have 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. Our 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 We will credit toward any Deductible in this Booklet any amount that would have been credited to the Deductible if this coverage had been the only plan.

If this coverage 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 Booklet, We will pay benefits first, but the amount paid will be calculated as if this coverage is a Secondary Health Plan. If the Other Plan(s) do not provide Us with the information necessary for Us to determine Our appropriate secondary benefits payment within a reasonable time after Our request, We shall assume their benefits are identical to Ours and pay benefits accordingly, subject to adjustment upon receipt of the information requested from the Other Plan(s) within two years of Our payment.

Nothing contained in this Coordination of Benefits provision requires Us 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 Our payment over what We would have paid in the absence of this Coordination of Benefits provision.

Right to Receive and Release Needed Information

Certain facts are needed to apply coordination of benefits provisions. We have the right to decide which facts We need. We 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 Us any information necessary or appropriate to administer this Coordination of Benefits provision. Receipt of such information by Us will be a condition precedent to Our obligation to provide benefits in this Booklet.

Facility of Payment

Any payment made under any Other Plan(s) may include an amount that should have been paid under this coverage. If so, We may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this coverage. We will not have to pay that amount 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 We provide benefits to or on behalf of You in excess of the amount that would have been payable by this coverage by reason of Your coverage under any Other Plan(s), We will be entitled to recover from You, Your assignee or beneficiary, or from the Other Plan(s) upon request.

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

Resolving Your Concerns

If You believe a policy, action or decision of Ours is incorrect, please contact Our Customer Service department.

If You have concerns regarding a decision, action or statement by Your Provider, We encourage You to discuss these concerns with the Provider. If You remain dissatisfied after discussing Your concern with Your Provider, You may contact Our Customer Service department at 1 (888) 367-2116 for assistance.

Our Grievance process is designed to help You resolve Your complaint or concern and to allow You to appeal an Adverse Benefit Determination. We offer two internal levels of appeal of Our Adverse Benefit Determinations. We also offer an external appeal with an Independent Review Organization (IRO) for some of Our Adverse Benefit Determinations if You remain dissatisfied with Our 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 Our determination (or, in the case of a first level appeal, within 180 days of Your receipt of Our 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 We receive an appeal request, We will send a written acknowledgement.

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 Our 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, We 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 We pay for the item or service during this time should You not prevail.

You may contact Us either in writing or verbally with a Grievance or to request an appeal. A written request can be made by sending it to Us at: Appeals Coordinator, Regence BlueCross BlueShield of Oregon, P.O. Box 4208, Portland, OR 97208-4208 or facsimile 1 (888) 496-1542. Verbal requests can be made by calling Us at 1 (888) 367-2116. We 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 we have mutually agreed to waive exhaustion, You are deemed to have exhausted the Internal Appeal process because We 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). **We are bound by the decision of the IRO and may be penalized by the Department of Consumer and Business Services if We fail to comply with the IRO's decision. You have the right to sue Us 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 We have 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.

We coordinate external appeals, but the decision is made by an IRO at no cost to You. We 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. We are bound by the decision made by the IRO, even if it conflicts with Our 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 Us at: Appeals Coordinator, Regence BlueCross BlueShield of Oregon, P.O. Box 5726, Portland, OR 97228. Verbal requests can be made by calling Us at 1 (888) 367-2116. We must notify the Department of Consumer and Business Services of Your request by the second business day after We receive 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 Our Customer Service department at 1 (888) 367-2116. 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 Us at: Appeals Coordinator, Regence BlueCross BlueShield of Oregon, P.O. Box 5726, Portland, OR 97228. Verbal requests can be made by calling Us at 1 (888) 367-2116.

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 Us.

External expedited appeals can be initiated through either written or verbal request. A written request can be made by sending it to Us at: Appeals Coordinator, Regence BlueCross BlueShield of Oregon, P.O. Box 5726, Portland, OR 97228. Verbal requests can be made by calling Us at 1 (888) 367-2116. We must notify the Department of Consumer and Business Services of Your request by the second business day after We receive 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.

We coordinate 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. We 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 Our Customer Service department at 1 (888) 367-2116 or You can write to Our Customer Service department at the following address: Regence BlueCross BlueShield of Oregon, P.O. Box 30805, Salt Lake City, UT 84130-0805.

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 Us, 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 Our denial, reduction or termination of a health care item or service, or Our 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 Our:

- 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 Us.

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 Us and/or through assignment to Us via state regulatory requirements. The IRO is unbiased and is not controlled by Us.

Internal Appeal means a review by Us of an Adverse Benefit Determination made by Us.

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

Pre-Service means any claim for benefits in this Booklet which We 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 Member who is an unmarried and dependent child and is less than 13 years old. For expedited appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative. Even if You have previously designated a person as Your Representative for a previous matter, an authorization designating that person as Your Representative in a new matter will be required (but redesignation is not required for a complaint that becomes an appeal or between each level of appeal). If no authorization exists and is not received in the course of the Grievance, the determination and any personal information will be disclosed to You, Your personal Representative or treating Provider only.

Who Is Eligible, How to Enroll and When Coverage Begins

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

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

This section also contains terms of eligibility for Oregon-certified domestic partners and Oregon non-certified domestic partners. Oregon-certified domestic partners are always covered under Your plan. However, Oregon non-certified domestic partners may be covered under Your plan. Please see Your Member Employer administrator to determine if non-certified domestic partners are covered.

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS

Coverage will be effective on the first day of the month coinciding with or following the completion of the eligibility waiting period determined by the Member Employer, provided You apply for coverage within 31 days of completion of the applicable eligibility waiting period as outlined below. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

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

New Member Employers

Regular full-time employees who have completed the applicable eligibility waiting period at the time an Member Employer becomes a participant with the Group will be eligible for coverage on the first day of the month the Member Employer becomes a participant with the Group.

Employees who have not completed the applicable eligibility waiting period at the time the Member Employer becomes a participant with the Group will receive credit for time worked toward the waiting period. They will be eligible to enroll on the first day of the month coinciding with or following completion of the waiting period.

