Regence BlueCross BlueShield of Oregon Policy

Individual Group Number: 38002001

2020 Medical Benefits

Regence

WO0120PHEPOD

Know your rights under the Balance Billing Protection Act

Beginning January 1, 2020, Washington state law protects you from 'surprise billing' or 'balance billing' if you receive emergency care or are treated at an in-network hospital or outpatient surgical facility

What is 'surprise billing' or 'balance billing' and when does it happen?

Under your health plan, you're responsible for certain cost-sharing amounts. This includes copayments, coinsurance and deductibles. You may have additional costs or be responsible for the entire bill if you see a provider or go to a facility that is not in your plan's provider network.

Some providers and facilities have not signed a contract with your insurer. They are called 'out-of-network' providers or facilities. They can bill you the difference between what your insurer pays and the amount the provider or facility bills. This is called 'surprise billing' or 'balance billing.'

Insurers are required to tell you, via their websites or on request, which providers, hospitals and facilities are in their networks. And hospitals, surgical facilities and providers must tell you which provider networks they participate in on their website or on request.

When you CANNOT be balance billed:

Emergency Services
The most you can be billed for emergency services is your plan's in-network cost-sharing amount even if you receive services at an out-of-network hospital in Washington, Oregon or Idaho or from an out-of-network provider that works at the hospital. The provider and facility cannot balance bill you for emergency services.

Certain services at an In-Network Hospital or Outpatient Surgical Facility
When you receive surgery, anesthesia, pathology, radiology, laboratory, or hospitalist services from an out-of-network provider while you are at an in-network hospital or outpatient surgical facility, the most you can be billed is your in-network cost-sharing amount. These providers cannot balance bill you.

In situations when balance billing is not allowed, the following protections also apply:

- Your insurer will pay out-of-network providers and facilities directly. You are only responsible for paying your in-network cost-sharing.
- Your insurer must:
    - Base your cost-sharing responsibility on what it would pay an in-network provider or facility in your area and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or certain out-of-network services(described above) toward your deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 30 business days.
- A provider, hospital, or outpatient surgical facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital or facility in any OTHER situation, you may still be balance billed, or you may be responsible for the entire bill.

***This law does not apply to all health plans. If you get your health insurance from your employer, the law might not protect you. Be sure to check your plan documents or contact your insurer for more information*.**

If you believe you've been wrongly billed, file a complaint with the Washington state Office of the Insurance Commissioner at www.insurance.wa.gov or call 1-800-562-6900.

NONDISCRIMINATION NOTICE

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

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

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

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

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

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

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

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

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

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

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

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

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

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

Language assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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SCHEDULE OF BENEFITS

Silver HSA 2700 EPO PeaceHealth

This Schedule of Benefits is a part of Your Policy and provides information regarding Your costs for Covered Services and how Provider choice affects Your out-of-pocket costs. Read the entire Policy for a complete understanding of the benefits, limitations, exclusions, definitions, and provisions of the plan.

Your costs are subject to all of the provisions of the Policy including the following terms: Allowed Amount, Coinsurance, Deductibles and Out-of-Pocket Maximum as explained in the Policy.

Deductible	
Per Member	**$2,700**
Per Family	**$5,400**

Out-of-Pocket Maximum	
Per Member	**$6,900**
Per Family	**$13,800**

YOUR PROVIDERS AND OUT-OF-POCKET EXPENSES

This plan uses the following networks:

PeaceHealth medical network
VSP Choice vision network
Participating Dental network

This plan requires You to see Providers in Your network (In-Network Providers) to receive benefits for Covered Services. Services received from Providers outside of Your network (Out-of-Network Providers) will not be covered except as specified below. A list of In-Network Providers is available on Our Web site aregence.com. We update this directory regularly, but it is subject to change. You may also call Us for current information and to verify that Your Provider is an In-Network Provider before You receive services.

- **In-Network.** You see an In-Network Provider and save the most in Your out-of-pocket expenses, and You will not be billed for balances beyond the Deductible, Copayment and/or Coinsurance for Covered Services.
- **Out-of-Network.** When You see an Out-of-Network Provider You are responsible for all expenses, except as otherwise specified below for Ambulance, Blood Bank and Emergency Room services. For these Out-of-Network services, an Out-of-Network Provider may bill You for any balances beyond the Deductible and/or Coinsurance (sometimes referred to as balance billing).

In-Network Benefits for Pediatric Vision

For Pediatric Vision services, this plan requires You to see a VSP Doctor (In-Network Provider).

- **VSP Doctor (In-Network Provider).** A VSP Doctor has a contract with VSP. You see a VSP Doctor and You save the most in Your out-of-pocket expenses, and You will not be billed for balances beyond the Allowed Amount.
- **Out-of-Network Provider.** If You see an Out-of-Network Provider that does not have a contract with VSP, You are responsible for all expenses.

	YOUR COSTS OF THE ALLOWED AMOUNT FOR SERVICES INSIDE THE SERVICE AREA	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Office Visits – Illness or Injury	After Deductible, 20% Coinsurance	Not covered
Outpatient Laboratory and Radiology Services • Diagnostic services not covered under Preventive Care and Immunizations or Complex Imaging - Outpatient	After Deductible, 20% Coinsurance	Not covered
Preventive Care and Immunizations	No charge	Not covered
Other Professional Services	After Deductible, 20% Coinsurance	Not covered
Acupuncture • 12 visits per Calendar Year	After Deductible, 20% Coinsurance	Not covered
Ambulance Services	After Deductible, 20% Coinsurance	
Blood Bank	After Deductible, 20% Coinsurance	
Complex Imaging – Outpatient	After Deductible, 20% Coinsurance	Not covered
Dental Hospitalization	After Deductible, 20% Coinsurance	Not covered
Detoxification	After Deductible, 20% Coinsurance	Not covered
Diabetic Education	After Deductible, 0% Coinsurance	Not covered
Dialysis	After Deductible, 20% Coinsurance	Not covered
Durable Medical Equipment	After Deductible, 20% Coinsurance	Not covered

	YOUR COSTS OF THE ALLOWED AMOUNT FOR SERVICES INSIDE THE SERVICE AREA	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Emergency Room	After Deductible, 20% Coinsurance	
Gene Therapy and Adoptive Cellular Therapy	After Deductible, 20% Coinsurance	Not covered
Genetic Testing	After Deductible, 20% Coinsurance	Not covered
Habilitative Services • 30 inpatient days per Calendar Year • 25 outpatient visits per Calendar Year	After Deductible, 20% Coinsurance	Not covered
Home Health Care • 130 visits per Calendar Year	After Deductible, 20% Coinsurance	Not covered
Hospice Care • 14 inpatient or outpatient respite days per Lifetime	After Deductible, 20% Coinsurance	Not covered
Hospital and Ambulatory Surgical Center Care	After Deductible, 20% Coinsurance	Not covered
Maternity Care	After Deductible, 20% Coinsurance	Not covered
Medical Foods	After Deductible, 20% Coinsurance	Not covered
Mental Health Services	After Deductible, 20% Coinsurance	Not covered
Neurodevelopmental Therapy • 25 outpatient visits per Calendar Year • No limit for inpatient days	After Deductible, 20% Coinsurance	Not covered
Newborn Care	After Deductible, 20% Coinsurance	Not covered
Nutritional Counseling	After Deductible, 20% Coinsurance	Not covered
Orthotic Devices	After Deductible, 20% Coinsurance	Not covered

	YOUR COSTS OF THE ALLOWED AMOUNT FOR SERVICES INSIDE THE SERVICE AREA	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Palliative Care • 30 visits per Calendar Year	After Deductible, 20% Coinsurance	Not covered
Pediatric Dental – Preventive and Diagnostic Dental Services	After Deductible, 0% Coinsurance	Not covered
Pediatric Dental – Basic Dental Services	After Deductible, 20% Coinsurance	Not covered
Pediatric Dental – Major Dental Services	After Deductible, 50% Coinsurance	Not covered
Pediatric Vision Examination	No charge	Not covered
Pediatric Vision Hardware – Lenses	No charge	Not covered
Pediatric Vision Hardware – Frames	No charge for frames from the Otis & Piper Eyewear Collection. All other frames You pay the full cost of the frame minus any discount. Refer to the Additional Discount provision in Your Policy.	Not covered
Pediatric Vision – Low Vision Benefit	No charge	Not covered

	YOUR COSTS OF THE ALLOWED AMOUNT FOR SERVICES INSIDE THE SERVICE AREA	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Prescription Medications – from a Participating or Preferred Pharmacy • 90-day supply for Prescription Medications (even if packaging includes larger supply). Copayment or Coinsurance is based on each 30-day supply. • 90-day supply for Self-Administrable Injectable Medications • 30-day supply for Specialty Medications • Up to a 12-month supply for refills of FDA-approved contraceptive drugs (may be dispensed on-site at a Provider's office, if available) • Multi-month Dispensing: largest allowed quantity is the smallest supply as packaged by the drug maker • After Deductible, Medications found on the Naloxone Value List that are intended to treat opioid overdose are covered at no cost sharing. The list is found on Our Web site or by calling Customer Service. • Deductible waived for Medications designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medications list. These medications are not intended to treat an existing Illness, Injury, or condition. To obtain this list visit Our Web site or contact Customer Service. Contact information is available in Your Policy.	After Deductible, 20% Coinsurance for each Preferred Generic Medication on the Drug List. You can receive a 5% discount if filled at a Preferred Pharmacy.	Not covered
	After Deductible, 25% Coinsurance for each Generic Medication on the Drug List. You can receive a 5% discount if filled at a Preferred Pharmacy.	Not covered
	After Deductible, 30% Coinsurance for each Preferred Brand-Name Medication on the Drug List. You can receive a 5% discount if filled at a Preferred Pharmacy.	Not covered
	After Deductible, 50% Coinsurance for each Brand-Name Medication on the Drug List. You can receive a 5% discount if filled at a Preferred Pharmacy.	Not covered
	After Deductible, 40% Coinsurance for each Preferred Specialty Medication on the Drug List. Preferred Specialty Medication first fill allowed at a Pharmacy. Additional fills must be provided by a Specialty Pharmacy.	Not covered
	After Deductible, 50% Coinsurance for each Specialty Medication on the Drug List. Specialty Medication first fill allowed at a Pharmacy. Additional fills must be provided by a Specialty Pharmacy.	Not covered

	YOUR COSTS OF THE ALLOWED AMOUNT FOR SERVICES INSIDE THE SERVICE AREA	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Prescription Medications – from a Mail-Order Supplier • 90-day supply for Self-Administrable Injectable Medications • 90-day supply for Prescription Medications • Up to a 12-month supply for refills of FDA-approved contraceptive drugs • Deductible waived for Medications designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medications list. These medications are not intended to treat an existing Illness, Injury, or condition. To obtain this list visit Our Web site or contact Customer Service. Contact information is available in Your Policy.	After Deductible, 15% Coinsurance for each Preferred Generic Medication on the Drug List.	Not covered
	After Deductible, 20% Coinsurance for each Generic Medication on the Drug List.	Not covered
	After Deductible, 25% Coinsurance for each Preferred Brand-Name Medication on the Drug List.	Not covered
	After Deductible, 45% Coinsurance for each Brand-Name Medication on the Drug List.	Not covered
Self-Administrable Cancer Chemotherapy Medications • 30-day supply	After Deductible, 20% Coinsurance for each Preferred Generic and Generic Medication on the Drug List.	Not covered
	After Deductible, 20% Coinsurance for each Preferred Brand-Name and Brand-Name Medication on the Drug List.	Not covered
	After Deductible, 20% Coinsurance for each Preferred Specialty and Specialty Medication on the Drug List. Preferred Specialty and Specialty Medications must be provided by a Specialty Pharmacy.	Not covered
Prosthetic Devices	After Deductible, 20% Coinsurance	Not covered
Reconstructive Services and Supplies	After Deductible, 20% Coinsurance	Not covered

	YOUR COSTS OF THE ALLOWED AMOUNT FOR SERVICES INSIDE THE SERVICE AREA	
BENEFIT	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Rehabilitation Services • 30 inpatient days per Calendar Year • 25 outpatient visits per Calendar Year	After Deductible, 20% Coinsurance	Not covered
Reproductive Health Care Services • Male condoms, and brand contraceptive drugs	No charge after IRS minimum deductible; see Covered Preventive Medications in Your Policy for more information	
• Vasectomy	No charge after IRS minimum deductible; see Preventive Care and Immunizations in Your Policy for more information	Not covered
• All other FDA-approved contraceptive drugs, devices, products and services	No charge	
Retail Clinic Office Visits	After Deductible, 20% Coinsurance	Not covered
Skilled Nursing Facility (SNF) Care • 60 inpatient days per Calendar Year	After Deductible, 20% Coinsurance	Not covered
Spinal Manipulations • Ten spinal manipulations per Calendar Year	After Deductible, 20% Coinsurance	Not covered
Substance Use Disorder Services	After Deductible, 20% Coinsurance	Not covered
Temporomandibular Joint (TMJ) Disorders	After Deductible, 20% Coinsurance	Not covered
Transplants	After Deductible, 20% Coinsurance	Not covered
Urgent Care Center	After Deductible, 20% Coinsurance	Not covered
Virtual Care • **Store and Forward Services**	After Deductible, 0% Coinsurance	Not covered
• **Telehealth**	After Deductible, 20% Coinsurance	Not covered
• **Telemedicine**	After Deductible, 20% Coinsurance	Not covered

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Endorsement to Your Medical Policy or Booklet

This Endorsement modifies Your medical Policy or Booklet, effective March 25, 2020, pursuant to Proclamation 20-29 issued by the Governor of the State of Washington and to Emergency Orders 20-01, 20-02, and 20-04 issued by the Office of Insurance Commissioner of the State of Washington.

This Endorsement is subject to the provisions, terms, conditions, limitations and exclusions set forth in the Policy or Booklet to which it is attached. If there is any inconsistency between this Endorsement and the Policy or Booklet, the terms of this Endorsement will prevail.

The following changes are made to Your Policy or Booklet:

1. Deductibles, Copayments, and Coinsurance will be waived for the FDA-authorized COVID-19 test and the associated Provider visit.

2. Any prior authorization requirements that previously may have applied to covered testing and treatment for COVID-19 illness will be suspended.

3. While You should use In-Network Providers whenever possible, COVID-19 associated Covered Services from Out-of-Network Providers will be covered at the In-Network cost sharing level for those COVID-19 associated Covered Services.

4. A one-time early refill of covered Prescription Medications prior to the expiration of the waiting time between refills will be allowed, taking into account patient safety risks associated with certain drug classes. This one-time early refill does not apply to opioid medications.

5. Benefits will be extended to permit the use of a non-HIPAA compliant platform for the provision of Covered Services by In-Network Providers through telehealth. Any requirement for a secure HIPAA-compliant platform will be suspended for In-Network Providers that do not already utilize or are unable to readily access a HIPAA-compliant platform.

6. Deductibles, Copayments, and Coinsurance will be waived for diagnostic test panels for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV), when such testing is determined to be medically necessary by Your Provider, and when billed in conjunction with a COVID-19 related diagnosis code.

7. Services provided at a drive-through site established for testing and assessment of COVID-19 are covered as a Provider visit when provided by In-Network Providers. The testing and assessment of COVID-19 symptoms performed at a drive-through site must be approved by either the U.S. Food and Drug Administration (FDA) or the Washington State Department of Health, and must be provided as ordered by Your Provider.

8. Any prior authorization requirements that may apply to long-term care facility or home health services following discharge from a Hospital will be suspended, when insufficient time exists to receive prior authorization before the delivery of care. Prior authorization for any other Covered Services necessary for discharge to a long-term care facility or home will be administered as an expedited prior authorization request.

9. The grace period for payment of monthly premiums is changed from 30 days to 60 days unless You are covered by a qualified health plan and receiving advanced premium tax credit through the Health Benefit Exchange. If monthly premium is not received within 60 days of the Premium Due Date (the grace period), coverage may end automatically and without further prior written notice on the thirty-

first day of the grace period, subject to Your continued obligation to pay premiums for the first thirty days of the grace period, and You potentially will be subject to billing from health care providers for unpaid claims for services rendered after the first thirty days of the grace period.

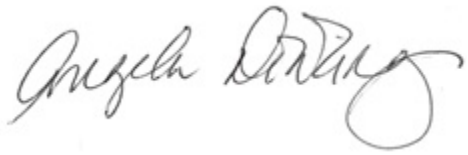
10. The amount which We reimburse an In-Network Provider furnishing a Medically Necessary Covered Service through telehealth will be the same as if the service was provided in person by the Provider.

