

SUMMARY PLAN DESCRIPTION FOR:

PIONEER EDUCATORS
HEALTH TRUST

Medical and Vision Plan



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

Regence BlueCross BlueShield of Oregon

Introduction

Welcome to participation in the self-funded group health plan (hereafter referred to as "Plan") provided for You by Your employer. Your employer has chosen Regence BlueCross BlueShield of Oregon to administer claims for Your group health plan.

EMPLOYER PAID BENEFITS

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

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

The following pages are the Summary Plan Description, the written description of the terms and benefits of coverage available under the Plan. This Summary Plan Description describes benefits effective April 1, 2015, or the date after that on which Your coverage became effective. This Summary Plan Description replaces any plan description, Summary Plan Description or certificate previously issued by Regence BlueCross BlueShield of Oregon and makes it void.

As You read this Summary Plan Description, please keep in mind that references to "You" and "Your" refer to both the Participant and Beneficiaries (except that in the Who Is Eligible, How To Enroll And When Coverage Begins, When Coverage Ends and COBRA Continuation sections, the terms "You" and "Your" mean the Participant only). The term "Claims Administrator" refers to Regence BlueCross BlueShield of Oregon and the term "Plan Sponsor" means the association through which Your employer has made arrangements for its employees to participate under this coverage. The term "Agreement" refers to the administrative services contract between the Plan Sponsor and the Claims Administrator. Other terms are defined in the Definitions Section at the back of this Summary Plan Description or where they are first used and are designated by the first letter being capitalized.

This employee benefit plan may be governed by the Employee Retirement Income Security Act (ERISA). Throughout the Summary Plan Description, references to "ERISA" will apply only if the Plan is part of an employee welfare benefit plan regulated under ERISA.

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

Statement of Rights Under the Newborns' and Mothers' Health Protection Act: Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (e.g., Your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain preauthorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain preauthorization. For information on preauthorization, contact Your Plan Administrator.

Mental Health Parity and Addiction Equity Act of 2008

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

Risk-Sharing Arrangements with Providers

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

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

CONTACT INFORMATION

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

And visit the Claims Administrator's Web site at: **www.Regence.com**

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

Using Your Summary Plan Description

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

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

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

- **In-Network (Preferred).** You choose to see a preferred Provider and save the most in Your out-of-pocket expenses. Choosing this Provider means You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **In-Network (Participating).** You choose to see a participating Provider and Your out-of-pocket expenses will generally be higher than if You choose an In-Network (Preferred) Provider because larger discounts with preferred Providers may be negotiated that will result in lower out-of-pocket amounts for You. Choosing an In-Network (Participating) Provider means You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.
- **Out-of-Network (Nonparticipating).** You choose to see a Provider that does not have a participating contract with the Claims Administrator and Your out-of-pocket expenses will generally be higher than an In-Network (Preferred) Provider. Also, choosing an Out-of-Network (Nonparticipating) Provider means You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. This is sometimes referred to as balance billing.

For each benefit in this Summary Plan Description, the Provider You may choose and Your payment amount for each provider option is indicated. See the Definitions Section of this Summary Plan Description for a complete description of In-Network (Preferred), In-Network (Participating) and Out-of-Network (Nonparticipating). You can also go to **www.Regence.com** for further Provider network information.

ADDITIONAL PARTICIPATION ADVANTAGES

Your Plan offers You access to valuable services. The advantages of Regence involvement as the Claims Administrator include admission to personalized health care planning information, health-related

events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to **www.Regence.com**, an interactive environment that can help You navigate Your way through health care decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE GROUP HEALTH PLAN, BUT ARE NOT INSURANCE.**

- **Go to www.Regence.com.** It is a health power source that can help You lead a healthy lifestyle, become a well-informed health care shopper and increase the value of Your health care dollar. Have Your Plan identification card handy to log on. Use the secure Web site to:
 - view recent claims, benefits and coverage;
 - find a contracting Provider;
 - participate in online wellness programs and use tools to estimate upcoming healthcare costs;
 - identify Participating Pharmacies;
 - find alternatives to expensive medicines;
 - learn about prescriptions for various illnesses; and
 - compare medications based upon performance and cost, as well as discover how to receive discounts on prescriptions.