Employees

You become eligible to enroll in coverage on the date You have worked for a Member Employer long enough to satisfy any required eligibility waiting period. To enroll and remain an eligible employee, an individual must meet all of the following requirements on a continuous basis:

- be classified for all purposes by the Member Employer as its employee;
- be actively engaged in performing personal services for the Member Employer;
- not be classified by the Member Employer as a temporary, seasonal, or substitute employee or not be the recipient of an IRS form 1099 from the Member Employer, i.e., not be classified as an independent contractor, agent, consultant, or an individual on retainer, regardless of whether the individual's status is later retroactively redetermined; and
- be regularly scheduled to work a minimum number of hours per week, as defined by the Member Employer.

The eligibility waiting period is determined by each Member Employer and applies to all employees within an eligibility classification.

If You are unable to work during the eligibility waiting period due to Your own illness or injury, that time of employment will count toward completion of the eligibility waiting period.

If You are laid off by Your employer before completing the eligibility waiting period, the time worked before You are laid off will count towards the eligibility waiting period provided You are recalled by Your employer within 180 days of the date You are laid off.

If Your employer lengthens the eligibility waiting period before You are eligible for coverage, You will be subject to the eligibility waiting period in effect at the time of hire.

If Your employer shortens the eligibility waiting period before You are eligible for coverage, You will be subject to the shortened eligibility waiting period.

A sole proprietor or partner meeting these requirements may be considered an eligible employee for purposes of this contract.

Temporary And Part-Time Employees

Temporary and part-time employees are eligible for coverage only after they become regular full-time employees. They are then subject to the eligibility rules for regular full-time employees and will be given credit for time worked as a temporary or part-time employee toward the eligibility waiting period.

Dependents

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

- The person to whom You are legally married (spouse).
- Your Oregon-Certified Domestic Partner. Oregon-Certified Domestic Partnership means a contract, in accordance with Oregon law, entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon.
- Your domestic partner who is not an Oregon-Certified Domestic Partner, provided that all of the following conditions are met:

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

- Your (or Your spouse's or Your Eligible Domestic Partner's) child who is under age 26 and who meets any of the following criteria:

    - Your (or Your spouse's or Your Eligible Domestic Partner's) natural child, step child, adopted child or child legally placed with You (or Your spouse or Your Eligible Domestic Partner) for adoption;
    - a child for whom You (or Your spouse or Your Eligible Domestic Partner) have court-appointed legal guardianship; and
    - a child for whom You (or Your spouse or Your Eligible Domestic Partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).

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

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

Our affidavit of dependent eligibility form is available by visiting Our Web site at **www.Regence.com** or by calling Our Customer Service department at 1 (888) 367-2116.

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request (and, for an Eligible Domestic Partner who is not an Oregon-Certified Domestic Partner, an affidavit of qualifying domestic partnership form) to the Group or Group Representative. Request for enrollment of a new child by birth, adoption or placement for adoption must be made within 60 days of the date of birth, adoption or placement for adoption. Request for enrollment of all other newly eligible dependents must be made within 30 days of the dependent's attaining eligibility. Coverage for such dependents will begin on their Effective Dates (which, for a new child by birth, adoption or placement for adoption, is the date of birth, adoption or placement for adoption, if enrolled within the specified 60 days).

New Spouse (Including Stepchildren)

If You marry while You are enrolled under the contract, benefits for Your spouse and his or her children will be effective on the first day of the month coinciding with or following the date of marriage, provided application is made within 30 days of the marriage. Your new stepchildren must meet the eligibility requirements for all children in order to be enrolled.

Newly Eligible Domestic Partner

A newly eligible domestic partner who is an Oregon-Certified domestic partner becomes eligible on the date the domestic partnership is registered at an Oregon County Clerk's office. Coverage for the eligible domestic partner will begin on the first day of the month coinciding with or following the date the domestic partnership is registered, provided application is made within 30 days of the date of registration.

The otherwise eligible children of Your Eligible Domestic Partner are eligible to apply for coverage even if Your Eligible Domestic Partner does not enroll, however a Certificate of Dependency will be required.

SPECIAL ENROLLMENT

There are certain situations when You may enroll Yourself and/or Your eligible dependents, even though You didn't do so when first eligible, and You do not have to wait for an annual enrollment period.

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

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

- You and/or Your eligible dependents lose coverage under another group or individual Health Benefit Plan due to one of the following:
  - an employer's contributions to that other plan are terminated;
  - exhaustion of federal COBRA or any state continuation; or
  - loss of eligibility, for instance, due to legal separation, divorce, termination of domestic partnership, death, termination of employment or reduction in hours.

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

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

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

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

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

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

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

ANNUAL ENROLLMENT PERIOD

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

DOCUMENTATION OF ELIGIBILITY

You must promptly furnish or cause to be furnished to Us any information necessary and appropriate to determine the eligibility of a dependent. We must receive such information before enrolling a person as a dependent under the Contract.

When Group Coverage Ends

This section describes the situations when coverage will end for You and/or Your Enrolled Dependents. You must notify Us within 30 days of the date on which an Enrolled Dependent is no longer eligible for coverage.

No person will have a right to receive any benefits in this Booklet after the date coverage is terminated. Termination of Your or Your Enrolled Dependent's coverage under the Contract for any reason will completely end all Our obligations to provide You or Your Enrolled Dependent benefits for Covered Services received after the date of termination. This applies whether or not You or Your Enrolled Dependent is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while the Contract was in effect, provided, however, when the Contract is terminated and coverage for the entire Group is immediately replaced by another group contract and You are in the Hospital on the day this coverage ends, We 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.)

CONTRACT TERMINATION

If the Contract is terminated or not renewed by the Group or Us, coverage ends for You and Your Enrolled Dependents on the date the Contract is terminated or not renewed.

If the Contract is terminated and coverage is not replaced by the Group, We will mail the Group a notice of termination. It is then the duty of the Group to send each Enrolled Employee a notice of the termination, explaining rights to continuation of coverage under federal and/or state law.

MEMBER EMPLOYMENT TERMINATION

If Your employer ceases to be a Member Employer, coverage ends for You and Your Enrolled Dependents on the date Your employer ceases to participate under the Contract.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, Your and Your Enrolled Dependents' coverage ends on the last day of the monthly period in which Your eligibility ends. However, it may be possible for You and/or Your Enrolled Dependents to continue coverage under the Contract according to the continuation of coverage provisions of this Booklet.