Regence BlueCross BlueShield of Oregon complies with all state and federal requirements regarding COVID-19. The changes to Your Policy or Booklet outlined by this endorsement will remain in effect until the underlying Proclamation or Emergency Order expires without extension, is rescinded, or is further modified by the Governor of the State of Washington or the Office of Insurance Commissioner of the State of Washington.

For more information, call Customer Service at the number listed in Your Policy or Booklet or visit **regence.com**.

All other terms and conditions of Your Policy or Booklet remain unchanged.

IN WITNESS WHEREOF, We, by Our duly authorized officer, have executed this Endorsement.



Angela Dowling
President
Regence BlueCross BlueShield of Oregon

Introduction

Regence BlueCross BlueShield of Oregon

Street Address:
100 SW Market Street
Portland, OR 97201

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

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

Medical/Dental Customer Service/Correspondence Address:
MS CS B32B
P.O. Box 1827
Medford, OR 97501-9884

Vision Customer Service/Correspondence Address:
Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100

Medical/Dental Appeals Address:
P.O. Box 1408
Lewiston, ID 83501

Vision Appeals Address:
Vision Service Plan Insurance Company
Attention: Complaint and Appeals Unit
P.O. Box 997100
Sacramento, CA 95899-7100

POLICY

This Policy is effective **December 1, 2020**, for the Policyholder and Enrolled Dependents, providing the evidence and a description of the terms and benefits of coverage. This Policy replaces any other contract You may have received.

Regence BlueCross BlueShield of Oregon, an independent licensee of the Blue Cross and Blue Shield Association, agrees to provide benefits for Medically Necessary services as described in this Policy, subject to all of the terms, conditions, exclusions and limitations in this Policy, including the Schedule of Benefits and any endorsements affixed hereto. This agreement is in consideration of the premium payments hereinafter stipulated and in further consideration of the application and statements currently on file with Us and signed by the Policyholder for and on behalf of the Policyholder and/or any Enrolled Dependents listed in this Policy, which are hereby referred to and made a part of this Policy.

EXAMINATION OF POLICY

After examination, if the Policyholder is not satisfied with this Policy for any reason, the above-named Policyholder will be entitled to return this Policy within 10 days after its delivery date. If the Policyholder returns this Policy to Us within the stipulated 10-day period, such Policy will be considered void as of the original Effective Date and the Policyholder generally will receive a refund of premiums paid, if any. (If benefits already paid under this Policy exceed the premiums paid by the Policyholder, We will be entitled to retain the premiums paid and the Policyholder will be required to repay Us for the amount of benefits paid in excess of premiums.) We shall pay the Policyholder an additional 10 percent of the refund amount if such refund is not made within 30 days of the return of this Policy to Us.

Angela Dowling
President
Regence BlueCross BlueShield of Oregon

Using Your Policy

YOUR PARTNER IN HEALTH CARE

We are pleased that You have chosen Us as Your partner in health care. It's important to have continued protection against unexpected health care costs. This plan provides coverage that's comprehensive, affordable and provided by a partner You can trust in times when it matters most. Your vision coverage is provided by Regence, in collaboration with Vision Service Plan Insurance Company (VSP), which coordinates benefits and claims processing for the Pediatric Vision portion of this plan.

The following sections may be useful to You:

- **Schedule of Benefits**: describes Your costs for Covered Services.
- **Additional Advantages of Membership**: describes other advantages of membership with Us.
- **Contact Information**: describes how to contact Us by phone or via Our Web site.
- **Understanding Your Benefits**: describes Maximum Benefits, Deductibles and/or Coinsurance and Out-of-Pocket Maximums.
- **Medical Benefits**: describes preauthorization and what is covered.
- **Exclusions**: describes in detail what is not covered.
- **Policy and Claims Administration**: describes how claims are submitted, what You must do if a third party is responsible for an Illness or Injury, and how benefits are paid when You have other coverage.
- **Appeals and Grievances**: describes what to do if You want to file an Appeal or a Grievance.
- **Who is Eligible, How to Apply and When Coverage Begins**: describes who is eligible to apply and when.
- **When Coverage Ends**: describes what happens when You are no longer eligible for coverage.
- **General Provisions and Legal Notices**: describes important general Policy provisions and legal notices.
- **Definitions**: describes important terms used in this Policy and Schedule of Benefits.

ADDITIONAL ADVANTAGES OF MEMBERSHIP

Advantages of membership include access to discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to Our Web site an interactive environment that can help You navigate Your way through health care decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE INDIVIDUAL POLICY, BUT ARE NOT INSURANCE.**

- Go to **regence.com**. It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your health care dollar. Have Your member card handy to log on. Use the secure Web site to:

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

*Note that if You choose to access these discounts, You may receive savings on an item or service that is covered by Your Policy, that also may create savings or administrative fees for Us. Any such discounts or coupons are complements to the individual Policy, but are not insurance.

CONTACT INFORMATION

- **Medical/Dental Customer Service:** 1 (888) 675-6570 (TTY: 711) or visit Our Web site: **regence.com** if You have questions, would like to learn more about Your plan, have not received or have lost Your member card, or would like to request written or electronic information regarding any health care plan We offer. Phone lines are open Monday-Friday 5 a.m. - 8 p.m. and Saturday 8 a.m. - 4:30 p.m. Pacific Time.

- **Vision Provider and benefit questions:** call VSP at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance), Monday-Friday 5 a.m. - 8 p.m. Saturday 7 a.m. - 8 p.m., and Sunday 7 a.m. - 7 p.m. You may also visit VSP's Web site at **vsp.com**.
- **For assistance in a language other than English,** call the Customer Service telephone number.
- **BlueCard® Program.** You have limited access to care through the BlueCard Program, which 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. Such access is further described in the Out-of-Area Services provision of this Policy. You can also contact Customer Service to learn about access to care through the BlueCard Program.
- **Health Plan Disclosure Information.** You may receive written or electronic copies of the following health plan disclosure information by calling the Customer Service telephone number or access that information through Our Web site at **https://www.regence.com/web/regence_individual/all-forms**. Available disclosure information includes, but is not limited to:

    - a listing of covered benefits, including prescription drug benefits;
    - a copy of the current Drug List;
    - exclusions, reductions, and limitations to covered benefits;
    - our Policies for protecting the confidentiality of Your health information;
    - cost of premiums and Insured cost-sharing requirements;
    - a summary of Adverse Benefit Determinations and the Grievance Processes; and
    - lists of In-Network primary care and specialty care Providers.

Table of Contents

Understanding Your Benefits

In this section, You will find information to help You understand what is meant by Maximum Benefits, Deductibles and/or Coinsurance and Out-of-Pocket Maximum.

This section defines cost-sharing elements, but You will need to refer to the Schedule of Benefits and the Medical Benefits section to see exactly how they are applied.

On this high deductible health plan, it is important to understand the difference between Single coverage and Family Coverage. Single Coverage means only one person has coverage under this Policy. Examples of Single Coverage include a Policyholder who is the only one in his or her Family who has coverage under this Policy and an Enrolled Dependent who is continuing insurance coverage on his or her own. Family Coverage means two or more members of the same Family have coverage under this Policy under a single application.

MAXIMUM BENEFITS

Some benefits may have a specific Maximum Benefit. Benefits are covered until the specified Maximum Benefit (which may be a number of days, visits, services, supplies, dollar amount or specified time period) has been reached. Amounts You pay toward Your Deductible also apply to any specified Maximum Benefit.

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

DEDUCTIBLES

The Deductible is the amount You are required to pay for Covered Services before We begin to pay benefits for Covered Services in a Calendar Year. The Family Coverage Deductible is the amount one or more members of Your Family are required to pay for Covered Services in a Calendar Year before We begin to pay benefits for Covered Services. Allowed charges and eligible expenses are applied towards the Calendar Year Deductible. Calendar Year Deductibles are specified on the Schedule of Benefits.

We do not pay for services applied toward 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. Any amount paid through use of a drug manufacturer coupon may not count toward the Deductible. Refer to the Schedule of Benefits to determine if a particular service is subject to the Deductible.

PERCENTAGE PAID UNDER THIS POLICY (COINSURANCE)

Once You have satisfied any applicable Deductible, 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 either the billed charges or the Allowed Amount. The percentage You pay varies, depending on the service or supply You received. Refer to the Schedule of Benefits for Coinsurance amounts You pay.

We do not reimburse Providers for charges above the Allowed Amount. An In-Network Provider will not charge You for any balances for Covered Services beyond Your applicable Deductible and/or Coinsurance amount. We generally do not cover services provided by Out-of-Network Providers; when Out-of-Network Providers are eligible to provide Covered Services, however, Out-of-Network Providers may bill You for any balances over Our payment level in addition to the Deductible and/or Coinsurance amount.

BALANCE BILLING

Balance billing occurs when You are billed for balances beyond any Deductible and/or Coinsurance for Covered Services provided to You by an Out-of-Network Provider when the Out-of-Network Provider's billed amount is not fully reimbursed by Us. You will not be balance billed for emergency services or for certain non-emergency surgical or ancillary services provided by an Out-of-network Provider at an In-Network hospital or Ambulatory Surgical Center. Non-emergency surgical or ancillary services include anesthesiology, pathology, radiology, laboratory, hospitalist, or surgical services. Any amounts You pay for emergency services or for non-emergency surgical or ancillary services will count toward Your

Deductible and Out-of-Pocket Maximum.

OUT-OF-POCKET MAXIMUM

Insureds can meet the In-Network Out-of-Pocket Maximum by their payments of Deductible and/or Coinsurance as specifically indicated on the Schedule of Benefits for Covered Services. Any amounts You pay for non-Covered Services and amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. Further, any reduction in Your Coinsurance for Prescription Medications resulting from the use of a drug manufacturer coupon may not count 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 Policy's Out-of-Pocket Maximum.

Once You reach the Out-of-Pocket Maximum, In-Network benefits will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year.

The In-Network Out-of-Pocket Maximum for any Insured on Family Coverage is satisfied when one or more family members' Deductibles and/or Coinsurance for Covered Services for that Calendar Year total and meet the Out-of-Pocket Maximum amount for Family Coverage. However, the maximum Out-of-Pocket amount for any Insured on Family Coverage is not to exceed his or her Out-of-Pocket Maximum amount for In-Network benefits. If an Insured reaches this maximum amount prior to satisfying the Family Out-of-Pocket Maximum, benefits will be paid at 100 percent of the Allowed Amount for that Insured. The In-Network Out-of-Pocket Maximum amounts are specified on the Schedule of Benefits.

HOW BENEFITS RENEW

Many provisions in this Policy (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 may have a separate Maximum Benefit based upon an Insured's Lifetime and do not renew every Calendar Year. These exceptions are noted in the Schedule of Benefits and the Medical Benefits section.

Medical Benefits

This section explains Your Policy's benefits. Referrals are not required under this Policy and nothing contained in this Policy is designed to restrict Your choice of Provider for care or treatment of an Illness or Injury. Most benefits are listed alphabetically.

Medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury, including chronic disease management services (except for any covered preventive care). All covered benefits are subject to the limitations, exclusions and provisions of this plan. A Health Intervention may be medically indicated or otherwise Medically Necessary, yet not be a Covered Service. In some cases, We may limit benefits or coverage to a less costly and Medically Necessary alternative item. See the Definitions section for descriptions of Medically Necessary and Health Intervention.

Reimbursement may be available for new medical supplies, equipment, and devices You purchase from a Provider or from an approved commercial seller, even though that seller is not a Provider. New medical supplies, equipment, and devices, such as a breast pump or wheelchair, purchased through an approved commercial seller are covered at the In-Network Provider level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item, or the retail market value for that item. To learn more about how to access an approved commercial seller and reimbursable new retail medical supplies, equipment, and devices, visit Our Web site or contact Customer Service.

If You choose to access new medical supplies, equipment and devices through Our Web site, We may receive administrative fees or similar compensation from the commercial seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to Your Policy, but are not insurance.

Some services may require preauthorization. Contracted Providers may be required to seek preauthorization from the Claims Administrator before providing some services for You. You will not be penalized if the Contracted Provider does not obtain preauthorization in advance from the Claims Administrator and the service is later determined to be not covered. Non-Contracted Providers are not required to obtain preauthorization from the Claims Administrator prior to providing services. You may be liable for the cost of services provided by a Non-Contracted Provider if those services are not Covered Services nor Medically Necessary. You may request that a Non-Contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to receiving those services.

We will not require preauthorization for emergency medical services, including admissions for emergency detoxification, or involuntarily committed mental health services provided by a state Hospital. No preauthorization is required for childbirth admissions, or admissions for newborns that need medical care at birth.

PREVENTIVE CARE AND IMMUNIZATIONS

We cover preventive care services provided by a professional Provider, facility, or Retail Clinic such as:

- routine physical examinations, well-baby care, women's care (including screening for gestational diabetes), and health screenings. Health screenings include screening for obesity in patients ages six and older, and appropriate referrals to comprehensive, intensive behavioral interventions to promote improvements in weight status;
- intensive multicomponent behavioral interventions for weight management;
- Provider counseling and prescribed medications for tobacco use cessation;
- preventive mammography services, including tomosynthesis;
- depression screening for all adults, including screening for maternal depression;
- immunizations for adults and children as recommended by the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA) and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- breastfeeding support and one new non-Hospital grade breast pump including its accompanying supplies per pregnancy, when obtained from an In-Network Provider (including a Durable Medical Equipment supplier), or a comparable new breast pump obtained from an approved commercial seller, even though that seller is not a Provider; and
- Food and Drug Administration (FDA) approved contraceptive drugs, devices, products and services (including vasectomy) as described under the Reproductive Health Care Services benefit.

Benefits will be covered if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the USPSTF, the HRSA or by the 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 complete list of services covered under this benefit, including information about how to access an approved commercial seller, obtaining a new breast pump and instructions for obtaining reimbursement for a new breast pump purchased from an approved commercial seller, retailer, or other entity that is not a Provider, visit Our Web site or contact Customer Service. If You choose to access new medical supplies, equipment, and devices through Our Web site, We may receive administrative fees or similar compensation from the commercial seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to Your Policy, but are not insurance.

Certain FDA-approved over-the-counter contraceptives, devices, and services (including vasectomy) are subject to the minimum deductible amounts permitted by the Internal Revenue Service (IRS) on a high deductible health plan that qualifies for use with a health care savings account. For 2020, those amounts are $1,400 for Single Coverage and $2,800 for Family Coverage. This amount also will accrue to the overall Plan Deductible. For more information on FDA-approved over-the-counter contraceptives, devices, and services subject to minimum deductible amounts, visit Our Web site or contact Customer Service. You must submit a claim for reimbursement for the purchase of certain over-the-counter contraceptives.

NOTE: Covered Services that do not meet these criteria (for example, immunizations for travel, occupation, or residency in a foreign country) will be covered the same as any other Illness or Injury.

OFFICE VISITS – ILLNESS OR INJURY

We cover office, home or Hospital outpatient department visits for treatment of Illness or Injury. All other professional services performed in the office, not billed as an office visit, or that are not related to the actual visit (such as separate Facility Fees billed in conjunction with the office visit) are not considered an office visit.

OTHER PROFESSIONAL SERVICES

Professional services and supplies include the following:

Diagnostic Procedures

We cover services for diagnostic procedures including services to diagnose infertility, cardiovascular testing, pulmonary function studies, stress tests, sleep studies and neurology/neuromuscular procedures.

Medical Services and Supplies

We cover professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider. Services and supplies also include those to treat a congenital anomaly and foot care associated with diabetes.

Additionally, We cover some general medical services and supplies, such as compression stockings, active wound care supplies, and sterile gloves, when Medically Necessary. Reimbursement for covered medical supplies may be available when these supplies are purchased new from an approved commercial seller, even though that seller is not a Provider. Eligible new general medical supplies purchased through an approved commercial seller are covered at the In-Network Provider level, with Your reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item or the retail market value for that item. To learn more about how to access an approved commercial seller and reimbursable new general medical supplies, visit Our Web site or contact Customer Service.

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 cover associated services (for example, anesthesiologist, radiologist, pathologist, surgical assistant, etc.) provided by Out-of-Network Providers at the In-Network benefit level. Contact Customer Service for further information and guidance.

Radiology and Laboratory

We cover services for treatment of Illness or Injury. This includes, but is not limited to, prostate screenings, colorectal laboratory tests and mammography services not covered under the Preventive Care and Immunizations benefit. NOTE: Outpatient complex imaging services are covered under the

Complex Imaging - Outpatient benefit.

Claims for independent clinical laboratory services will be submitted to this plan or any other Blue Cross and/or Blue Shield Licensee in the locale in which the referring Provider is located, regardless of where the examination of the specimen occurred. Refer to the plan network where the referring Provider is located for coverage of independent clinical laboratory services.