GUIDANCE AND SERVICE ALONG THE WAY

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

- **Learn more and receive answers about Your coverage.** Just call Customer Service: 1 (866) 240-9580 to talk with one of the Claims Administrator's Customer Service representatives. Phone lines are open Monday-Friday 6 a.m. - 6 p.m. You may also visit the Claims Administrator's Web site at: **www.Regence.com**.
- **Case Management.** You can request that a case manager be assigned or You may be assigned a case manager to help You and Your Physician best use Your benefits and navigate the health care system in the best way possible. Case managers assess Your needs, develop plans, coordinate resources and negotiate with Providers. Call Case Management at 1 (866) 543-5765.
- **BlueCard® Program.** Learn how to have access to care through the BlueCard Program. This unique program enables You to access Hospitals and Physicians when traveling outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world.

Table of Contents

UNDERSTANDING YOUR BENEFITS	1
MAXIMUM BENEFITS	1
OUT-OF-POCKET MAXIMUM.....	1
COPAYMENTS.....	1
PERCENTAGE PAID UNDER THE PLAN (COINSURANCE)	1
DEDUCTIBLES.....	2
HOW CALENDAR YEAR BENEFITS RENEW	2
MEDICAL BENEFITS	3
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	3
COPAYMENTS AND COINSURANCE.....	3
CALENDAR YEAR DEDUCTIBLES	3
PREVENTIVE CARE AND IMMUNIZATIONS.....	3
OFFICE VISITS - ILLNESS OR INJURY	5
OTHER PROFESSIONAL SERVICES	5
AMBULANCE SERVICES.....	6
APPROVED CLINICAL TRIALS	6
BLOOD BANK.....	7
DENTAL HOSPITALIZATION.....	7
DETOXIFICATION.....	8
DIABETES SUPPLIES AND EQUIPMENT	8
DIABETIC EDUCATION	8
DURABLE MEDICAL EQUIPMENT.....	8
EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)	9
FAMILY PLANNING.....	9
GENETIC TESTING	9
HEARING AIDS	10
HOME HEALTH CARE	10
HOSPICE CARE.....	10
HOSPITAL CARE - INPATIENT, OUTPATIENT AND AMBULATORY SERVICE FACILITY	11
IMMUNIZATIONS - ADULT (NON PREVENTIVE).....	11
KIDNEY DIALYSIS – OUTPATIENT.....	12
MATERNITY CARE	13
MEDICAL FOODS (PKU)	13
MENTAL HEALTH OR CHEMICAL DEPENDENCY SERVICES.....	14
NEURODEVELOPMENTAL THERAPY	14
NEWBORN CARE	15
NUTRITIONAL COUNSELING	15
ORTHOTIC DEVICES	15
PEDIATRIC VISION.....	16
PROSTHETIC DEVICES.....	16
REHABILITATION SERVICES	17
REPAIR OF TEETH.....	17
SKILLED NURSING FACILITY (SNF) CARE	17
TELEMEDICINE	18
TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS.....	18
TOBACCO USE CESSATION.....	18
TRANSPLANTS.....	19
PRESCRIPTION MEDICATION BENEFITS.....	21
CALENDAR YEAR DEDUCTIBLES	21
COPAYMENTS AND COINSURANCE.....	21
COVERED PRESCRIPTION MEDICATIONS	21