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Contract, Your coverage will end for You and all Enrolled Dependents on the last day of the monthly period in which eligibility ends. If within 30 days of the termination date, You are rehired by Your employer, Your coverage will be effective on the first day of the month coinciding with or following Your rehire date. If more than 30 days pass before You are rehired, Your coverage will be effective on the first day of the month coinciding with or following completion of the applicable eligibility waiting period.

REDUCTION IN HOURS OF EMPLOYMENT

If Your Member Employer reduces your hours of employment so that You are no longer regularly scheduled to work the required minimum number of hours per week, as defined by Your employer, Your coverage will end for You and Your Enrolled Dependents on the last day of the month during which You no longer meet the eligibility criteria.

It may be possible for You and Your Enrolled Dependents to continue coverage under the contract according to the COBRA CONTINUATION OF COVERAGE Section of this benefits booklet.

If Your work schedule is later increased, You may again become eligible for benefits. Refer to Temporary And Part-Time Employees sections for additional information.

TRANSFER TO A JOB CLASSIFICATION THAT IS NOT ELIGIBLE FOR COVERAGE

If Your Member Employer transfers You to a job classification that is not eligible for coverage under the contract, Your coverage will end for You and Your Enrolled Dependents on the last day of the month during which You no longer meet the eligibility criteria.

If You are reinstated to a job classification that is eligible for coverage, Your coverage will be effective on the first day of the month coinciding with or following Your transfer to an eligible job classification, provided You meet the eligibility criteria as of the date You are reinstated to an eligible job classification.

NONPAYMENT OF PREMIUM

If You fail to make required timely contributions to premium, Your coverage will end for You and all Enrolled Dependents on the last day of the monthly period for which premiums are paid.

FAMILY AND MEDICAL LEAVE

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

During the FMLA leave, You must continue to pay Your portion of the monthly premium through Your employer to the Group or the Group Representative on time. The provisions described here will not be available if the Contract terminates or Your employer ceases to be a Member Employer.

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

Persons entitled to coverage under this provision will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this provision. Entitlement to FMLA leave does not constitute a qualifying event for the purposes of COBRA continuation. However, a person who does not return to active employment following FMLA leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave. If You do not promptly return to active employment when Your FMLA leave ends, Your FMLA rights also end. You will not be entitled to immediate reinstatement of benefits and a COBRA qualifying event will occur for You and Your qualified beneficiaries on the last day of Your FMLA leave.

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. This leave provision is available only to groups that are required by law to comply. The Group or the Group Representative must keep Us advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

LEAVE OF ABSENCE

A leave of absence is a period off work granted by Your Member Employer at Your request during which You are still considered to be employed and are carried on the employment records of the Member Employer. A leave can be granted for any reason acceptable to the Member Employer, including but not limited to disability and pregnancy. This section applies to leaves of absence when You take any non-FMLA leave of absence.

Your coverage will end for You and Your Enrolled Dependents on the last day of the month in which You begin a non-FMLA leave of absence. You and/or Your Enrolled Dependents may be eligible to elect COBRA continuation coverage but will not have any special rights under FMLA. (However, if You reside in a state that has laws governing employee leaves of absence You may have special rights under that state's laws.)

If You return to work within 90 days from the date the leave began, Your coverage will be reinstated on the first day of the month coinciding with or following the date You return to work. You will not have to re-serve the group eligibility waiting period regardless of whether or not You elected COBRA continuation coverage while on a leave of absence.

If You return to work more than 90 days after the date the leave began, Your coverage will be effective on the first day of the month coinciding with or following completion of the applicable group eligibility waiting period, regardless of whether or not You elected COBRA continuation coverage while on a leave of absence.

However, if You reside in the state of Oregon, You may have immediate reinstatement rights when You return to work. You should contact Your Member Employer to determine if and how the state law applies to Your leave of absence.

If Your leave of absence starts as an FMLA leave of absence and then becomes a non-FMLA leave of absence, the 90 days will be counted from the first day of the FMLA leave of absence.

MILITARY LEAVE OF ABSENCE

If You are covered under this Contract when You are called to active duty by or join any of the armed forces of the United States of America and You qualify for reemployment rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA), You may continue coverage under the Contract for Yourself and any of Your Enrolled Dependents for up to 24 months or the period of uniformed service leave, whichever is shortest. Premiums must be paid through Your employer to the Group or the Group Representative in order to maintain coverage during a leave of absence. If the leave is less than 30 days, the contribution rate will be the same as for active employees. If the leave is 30 days or longer, the required contribution will not exceed 102 percent of the cost of coverage for active employees.

This continued coverage is in lieu of and not in addition to any other continuation of coverage provisions of the Contract.

Whether or not You elect continuation coverage under USERRA, coverage under the Contract as an active employee will be reinstated on the first day You return to active employment with the group if You are released under honorable conditions and You return to employment:

- on the first full business day following completion of Your military service for a leave of 30 days or less;
- within 14 days of completing Your military service for a leave of 31 to 180 days; or
- within 90 days of completing Your military service for a leave of more than 180 days (a reasonable amount of travel time or recovery time for an illness or injury determined by the Veterans' Administration of the United States (VA) to be service connected will be allowed).

When coverage as an active employee under this Contract is reinstated, all provisions and limitations of the Contract will apply to the extent that they would have applied if You had not taken Your military leave and Your coverage under the Contract had been continuous. You do not have to re-serve any group eligibility waiting period and the period of Your military leave will be credited toward any preexisting condition exclusion period. (These waivers of limitations do not provide coverage for any illness or injury caused or aggravated by Your military service, as determined by the VA.) For complete information regarding Your rights under the USERRA, contact Your employer.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), his or her coverage will end on the last day of the monthly period in which his or her

eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Contract according to the continuation of coverage provisions of this Booklet.

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

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

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

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

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

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

Fraudulent Use of Benefits
If You or Your Enrolled Dependent 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 Contract will terminate for that Member.