Surgical Services
We cover surgical services and supplies including cochlear implants and the services of a surgeon, an assistant surgeon and an anesthesiologist. We also cover medical colonoscopies. Preventive colonoscopies and colorectal cancer examinations are covered under the Preventive Care and Immunizations benefit.

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

ACUPUNCTURE
We cover acupuncture services provided by a Provider.

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

APPROVED CLINICAL TRIALS
If an In-Network Provider is participating in the Approved Clinical Trial and will accept You as a trial participant, benefits will be provided only if You participate in the Approved Clinical Trial through that Provider. If 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. We cover Your Routine Patient Costs in connection with an Approved Clinical Trial in which You are enrolled and participating subject to any Deductible and/or Coinsurance and Maximum Benefits.

BLOOD BANK
We cover the services and supplies of a blood bank.

COMPLEX IMAGING – OUTPATIENT
We cover services and supplies for outpatient complex imaging for the treatment of Illness or Injury. Outpatient complex imaging is limited to the following imaging services: Computer Tomography (CT) Scan, Positron Emission Tomography (PET), Magnetic Resonance Angiogram (MRA), Single-Proton Emission Computerized Tomography (SPECT), Bone Density Study and Magnetic Resonance Imaging (MRI).

DENTAL HOSPITALIZATION
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 because treatment in a dental office would be neither safe nor effective.

DETOXIFICATION
We cover Medically Necessary detoxification services.

DIABETIC EDUCATION
We cover services and supplies for diabetic self-management training and education provided by Providers with expertise in diabetes. Diabetic nutritional counseling and therapy is covered under the Nutritional Counseling benefit.

DIALYSIS
We cover inpatient, outpatient, and home services and supplies for dialysis (including outpatient hemodialysis, peritoneal dialysis and hemofiltration).

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment must be provided by a Provider practicing within the scope of his or her license and must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Applicable sales tax for Durable Medical Equipment and mobility enhancing equipment is also covered. 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 Insured's home. Examples include oxygen equipment, wheelchairs, and insulin pumps and their supplies. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item.

Reimbursement may also be available for Durable Medical Equipment when purchased new from an approved commercial seller, even though this entity is not a Provider. Eligible new Durable Medical Equipment purchased through an approved commercial seller is covered at the In-Network Provider level, with Your reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item or the retail market value for that item. Claims for the purchase of Durable Medical Equipment will be submitted to the plan in the locale in which the equipment was received. To find ways to access new Durable Medical Equipment, including how to access an approved commercial seller, visit Our Web site or contact Customer Service. If You choose to access new Durable Medical Equipment through Our Web site, We may receive administrative fees or similar compensation from the commercial seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to Your Policy, but are not insurance.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

We cover emergency room services and supplies, including outpatient charges for patient observation, medical screening examinations and treatment, routinely available ancillary evaluative services, and Medically Necessary detoxification services that are required for the stabilization of a patient experiencing an Emergency Medical Condition.

"Stabilization" means to provide Medically Necessary treatment:

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

Emergency room services do not need to be pre-authorized.

If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. If services were not covered at the In-Network benefit level, contact Customer Service for further information and guidance.

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

If You fulfill Medical Necessity criteria and receive therapy from a Provider expressly identified by Us as a Center of Excellence for that therapy, We cover gene therapies and/or adoptive cellular therapies and associated Medically Necessary Covered Services under this benefit. You may contact Customer Service for a current list of covered gene and cellular therapies, or to identify a Center of Excellence.

Travel Expenses

We reimburse travel expenses for covered gene therapy and/or adoptive cellular therapy provided at a Center of Excellence (limited to transportation, food, and lodging) for You and a companion (or two companions if You are under age 19) up to the combined dollar limit per course of treatment, as specified on the Schedule of Benefits. Reimbursable transportation includes only commercial airfare, commercial train fare, or documented auto mileage (calculated per IRS allowances) to the treatment area and local ground transportation to and from treatment within that area during the course of treatment. Documentation of travel expenses should be retained for submission for reimbursement.

GENETIC TESTING

We cover Medically Necessary services for genetic testing.

HABILITATIVE SERVICES

We cover Medically Necessary health care services and health care devices designed to assist a person

to keep, learn or improve skills and functioning for daily living. Examples include services for a child who isn't walking or talking at the expected age, or services to assist with keeping or learning skills and functioning within an individual's environment, or to compensate for a person's progressive physical, cognitive, and emotional illness. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and outpatient settings. Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, and vocational or custodial services are not classified as habilitative services and are not covered under this Policy.

Cardiac rehabilitation, pulmonary rehabilitation, respiratory therapy, and breast cancer lymphedema services are covered as any other medical condition under the applicable benefits of the plan and do not accrue to Habilitative Services benefit limits.

HOME HEALTH CARE

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

Alternative Benefits

Home health care furnished by duly licensed home health, hospice and home care agencies covered by this Policy may be substituted as an alternative to hospitalization or inpatient care if hospitalization or inpatient care is Medically Necessary and such home health care:

- can be provided at equal or lesser cost;
- is the most appropriate and cost-effective setting; and
- is substituted with the consent of the Insured and upon the recommendation of the Insured's attending Physician or licensed health care Provider that such care will adequately meet the Insured's needs.

The decision to substitute less expensive or less intensive services shall be made based on the medical needs of the individual Insured. We may require a written treatment plan that has been approved by the Insured's attending Physician or licensed health care Provider. Coverage of substituted home health care is limited to any Maximum Benefits available for hospital care or other inpatient care under this Policy, and is subject to any applicable Deductible, Coinsurance, and Policy limits.

HOSPICE CARE

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 Insured and allow temporary relief to family members from the duties of caring for the Insured.

HOSPITAL AND AMBULATORY SURGICAL CENTER CARE

We cover the inpatient and outpatient services and supplies of a Hospital or the outpatient services and supplies of an Ambulatory Surgical Center for Illness and Injury (including Prescription Medications and services of staff Providers billed by the Hospital or Ambulatory Surgical Center). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. Please contact Customer Service for further information and guidance.

MATERNITY CARE

We cover prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), Medically Necessary supplies of home birth, complications of pregnancy, termination of pregnancy, and related conditions for all female Insureds (including eligible dependents of dependents who have enrolled under this Policy). There is no limit for the mother's length of inpatient stay. The attending Provider, if any, will

determine an appropriate discharge time, in consultation with the mother.

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

You must notify Us within 30 days of entering into any agreement to Act as a Surrogate and agree to cooperate with Us as needed to ensure Our ability to recover the costs of Covered Services received by You for which We are entitled to reimbursement. To notify Us, or to request additional information on Your responsibilities related to these notification and cooperation requirements, contact Customer Service. Refer to the Right of Reimbursement and Subrogation Recovery section for more information.

MEDICAL FOODS
We cover medical foods for inborn errors of metabolism, including, but not limited to, formulas for Phenylketonuria (PKU). We also cover Medically Necessary elemental formula when a Provider diagnoses and prescribes the formula for an Insured with eosinophilic gastrointestinal associated disorder. "Medical food" means a food which is formulated to be consumed or administered orally or enterally under the supervision of a Physician. Medical foods are intended for specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

MENTAL HEALTH SERVICES
We cover inpatient and outpatient Mental Health Services for treatment of Mental Health Conditions, including Applied Behavioral Analysis (ABA) therapy services covered for treatment of Autism Spectrum Disorders when Insureds seek services from licensed Providers qualified to prescribe and perform ABA therapy services.

NEURODEVELOPMENTAL THERAPY
We cover inpatient and outpatient neurodevelopmental therapy services. Such services must be to restore and improve function. Covered Services are limited to physical therapy, occupational therapy and speech therapy and maintenance services, if significant deterioration of the Insured's condition would result without the service. You will not be eligible for both the Rehabilitation Services benefit and this benefit for the same services for the same condition.

NEWBORN CARE
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, if applicable, as explained 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. "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
We cover nutritional counseling and therapy for all conditions including diabetic counseling and obesity.

ORTHOTIC DEVICES
We cover braces, splints, orthopedic appliances and orthotic supplies or apparatuses purchased to support, align or correct deformities or to improve the function of moving parts of the body. Orthopedic shoes, regardless of diagnosis, and off-the-shelf shoe inserts are not covered.

Orthotic devices must be provided by a Provider practicing within the scope of his or her license and must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). In some cases, We may limit benefits or coverage to a less costly and Medically Necessary alternative item.

Reimbursement may also be available for new orthotic devices when purchased new from an approved commercial seller, even though that seller is not a Provider. Eligible new orthotic devices purchased

through an approved commercial seller are covered at the In-Network Provider level, with Your reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item, or the retail market value for that item.

To learn more about how to access reimbursable new retail orthotic devices, including how to access an approved commercial seller, visit Our Web site or contact Customer Service. If You choose to access new orthotic devices through Our Web site, We may receive administrative fees or similar compensation from the commercial seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to Your Policy, but are not insurance.

PALLIATIVE CARE

We cover palliative care when a Provider has assessed that an Insured is in need of palliative care services for serious Illness (including remission support), life-limiting Injury, or end of life. "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. All other Covered Services for an Insured receiving palliative care remain covered the same as any other Illness or Injury.

PEDIATRIC DENTAL

We cover pediatric Dental Services for Insureds under the age of 19. Coverage will be provided until the last day of the month in which the Insured turns 19 years of age. Benefits are paid under this Pediatric Dental benefit, not any other benefit of this Policy, if a service or supply is covered under both.

Preventive And Diagnostic Dental Services

We cover the following preventive and diagnostic Dental Services:

- bitewing x-rays, limited to two sets (4 x-rays total) per Calendar Year;
- cephalometric films, limited to once in a two-year period;
- complete intra-oral mouth x-rays, limited to one in a three-year period;
- cleanings, limited to two per Calendar Year;
- diagnostic casts when Dentally Appropriate;
- limited oral evaluations to evaluate the Insured for a specific dental problem or oral health complaint, dental emergency or referral for other treatment;
- visual oral assessments or screenings, not performed in conjunction with other clinical oral evaluation services, limited to two per Calendar Year;
- occlusal intraoral x-rays, limited to once in a two-year period;
- oral hygiene instruction, limited to two sessions per Calendar Year, if not billed on the same day as a cleaning;
- periapical x-rays that are not included in a complete series for diagnosis in conjunction with definitive treatment;
- photographic images (oral and facial) when Dentally Appropriate;
- periodic and comprehensive oral examinations, limited to two per Calendar Year;
- problem focused oral examinations;
- panoramic mouth x-rays, limited to one in a three-year period;
- sealants, limited to permanent bicuspids and molars;
- topical fluoride application, limited to three applications per Calendar Year. Additional topical fluoride applications are covered when determined Dentally Appropriate; and
- space maintainers (fixed unilateral or fixed bilateral) includes:

    - re-cementation of space maintainers;
    - removal of space maintainers; and
    - replacement space maintainers are covered when Dentally Appropriate.

Basic Dental Services

We cover the following basic Dental Services:

- Complex oral surgery procedures including surgical extractions of teeth, impactions, alveoloplasty, frenulectomy, frenuloplasty, vestibuloplasty and residual root removal.
- Emergency treatment for pain relief.
- Endodontic services consisting of:

    - apexification for apical closures of anterior permanent teeth;

- apicoectomy;
- retrograde filling for anterior teeth;
- debridement;
- direct pulp capping;
- pulpal therapy;
- pulp vitality tests;
- pulpotomy; and
- root canal treatment, including: treatment with resorbable material for primary maxillary incisor teeth D, E, F and G, if the entire root is present at treatment; treatment for permanent anterior, bicuspid, and molar teeth (excluding teeth 1, 16, 17 and 32); and retreatment for the removal of post, pin, old root canal filling material, and all procedures necessary to prepare the canal with placement of new filling material.

- Endodontic benefits will not be provided for indirect pulp capping.
- Fillings consisting of composite and amalgam restorations:

  - five surfaces per tooth for permanent posterior teeth, except for upper molars;
  - six surfaces per tooth for teeth 1, 2, 3, 14, 15 and 16;
  - six surfaces per tooth for permanent anterior teeth;
  - restorations on the same tooth are limited to once in a two-year period; and
  - two occlusal restorations for the upper molars on teeth 1, 2, 3, 14, 15 and 16.

- General dental anesthesia or intravenous sedation administered in connection with the extractions of partially or completely bony impacted teeth and to safeguard the Insured's health. Other services related to general anesthesia or intravenous sedation are covered as follows:

  - drugs and/or medications only when used with parenteral conscious sedation, deep sedation, or general anesthesia;
  - inhalation of nitrous oxide, once per day; and
  - local anesthesia and regional blocks, including office-based oral or parenteral conscious sedation, deep sedation or general anesthesia.

- Periodontal services consisting of:

  - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery), once per quadrant in a five-year period;
  - debridement;
  - gingivectomy and gingivoplasty, once per quadrant in a three-year period;
  - periodontal maintenance, once per quadrant in a Calendar Year; and
  - scaling and root planing, once per quadrant in a two-year period.

- Uncomplicated oral surgery procedures including brush biopsy, removal of teeth, incision and drainage.

Major Dental Services

We cover the following major Dental Services:

- Adjustment and repair of dentures and bridges:

  - adjustments within 90 days of delivery (placement) will not be separately reimbursed;
  - the cost of repairs cannot exceed the cost of a replacement denture or a partial denture; and
  - additional repairs on a case-by-case basis and when prior authorized.

- Behavior management.
- Bridges (fixed partial dentures), except that benefits will not be provided for replacement made fewer than seven years after placement.
- Crowns and core build-ups, limited to the following:

  - an indirect crown, for permanent anterior teeth, one per tooth in a five-year period;
  - cast post and core or prefabricated post and core, on permanent teeth when performed in conjunction with a crown;
  - core build-ups, including pins, only on permanent teeth when performed in conjunction with a

crown;
- recementations of permanent indirect crowns;
- stainless steel crowns for primary anterior and posterior teeth, once in a three-year period; and
- stainless steel crowns for permanent posterior teeth (excluding teeth 1, 16, 17 and 32), once in a three-year period.

- Dental implant crown and abutment related procedures, limited to one per tooth in a seven-year period.
- Dentures, full and partial, including:

  - adjustment and repair of dentures and bridges, limited to one per arch in a 12-month period;
  - denture rebase, limited to one per arch in a three-year period, if performed at least six months from the seating date;
  - denture relines, limited to one per arch in a three-year period if performed at least six months from the seating date;
  - one complete upper and lower denture, and one replacement denture per Lifetime after at least five years from the seat date; and
  - one resin-based partial denture, replaced once within a three-year period.

- Home visits, including extended care facility calls, limited to two calls per facility per Provider.
- Medically Necessary orthodontic services for Insureds with malocclusions associated with:

  - cleft lip and palate, cleft palate and cleft lip with alveolar process involvement; and
  - craniofacial anomalies for hemifacial microsomia, craniosynostosis syndromes, anthrogryposis or Marfan syndrome.

- Occlusal guards.
- Post-surgical complications.
- Repair of crowns, limited to one per tooth per Lifetime.
- Repair of implant supported prosthesis or abutment, limited to one per tooth per Lifetime.

EXCLUSIONS

In addition to the exclusions in the General Exclusions section, the following exclusions apply to this Pediatric Dental benefit:

Aesthetic Dental Procedures

Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.

Antimicrobial Agents

Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.

Collection of Cultures and Specimens

Connector Bar or Stress Breaker

Cosmetic/Reconstructive Services and Supplies

Except for Dentally Appropriate services and supplies to treat a congenital anomaly and to restore a physical bodily function lost as a result of Illness or Injury, We do not cover cosmetic and/or reconstructive services and supplies.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance (for example, bleaching of teeth).

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 generally performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

Desensitizing

Application of desensitizing medicaments or desensitizing resin for cervical and/or root surface.

Duplicate X-Rays

Fractures of the Mandible (Jaw)
Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

Gold-Foil Restorations

Implants
Services and supplies provided in connection with implants, whether or not the implant itself is covered including:

- endodontic endosseous implants;
- interim endosseous implants;
- eposteal and transosteal implants;
- sinus augmentations or lifts;
- implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis;
- radiographic/surgical implant index; and
- unspecified implant procedures.

Interim Partial or Complete Dentures

Medications and Supplies
Charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and supplies are not covered, except as explicitly provided in the Pediatric Dental benefit.

Occlusal Treatment
Services and supplies provided in connection with dental occlusion, including occlusal analysis and adjustments are not covered, except as explicitly provided in the Pediatric Dental benefit.

Oral Surgery
Oral surgery treating any fractured jaw and orthognathic surgery. "Orthognathic surgery" means surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.