GENERAL PRESCRIPTION MEDICATION BENEFITS INFORMATION (NETWORK, SUBMISSION OF CLAIMS AND MAIL-ORDER)	22
PREAUTHORIZATION	22
LIMITATIONS	23
EXCLUSIONS	24
DEFINITIONS	25
ADULT VISION BENEFITS	27
VISION EXAMINATION	27
VISION HARDWARE	27
CARE MANAGEMENT PROGRAMS	28
CASE MANAGEMENT	28
CASE MANAGED KIDNEY DIALYSIS AND SUPPLEMENTAL KIDNEY DIALYSIS	28
REGENCE CONDITION MANAGER	28
GENERAL EXCLUSIONS	29
PREEXISTING CONDITIONS	29
SPECIFIC EXCLUSIONS	29
CLAIMS ADMINISTRATION	34
PREAUTHORIZATION	34
PLAN IDENTIFICATION CARD	34
SUBMISSION OF CLAIMS AND REIMBURSEMENT	35
OUT-OF-AREA SERVICES	37
BLUECARD WORLDWIDE®	39
NONASSIGNMENT	39
CLAIMS RECOVERY	39
RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS	39
LIMITATIONS ON LIABILITY	40
RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY	40
COORDINATION OF BENEFITS	42
APPEAL PROCESS	47
APPEALS	47
CIVIL ACTION	47
EXPEDITED APPEALS	47
INFORMATION	48
DEFINITIONS SPECIFIC TO THE APPEAL PROCESS	48
WHO IS ELIGIBLE, HOW TO ENROLL AND WHEN COVERAGE BEGINS	49
INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS	49
NEWLY ELIGIBLE DEPENDENTS	50
SPECIAL ENROLLMENT	50
ANNUAL ENROLLMENT PERIOD	51
DOCUMENTATION OF ELIGIBILITY	51
WHEN COVERAGE ENDS	52
AGREEMENT TERMINATION	52
MEMBER EMPLOYER TERMINATION	52
WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE	52
TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE	52
NONPAYMENT	52
FAMILY AND MEDICAL LEAVE	52
LEAVE OF ABSENCE	53
WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE	53

OTHER CAUSES OF TERMINATION.....	54
COBRA CONTINUATION OF COVERAGE	55
OTHER CONTINUATION OPTIONS.....	56
GENERAL PROVISIONS	57
CHOICE OF FORUM.....	57
GOVERNING LAW	57
PLAN SPONSOR IS AGENT	57
NO WAIVER	57
NOTICES.....	57
RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION.....	57
REPRESENTATIONS ARE NOT WARRANTIES	57
WHEN BENEFITS ARE AVAILABLE	58
WOMEN'S HEALTH AND CANCER RIGHTS.....	58
DEFINITIONS.....	59
DISCLOSURE STATEMENT PATIENT PROTECTION ACT	63
WHAT ARE MY RIGHTS AND RESPONSIBILITIES AS A CLAIMANT OF REGENCE BLUECROSS BLUESHIELD OF OREGON?.....	63
HOW DO I ACCESS CARE IN THE EVENT OF AN EMERGENCY?.....	63
HOW WILL I KNOW IF MY BENEFITS CHANGE OR ARE TERMINATED?	63
WHAT HAPPENS IF I AM RECEIVING CARE AND MY DOCTOR IS NO LONGER A CONTRACTING PROVIDER?	63
HOW CAN I PARTICIPATE IN THE DEVELOPMENT OF THE CLAIMS ADMINISTRATOR'S CORPORATE POLICIES AND PRACTICES?	64
WHAT IS THE CLAIMS ADMINISTRATOR'S PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT CRITERIA?	65
HOW ARE IMPORTANT DOCUMENTS (SUCH AS MY MEDICAL RECORDS) KEPT CONFIDENTIAL?.....	65
WHAT ADDITIONAL INFORMATION CAN I GET FROM THE CLAIMS ADMINISTRATOR UPON REQUEST?.....	65
WHAT OTHER SOURCE CAN I TURN TO FOR MORE INFORMATION ABOUT REGENCE BLUECROSS BLUESHIELD OF OREGON?	65
SUMMARY PLAN DESCRIPTION	67
PLAN NAME	67
NAME, ADDRESS AND PHONE NUMBER OF PLAN SPONSOR.....	67
EMPLOYER IDENTIFICATION NUMBER ASSIGNED FOR THIS PLAN BY THE IRS.....	67
PLAN NUMBER	67
TYPE OF PLAN	67
TYPE OF ADMINISTRATION.....	67
NAME, ADDRESS AND PHONE NUMBER OF THE AGENT FOR SERVICE OF LEGAL PROCESS.....	67
SOURCES OF CONTRIBUTIONS TO THE PLAN	67
FUNDING MEDIUM	67
PLAN FISCAL YEAR ENDS ON.....	68
PLAN TERMINATION PROVISIONS	68
NOTICE OF ERISA RIGHTS.....	68