Fraud or Misrepresentation in Application
We have issued this Booklet in reliance upon all information furnished to Us by You or on behalf of You and Your Enrolled Dependents. In the event of any intentional misrepresentation of material fact or fraud regarding a Member (including, but not limited to, a person who is listed as a dependent, but does not meet the eligibility requirements in effect with the Member Employer), We may take any action allowed by law or Contract, including denial of benefits or termination of coverage, and may subject the person making the misrepresentation or fraud to prosecution for insurance fraud and associated penalties.

If We rescind Your coverage, other than for failure to pay premium, We will provide You with at least 30 days advance written notice prior to rescinding coverage.

COBRA Continuation of Coverage

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

If Your group coverage is subject to COBRA, COBRA continuation is available to Your Enrolled Dependents if they lose eligibility because:

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

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

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

General Rules

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

In order to preserve Your and Your Enrolled Dependent's rights under COBRA, You or Your Enrolled Dependents must inform the Group Representative in writing within 60 days of:

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

The Member Employer also must meet certain notification, election and payment deadline requirements. It is therefore very important that You keep Your employer and the Group Representative informed of the current address of all Members who are or may become qualified beneficiaries.

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

Notice

The Contract includes additional details on the COBRA Continuation provisions outlined here and complete details are available from Your employer or Group Representative.

Other Continuation Options

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

Reenrolling After Layoff

If You are rehired and return to active work within 180 days of being laid off, You and any previously Enrolled Dependents may reenroll under the Contract on the first day of the month coinciding with or following Your return to work, regardless of any lapse in coverage. In order to enroll newly acquired dependents upon return from layoff, You must submit an enrollment application within 31 days of returning to work. Any previously eligible dependent not enrolled before the layoff, or any newly eligible dependent not enrolled upon return from layoff, may be eligible to enroll during the next annual enrollment period. Your employer must notify Us or the Group Representative that You are being rehired following a layoff and the necessary premiums for Your coverage must be paid. All Contract provisions will resume at the time You reenroll whether or not there was a lapse in Your coverage. Any exclusion period not completed at the time the employee was laid off must be satisfied. However, the period of Your layoff will be counted toward the exclusion period. At the time You are rehired, You do not have to re-satisfy any eligibility waiting period required by the Contract.

If You return to active work more than 180 days after being laid off, Your coverage will be effective on the first day of the month coinciding with or following completion of any eligibility waiting period required by the Contract.

Strike or Lockout

If You are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, Your coverage can be continued for up to six months. You must pay the full premium, including any part usually paid by Your employer, the Group or the Group Representative, directly to the union or trust that represents You. And the union or trust must continue to pay Us the premiums according to the Contract. Coverage cannot be continued if less than 75 percent of those normally enrolled continue coverage or if You otherwise lose eligibility under the Contract. This six months of continued coverage is in lieu of and not in addition to any continuation of coverage provisions of the Contract.

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, the Group or the Group Representative, as instructed and within the 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 Contract.

General Provisions

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

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

ERISA (IF APPLICABLE)
This provision applies if the Contract is part of an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA).

The Group and Member Employers intend that the Contract be maintained for the exclusive benefit of the employees.

The Group and Member Employers intend to continue this coverage indefinitely, but also reserve the right to discontinue or change this coverage at any time. If the Contract is terminated for any reason and is not replaced with comparable benefits, employees will receive ample notice. Employees will also receive instructions for converting their coverage to an individual plan.

Rights and Protection
Employees are entitled to certain rights and protection under ERISA. ERISA provides that all employees shall be entitled to:

- Examine without charge, at the plan administrator's office, all policy documents, including insurance policies and copies of certain documents filed by the plan administrator with the U.S. Department of Labor, such as detailed annual reports and policy descriptions.
- Obtain copies of documents governing the operation of the plan upon written request to the plan administrator. The plan administrator may make a reasonable charge for the copies.
- Continue, generally at their own expense, health care coverage of themselves, their spouses and children if coverage ends due to certain qualifying events. Review the summary plan description and governing documents of the coverage for rules and other details about such COBRA continuation rights.

Duties
In addition to creating rights for employees, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries," have a duty to do so prudently and in the interest of employees and their dependents. No one, including the employer, or any other person, may fire an employee or otherwise discriminate against one in any way to prevent an employee from obtaining a welfare benefit or exercising his or her rights under ERISA.

If an employee's claim for a welfare benefit is denied (or ignored) in whole or in part, he or she must receive a written explanation of the reason for the denial. Employees have the rights to obtain copies of related documents without charge and to appeal any denial within certain time frames. Under ERISA, there are steps they can take to enforce the above rights. For instance, if an employee requests certain materials from the plan administrator in writing and does not receive them within 30 days, the employee may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay an employee up to $110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the plan administrator.

Denied Claims
If an employee has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or federal court. An employee may also do so if he or she disagrees with a decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order. If fiduciaries misuse money, or if an employee is discriminated against for asserting his or her rights, employees may seek assistance from the U.S. Department of Labor or file suit in a federal court. The court will decide who should pay court costs and legal fees. If an employee is successful, the court may

order the person an employee has sued to pay these costs and fees. If an employee loses, the court may order the employee who sued to pay these costs and fees, for example, if it finds the claim frivolous. If an employee has any questions about the plan, he or she should contact the plan administrator.

If You Need More ERISA Information

If an employee has any questions about this statement or his or her rights under ERISA, or if he or she needs assistance obtaining documents from the plan administrator, the employee should contact the nearest Field Office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in the telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Employees can also obtain publications about their ERISA rights and responsibilities by calling the publications hotline of the Employee Benefits Security Administration.

GOVERNING LAW

The Contract 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.

GROUP IS AGENT

The Group is Your agent for all purposes under the Contract and not the agent of Regence BlueCross BlueShield of Oregon. You are entitled to health care benefits pursuant to an agreement between Us and the Group. In the Contract, the Group agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in the Contract. You, through the enrollment form signed by the Enrolled Employee, and as beneficiaries of the Contract, acknowledge and agree to the terms, provisions, limitations and exclusions in this Booklet.