Orthodontic Dental Services
Services and supplies provided in connection with orthodontics are not covered, except as explicitly provided in the Pediatric Dental benefit, including:

- correction of malocclusion;
- craniomandibular orthopedic treatment;
- other orthodontic treatment;
- preventive orthodontic procedures; and
- procedures for tooth movement, regardless of purpose.

Precision Attachments

Provisional Splinting

Replacements
Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken are not covered, except as explicitly provided in the Pediatric Dental benefit.

Separate Charges
Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including:

- any supplies;
- local anesthesia; and

- sterilization.

Services Performed in a Laboratory

Surgical Procedures
Services and supplies provided in connection with the following surgical procedures:

- exfoliative cytology sample collection;
- incision and drainage of abscess extraoral soft tissue, complicated or non-complicated;
- radical resection of maxilla or mandible;
- removal of nonodontogenic cyst, tumor or lesion;
- surgical stent; and
- surgical procedures for isolation of a tooth with rubber dam.

Temporomandibular Joint (TMJ) Disorder Treatment
Services and supplies provided in connection with temporomandibular joint (TMJ) disorder, except as explicitly provided in the Medical Benefits section.

Tooth Transplantation
Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization.

Veneers

GENERAL INFORMATION
In-Network Dentist Claims
You must present Your member card when obtaining Covered Services from an In-Network Dentist. You must also furnish any additional information requested. The In-Network Dentist will furnish Us with the forms and information needed to process Your claim.

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

PEDIATRIC VISION
We cover pediatric vision care for Insureds under the age of 19. Coverage will be provided until the last day of the month in which the Insured turns 19 years of age. Covered Services are those services required for the diagnosis or correction of visual acuity and must be provided by a Physician or optometrist practicing within the scope of his or her license.

All terms and conditions of this Policy apply to this Pediatric Vision benefit, except as otherwise noted. Benefits are paid under this Pediatric Vision benefit, not any other benefit in this Policy, if a service or supply is covered under both.

PEDIATRIC VISION EXAMINATION
We cover routine vision screening and comprehensive eye examination services, including:

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

PEDIATRIC VISION HARDWARE
We cover hardware including frames, contacts (instead of glasses) and all lenses and tints. One pair of standard lenses are covered in either glass or plastic per Calendar Year, including:

- spectacle;
- single vision;
- lined bifocal;
- lined trifocal;
- lenticular;
- polycarbonate;
- scratch coating;
- UV (ultraviolet) protected lenses; or
- photochromic lenses; tinted lenses.

Also covered are high power spectacles, magnifiers and telescopes. Frames are available once per Calendar Year.

One contact lens evaluation and fitting examination is also covered per Calendar Year.

Contacts are available once per Calendar Year instead of all other lenses and frames. When You receive contact lenses, You will not be eligible for any lenses and/or frames again until the next Calendar Year. An annual supply of Necessary Contact Lenses, including disposable lenses for monthly, bi-weekly, or daily use, is covered if You have a specific condition for which contact lenses provide better visual correction.

If You choose non-Medically Necessary contact lenses instead of glasses, one of the following elective contact lens types may be chosen:

- standard (one pair annually);
- monthly (six-month supply);
- bi-weekly (three-month supply); or
- dailies (three-month supply).

Limitations

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

- optional cosmetic processes;
- anti-reflective coating;
- color coating;
- mirror coating;
- blended lenses;
- cosmetic lenses;
- laminated lenses;
- oversize lenses;
- standard, premium and custom progressive multifocal lenses; and
- contact lenses not previously described as covered.

LOW VISION BENEFIT

We cover low vision benefits for Insureds, including optical devices, aids, annual comprehensive low vision examinations and follow-up visits, (age 19 and under) if vision loss is sufficient enough to prevent reading and performing daily activities. You will be entitled to professional services as well as ophthalmic materials, subject to the frequency and benefit limitations of this Low Vision benefit. Consult Your VSP Doctor for more details.

Supplemental Testing

We cover supplemental testing (complete low vision analysis and diagnosis) every two Calendar Years. This includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or low vision aids where indicated.

Supplemental Aids

We cover low vision aids every two Calendar Years, including, but not limited to, optical and non-optical aids and the associated training.

EXCLUSIONS
In addition to the exclusions in the General Exclusions section, the following exclusions apply to this Pediatric Vision benefit:

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

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

Corrective Vision Treatment of an Experimental Nature

Costs for Services and/or Supplies Exceeding Benefit Allowances

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

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

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

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

Services and/or Supplies Not Described As Covered Under This Vision Benefit

Two Pair of Glasses instead of Bifocals

GENERAL INFORMATION
Submission of Claims and Reimbursement
When You visit a VSP Doctor, the doctor will submit the claim directly to VSP for payment.

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

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

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

PRESCRIPTION MEDICATIONS
We cover Prescription Medications listed under the Drug List, which can be viewed on Our Web site.

Drug List Changes

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

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

Drug List Exception Process

Non-Drug List medications are not routinely covered under Your Prescription Medications benefit; however, Prescription Medication not on the Drug List may be covered under certain circumstances. Non-Drug List means those self-administered Prescription Medications not listed in the Drug List for Your plan.

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

- You are not able to tolerate a covered Prescription Medication on the Drug List;
- Your Provider determines that the Prescription Medication on the Drug List is not therapeutically efficacious for treating Your covered condition; or
- Your Provider determines that a dosage required for efficacious treatment of Your covered condition differs from the Prescription Medication on the Drug List dosage limitation.

The specific medication policy criteria to determine if a Prescription Medication not on the Drug List is Medically Necessary are available on Our Web site. You or Your Provider may request prior authorization by calling Customer Service, or by completing and submitting the form available on Our Web site. You or Your requesting Provider will be notified of Our determination no later than 72 hours following receipt of the request. If You are suffering from a health condition that may seriously jeopardize Your life, health, or ability to regain maximum function or if You are undergoing a current course of treatment using a non-Drug List medication, You or Your requesting Provider will be notified of Our determination no later than 24 hours following receipt of the request.

Once preauthorization has been approved, the Prescription Medication not on the Drug List will be covered at the Substituted Medication benefit level and will count toward Your Deductible or Out-of-Pocket Maximum.

If preauthorization has not been approved for Your request, You have the right to appeal. Refer to the Appeal Process section for more information on how to initiate an Appeal request.

The Drug List exception process may also be used to substitute a covered Prescription Medication for another drug on the Drug List if:

- You do not tolerate the covered Drug List medication; or
- Your Provider determines that the covered Drug List medication is not therapeutically efficacious for treating Your covered condition.

Emergency Fill

You may be eligible to receive an Emergency Fill for Prescription Medications at no cost to You. A list of these medications is available on Our Web site or by calling Customer Service. The cost share amounts noted in the Schedule of Benefits apply to all other medications obtained through an Emergency Fill request as requested through Your Provider or by calling Customer Service. An Emergency Fill is only applicable when:

- the dispensing Pharmacy cannot reach Our prior authorization department by phone as it is outside of business hours; or

- We are available to respond to phone calls from a dispensing Pharmacy regarding a covered benefit, but cannot reach the prescriber for a full consultation.

Covered Prescription Medications For Treatment of Illness or Injury

Prescription Medications benefits are available for the following:

- insulin and diabetic supplies (including, but not limited to, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, urine test strips, prescriptive oral agents for controlling blood sugar levels and glucagon emergency kits, but not insulin pumps or continuous glucose monitors and their supplies), when obtained with a Prescription Order (insulin pumps and continuous glucose monitors and their supplies are covered under the Durable Medical Equipment benefit);
- Prescription Medications;
- Emergency Fill five-day supply or the minimum packaging size available at the time the Emergency Fill is dispensed;
- Foreign Prescription Medications for Emergency Medical Conditions while traveling outside the United States or while residing outside the United States. The foreign Prescription Medication must have an equivalent FDA-approved Prescription Medication that would be covered under this benefit if obtained in the United States, except as may be provided under the Experimental/Investigational definition in the Definitions section;
- certain Prescription Medications that are administered by Your Provider as determined by the Pharmacy and Therapeutics (P&T) Committee;
- medications intended to treat opioid overdose that are on the Naloxone Value List found on Our Web site or by calling Customer Service;
- Specialty Medications (including, but not limited to, medications for multiple sclerosis, rheumatoid arthritis, cancer, clotting factor for hemophilia or similar clotting disorders and hepatitis C);
- Self-Administrable Cancer Chemotherapy Medication;
- Self-Administrable Hemophilia Factor Drugs;
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Injectable Medications) and teaching doses by which an Insured is educated to self-inject; and
- growth hormones (if preauthorized).

Covered Preventive Medications

- certain preventive medications (including, but not limited to, aspirin, fluoride, iron and medications for tobacco use cessation) according to, and as recommended by, the USPSTF, when obtained with a Prescription Order;
- all FDA-approved prescription and over-the-counter contraception methods as described under the Reproductive Health Care Services benefit;
- immunizations for adults and children according to, and as recommended by, the CDC;
- immunizations for purposes of travel, occupation, or residency in a foreign country; and
- Medications on the Optimum Value Medications list. These medications are specifically designated as preventive for treatment of certain chronic diseases and are not intended to treat an existing Illness, Injury, or condition.

You are not responsible for any applicable Deductible and/or Coinsurance when You fill prescriptions at a Preferred or Participating Pharmacy for specific strengths or quantities of medications that are specifically designated as preventive medications by the USPSTF or HRSA, or for immunizations (except for immunizations for the purpose of travel, occupation, or residency in a foreign country), as specified above.

NOTE: FDA-approved over-the-counter contraceptive drugs, devices, and products are available from a participating pharmacy without a prescription and with minimal or no cost-sharing. Certain FDA-approved prescriptions (including brand-name contraceptive medications) and over-the-counter contraceptive products (including male condoms) are subject to the minimum deductible amounts permitted by the IRS on a high deductible health plan that qualifies for use with a health care savings account. For 2020, those amounts are $1,400 for Single Coverage and $2,800 for Family Coverage. This amount also will accrue to the overall Plan Deductible. For more information on FDA-approved prescriptions and over-the-counter contraceptive products subject to minimum deductible amounts, visit Our Web site or contact Customer Service. You must submit a claim for reimbursement for the purchase of certain over-the-counter contraceptives. To receive reimbursement for these items, complete a Drug Claim Form and submit to Us

for processing. The Drug Claim Form may be found at https://regence.myprime.com/v/RBO/COMMERCIAL/en/forms.html.

Certain prescribed brand-name insulin drugs are made available at the Generic Medication payment level. If those designated insulin drugs are ineffective, other insulin drugs may be made available to You through Our Drug List exception process at the Generic Medication payment level. For more information, visit Our Web site or contact Customer Service.

Drugs prescribed for a use other than that stated in its FDA approved labelling, commonly referred to as off-label, will be covered as any other drug subject to the Drug List.

Pharmacy Network Information

A nationwide network of Preferred and Participating Pharmacies is available to You. Pharmacies that participate in this network submit claims electronically. There are more than 1,200 Participating Pharmacies in Our Washington State network from which to choose.

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 an Insured with Regence BlueCross BlueShield of Oregon, a Preferred Pharmacy, Participating Pharmacy or Mail-Order Supplier may charge You more than the Covered Prescription Medication Expense. You can find Preferred and Participating Pharmacies and a Pharmacy locator on Our Web site or by contacting Customer Service.

Claims Submitted Electronically

You must present Your member card at a Preferred or Participating Pharmacy for the claim to be submitted electronically. You must pay any required Deductible and/or Coinsurance 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, complete a Prescription Medication claim form and mail the form and receipt to Us. The Prescription Medication claim form is available on Our Web site or by contacting Customer Service. We will reimburse You based on the Covered Prescription Medication Expense, less the applicable Deductible and/or Coinsurance that would have been required had the medication been purchased from and submitted electronically by a Preferred or Participating Pharmacy. We will send payment directly to You.

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, 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 (which also includes refill instructions):

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

Your Prescription Drug Rights

You have the right to safe and effective Pharmacy services. You also have the right to know what drugs are covered by Your plan and the limits that apply. If You have a question or concern about Your prescription drug benefits, contact Us at 1 (888) 675-6570 or visit Our Web site.

If You would like to know more about Your rights, or if You have concerns about Your plan, You may contact the Washington State Office of Insurance Commissioner at 1 (800) 562-6900 or www.insurance.wa.gov. If You have a concern about the Pharmacists or Pharmacies serving You, contact the Washington State Department of Health at 1 (360) 236-4700.

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. This list can be found on Our Web site or by contacting Customer Service. In addition, We notify 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 Medications benefit, except for over-the-counter preventive medications, and immunizations as specified in the Covered Preventive Medications provision:

- **Day Supply Limits**
  Prescription Medications benefits are limited to the days' supply shown in the Schedule of Benefits.

- **Maximum Quantity Limit**
  For certain Prescription Medications, We establish maximum quantities other than those shown in the Schedule of Benefits. 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. 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 cover refills from a Pharmacy when You have taken 75 percent of the previous prescription or 70 percent of the previous topical ophthalmic prescription. However, Schedule II or III controlled substance medications may be refilled only after You have taken 85 percent of the previous prescription.

  Other than FDA-approved contraceptive drugs, refills obtained from a Mail-Order Supplier are allowed after You have taken all but 20 days of the previous Prescription Order. If You 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 or 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. Request an exception by calling Customer Service.

  If You receive maintenance medications for chronic conditions, You may qualify for Our prescription refill synchronization which allows refilling Prescription Medications on the same day of the month. For further information on prescription refill synchronization, call Customer Service.

- **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.

Manufacturer Coupons

Any reduction in Your cost-sharing resulting from the use of a drug manufacturer coupon may not count toward the Out-of-Pocket Maximum.

Exclusions

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

Biological Sera, Blood or Blood Plasma

Bulk Powders
Non-FDA approved bulk powders that are not included on Our Drug List (which requires a Prescription Order by a Physician or Practitioner).

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

Diagnostic Agents
Medications used to aid in diagnosis rather than treatment. Coverage for these medications may otherwise be provided under the Medical Benefits section.

Foreign Prescription Medications
We do not cover foreign Prescription Medications for non-Emergency Medical Conditions while outside the United States.

General Anesthetics
Coverage for general anesthetics may otherwise be provided under the Medical Benefits section.

Medical Foods
Coverage for these products may otherwise be provided under the Medical Benefits section.

Medications not on the Drug List, Unless Provided Through the Drug List Exception Process

Non-Self-Administrable Medications
Coverage for these medications may otherwise be provided under the Medical Benefits section or as specifically indicated in this Prescription Medications benefit.

Nonprescription Medications
Medications that by law do not require a Prescription Order, for example, over-the-counter medications, including vitamins, minerals, food supplements, homeopathic medicines, and nutritional supplements, except medications included on Our Drug List, approved by the FDA, and prescribed by a Physician or Practitioner licensed to prescribe Prescription Medications. This includes medications listed as over-the-counter in standard drug references, regardless of state law prescription requirements, such as pseudoephedrine and cough syrup products.

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. Coverage for these medications may otherwise be provided under the Medical Benefits section. Medications dispensed upon discharge should be processed under this benefit if obtained from a Pharmacy.

Prescription Medications for the Treatment of Infertility

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

Prescription Medications Not Approved by the United States Food and Drug Administration (USFDA)

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

Prescription Medications Not Dispensed by a Preferred or Participating Pharmacy

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

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

Prescription Medications without Examination
We do not cover prescriptions made by a Provider without recent and relevant in-person, or virtual care examination of the patient, whether the Prescription Order is provided by mail, telephone, internet or some other means. An examination is "recent" if it occurred within 12 months of the date of the Prescription Order and is "relevant" if it involved the diagnosis, treatment or evaluation of the same or a related condition for which the Prescription Medication is being prescribed.

Professional Charges for Administration of Any Medication

Repackaged Medications, Institutional Packs and Clinic Packs

PROSTHETIC DEVICES
We cover prosthetic devices for functional reasons to replace a missing body part, including artificial limbs, mastectomy bras only for Insureds who have had a mastectomy, 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 benefit (Hospital inpatient care, Hospital outpatient care, or Ambulatory Surgical Center care). We will cover repair or replacement of a prosthetic device due to normal use or growth of a child.

RECONSTRUCTIVE SERVICES AND SUPPLIES
We cover inpatient and outpatient services for treatment of reconstructive services and supplies:

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

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.

REHABILITATION SERVICES
We cover inpatient and outpatient rehabilitation services and accommodations to restore or improve lost function because of an Injury, Illness or disabling condition. Rehabilitation services are physical, occupational, and speech therapy services necessary to help get the body back to normal health or function, and include services such as massage when provided as a therapeutic intervention. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition.

Cardiac rehabilitation, pulmonary rehabilitation, respiratory therapy, and breast cancer lymphedema services are covered as any other medical condition under the applicable benefits of the plan and do not accrue to Rehabilitation Services benefit limits.