MODIFICATION OF CONTRACT

We shall have the right to modify or amend the Contract from time to time. However, no modification or amendment will be effective until 30 days (or longer, as required by law) after written notice has been given to the Group, and modification must be uniform within the product line and at the time of renewal. Exceptions to this modification provision for circumstances beyond Our control are further addressed in the Contract. No modification or amendment of the Contract will affect the benefits of any Member who is, on the Effective Date of such modification or amendment, confined in a Hospital or other facility on an inpatient basis, until the first discharge from such facility occurring after such Effective Date.

NO WAIVER

The failure or refusal of either party to demand strict performance of the Contract 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 Contract will be considered waived by Us unless such waiver is reduced to writing and signed by one of Our authorized officers.

NOTICES

Any notice to Members required in the Contract will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Enrolled Employee will be addressed to the Enrolled Employee or to the Group at the last known address appearing in Our records. If We receive a United States Postal Service change of address form (COA) for an Enrolled Employee, We will update Our records accordingly. Additionally, We may forward notice for an Enrolled Employee to the Group if We become aware that We don't have a valid mailing address for the Enrolled Employee. Any notice to Us required in the Contract may be given by mail addressed to: Regence BlueCross BlueShield of Oregon, P.O. Box 30805, Salt Lake City, UT 84130-0805; provided, however that any notice to Us will not be considered to have been given to and received by Us until physically received by Us.

PREMIUMS

Premiums are to be paid to Us by the Member Employer or the Group Representative, in advance, and on or before the premium due date. Failure by the Member Employer to make timely payment of premiums may result in Our terminating the Group's, a Member Employer’s, or a Member's coverage on the last day of the monthly period through which premiums are paid or such later date as is provided by applicable law.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Group on behalf of itself and its Member Employers expressly acknowledges its understanding that the Contract constitutes an agreement solely between the Group 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 Us 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 We are not contracting as the agent of the Association. The Group on behalf of itself and its Member Employers further acknowledges and agrees that it has not entered into the Contract based upon representations by any person or entity other than Regence BlueCross BlueShield of Oregon and that no person or entity other than Regence BlueCross BlueShield of Oregon will be held accountable or liable to the Group or the Members for any of Our obligations to the Group, its Member Employers or the Members created under the Contract. This paragraph will not create any additional obligations whatsoever on the part of Regence BlueCross BlueShield of Oregon other than those obligations created under other provisions of the Contract.

REPRESENTATIONS ARE NOT WARRANTIES

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

WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered in this Booklet, 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 of the Contract;
- the person has enrolled in coverage and has been enrolled by Us; and
- premium for the person for the current month has been paid by the Group or the Group Representative on a timely basis.

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 Contract is terminated and coverage for the entire Group is immediately replaced by another group contract and You are in the Hospital on the day this coverage ends, We 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, We will provide coverage (subject to the same provisions as any other benefit) for:

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

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 We have a relationship that allows access to Providers in the state in which the Affiliate serves and includes the following companies: Regence BlueShield of Idaho in the state of Idaho, Regence BlueCross BlueShield of Utah in the state of Utah and Regence BlueShield in parts of the state of Washington.

Allowed Amount means:

- For In-Network Providers (see definition of "In-Network" below), the amount that they have contractually agreed to accept as payment in full for a service or supply.
- For Out-of-Network Providers (see definition of "Out-of-Network" below) who are not accessed through the BlueCard Program, the amount We have 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 Us or as otherwise required by law.
- For Out-of-Network Providers accessed through the BlueCard Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to Us 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 Us.

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.

Booklet is the description of the benefits for this coverage. The Booklet is part of the Contract between the Group and Us.

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

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 specified by Us, following Our receipt of the enrollment form, as the date coverage begins for You and/or Your dependents.

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 Member's health, or with respect to a pregnant Member, 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.

Enrolled Dependent means an Enrolled Employee's eligible dependent who is listed on the Enrolled Employee's completed enrollment form and who is enrolled under the Contract.

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

Family means an Enrolled Employee and his or her Enrolled Dependents.

Group Representative means the Vigilant Group Benefits Trust administrator who has been designated by the Group to act as its agent to remit the premium of all Member Employers to Us and to give and receive notices under this plan.

Health Benefit Plan means any Hospital-medical-surgical expenses policy or certificate issued by insurers including health care service contractors and health maintenance organizations, and includes 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.

In-Network means a Provider that has an effective participating contract with Us that designates him, her or it as a network Provider and who is a member of Your chosen Provider network. For In-Network Provider reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services. When Enrolled Employees have more than one Provider network from which to choose for benefits in this Booklet, the Providers contracted under the network the Enrolled Employee selected will be considered the only In-Network Providers for the purpose of payment of benefits in this Booklet.

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, We 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 Member is covered under the Contract (which may include more than one coverage) through the Group with Us.

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 means an Enrolled Employee or an Enrolled Dependent.

Member Employer means a business entity qualifying for membership or participation in the Group and choosing to participate under the Contract to provide coverage to its employees and their dependents as Enrolled Employees and Enrolled Dependents, respectively.

Out-of-Network refers to a Provider that is not in Your selected Provider network, a Provider outside the area that We or one of Our Affiliates serves, but who has contracted with another Blue Cross and/or Blue Shield organization in the BlueCard Program, as well as a Provider that does not have an effective participating contract with Us or one of Our Affiliates to provide services and supplies to Members. For reimbursement of these Out-of-Network Provider services, You may be billed for balances over Our payment level in addition to any Deductible, Copayment and/or Coinsurance amount for Covered Services provided inside or outside the area that We or one of Our Affiliates serves.

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

Practitioner means an individual who is duly licensed to provide medical or surgical services that are similar to those provided by Physicians. Practitioners include podiatrists who do not meet the definition of Physician, Physician's assistants, psychologists, licensed clinical social workers, certified nurse

Practitioners, registered physical, occupational, speech or audiological therapists; registered nurses or licensed practical nurses, (but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill patients), dentists (doctor of medical dentistry or doctor of dental surgery, or a denturist) and other health care professionals practicing within the scope of their respective licenses.

Primary Physician or Practitioner means a Physician, osteopathic Physician or Practitioner that is licensed in general practice, family practice, internal medicine, pediatrics, geriatrics, obstetrics/gynecology (Ob/Gyn), preventive medicine, adult medicine, women's health care or naturopathy who, when acting within the scope of their state license, provides Your primary care or coordinates referral services when needed. Primary Physician or Practitioner also means any Physician assistant, nurse Practitioner or advanced registered nurse Practitioner licensed in one of the above specialties and working under a Physician, osteopathic Physician or Practitioner who is licensed in the same specialty.

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 Us, that falls within the range of average payments We make to Providers, who have an effective participating contract with Us, for the same or similar service or supply in Our 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.

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.

Specialist means a Physician or Practitioner that does not otherwise meet the definition of a Primary Physician or Practitioner.

Upfront Benefit means those Covered Services designated as "Upfront" which are usually accessible to the Member without first having to satisfy any Deductible amount. Generally, there will also be no Coinsurance amount required for an Upfront Benefit, however, a Copayment or Coinsurance may still apply for each visit or access to an Upfront Benefit. Once an Upfront Benefit dollar or visit maximum (if applicable) has been reached, additional coverage is available subject to a Deductible, Copayment and/or Coinsurance. Refer to the Upfront Benefit provisions in the Medical Benefits Section to determine coverage.

Disclosure Statement Patient Protection Act

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

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

No one can deny You the right to make Your own choices. As a Member, You have the right to: be treated with dignity and respect; impartial access to treatment and services without regard to race, religion, gender, national origin or disability; know the name of the Physicians, nurses or other health care professionals who are treating You; the medical care necessary to correctly diagnose and treat any covered Illness or Injury; have Providers tell You about the diagnosis, the treatment ordered, the prognosis of the condition and instructions required for follow-up care. You also have the right to know why various tests, procedures or treatments are done, who the persons are who give them and any risks You need to be aware of; refuse to sign a consent form if You do not clearly understand its purpose, cross out any part of the form You don't want applied to care or have a change of mind about treatment You previously approved; refuse treatment and be told what medical consequences might result from Your refusal; be informed of policies regarding "living wills" as required by state and federal laws (these kinds of documents explain Your rights to make health care decisions, in advance, if You become unable to make them); expect privacy about care and confidentiality in all communications and in Your medical records; expect clear explanations about benefits and exclusions; contact Our Customer Service department and ask questions or present complaints; and be informed of the right to appeal an action or denial and the related process.

You have a responsibility to: tell the Provider You are covered by Regence BlueCross BlueShield of Oregon and show a Member card when requesting health care services; be on time for appointments and to call immediately if there is a need to cancel an appointment or if You will be late. You are responsible for any charges the Provider makes for "no shows" or late cancellations; provide complete health information to the Provider to help accurately diagnose and treat Your condition; follow instructions given by those providing health care to You; review this health care benefits Booklet to make sure services are covered by the Contract; make sure services are preauthorized when required by the Contract before receiving medical care; contact Our Customer Service department if You believe adequate care is not being received; read and understand all materials about Your health benefits and make sure Family Members that are covered under the Contract also understand them; give a Member card to Your enrolled Family Members to show at the time of service; and pay any required Copayments at the time of service.

HOW DO I ACCESS CARE IN THE EVENT OF AN EMERGENCY?

If You experience an emergency situation, You should obtain care from the nearest appropriate facility, or dial 911 for help.

If there is any doubt about whether Your condition requires emergency treatment, You can always call the Provider for advice. The Provider is able to assist You in coordinating medical care and is an excellent resource to direct You to the appropriate care since he or she is familiar with Your medical history.

HOW WILL I KNOW IF MY BENEFITS CHANGE OR ARE TERMINATED?

If You are insured through a group plan at work, Your employee benefits administrator will let You know if and when Your benefits change. In the event Your Group contract terminates and Your employer does not replace the coverage with another group contract, Your employer is required by law to advise You in writing of the termination.

WHAT HAPPENS IF I AM RECEIVING CARE AND MY DOCTOR IS NO LONGER A CONTRACTING PROVIDER?

When a Physician's or Practitioner's (herein Provider) contract ends with Us for any reason, We will give notice to those Members that We know, or should reasonably know, are under the care of the Provider of his or her rights to receive continued care (called "continuity of care"). We will send this notice no later than ten days after the Provider's termination date or ten days after the date We learn the identity of an

affected Member, whichever is later. The exception to Our sending the notice is when the Provider is part of a group of Providers and We have agreed to allow the Provider group to provide continuity of care notification to Members.

When Continuity Of Care Applies. If You are undergoing an active course of treatment by a preferred or participating Provider and benefits for that Provider would be denied (or paid at a level below the benefit for a nonparticipating Provider) if the Provider's contract with Us is terminated or the Provider is no longer participating with Us, We will continue to pay benefits for services and supplies provided by the Provider as long as: You and the Provider agree that continuity of care is desirable and You request continuity of care from Us; the care is Medically Necessary and otherwise covered under the Contract; You remain eligible for benefits and enrolled under the Contract; and the Contract has not terminated.

Continuity of care does not apply if the contractual relationship between the Provider and Us ends in accordance with quality of care provisions of the Contract between the Provider and Us, or because the Provider: retires; dies; no longer holds an active license; has relocated outside of Our service area; has gone on sabbatical; or is prevented from continuing to care for patients because of other circumstances.

How Long Continuity Of Care Lasts. Except as follows for pregnancy care, We will provide continuity of care until the earlier of the following dates: the day following the date on which the active course of treatment entitling You to continuity of care is completed; or the 120th day after notification of continuity of care. If You become eligible for continuity of care after the second trimester of pregnancy, We will provide continuity of care for that pregnancy until the earlier of the following dates: the 45th day after the birth; the day following the date on which the active course of treatment entitling You to continuity of care is completed; or the 120th day after notification of continuity of care.

The notification of continuity of care will be the earlier of the date We or, if applicable, the Provider group notifies You of the right to continuity of care, or the date We receive or approve the request for continuity of care.

COMPLAINT AND APPEALS: IF I AM NOT SATISFIED WITH MY HEALTH PLAN OR PROVIDER WHAT CAN I DO TO FILE A COMPLAINT OR GET OUTSIDE ASSISTANCE?