REPRODUCTIVE HEALTH CARE SERVICES
We cover all FDA-approved prescription and over-the-counter contraceptive drugs, devices, products, and services, including, but not limited to:

- sterilization surgery (such as tubal ligation and vasectomy) and sterilization implants;
- implantable contraceptive devices, including insertion and removal, such as IUD copper, IUD with progestin, and implantable rods;
- contraceptive shots or injections;
- oral contraceptives (combined pill, extended/continuous use combined pill, and the mini pill);
- contraceptive products, such as condoms, vaginal rings, patches, diaphragms, sponges, cervical caps, and spermicide; and

- emergency contraceptives (such as levonorgestrel and ulipristal acetate).

We will cover up to a 12-month supply of FDA-approved contraceptive drugs from a Pharmacy or Mail-Order Supplier (may be dispensed on-site at a Provider's office, if available).

FDA-approved prescription and over-the-counter contraceptive drugs, devices, products, and services are available without a prescription and with minimal or no cost-sharing as explicitly described in both the Preventive Care and Immunizations benefit section and the Covered Preventive Medications provision. You must submit a claim for reimbursement for the purchase of certain over-the-counter contraceptive drugs, devices, and products. To receive reimbursement for these items, complete a Drug Claim Form and submit to Us for processing. The Drug Claim Form may be found at https://regence.myprime.com/v/RBO/COMMERCIAL/en/forms.html. For more information, visit Our Web site or contact Customer Service.

RETAIL CLINIC OFFICE VISITS

We cover office visits in a Retail Clinic for treatment of Illness or Injury. All other professional services performed in the Retail Clinic, not billed as an office visit, are not considered an office visit under this benefit.

SKILLED NURSING FACILITY

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. 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 the Maximum Benefit limit on Skilled Nursing Facility care.

SPINAL MANIPULATIONS

We cover chiropractic and osteopathic spinal manipulations performed by a Provider. Manipulations of extremities are covered under the Neurodevelopmental Therapy and Rehabilitation Services benefits.

SUBSTANCE USE DISORDER SERVICES

We cover Substance Use Disorder Services for treatment of Substance Use Disorder Conditions, including the following:

- acupuncture services (when provided for Substance Use Disorder Conditions, these acupuncture services do not apply toward the overall acupuncture Maximum Benefit); and
- Prescription Medications that are prescribed and dispensed through a substance use disorder treatment facility (such as methadone).

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

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 Medical 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 Experimental or primarily for Cosmetic purposes.

Dental Services are not Covered Services by this plan. "Dental 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 dental practice; and
- not Experimental or primarily for Cosmetic purposes.

TRANSPLANTS

We cover transplants, including Hospital or outpatient Facility Fees, transplant-related services and supplies. A transplant recipient who is covered under this Policy and fulfills Medically Necessary criteria will be eligible for the following transplants, including any artificial organ transplants based on medical guidelines and manufacturer recommendations:

- 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), which may involve the following donors:
    - autologous (self-donor);
    - allogeneic (related or unrelated donor);
    - syngeneic (identical twin donor); or
    - umbilical cord blood (only covered for certain conditions).

Transplants and related services for gene therapies or adoptive cellular therapies are covered benefits under the Gene Therapy and Adoptive Cellular Therapy benefit section.

Donor Organ Benefits

We cover donor organ procurement costs, including Hospital or outpatient Facility Fees if the recipient is covered for the transplant under this Policy. Procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ and other such Medically Necessary procurement costs.

URGENT CARE CENTER

We cover office visits for treatment of Illness or Injury. All other professional services not billed as an office visit, or that are not related to the actual visit (such as separate Facility Fees billed in conjunction with the office visit) are not considered an office visit under this benefit. We also cover outpatient services and supplies (not billed as an office visit) provided by an urgent care center.

VIRTUAL CARE

We cover Virtual Care services. Virtual Care refers to the utilization of telehealth, telemedicine, or store and forward services received from a remote Provider, rather than an in-person office visit, for the diagnosis, treatment, or management of a covered medical condition. To learn more about how to access Virtual Care services, please visit Our Website or contact Customer Service.

Store and Forward Services

We cover store and forward services. "Store and forward services" mean secure one-way electronic asynchronous (not live or real-time) electronic transmission (sending) of Your medical information to a Provider which may include some forms of secure HIPAA compliant texting, chatting or data sharing. Store and forward services do not include, for example, non-secure HIPAA compliant telephone, fax, short message service (SMS) texting or e-mail communication. Your Provider is responsible for meeting applicable requirements and community standards of care.

Telehealth

We cover telehealth services. "Telehealth" means Your live (real-time audio-only or audio and video

communication with a remote Provider) services through a secure HIPAA compliant platform when you are not in a healthcare facility.

Telemedicine
We cover telemedicine services. "Telemedicine" means Your live (real-time audio-only or audio and video communication with a remote Provider) services through a secure HIPAA compliant platform when you are at a healthcare facility.

General Exclusions

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

PREEXISTING CONDITIONS

This coverage does not have an exclusion period for treatment of preexisting conditions. A preexisting condition normally means a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within a specified period of time before the enrollment date. Any references in this Policy to preexisting conditions therefore do not apply to Your coverage.

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; or 2) a preventive service as specified under the Preventive Care and Immunizations and Prescription Medications benefits.

Activity Therapy

Creative arts, play, dance, aroma, music, equine or other animal-assisted, recreational, or similar therapy; sensory movement groups; and wilderness or adventure programs.

Adult Dental Services

For Insureds age 19 and over, We do not cover preventive and diagnostic Dental Services or Dental Services provided to treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

Assisted Reproductive Technologies

We do not cover any assisted reproductive technologies, including, but not limited to:

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

Aviation

Services in connection with Injuries sustained in aviation accidents (including accidents occurring in flight or in the course of take-off or landing), unless the injured Insured is a passenger on a scheduled commercial airline flight or air ambulance.

Certain Therapy, Counseling, and Training

Educational, vocational, social, image, milieu, or marathon group therapy, premarital or marital counseling, IAP/EAP services; job skills or sensitivity training.

Conditions Caused By Active Participation In a War or Insurrection

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

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

The treatment of any Insured'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 Services and Supplies

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

Counseling

Counseling in the absence of Illness, except as covered under the Preventive Care and Immunizations benefit.

Custodial Care
Non-skilled care and helping with activities of daily living not covered under the Palliative Care benefit.

Expenses Before Coverage Begins or After Coverage Ends
Services and supplies incurred before Your Effective Date under this Policy or after Your termination under this Policy.

Family Counseling
Family counseling is excluded unless the patient is a child or adolescent with a covered diagnosis, and the family counseling is part of the treatment.

Family Planning
Over-the-counter contraceptive supplies, except as covered under the Reproductive Health Care Services benefit.

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 or as outlined in the Durable Medical Equipment benefit.

Government Programs
Except for facilities that contract with Us and except as required by law, such as for cases of Emergency Medical Conditions or for coverage provided by Medicaid, We do not cover benefits that are covered, or would be covered in the absence of this Policy, by any federal, state or government program. 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 Aids, and Other Hearing Devices
Hearing aids (externally worn or surgically implanted), and other hearing devices are excluded. This exclusion does not apply to cochlear implants.

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

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

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

Infertility Treatment
Treatment of infertility, including, but not limited to surgery, fertility drugs, and other medications associated with fertility treatment are excluded.

Investigational Services
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 of Experimental/Investigational in the Definitions section. Approved clinical trials are covered under the Approved Clinical Trials benefit in the Medical Benefits section.

Motor Vehicle No-Fault Coverage
Expenses for services and supplies that have been covered or have been accepted for coverage under any automobile medical personal injury protection ("PIP") no-fault coverage. If Your expenses for services and supplies have been covered or have been accepted for coverage by an automobile medical personal injury protection ("PIP") carrier, We will provide benefits according to this Policy once Your claims are no

longer covered by that carrier.

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

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

Obesity or Weight Reduction/Control
Medical treatment, medications, surgical treatment (including revisions, reversals, and treatment of complications), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions, except to the extent Covered Services are required as part of the USPSTF, HRSA, or CDC requirements.

Orthognathic Surgery
Services and supplies for orthognathic surgery not required due to temporomandibular joint disorder, Injury, sleep apnea or congenital anomaly. 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.

Personal Items
Items that are primarily for comfort, convenience, contentment, cosmetics, hygiene, environmental control, education, or general physical fitness. For example, We do not cover telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps, light boxes, weight lifting equipment, and therapy or service animals, including the cost of training and maintenance.

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 Insured's Provider.

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

Reversal of Sterilizations
Services and supplies related to reversal of sterilization.

Riot, Rebellion, War and Illegal Acts
Services and supplies for treatment of an Illness or Injury caused by an Insured's unlawful instigation and/or participation in a riot, war, insurrection, rebellion, armed invasion or aggression; or sustained by an Insured while in the act of committing an illegal act.

Routine Foot Care

Routine Hearing Examination

Self-Help, Self-Care, Training or Instructional Programs
Self-help, non-medical self-care, training programs, including:

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

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family. "Immediate family" means:

- You and Your parents, parents' spouses or domestic partners, spouse or domestic partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or domestic partner's parents, parents' spouses or domestic partners, siblings and

half-siblings;
- Your child's or stepchild's spouse or domestic partner; and
- any other of Your relatives by blood or marriage who share a residence with You.

Services for Administrative or Qualification Purposes
Physical or mental examinations and associated services, such as laboratory or similar tests, primarily for administrative or qualification purposes. Such purposes include, but are not limited to, admission to or remaining in a school, camp, sports team, the military or other institution; athletic training evaluation; legal proceedings, such as establishing paternity or custody; qualification for employment, marriage, insurance, occupational injury benefits, licensure or certification; or immigration or emigration.

Sexual Dysfunction
Treatment, services and supplies (including medications) for or in connection with sexual dysfunction, regardless of cause, except for covered Mental Health Services.

Surrogacy
Maternity and related medical services received by You Acting as a Surrogate are not Covered Services up to the amount You or any other person or entity is entitled to receive as payment or other compensation arising out of, or in any way related to, Your Acting as a Surrogate. "Maternity and related medical services" includes otherwise Covered Services for conception, prenatal, maternity, delivery and postpartum care. Refer to the Maternity Care and/or Right of Reimbursement and Subrogation Recovery sections for more information.

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

Travel and Transportation Expenses
Travel and transportation expenses when the transportation is for personal or convenience purposes, except for travel expenses specified under the Gene Therapy and Adoptive Cellular Therapy benefit.

Varicose Veins Treatment
Treatment of varicose veins, except when there is associated venous ulceration or persistent or recurrent bleeding from ruptured veins.

Vision Care
We do not cover routine eye examinations and vision hardware for Insureds age 19 and over.

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

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

Work-Related Conditions
Expenses for services and supplies incurred as a result of any work-related Illness or Injury, including any claims that are resolved related to a disputed claim settlement. We may require You or one of Your eligible dependents to file a claim for workers' compensation benefits before providing any benefits under this Policy. The only exception is if You or one of Your eligible dependents are exempt from state or federal workers' compensation law. If the entity providing workers' compensation coverage denies Your claims and You have filed an Appeal, We may advance benefits for Covered Services if You agree to hold any recovery obtained in trust for Us according to the Right of Reimbursement and Subrogation Recovery provision.

Policy and Claims Administration

This section explains administration of benefits and claims, including situations where Your health care expenses are the responsibility of a source other than Us.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims payment is due, We decide whether We will pay the Insured, the Provider and Insured jointly, or the Provider directly, subject to any legal requirements.

In-Network Provider Claims and Reimbursement

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

Out-of-Network Provider Claims and Reimbursement

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

Our standard policy is to make payment for Out-of-Network Provider claims on joint payee checks issued to both the Insured and the Provider or, with submission of sufficient documentation that the Insured has already "paid in full," on checks issued solely to the Insured. However, in some situations, We choose to pay the Out-of-Network Provider directly by check issued solely to the Provider.

Out-of-Network Providers may not agree to accept the Allowed Amount as payment for Covered Services. You may be 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 and/or Coinsurance. For Out-of-Network Providers, the Allowed Amount may be based upon the billed charges, as determined by Us or as otherwise required by law.

Timely Filing of Claims

You must provide written proof of loss within one year after the date of service of the claim. If You can show that it was not reasonably possible to provide such proof and that such proof was provided 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 appeal a denial in order to demonstrate that the claim could not have been filed in a timely manner, as outlined in the Appeal Process section.

Ambulance Claims

When You or Your Provider submits a claim for ambulance services, it must show the location the patient was picked up from and the facility where he or she was taken. It should also show the date of service, the patient's name and the patient's identification number.

Claims Determinations

Within 30 days of Our receipt of a claim, We will notify You of Our action. However, this 30-day period may be extended by an additional 15 days when We cannot take action on the claim due to lack of information or extenuating circumstances. We will notify You of the extension within the initial 30-day period and provide an explanation why the extension is necessary. If We require additional information to process the claim, We must allow You at least 45 days to provide it to Us. If We do not receive the requested information within the time We have allowed, We will deny the claim.

OUT-OF-AREA SERVICES

We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed

Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). 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 Arrangements.

When You receive care outside of Our Service Area, You will receive it from one of two kinds of Providers. Most Providers ("In-Network Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Out-of-Network Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers.

We cover only limited healthcare services received outside of Our Service Area. As used in this section, "Out-of-Area Covered Healthcare Services" are limited to otherwise covered emergency care (including ambulance) obtained outside the geographic area We serve. Out-of-area urgent care is covered only when received from an In-Network Provider. Any other services will not be covered when processed through any Inter-Plan Arrangements.

BlueCard Program

Under the BlueCard Program, when You receive Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, We will remain responsible for doing what We agreed to in the Policy. However, the Host Blue is responsible for contracting with and generally handling all interactions with its In-Network Providers.

The BlueCard Program enables You to obtain Out-of-Area Covered Healthcare Services, as defined above, or urgent care from an In-Network Provider, where available. The In-Network Provider will automatically file a claim for the Out-of-Area Covered Healthcare Services or urgent care provided to You, so there are no claim forms for You to fill out. You will be responsible for any Deductible, Copayment and/or Coinsurance, if applicable.

Emergency Care Services: If You experience a medical emergency while traveling outside the service area, go to the nearest emergency or urgent care facility.

When You receive Out-of-Area Covered Healthcare Services outside Our service area and the claim is processed through the BlueCard Program, the amount You pay for the Out-of-Area Covered Healthcare Services is calculated based on the lower of:

- The billed charges for Your Out-of-Area Covered Healthcare 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 healthcare Provider or Provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

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

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, We will include any surcharge, tax or other fee as part of the claim charge passed on to You.

Nonparticipating Providers Outside Our Service Area

- Your Liability Calculation. When Out-of-Area Covered Healthcare Services are provided outside of Our Service Area by Out-of-Network Providers, the amount You pay for such services will normally be based on either the Host Blue's Out-of-Network Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be responsible for the difference between the amount that the Out-of-Network Provider bills and the payment We will make for the Out-of-Area Covered Healthcare Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for Out-of-Network emergency services.
- Exceptions. In certain situations, We may use other payment methods, such as billed charges for

Out-of-Area Covered Healthcare Services, the payment We would make if the health care services had been obtained within Our Service Area, or a special negotiated payment to determine the amount We will pay for services provided by Out-of-Network Providers. In these situations, You may be liable for the difference between the amount that the Out-of-Network Provider bills and the payment We will make for the Out-of-Area Covered Healthcare Services as set forth in this paragraph.

BLUE CROSS BLUE SHIELD GLOBAL® CORE

If You are outside the United States, You may be able to take advantage of Blue Cross Blue Shield Global Core when accessing covered health services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States in certain ways. For instance, although Blue Cross Blue Shield Global Core assists You with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when You receive care from Providers outside the United States, You will typically have to pay the Providers and submit the claims Yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a doctor or Hospital) outside the United States, You should call the service center at 1 (800) 810-BLUE (2583) or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a Physician appointment or hospitalization, if necessary.

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

- **Outpatient Services**
  Physicians, urgent care centers and other outpatient Providers located outside the United States will typically require You to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**
  When You pay for covered healthcare services outside the BlueCard service area, You must submit a claim to obtain reimbursement. For institutional and professional claims, You should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of Your claim. The claim form is available from Us, the service center or online at **www.bcbsglobalcore.com**. If You need assistance with Your claim submission, You should call the service center at 1 (800) 810-BLUE (2583) or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week.

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 have the right, at Our discretion, 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 Policyholder 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 the experience of the pool under which You are 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 Policy and Claims Administration section for additional information.

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

This section explains how We treat various matters having to do with administering Your benefits and/or

claims, including situations that may arise in which Your health care expenses are the responsibility of a source other than Us.