To voice a complaint with Us, simply follow the process outlined in the Resolving Your Concerns Section of this Booklet. This includes if applicable, information about filing an appeal through an Independent Review Organization without charge to You.

You also have the right to file a complaint and seek assistance from the Oregon 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.

HOW CAN I PARTICIPATE IN THE DEVELOPMENT OF YOUR CORPORATE POLICIES AND PRACTICES?

Your feedback is very important to Us. If You have suggestions for improvements about coverage or Our services, We would like to hear from You.

We have formed several advisory committees to allow participation in the development of corporate policies and to provide feedback:

- the Member advisory committee for Members;
- the marketing advisory panel for employers; and
- the Provider advisory committee for health care professionals.

If You would like to become a Member of the Member advisory committee, send Your name, identification number, address and phone number to the vice president of Customer Service at the following address. The advisory committees generally meet two times per year.

Regence BlueCross BlueShield of Oregon ATTN: Vice President, Customer Service, P.O. Box 1271, Portland, OR 97207-1271 or send Your comments to Us over the internet at: **www.Regence.com**.

Please note that the size of the committees may not allow Us to include all those who indicate an interest in participating.

WHAT ARE YOUR PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT CRITERIA?

Prior authorization, also known as preauthorization, is the process We use to determine the benefits, eligibility and Medical Necessity of a service before it is provided. Contact Our Customer Service department at the phone number on the back of Your Member card, or ask Your Provider for a list of services that need to be preauthorized. Many types of treatment may be available for certain conditions; the preauthorization process helps the Provider work together with You, other Providers and Us to determine the treatment that best meets Your medical needs and to avoid duplication of services.

This teamwork helps save thousands of dollars in premiums each year, which then translates into savings for You. And, preauthorization is Your assurance that medical services won't be denied because they are not Medically Necessary.

Utilization management is a process in which We examine services a Member receives to ensure that they are Medically Necessary and appropriate with regard to widely accepted standards of good medical practice. For further explanation, look at the definition of Medically Necessary in the Definitions Section of this Booklet.

Let Us know if You would like a written summary of information that We may consider in Our utilization management of a particular condition or disease. Simply call the Customer Service phone number on the back of Your Member card, or log onto Our Web site at **www.Regence.com**.

HOW ARE IMPORTANT DOCUMENTS (SUCH AS MY MEDICAL RECORDS) KEPT CONFIDENTIAL?

We have a written policy to protect the confidentiality of health information. Only employees who need to know in order to do their jobs have access to a Member's personal information. Disclosure outside the company is permitted only when necessary to perform functions related to providing Your coverage and/or when otherwise allowed by law. Note that with certain limited exceptions, Oregon law requires insurers to obtain a written authorization from the Member or his or her representative before disclosing personal information. One exception to the need for a written authorization is disclosure to a designee acting on behalf of the insurer for the purpose of utilization management, quality assurance or peer review.

MY NEIGHBOR HAS A QUESTION ABOUT THE POLICY THAT HE HAS WITH YOU AND DOESN'T SPEAK ENGLISH VERY WELL. CAN YOU HELP?

Yes. Simply have Your neighbor call Our Customer Service department at the number on his or her Member card. One of Our representatives will coordinate the services of an interpreter over the phone. We can help with sign language as well as spoken languages.

WHAT ADDITIONAL INFORMATION CAN I GET FROM YOU UPON REQUEST?

The following documents are available by calling a Customer Service representative:

- Rules related to Our medication Formulary, including information on whether a particular medication is included or excluded from the Formulary.
- Provisions for referrals for specialty care, behavioral health services and Hospital services and how Members may obtain the care or services.
- Our annual report on complaints and appeals.
- A description of Our risk-sharing arrangements with Physicians and other Providers consistent with risk-sharing information required by the Health Care Financing Administration. A description of Our efforts to monitor and improve the quality of health services.
- Information about procedures for credentialing network Providers and how to obtain the names, qualifications and titles of the Providers responsible for a Member's care.
- Information about Our prior authorization and utilization management procedures.

WHAT OTHER SOURCE CAN I TURN TO FOR MORE INFORMATION ABOUT YOUR COMPANY?

The following information regarding the Health Benefit Plans of Regence BlueCross BlueShield of Oregon is available from the Oregon Insurance Division:

- The results of all publicly available accreditation surveys.
- A summary of Our health promotion and disease prevention activities.
- Samples of the written summaries delivered to policyholders.
- An annual summary of Grievances and appeals.
- An annual summary of utilization management policies.
- An annual summary of quality assessment activities.
- An annual summary of scope of network and accessibility of services.

To obtain the mentioned information, You can call the Oregon Insurance Division at (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 can also contact Our Customer Service department at 1 (888) 367-2116.

Summary Plan Description

The Plan is an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA). For further information regarding ERISA, contact the Plan Sponsor.

PLAN NAME
Vigilant Group Benefits Trust

NAME, ADDRESS AND PHONE NUMBER OF PLAN SPONSOR
Vigilant
6825 SW Sandburg Street, Tigard, OR 97223
(503) 620-1710

The plan is maintained by more than one employer. Contact Your employer to obtain its address and other identifying information. For information about any other employer that may be participating in the Trust, please contact the Plan Administrator.

EMPLOYER IDENTIFICATION NUMBER ASSIGNED FOR THIS PLAN BY THE IRS
EIN 93-0496390

PLAN NUMBER
512

TYPE OF PLAN
Welfare Benefit Plan: medical and prescription medication benefits

TYPE OF ADMINISTRATION
This Plan is administered in accordance with the terms of the group insurance contract issued by Regence BlueCross BlueShield of Oregon.

NAME, ADDRESS AND PHONE NUMBER OF PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS
Board of Trustees
Vigilant Group Benefits Trust,
6825 SW Sandburg Street
Tigard, OR 97223
(503) 620-1710

NAME AND ADDRESS OF AGENT FOR SERVICE OF PROCESS
DiMartino Associates
1501 Fourth Avenue, Suite 2400
Seattle, WA 98101
(206) 623-2430

Service of Process may also be made on the Plan's Trustees.

NAMES, TITLES AND ADDRESSES OF BOARD OF TRUSTEES
Rodger M. Glos, Trustee Chair, Vigilant 6825 SW Sandburg Street, Tigard, OR 97223

Jim Everett, Vanport International, P.O. Box 97, Boring, OR 97009

Tom Jackman, IFA Nurseries, Inc., 9450 SW Commerce Circle Suite 370, Wilsonville, OR 97070

SOURCES OF CONTRIBUTIONS TO THE PLAN
This Plan is funded through Member Employer and, in some instances, employee contributions at rates determined by the Trust based on costs of providing Plan benefits. Contact Your employer for employee contribution information.

ENTITLES USED FOR ACCUMULATION OF ASSETS AND PAYMENT OF BENEFITS

The Member Employer premiums are paid to Regence BlueCross BlueShield of Oregon, an insurance company that underwrites and provides fully insured coverage. The benefits are provided by Regence BlueCross BlueShield of Oregon.

FUTURE OF THE PLAN

Vigilant and the Trustees expect to continue the Plan indefinitely. However, they reserve the right to amend, modify or reduce benefits, or terminate the Plan at any time, for any reason, subject to the applicable provisions of the group insurance policy and the Trust document.

Claims incurred before the effective date of a Plan change or termination will not be affected. Claims incurred after the Plan changes will be covered according to the provisions in effect at the time claim is incurred. Claims incurred after the Plan is terminated will not be covered. You will not be vested in any Plan benefits or have any further rights, subject to applicable law.

NOT CONTRACT OF EMPLOYEMENT

This Plan shall not be a contract of employment between any employer and any covered employee, or be consideration for, or an inducement or condition of, the employment of any employee. Any employer may discharge any employee at any time.

BENEFITS NOT ASSIGNABLE

This Trust and the related Plan are for the personal protection of the covered employees and their dependents. No vested or unvested interest of any covered employee or dependent may be assigned, seized by legal process, transferred or subjected to the claims of creditors in any way.

PLAN'S RIGHT OF RECOVERY

When a payment is made that exceeds the normal Plan benefits for You or Your covered family members, the insurance company has the right to recover the excess amount. An overpayment may result when the Plan pays more for Your claim than the total benefit due under the Plan. Overpayments may also occur when the Plan makes a payment that should have been made under another group plan.

The parties from whom the claims administrator could seek recovery include You, the person or organization paid, or any other insurance companies or organizations. As an alternative, the insurance company may deduct the overpayment from any subsequent Plan benefits payable to You or a family member.

AUTHORITY TO ADMINISTER PLANS

The Trustees of the Trust are the Plan Administrator as defined in ERISA and the Trust has the discretionary authority to determine eligibility for participation or coverage.

The Trust grants us discretionary authority to administer claims, to determine the nature, amount and duration of benefits and to determine any other questions arising out of or in connection with the administration of claims under the Plan.

DISPOSITION OF PLAN ASSETS AFTER TERMINATION

The Trustees may terminate the Plan as to all participating employees at any time by giving written notice to the employers at least 30 days before the end of the month the termination is to become effective.

If the Trust is terminated, the Trustees shall continue this Trust until all assets have been used to provide for payment of benefits in accordance with the Plan.

EXCLUSIVE BENEFIT

The Plan is maintained for the exclusive benefit of employees of participating employers.

PLAN FISCAL YEAR ENDS ON

December 31

NOTICE OF ERISA RIGHTS

As a participant of Vigilant Group Benefits Trust, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan And Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Employer Health Plan Coverage

Continue health care coverage for Yourself, spouse, or children if there is a loss of coverage under the Plan as a result of a qualifying event under COBRA. You or Your Beneficiaries may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for a description of the rules governing Your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights

If Your claim for a health and welfare benefit is denied in whole or in part, You must receive a written explanation of the reasons for the denial. You have the right to have the Plan Sponsor review and reconsider Your claim. Under ERISA, there are steps You can take to enforce these rights. For instance, if You request materials from the Plan and You do not receive them within 30 days, You may file suit in the Federal court. In such case, the court may require the Plan Administrator to provide the material and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

Procedures For Filing Claims

If You have a claim for benefits (for Yourself or for one of Your Beneficiaries) which is denied or ignored in whole or in part, You have the right to a hearing before the Plan Sponsor at which You may present Your position and any supporting evidence. You also have the right to be represented by an attorney or any other representative of Your choice. Further, if You are dissatisfied with the Plan Sponsor's determination, You may pursue an action pursuant to 29 USC§1132(a).

For detailed information on how to submit a claim for benefits or how to file an appeal on a processed claim, refer to the Submission And Payment Of Claims and Grievance and Appeal Procedures provisions of this Plan Summary Plan Description.

In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that the plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the US Department of Labor, or You may file suit in Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance With Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA You should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue NW, Washington DC 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

FOR YOUR INFORMATION

CLAIMS INFORMATION
Regence BlueCross BlueShield of Oregon

Attn: Claims Department

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

GENERAL INFORMATION
Contact Customer Service at 1 (888) 367-2116

Visit our Website address at **www.Regence.com**

PHARMACY INFORMATION
To find a list of Participating Pharmacies, visit Our Web sites at **www.regence.com**

For Pharmacy Preauthorization, call Customer Service at 1 (888) 367-2116

CASE MANAGEMENT
For Case Management questions, contact 1 (866) 543-5765

GRIEVANCE AND APPEALS INFORMATION
Send written requests to: Appeals Coordinator, Regence BlueCross BlueShield of Oregon, P.O. Box 4208, Portland, OR 97208-4208 or facsimile 1 (888) 496-1542

For verbal requests, contact Customer Service at 1 (888) 367-2116

ASSISTANCE WITH YOUR QUESTIONS ABOUT COBRA
Contact Benefit Solutions Inc, P.O. Box 65, Mukilteo, Washington 97275

Call: (206) 859-2600. Fax: (425) 771-1226.

Regence BlueCross BlueShield of Oregon is an independent licensee of the Blue Cross and Blue Shield Association.

For more information call us at 1 (888) 367-2116 or you can write to us at 100 SW Market Street, Portland, OR 97201

www.Regence.com

Regence BlueCross BlueShield of Oregon