As used herein, the term "Third Party" means any party that is, or may be, or is claimed to be, responsible for Illness or Injuries to You. Such Illness or Injuries are referred to as "Third Party Injuries." Third Party includes any party responsible for payment of expenses associated with the care or treatment of Third Party Injuries.

If this plan pays benefits under this Policy to You for expenses incurred due to Third Party Injuries, then We retain the right to repayment of the full cost, to the extent permitted by law of all benefits provided by this plan on Your behalf that are associated with the Third Party Injuries. Our rights of recovery apply to any recoveries made by or on Your behalf from the following sources, including but not limited to:

- Payments made by a Third Party or any insurance company on behalf of the Third Party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate You for Injuries resulting from an accident or alleged negligence.

By accepting benefits under this plan, You specifically acknowledge Our right of subrogation. When this plan pays health care benefits for expenses incurred due to Third Party Injuries, We shall be subrogated to Your right of recovery against any party to the extent of the full cost, to the extent permitted by law of all benefits provided by this plan. We may proceed against any party with or without Your consent.

By accepting benefits under this plan, You also specifically acknowledge Our right of reimbursement. This right of reimbursement attaches when this plan has paid health care benefits for expenses incurred due to Third Party Injuries and You or Your representative has recovered any amounts from any sources, including but not limited to: payments made by a Third Party or any payments or awards under an uninsured or underinsured motorist coverage policy; any Workers' Compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and any other payments from a source intended to compensate You for Third Party Injuries. By providing any benefit under this Policy, We are granted an assignment of the proceeds of any settlement, judgment or other payment received by You to the extent permitted by law of the full cost of all benefits provided by this plan. Our right of reimbursement is cumulative with and not exclusive of Our subrogation right and We may choose to exercise either or both rights of recovery.

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

We will not exercise Our rights of recovery and subrogation until You have been fully compensated for Your loss and expense incurred.

This provision applies when You incur health care expenses in connection with an Illness or Injury for which one or more third parties is responsible. In that situation, benefits for otherwise Covered Services are excluded under this Policy to the extent You receive a recovery from or on behalf of the responsible Third Party in excess of full compensation for the loss. If You do not pursue a recovery of the benefits We have advanced, We may choose, in Our discretion, to pursue recovery from another responsible party, including automobile medical no-fault, personal injury protection ("PIP") carrier on Your behalf.

Here are some rules which apply in these Third Party liability situations:

- By accepting benefits under this plan, You or Your representative agree to notify Us promptly (within 30 days) and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party Injuries sustained by You.
- You or Your representative agrees to cooperate with Us and do whatever is necessary to secure Our rights of subrogation and reimbursement under this Policy. In addition, You or Your representative agrees to do nothing to prejudice Our subrogation and reimbursement rights. This includes, but is not

limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the plan.

- If a claim for health care expense is filed with Us and You have not yet received recovery from the responsible Third Party, We may advance benefits for Covered Services if You agree to hold, or direct Your attorney or other representative to hold, the recovery against the Third Party in trust for Us, up to the amount of benefits We paid in connection with the Illness or Injury.
- You and/or Your agent or attorney must agree to serve as constructive trustee and keep any recovery or payment of any kind related to Your Illness or Injury which gave rise to the plan's right of subrogation or reimbursement segregated in its own account, until Our right is satisfied or released.
- Further, You or Your representative give Us a lien on any recovery, settlement, judgment or other source of compensation which may be had from any party to the extent permitted by law to the full cost of all benefits associated with Third Party Injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- You or Your representative also agrees to pay from any recovery, settlement, judgment or other source of compensation, any and all amounts due Us as reimbursement for the full cost of all benefits, to the extent permitted by law, associated with Third Party Injuries paid by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- In the event You and/or Your agent or attorney fails to comply with any of the above conditions, We may recover any benefits We have advanced for any Illness or Injury through legal action against You and/or Your agent or attorney.
- If We pay benefits for the treatment of an Illness or Injury, We will be entitled to have the amount of the benefits We have paid for the condition separated from the proceeds of any recovery You receive out of any settlement or recovery from any source, including any arbitration award, judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Illness or Injury for which We have provided benefits. This is true regardless of whether:

    - the Third Party or the Third Party's insurer admits liability;
    - the health care expenses are itemized or expressly excluded in the Third Party recovery; or
    - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered under the Policy. The amount to be held in trust shall be calculated based upon claims that are incurred on or before the date of settlement or judgment, unless agreed to otherwise by the parties.

- Any benefits We advance are solely to assist You. By advancing such benefits, We are not acting as a volunteer and are not waiving any right to reimbursement or subrogation.

We may recover to the extent permitted by law, the full cost of all benefits paid by this plan under this Policy without regard to any claim of fault on Your part, whether by comparative negligence or otherwise. You may incur attorney's fees and costs in connection with obtaining recovery. If this Policy is not subject to ERISA, We shall pay a proportional share of such attorney's fees and costs incurred by You at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to Us to less than the full amount of benefits paid by Us. If this Policy is subject to ERISA, You may request and We may contribute an amount toward attorney's fees incurred by You at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to Us to less than the full amount of benefits paid by Us. In the event You or Your representative fail to cooperate with Us, You shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by Us in obtaining repayment.

No-Fault Coverage

This provision applies when You incur health care expenses in connection with an Illness or Injury for which no-fault coverage is available. In that situation, benefits for otherwise Covered Services are excluded under this Policy to the extent Your expenses for services and supplies have been covered or have been accepted for coverage by a no-fault carrier.

Motor Vehicle Coverage

Most motor vehicle insurance policies provide medical expense coverage and uninsured and/or underinsured motorist insurance. When We use the term motor vehicle insurance below, it includes medical expense coverage, personal injury protection coverage, uninsured motorist coverage, underinsured motorist coverage or any coverage similar to any of these coverages. Benefits for health care expenses are excluded under this Policy if You receive payments from uninsured motorist coverage

or underinsured motorist coverage for such expenses to the extent those payments exceed the amount necessary to fully compensate You, along with all other payments You receive to compensate You for Your Injuries, losses or damages, for those Injuries, losses or damages.

Here are some rules which apply with regard to motor vehicle insurance coverage:

- If a claim for health care expenses arising out of a motor vehicle accident is filed with Us and motor vehicle insurance has not yet paid, We may advance benefits for Covered Services as long as You agree in writing:
  - to give Us information about any motor vehicle insurance coverage which may be available to You; and
  - to otherwise secure Our rights and Your rights.
- If We have paid benefits before motor vehicle insurance has paid, We are entitled to have the amount of the benefits We have paid separated from any subsequent motor vehicle insurance recovery or payment made to or on behalf of You held in trust for Us. The amount of benefits We are entitled to will never exceed the amount You receive from all insurance sources that fully compensates You for Your loss and We will only seek to recover amounts You have received from other insurance sources to the extent those amounts exceed full compensation to You for Your Injuries, losses or damages.
- 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, both this provision and the Right of Reimbursement and Subrogation Recovery provision apply. However, We will not seek double reimbursement.

Workers' Compensation

This provision applies if You have filed or are entitled to file a claim for workers' compensation. Benefits for treatment of an Illness or Injury arising out of or in the course of employment or self-employment for wages or profit are excluded under this Policy. The only exception would be if You or one of Your eligible dependents are exempt from state or federal workers' compensation law.

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.
- If the entity providing workers' compensation coverage denies Your claims and You have filed an appeal, We may advance benefits for Covered Services if You agree to hold any recovery obtained in trust for Us according to the Right of Reimbursement and Subrogation Recovery provision.

Fees and Expenses

You may incur attorney's fees and costs in connection with obtaining recovery. If this Policy is not subject to ERISA, We shall pay a proportional share of such attorney's fees and costs incurred by You at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to Us to less than the full amount of benefits paid by Us. If this Policy is subject to ERISA, You may request and We may contribute an amount toward attorney's fees incurred by You at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to Us to less than the full amount of benefits paid by Us.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when You have health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays

so that payments from all Plans do not exceed 100 percent of the total Allowable Expense.

Coordination of Benefits When This Plan is Used With an HSA

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

Definitions

For the purpose of this section, the following definitions shall apply:

A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

- Plan includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), Closed Panel Plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
- Plan does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under the above bullet points is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means, in a COB provision the part of this Policy providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of this Policy providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a "Primary Plan" or "Secondary Plan" when You have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total Allowable Expense for that claim. This means that when This Plan is secondary, it must pay the amount that which, when combined with what the Primary Plan paid, totals not less than the same Allowable Expense that This Plan would have paid if it were the Primary Plan. When the Primary Plan is Medicare and This Plan is secondary, it must pay the amount that which, when combined with what the Primary Plan paid, totals not less than the Medicare Allowable Expense. In addition, if This Plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for You. This reserve must be used to pay any expenses during that Calendar Year, whether or not they are an Allowable Expense under This Plan. If This Plan is secondary, it will not be required to pay an amount in excess of its Maximum Benefit plus any accrued savings.

Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services,

the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowable Expense.

When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the Allowable Expense. The following are examples of expenses that are not Allowable Expenses:

- The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
- If You are covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
- If You are covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

Closed Panel Plan is a Plan that provides health care benefits to You in the form of services through a panel of providers who are primarily employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

Order of Benefit Determination Rules

When You are covered by two or more Plans, the rules for determining the order of benefit payments are as follows. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan. A Plan that does not contain a coordination of benefits provision that is consistent with chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both Plans state that the complying plan is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Non-Dependent or Dependent. The Plan that covers You other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers You as a dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering You as a dependent, and primary to the Plan covering You as other than a dependent (for example, a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering You as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a child is covered by more than one Plan the order of benefits is determined as follows:

- For a child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
- For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is

given notice of the court decree. 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 policy year;

- If a court decree states one parent is to assume primary financial responsibility for the child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
- If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of the first bullet point above (for child(ren) whose parents are married or are living together) determine the order of benefits; or
- If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

  The Plan covering the Custodial Parent, first;

  The Plan covering the spouse of the Custodial Parent, second;

  The Plan covering the noncustodial parent, third; and then

  The Plan covering the spouse of the noncustodial parent, last.

- For a child covered under more than one Plan of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for child(ren) whose parents are married or are living together or for child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering You as a retired or laid-off employee is the Secondary Plan. The same would hold true if You are a dependent of an active employee and You are a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

COBRA or State Continuation Coverage. If Your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering You as an employee, member, subscriber or retiree or covering You as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the Non-Dependent or Dependent provision above can determine the order of benefits.

Longer or Shorter Length of Coverage. The Plan that covered You as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim cannot be less than the same Allowable Expense as the Secondary Plan would have paid if it was the Primary Plan. Total Allowable Expense is the highest Allowable Expense of the Primary Plan or the Secondary Plan. In addition, the Secondary Plan must credit to its plan deductible any amounts it would

have credited to its deductible in the absence of other health care coverage.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering You. We need not tell, or get the consent of, any person to do this. You, to claim benefits under This Plan, must give Us any facts We need to apply those rules and determine benefits payable.

Facility of Payment

If payments that should have been made under This Plan are made by another Plan, We have the right, at Our discretion, to remit to the other Plan the amount We determine appropriate to satisfy the intent of this provision. The amounts paid to the other Plan are considered benefits paid under This Plan. To the extent of such payments, We are fully discharged from liability under This Plan.

Right of Recovery

We have the right to recover excess payment whenever We have paid Allowable Expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. We may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

If You are covered by more than one health benefit plan, and You do not know which is Your primary plan, You or Your provider should contact any one of the health plans to verify which plan is primary. The health plan You contact is responsible for working with the other plan to determine which is primary and will let You know within 30 calendar days.

CAUTION: All health plans have timely claim filing requirements. If You or Your provider fail to submit Your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If You experience delays in the processing of Your claim by the primary health plan, You or Your provider will need to submit Your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if You are covered by more than one plan You should promptly report to Your providers and plans any changes in Your coverage.

If You have questions about this Coordination of Benefits provision, contact the Washington State Insurance Department.

Appeal Process

We have delegated the Appeals process for pediatric vision benefits to VSP, though We retain ultimate responsibility over the Appeals process. The terms "We," "Us" and "Our" in this Appeal Process section refer to VSP. Appeals can be initiated through either a written or verbal request. A written request can be made by completing the form available on **vsp.com** or by sending the written request by mail to VSP at: Vision Service Plan Insurance Company, Attention: Complaint and Appeals Unit, P.O. Box 997100, Sacramento, CA 95899-7100. Verbal requests can be made by calling VSP's Customer Service department at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance).

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action by Us under this Policy and wish to have it reviewed, You may Appeal. There is one level of Internal Appeal, as well as an External Appeal with an Independent Review Organization You may pursue. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section. For Grievances or complaints not involving an Adverse Benefit Determination, refer to the Grievance Process within this Policy.

APPEALS

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 1408, Lewiston, ID 83501 or facsimile 1 (888) 496-1542. Verbal requests can be made by calling Us at 1 (888) 675-6570.

Each level of Appeal, including Expedited Appeals, must be pursued within 180 days of Your receipt of Our determination (or, in the case of the Internal level, within 180 days of Your receipt of Our original adverse decision that You are Appealing). If You don't Appeal 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 within 72 hours of receiving the request.

Upon request and free of charge, You, or Your Representative, have the right to review copies of all documents, records and information relevant to any claim that is the subject of the determination being appealed.

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. See Expedited Appeals later in this section for more information.

If We reverse Our initial Adverse Benefit Determination, which We may do at any time during the review process, We will provide You with written or electronic notification of the decision immediately, but in no event more than two business days of making the decision. An Adverse Benefit Determination may be overturned by Us at any time during the Appeal process if We receive newly submitted documentation and/or information which establishes coverage, or upon the discovery of an error, the correction of which would result in overturning the Adverse Benefit Determination.

If You request a review of an Adverse Benefit Determination, We will continue to provide coverage for disputed inpatient care benefits or any benefit for which a continuous course of treatment is Medically Necessary, pending outcome of the review. If We prevail in the Appeal, You may be responsible for the cost of coverage received during the review period. The decision at the external review level is binding unless other remedies are available under state or federal law.

Internal Appeals

Internal Appeals, including internal Expedited Appeals, are reviewed by an employee or employees who were not involved in the initial decision that You are Appealing. You or Your Representative, on Your behalf, will be given a reasonable opportunity to provide written materials, including written testimony. In Appeals that involve issues requiring medical judgment, the decision is made by Our staff of health care professionals. If the Appeal involves a Post-Service investigational issue, a written notice of the decision will be sent within 20 working days after receiving the Appeal. For all other Appeals, the written notice will be sent within 14 days of receipt. You will be notified if, for good cause, We require additional time. An extension cannot delay the decision beyond 30 days without Your informed written consent.

VOLUNTARY EXTERNAL APPEAL - IRO

A voluntary Appeal to an Independent Review Organization (IRO) is available to You if the Appeal involves an Adverse Benefit Determination based on Medical Necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria and only after You have exhausted the internal level of Appeal, or We have failed to provide You with an Internal Appeal decision within the requirements of the Internal Appeal process.

We coordinate voluntary External Appeals, but the decision is made by an IRO at no cost to You. We will provide the IRO with the Appeal documentation, which is available to You or Your Provider upon request. You will also be provided five business days to submit, in writing, any additional information to the IRO. A written notice of the IRO's decision will be sent to You within 15 days after the IRO receives the necessary information or 20 days after the IRO receives the request. Choosing the voluntary External Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision, except to the extent other remedies are available under state or federal law.

The voluntary External Appeal by an IRO is optional and You should know that other forums may be utilized as the final level of Appeal to resolve a dispute You have with Us. This includes, but is not limited to, civil action under Section 502(a) of ERISA, where applicable.

EXPEDITED APPEALS

An Expedited Appeal is available if one of the following applies:

- You are currently receiving or are prescribed treatment for a medical condition; or
- Your treating Provider believes the application of regular Appeal time frames on a Pre-Service or concurrent care claim could seriously jeopardize Your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- the Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where You have not been discharged.

You may request concurrent expedited internal and external reviews of Adverse Benefit Determinations (meaning the reviews will be done simultaneously). When concurrent expedited reviews are requested, We will not extend the timelines by making the determinations consecutively. The requisite timelines will be applied concurrently.

Internal Expedited Appeal

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. Reviewers will include an appropriate clinical peer in the same or similar specialty as would typically manage the case. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the Expedited Appeals time frame) to provide written materials, including written testimony on Your behalf. Verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal. This will be followed by written notification within 72 hours of the date of decision.

Voluntary Expedited Appeal - IRO

If You disagree with the decision made in the internal Expedited Appeal and You or Your Representative reasonably believes that preauthorization or concurrent care (Pre-Service) remains clinically urgent, You may request a voluntary Expedited Appeal to an IRO. The criteria for a voluntary Expedited Appeal to an IRO are the same as described above for non-urgent IRO review. You may request a voluntary Expedited External Appeal at the same time You request an Expedited Appeal from Us.

We coordinate voluntary Expedited Appeals, but the decision is made by an IRO at no cost to You. We will provide the IRO with the Expedited Appeal documentation, which is available to You or Your Provider upon request. 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 the IRO's receipt of the necessary information. This will be followed by written notification within 48 hours of the verbal notice. Choosing the voluntary Expedited Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision, except to the extent other remedies are available under state or federal law.

The voluntary Expedited Appeal by an IRO is optional and You should know that other forums may be

used as the final level of Expedited Appeal to resolve a dispute You have with Us, 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, contact Customer Service, or write to Customer Service at the following address: Regence BlueCross BlueShield of Oregon, MS CS B32B, P.O. Box 1827, Medford, OR, 97501-9884. If you have any questions about the VSP Appeal process, You may contact VSP's Customer Service department at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance), Monday-Friday 5 a.m. to 8 p.m., Saturday 7 a.m. to 8 p.m., and Sunday 7 a.m. to 7 p.m.

ASSISTANCE

For assistance with internal claims and Appeals and the external review process, contact:

Office of the Insurance Commissioner
Consumer Protection Division
PO Box 40256
Olympia, WA 98504-0256
Toll Free: 1 (800) 562-6900
TDD: 1 (360) 586-0241
Olympia: 1 (360) 725-7080
Fax: 1 (360) 586-2018
E-mail: **cap@oic.wa.gov**
Web: **www.insurance.wa.gov**

Grievance Process

If You or Your Representative (any Representative authorized by You) has a complaint not involving an Adverse Benefit Determination and wishes to have it resolved, You may submit a Grievance to Us. Grievances may be submitted orally or in writing through either of the following contacts:

Call Customer Service at 1 (888) 675-6570 or write to Customer Service at the following address: Regence BlueCross BlueShield of Oregon, MS CS B32B, P.O. Box 1827, Medford, OR, 97501-9884.

A Grievance may be registered when You or Your Representative expresses dissatisfaction with any matter not involving an Adverse Benefit Determination, including but not limited to, Our customer service or quality or availability of a health service. Once received, Your Grievance will be responded to in a timely and thorough manner. Grievances will also be collectively evaluated by Us, on a quarterly basis, for improvements. If You would like a written response or acknowledgement of Your Grievance from Us, request one at the time of submission.

For any complaints involving an Adverse Benefit Determination, refer to the Appeals Process section.

Who Is Eligible, How to Apply and When Coverage Begins

This section contains the terms of eligibility and enrollment under this Policy for You and Your dependents. It describes when coverage under this Policy begins for You and/or Your eligible dependents through payment of any corresponding monthly premiums is required for coverage to begin on the indicated dates.

WHEN COVERAGE BEGINS

You must complete an application for coverage for Yourself and Your eligible dependents or enroll through the Washington Health Benefit Exchange (HBE). Subject to meeting the eligibility requirements as stated in the following paragraphs, coverage for You and Your applying eligible dependents will begin on the first day of the month (provided that the application is received on or prior to the 15th of the previous month) following receipt and acceptance of the application by Us, except as required otherwise by the Special Enrollment provision. If You enrolled through the HBE, coverage will begin as of the Effective Date determined by the HBE.

Medicare Enrollee

To be eligible to apply for coverage under this Policy, You must not be enrolled in a Medicare plan. Additionally, any dependent enrolled in a Medicare plan will not be eligible to apply for coverage under this Policy.

Residency Requirement

To be eligible to apply for coverage under this Policy, You must reside in Our Service Area and continue to live in Our Service Area six months or more per Calendar Year. We routinely verify the residence of Our applicants. Whether enrolling with Us or through the HBE, We may require You to provide Us with a copy of the following to verify Your current residency status:

- A current utility bill containing both service and mailing addresses;
- if You are a student, a letter from the college/university registrar noting Your local residence address; or
- alternative documentation as authorized by Us.

For the purpose of maintaining this Policy, You must maintain a fixed permanent home within the Service Area. If it is necessary for You to leave the Service Area for an extended period of time, You may be required to submit appropriate documentation as proof of maintaining Your primary residence within the Service Area during Your absence. Treatment received in a Residential Care facility is not considered an eligibility qualification for this Residency Requirement provision.

If You move and are no longer a Resident in Our Service Area, We will terminate this Policy and refund any premium payments made for periods after the end of the billing cycle in which We acquire actual knowledge that You are no longer a Resident. However, if You are a military service member who is stationed outside of Our Service Area, You will not be terminated if Your legal residence continues to be within Our Service Area.

Dependents

Dependents are also eligible to enroll under this Policy. Your Dependents are eligible for coverage when You have listed them on the application or on subsequent change forms and when We have enrolled them in coverage under this Policy, or when You have completed the HBE enrollment process. Eligible dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your domestic partner.
- Your (or Your spouse's or Your domestic partner's) child who is under age 26 and who meets any of the following criteria:
    - Your (or Your spouse's or Your domestic partner's) natural child, step child, adopted child or child legally placed with You (or Your spouse or Your domestic partner) for adoption;
    - a child for whom You (or Your spouse or Your domestic partner) have court-appointed legal guardianship; and
    - a child for whom You (or Your spouse or Your domestic partner) are required to provide coverage

by a legal qualified medical child support order (QMCSO).

- Your (or Your spouse's or Your 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:

  - 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 or an individual plan issued by Us since that birthday.

If enrolling through Us, a Disabled Dependent must meet the requirements of the definition provided in the Definitions section. Completion and submission of Our affidavit of dependent eligibility form, with written evidence of the child's incapacity, is required within 31 days of the later of the child's 26th birthday or Your Effective Date. Our affidavit of dependent eligibility form is available by visiting Our Web site or by contacting Customer Service. We may request an annual update on the child's disability or handicap following the dependent's 28th birthday. If enrolling through the HBE, contact the HBE for additional information on enrolling Disabled Dependents.

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an application to Us or through application to the HBE. Applications 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 if payment of additional premium is required to provide coverage for the child. Applications 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 the Effective Date. For a new child by birth, the Effective Date is the date of birth. For a new child adopted or placed for adoption within 60 days of birth, the Effective Date is the date of birth, if any associated additional premium has been paid within 60 days of birth. The Effective Date for any other child by adoption or Placement for Adoption is the date of Placement for Adoption. For other newly eligible dependents, the Effective Date is the first day of the month following receipt of the application for enrollment.

NOTE: The regular benefits of this Policy will be provided for a newborn child for up to 21 days following birth when delivery of the child is covered under this Policy. Such benefits will not be subject to enrollment requirements for a newborn as specified here, or the payment of a separate premium for coverage of the child. Coverage, however, is subject to all provisions, limitations and exclusions of this Policy. No benefits will be provided after the 21st day unless the newborn is enrolled according to the enrollment requirements for a newborn.

NOTE: Due to the nature of this high deductible health plan, adding dependents after January 1 of any year may change Your coverage from Single Coverage to Family Coverage, and may change the amount of Deductible and Out-of-Pocket Maximum that applies to Your coverage.

SPECIAL ENROLLMENT

You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to enroll (except as specified otherwise below) for coverage under this Policy outside of the open enrollment period if one of the following qualifying events is met:

- You, Your spouse or domestic partner gain a new dependent child or, for a child, become a dependent child by birth, adoption, or Placement for Adoption;
- You, Your spouse or domestic partner gain a new dependent child or, for a spouse or domestic partner or child, become a dependent through marriage or beginning a domestic partnership;
- Unintentional, inadvertent, or erroneous enrollment or non-enrollment resulting from an error, misrepresentation, or inaction by an officer, employee, or agent of the HBE or U.S. Department of Health and Human Services;
- You and/or Your eligible dependents can adequately demonstrate that a qualified health plan has substantially violated a material provision of its contract with regard to You and/or Your eligible dependents;
- You become newly eligible or newly ineligible for advance payment of premium tax credits or have a change in eligibility for cost-sharing reductions;
- Loss of eligibility for group coverage due to: death of a covered employee, an employee's termination

of employment (other than for gross misconduct), an employee's reduction in working hours, an employee's divorce or legal separation, an employee's entitlement to Medicare, a loss of dependent child status, or certain employer bankruptcies;
- Loss of coverage as the result of termination of a domestic partnership;
- Permanent change of residence, work, or living situation such that a health plan by which You were covered does not provide coverage in Your new service area;
- The plan by which You were covered no longer offers benefits to the class of similarly situated individuals that includes You;
- The HBE terminates Your qualified health plan coverage pursuant to 45 CFR 155.430 and any applicable 3-month grace period expires;
- Exhaustion of COBRA coverage due to failure of the employer to remit premium;
- Loss of COBRA coverage by exceeding the lifetime limit and no other COBRA coverage is available;
- Discontinuation of high-risk pool coverage;
- Loss of eligibility for Medicaid or a public program providing health benefits;
- Permanent move resulting in new eligibility for a previously unavailable plan;
- Permanently move to a new service area;
- Loss of minimum essential coverage, including because an age is reached at which dependent status ends or because an employer stops contributing toward group coverage;
- If enrolled through the HBE, other exceptional circumstances as the HBE may provide; or
- If enrolled through the HBE, an individual, not previously lawfully present, gains status as a citizen, national, or lawfully present individual in the U.S.

Note that a qualifying event due to loss of minimum essential coverage does not include a loss because You failed to timely pay Your portion of the premium on a timely basis (including COBRA) or when termination of such coverage was because of rescission. It also doesn't include Your decision to terminate coverage.

For the above qualifying events, Your completed application must be submitted within 60 days of the qualifying event. Coverage will be effective on the first of the calendar month following the date of the qualifying event (provided that the application is received on or prior to the 15th of the previous month); however, when 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.

If enrolling through the HBE, and You are classified as an "Indian" under federal law, You may move between qualified health plans one time per month.

OPEN ENROLLMENT PERIOD

Open enrollment is a specific period of time each Calendar Year during which enrollment under this Policy is open to all who qualify. The dates of the open enrollment period are established by the HBE. Refer to the HBE for the most current open enrollment dates.

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 this Policy.

When 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. If You enrolled through the HBE, coverage will end as of the date determined by the HBE.

No person will have a right to receive benefits after the date it is terminated. Termination of Your or Your Enrolled Dependent's coverage under this Policy 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 this Policy was in effect.

GUARANTEED RENEWABILITY AND POLICY TERMINATION

This Policy is guaranteed renewable, at Your option, upon payment of the monthly premium when due or within the grace period, except that We may terminate this Policy or the coverage for an individual, for any one of the following reasons:

- Nonpayment of the premium by the end of the grace period (see also the Nonpayment of Premium and Grace Period provisions below).
- Violation of Our published policies that have been approved by the Washington State Insurance Commissioner, if any.
- Insureds who fail to pay the Deductible amount owed to Us and not the Provider of health care services.
- For fraud or intentional misrepresentation of material fact by the Insured (see also the Other Causes of Termination provision below).
- Insureds who materially breach this Policy.
- There is a change or implementation of federal or state laws that no longer permits the continued offering of this Policy.
- There is zero enrollment on the product.

In the event We eliminate the coverage described in this Policy for You and Your Enrolled Dependents, We will provide 90-days written notice to all Insureds covered under this Policy. We will make available to You, on a guaranteed issue basis and without regard to the health status of any Insured covered through it, the option to purchase all other individual coverage(s) being offered by Us for which You qualify.

In addition, if We choose to discontinue offering coverage in the individual market, We will provide 180-days prior written notice to the Washington State Insurance Commissioner and affected Insureds.

If this Policy is terminated or not renewed by You or Us, coverage ends for You and Your Enrolled Dependents on the last day of the calendar month in which this Policy is terminated or not renewed so long as premium has been received for the calendar month.

MILITARY SERVICE

An Insured whose coverage under this Policy terminates due to entrance into military service may request, in writing, a refund of any prepaid premium on a pro rata basis for any time in which this coverage overlaps such military service.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, coverage ends for You and Your Enrolled Dependents on the last day of the calendar month in which Your eligibility ends so long as premium has been received for the calendar month, or on the date assigned by the HBE.

NONPAYMENT OF PREMIUM

If You fail to timely pay premium as required, coverage will end for You and all Enrolled Dependents.

GRACE PERIOD

A grace period of 30 days, or of 90 days for Insureds enrolling through the HBE whose premium is subsidized by the federal government's payment of a portion of Your premium as an advance of the premium tax credit, will be granted for the payment of the regular monthly premium after payment of the first month's premium. During this grace period this Policy shall not be terminated, however, if the premium has not been received by the last day of the grace period, this Policy shall be terminated at the

end of the month for which premium has been paid in full.

TERMINATION BY YOU

You have the right to terminate this Policy with respect to Yourself and Your Enrolled Dependents by giving Us notice within 30 days or by contacting the HBE, which will provide Us with the notice of termination. Coverage will end on the last day of the calendar month following the date We receive such notice so long as premium has been received for the calendar month. However, it may be possible for an ineligible dependent to continue coverage under this Policy according to the provisions below.

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 calendar month in which his or her eligibility ends, so long as premium has been received for the calendar month, or on the date assigned by the HBE. However, it may be possible for an ineligible dependent to continue coverage according to the provisions below.

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 calendar month following the date a divorce or annulment is final, so long as premium has been received for the calendar month, or on the date assigned by the HBE.

Death of the Enrolled Policyholder

If You die, coverage for Your Enrolled Dependents ends on the last day of the calendar month in which Your death occurs, so long as premium has been received for the calendar month, or on the date assigned by the HBE.

Policy Continuation

In the event that an Enrolled Dependent no longer meets eligibility as set forth above due to divorce, annulment, or Your death, such Enrolled Dependent shall have the right to continue the coverage of this Policy.

Termination of Domestic Partnership

If Your domestic partnership terminates after the Effective Date, 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 calendar month following the date of termination of the domestic partnership, so long as the premium has been received for the calendar month, or on the date assigned by the HBE. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence. This termination provision does not apply to any termination of domestic partnership that occurs as a matter of law because the parties to the domestic partnership enter into a marriage (including any entry into marriage by virtue of an automatic conversion of the domestic partnership into a marriage).

Loss of Dependent Status for an Enrolled Child

Eligibility ends on the last day of the calendar month in which an enrolled child exceeds the dependent age limit so long as the premium has been received for the calendar month, or by the date assigned by the HBE. An enrolled child will also lose eligibility on the date the child is removed from placement, or by the date assigned by the HBE, if there is a disruption of placement before legal adoption.

OTHER CAUSES OF TERMINATION

Insureds may be terminated for any of the following reasons:

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 this Policy will terminate for that Insured.

Fraud or Misrepresentation in Application

We have issued this Policy 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 an Insured, We will take any action allowed by law or Policy, including denial of benefits,

termination of coverage and/or pursuit of criminal charges and penalties.

MEDICARE SUPPLEMENT

When eligibility under this Policy terminates, You may be eligible for coverage under a Medicare supplement plan through Us. Additional information is available by calling Customer Service at 1 (888) 675-6570.

General Provisions and Legal Notices

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

CHOICE OF FORUM

Any legal action arising out of this Policy must be filed in a court in the state of Washington.

GOVERNING LAW AND BENEFIT ADMINISTRATION

This Policy 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 Washington without regard to its conflict of law rules. We are a health care service contractor that provides health care coverage to this benefit plan and makes determinations for eligibility and the meaning of terms subject to the Insured rights under this benefit plan that include the right to Appeal, review by an Independent Review Organization and civil action.

LIMITATIONS ON LIABILITY

In all cases, You have the exclusive right to choose a health care Provider. 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. We are responsible for the quality of health care You receive only as provided by law. 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.

MODIFICATION OF POLICY

We shall have the right to modify or amend this Policy from time to time. However, no modification or amendment will be effective until a minimum of 30 days (or as required by law) after written notice has been given to the Policyholder. The modification must be uniform within the product line and at the time of renewal.

However, when a change in this Policy is beyond Our control (for example, legislative or regulatory changes take place), We may modify or amend this Policy on a date other than the renewal date, including changing the premium rates, as of the date of the change in this Policy. We will give You prior notice of a change in premium rates when feasible. If prior notice is not feasible, We will notify You in writing of a change of premium rates within 30 days after the later of the Effective Date or the date of Our implementation of a statute or regulation.

Provided We give notice of a change in premium rates within the above period, the change in premium rates shall be effective from the date for which the change in this Policy is implemented, which may be retroactive.

Payment of new premium rates after receiving notice of a premium change constitutes the Policyholder's acceptance of a premium rate change.

Changes can be made only through a modified Policy, amendment, endorsement or rider authorized and signed by one of Our officers. No other agent or employee of Ours is authorized to change this Policy.

NO WAIVER

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

NONASSIGNMENT

Only You are entitled to benefits under the Policy. These benefits are not assignable or transferable 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.

NOTICES

Any notice to Insureds required in this Policy will be considered properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Insured will be addressed to the last known address appearing in Our records. If We receive a United States Postal Service change of address (COA) form for a Policyholder, We will update Our records accordingly. Additionally, We may forward notice for an Insured if We become aware that We don't have a valid mailing address for the Insured. Any notice to Us required in this Policy may be given by mail addressed to Our Customer Service address; however, any notice to Us will not be considered to have been given to and received by Us until physically received by Us.

NOTICE OF PRIVACY PRACTICES

We have a Notice of Privacy Practices that is available by calling Customer Service or visiting Our Web site.

PREMIUMS

Premiums are to be paid to Us by You on or before the premium due date, or within the grace period. Failure by the Policyholder to make timely payment of premiums may result in Our terminating this Policy on the last day of the month through which premiums are paid or such later date as is provided by applicable law.

If enrolling through the HBE, and the federal government is paying a portion of Your payment as an advance of the premium tax credit, the federal government will also determine if they will pay a portion of the payment for a new dependent.

Premium Charges

This Policy is issued in consideration of an accepted application or notification of enrollment through the HBE and the payment of the required premium charges. Premium charges are not accepted from third-party payers including employers, Providers, non-profit or government agencies, except as required by law.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

You, on behalf of Yourself and any Enrolled Dependents, expressly acknowledge Your understanding that this Policy constitutes an agreement solely with 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. You, on behalf of Yourself and any Enrolled Dependents, further acknowledge and agree that You have not entered into this Policy 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 You for any of Our obligations to You created under this Policy. 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 this Policy.

REPRESENTATIONS ARE NOT WARRANTIES

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

It is important to understand that Your personal health information may be requested or disclosed by Us. This information will be used in accordance with Our Notice of Privacy Practices. To request a copy, visit Our Web site or contact Customer Service.

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 visiting Our Web site or contacting Customer Service.

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

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

TAX TREATMENT

We do not provide tax advice. Consult your financial or tax advisor for information about the appropriate tax treatment of benefit payments and reimbursements.

WE ARE NOT RESPONSIBLE FOR HEALTH SAVINGS ACCOUNT FINANCIAL OR TAX ARRANGEMENTS

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

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

WHEN BENEFITS ARE AVAILABLE

In order for health expenses to be covered under this Policy, 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 this Policy;
- the person has applied and has been accepted for coverage by Us or by the HBE; and
- premium for the person for the current month has been paid by You 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.

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; and
- prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Definitions

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

PROVIDER DEFINITIONS
For Providers of care, we use the following terms:

Contracted Dentist means a Provider that has a contract with Us or whose contract We may access through a network leasing agreement. These Providers may or may not be in Your network.

Contracted Provider means a Provider that has a contract with Us or whose contract We may access through a network leasing agreement. These Providers may or may not be in Your network.

Dentist means an individual who is licensed to practice dentistry (including a doctor of medical dentistry, doctor of dental surgery or a denturist). A Dentist also means a dental hygienist who is permitted by his or her respective state licensing board, to independently bill third parties.

In-Network Dentist means a Contracted Dentist who is in Your Provider network. In-Network Dentists will not bill You for the amount above the Allowed Amount for a Covered Service. The Provider network for an In-Network Dentist is: Participating Dental.

In-Network Provider means a Contracted Provider that is in Your Provider network. In-Network Providers will not bill You for the amount above the Allowed Amount for a Covered Service. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, In-Network Providers include only Our identified Centers of Excellence for the particular therapy.

In-Network Provider, for the Pediatric Vision benefit, means a VSP Doctor. The Provider network for In-Network Pediatric Vision benefit is: VSP Choice.

Non-Contracted Provider means a Provider that does not have a contract with Us or whose contract cannot be accessed through a network leasing agreement. If a Covered Service is provided by a Non-Contracted Provider, the Provider may bill You the amount above the Allowed Amount.

Out-of-Network Dentist means a Dentist who is not in Your Provider network.

Out-of-Network Provider means a Provider that is not In-Network. For services under the Gene Therapy and Adoptive Cellular Therapy benefit, Out-of-Network Providers include any Provider that is not one of Our identified Centers of Excellence for the particular therapy. Refer to the Schedule of Benefits for an explanation of the Covered Services Out-of-Network Providers can provide.

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

Physician means an individual who is duly licensed as a doctor of medicine (M.D.), doctor of osteopathy (D.O.), doctor of podiatric medicine (D.P.M.) or doctor of naturopathic medicine (N.D.) who is a Provider covered under this Policy.

Practitioner means a healthcare professional, other than a Physician, who is duly licensed to provide medical or surgical services. Practitioners include, but are not limited to, chiropractors, psychologists, registered nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, Dentists (doctor of medical dentistry or doctor of dental surgery, or a denturist) and other professionals practicing within the scope of their respective licenses, such as massage therapists, physical therapists and mental health counselors.

Primary Care Provider means a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who has a specialty type of general practice, family practice, internal medicine, pediatrics, geriatrics, OB/GYN and obstetrics, preventive medicine, adult medicine, women's health care practitioner or naturopath. Primary Care Provider also includes any physician assistant, nurse practitioner or advance registered nurse practitioner if their primary specialty is one of the above and they are working under the license of an M.D. or D.O. in these specialties. Selection of a particular Provider to coordinate referrals or to receive primary care services is not required. You may change the Provider of Your care (including primary care) at any time by consulting a different Provider. If We terminate the contract of Your Primary Care Provider

without cause, We will continue to cover Your Primary Care Provider, on the same terms, for at least ninety days following notice of termination.

Provider means a Hospital, Skilled Nursing Facility, ambulatory services facility, Physician, Practitioner or other individual or organization which is duly licensed to provide medical or surgical services.

Specialist means a Physician, Practitioner or urgent care center that does not otherwise meet the definition of a Primary Care Provider.

VSP Doctor means an optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials to Insureds.

GENERAL DEFINITIONS

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

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination or failure to provide or make payment that is based on a determination of an Insured's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Allowed Amount means:

- For In-Network Providers, the amount that they have contractually agreed to accept as full payment for a service or supply.
- For Out-of-Network Providers, the amount We have determined to be reasonable charges for Covered Services or supplies. The Allowed Amount may be based upon the billed charges, as determined by Us or as otherwise required by law.
- For In-Network Dentists, the amount In-Network Dentists have contractually agreed to accept as full payment for Covered Services.
- For VSP Doctors (see definition of "VSP Doctor"), the amount that these Providers have contractually agreed to accept as full payment for a service or supply.

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

Ambulatory Surgical Center means a distinct facility or that portion of a facility licensed by the state in which it is located, that operates primarily to provide specialty or multispecialty 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 specialty or multispecialty outpatient surgical treatment on a regular and organized basis; or 2) a portion of a licensed Hospital designated for outpatient surgical treatment.

Appeal means a written or verbal request from an Insured or, if authorized by the Insured, the Insured's Representative, to change a previous decision made by Us concerning:

- access to health care benefits, including an adverse determination made pursuant to utilization management;
- claims payment, handling or reimbursement for health care services;
- matters pertaining to the contractual relationship between an Insured and Us;
- rescissions of Your benefit coverage by Us; and
- other matters as specifically required by state law or regulation.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation

to prevention, detection, or treatment of cancer or other Life-threatening Condition and 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.

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

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.

Covered Service means a service, supply, treatment or accommodation that is listed in the Schedule of Benefits and Medical Benefits section of this Policy.

Covered Service, within the Pediatric Dental benefit, means those services or supplies that are required to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues and are Dentally Appropriate. These services must be performed by a Dentist or other Provider practicing within the scope of his or her license.

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

Dental 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.

Dentally Appropriate means a dental service recommended by the treating Dentist or other Provider, who has personally evaluated the patient, and determined by Us (or Our designee) to be all of the following:

- appropriate, based upon the symptoms, for determining the diagnosis and management of the condition;
- appropriate for the diagnosed condition, disease or Injury in accordance with recognized national standards of care;
- not able to be omitted without adversely affecting the Insured's condition; and
- not primarily for the convenience of the Insured, Insured's Family or Provider.

A dental service may be Dentally Appropriate yet not be a covered service under this policy.

Disabled Dependent means a child who is and continues to be both: 1) incapable of self-sustaining employment by reason of developmental disability or physical handicap; and 2) chiefly dependent upon the Policyholder for support and maintenance.

Drug List means Our list of selected Prescription Medications. We established Our Drug List and We review and update it routinely. It is available on Our Web site or by contacting Customer Service. Medications are reviewed and selected for inclusion in Our Drug List by an outside committee of

providers, including Physicians and Pharmacists.

Effective Date means the first day of coverage for You and/or Your dependents following receipt and acceptance of the application by Us or by the HBE.

Emergency Fill means a limited dispensed amount of medication that allows time for the processing of a preauthorization request. Emergency fill only applies to those circumstances where an Insured goes to a contracted Pharmacy with an immediate therapeutic need for a prescribed medication that requires a prior authorization.

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 Insured's health, or with respect to a pregnant Insured, 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 a Policyholder's eligible dependent who is listed on the Policyholder's completed application and who has been accepted for coverage under the terms of this Policy by Us.

Expedited Appeal means an Appeal where:

- You are currently receiving or are prescribed treatment for a medical condition; and
- Your treating Provider believes the application of regular Appeal time frames on a Pre-Service or concurrent care claim could seriously jeopardize Your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- the Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where You have not been discharged.

Experimental/Investigational means a Health Intervention that We have classified as Experimental or Investigational. 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 to determine if it is Experimental or Investigational. A Health Intervention not meeting all of the following criteria, is, in Our judgment, Experimental or Investigational:

- 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 which it is being prescribed, benefits for that use will not be excluded. To be considered "effective" for other than its FDA-approved use, a medication must be so recognized in one of the standard reference compendia or, if not, then in a majority of relevant Peer-Reviewed Medical Literature; or by the United States Secretary of Health and Human Services. The following additional definitions apply to this provision:
    - Peer-Reviewed Medical Literature is scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-Reviewed Medical Literature does not include in-house publications of pharmaceutical manufacturing companies.
    - Standard Reference Compendia is one of the following: the American Hospital Formulary Service-Drug Information, the United States Pharmacopoeia-Drug Information or other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services or the Washington State Insurance Commissioner.
- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Illness or Injury, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- Medications approved under the FDA's Accelerated Approval Pathway must show improved Health Outcomes.

- The Scientific Evidence must show that the Health Intervention is at least as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

Upon receipt of a fully documented claim or request for preauthorization related to a possible Experimental or Investigational Health Intervention, a decision will be made and communicated to You within 20 working days. Contact Us for details on the information needed to satisfy the fully documented claim or request requirement. You may also have the right to an Expedited Appeal. Refer to the Appeal Process section for additional information on the Appeal process.

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

External Appeal means a review of an Adverse Benefit Determination performed by an Independent Review Organization to determine whether Regence's Internal Appeal decisions are correct.

Facility Fee means any separate charge or billing by a provider-based clinic in addition to a professional fee for office visits that are intended to cover room and board, building, electronic medical records systems, billing, and other administrative or operational expenses.

Family means a Policyholder and his or her Enrolled Dependents.

Grievance means a written or oral complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, Provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

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. A Health Intervention is considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

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 this Policy).

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary External Appeals and voluntary 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.

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 bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

Insured means any person who satisfies the eligibility qualifications and is enrolled for coverage under this Policy.

Internal Appeal means a review and reconsideration of an Adverse Benefit Determination performed by Regence.

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

Lifetime means the entire length of time an Insured is covered under this Policy (which may include more than one coverage) with Us.

Mail-Order Supplier means a mail-order Pharmacy with which We have contracted for mail-order services.

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

- in accordance with generally accepted standards of medical practice;
- 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. (If "Medically Necessary" or "Medical Necessity" is specifically defined in any benefit under the Medical Benefits section of this Policy, such definition shall be applicable for purposes of that benefit instead of this definition.)

Medical Necessity determinations are made by health professionals applying their training and experience, and using applicable medical policies developed through periodic review of generally accepted standards of medical practice.

Mental Health Conditions means mental disorders, including eating disorders, included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association except as otherwise excluded. Mental disorders that accompany an excluded diagnosis are covered.

Mental Health Services means 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), and court ordered treatment (unless the treatment is determined by Us to be Medically Necessary).

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

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 or Preferred 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 or Preferred Pharmacies may submit claims electronically. To find a Participating or Preferred Pharmacy, visit Our Web site or contact Customer Service. 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 submit claims electronically.

Pharmacy and Therapeutics (P&T) Committee means an officially chartered group of practicing Physicians and Pharmacists, all of whom are free from conflict of interest of drug manufacturers and the

majority of whom are free from conflict of interest of Your coverage, who review the medical and scientific literature regarding medication use and provide input and oversight of the development of the Drug List and medication policies.

Placement for Adoption means an assumption of a legal obligation for total or partial support of a child in anticipation of adoption of the child. Upon termination of all legal obligation for support, placement ends.

Policy is the description of the benefits for this coverage. This Policy is also the agreement between You and Us for a health benefit plan.

Policyholder means a person who is enrolled for coverage under this Policy, and whose name appears on Our records as the individual to whom this Policy was issued.

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

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

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

Preferred Specialty Medication and Specialty Medication means a medication that may be used to treat complex conditions, including, but not limited to, multiple sclerosis, rheumatoid arthritis, cancer, clotting factor for hemophilia or similar clotting disorders, and hepatitis C. Information from the manufacturer, scientific literature, practice standards, Medicare practices and other information that is considered relevant and reliable is used to determine a Specialty Medication. For a list of such medications, visit Our Web site or contact Customer Service.

Prescription Medication (also Prescribed Medication) means a medication or biological that relates 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 Drug List.

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

Pre-Service means any claim for benefits 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 Appeal. The Representative may be Your personal Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the Appeal. No authorization is required from the parent(s) or legal guardian of an Insured 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 without additional authorization. Even if You have previously designated a person as Your Representative for a previous matter, an authorization designating that person as Your Representative in a new matter will be required (but redesignation is not required for each Appeal level). If no authorization exists and is not received in the course of the Appeal, the determination and any personal information will be disclosed to You, Your personal Representative or treating Provider only.

Resident means a person who is able to provide satisfactory proof of having residence within the Service Area as his or her primary place of domicile for six months or more in a Calendar Year, for the purpose of being an eligible applicant.

Residential Care means care received in an organized program which is provided by a residential facility, Hospital, or other facility licensed, for the particular level of care for which reimbursement is being sought,

by the state in which the treatment is provided.

Retail Clinic means a walk-in health clinic located within a retail operation and providing, on an ambulatory basis, preventive and primary care services. A Retail Clinic does not include an office or independent clinic outside a retail operation, or an Ambulatory Surgical Center, urgent care center, Hospital, Pharmacy, rehabilitation facility or Skilled Nursing Facility.

Routine Patient Costs means items and services that typically are Covered Services for an Insured 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;
- Items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the Insured; or
- A service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

Schedule of Benefits means the summary of Your costs for Covered Services and network for this plan.

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.

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

Service Area means the geographic area in Washington state where We have been authorized by the State of Washington to sell and market this plan and the area in which an individual must live in order to be eligible for this plan. The Service Area for this plan is the following county: Clark County.

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.

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, visit Our Web site or contact Customer Service.

Substance Use Disorder Conditions means substance-related disorders included in the most recent edition of the DSM published by the American Psychiatric Association. Substance use disorder is an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological, or physical adjustment to common problems. Substance use disorder does not include addiction to or dependency on tobacco, tobacco products, or foods.

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) and court ordered treatment (unless the treatment is determined by Us to be Medically Necessary).

For the Substance Use Disorder Services benefit, "medically necessary" or “medical necessity" is defined

by the American Society of Addiction Medicine patient placement criteria. Patient placement criteria means the admission, continued service and discharge criteria set forth in the most recent version of the Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders as published by the American Society of Addiction Medicine.

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

Washington Health Benefit Exchange (or HBE) means the state authorized entity which determines eligibility to enroll in plans offered by the HBE.

We, Us and Our mean Regence BlueCross BlueShield of Oregon.

You and Your mean the Policyholder and Enrolled Dependents, except that within the Who Is Eligible, How to Apply and When Coverage Begins, When Coverage Ends, and General Provisions sections, You refers to the Policyholder only.

For more information call Us at 1 (888) 675-6570

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