Understanding Your Benefits

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

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

MAXIMUM BENEFITS

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

OUT-OF-POCKET MAXIMUM

Claimants can meet the Out-of-Pocket Maximum by payments of Deductibles, Copayments and Coinsurance as specifically indicated in the Medical Benefits and Prescription Medication Benefits Sections. There are two Out-of-Pocket Maximum amounts: one for In-Network benefits (Preferred and Participating combined), and another Out-of-Pocket Maximum amount for Out-of-Network benefits. The Medical Benefits Section describes this more fully, but in this Summary Plan Description, the term is referred to simply as "the Out-of-Pocket Maximum." A Claimant's Deductible (if applicable), Copayment and/or Coinsurance payment for detoxification, emergency room services, Prescription Medication Benefits and benefits listed in the Medical Benefits Section that show under the Provider "All" will apply toward the In-Network (Preferred and Participating combined) Out-of-Pocket Maximum amount. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach the Out-of-Pocket Maximum of the Plan.

Once You reach the Out-of-Pocket Maximum, benefits subject to the Out-of-Pocket Maximum will be paid at 100 percent of the Allowed Amount for the remainder of the Calendar Year. The Coinsurance for some benefits of the Plan does not change to a higher payment level or apply to the Out-of-Pocket Maximum. Those exceptions are specifically noted in the Medical Benefits Section of this Summary Plan Description.

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

COPAYMENTS

Copayments are the fixed dollar amount that You must pay directly to the Provider for office visits, emergency room visits or Prescription Medication each time You receive a specified service or medication (as applicable). The Copayment will be the lesser of the fixed dollar amount or the Allowed Amount for the service or medication. Refer to the Medical Benefits Section to understand what Copayments You are responsible for.

Copayments applicable to Prescription Medications are located in the Prescription Medication Benefits Section of this Summary Plan Description.

PERCENTAGE PAID UNDER THE PLAN (COINSURANCE)

Once You have satisfied any applicable Deductible and any applicable Copayment, the Plan pays a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When

payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). Your Coinsurance will be based upon the lesser of the billed charges or the Allowed Amount. The percentage the Plan pays varies, depending on the kind of service or supply You received and who rendered it.

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

DEDUCTIBLES

The Plan will begin to pay benefits for Covered Services in any Calendar Year only after a Claimant satisfies the Calendar Year Deductible. There are two Deductibles: one for In-Network benefits (Preferred and Participating combined), and another for Out-of-Network benefits. The Medical Benefits Section describes this more fully, but in this Summary Plan Description, the term is referred to simply as "the Deductible." A Claimant satisfies the Deductible by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible. A Claimant's Deductible amount paid toward Covered Services listed in the Medical Benefits Section under the Provider "All" will apply toward the In-Network (Preferred and Participating combined) Deductible amount.

There are two Family Calendar Year Deductible amounts: one for In-Network benefits (Preferred and Participating combined), and another for Out-of-Network benefits. The Family Calendar Year Deductible is satisfied when three or more covered Family Members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Deductible amount. One Claimant may not contribute more than the individual Deductible amount. The Plan does not pay for services applied toward the Deductible. Refer to the Medical Benefits Section to see if a particular service is subject to the Deductible. Any amounts You pay for non-Covered Services, Copayments or amounts in excess of the Allowed Amount do not count toward the Deductible.

In addition, if Covered Services are incurred during the last three months of a Calendar Year and are applied toward the Deductible for that year, but do not meet the Deductible, then any amount for Covered Services applied toward such Deductible during the last three months will be carried forward and applied toward the Deductible for the following year.

HOW CALENDAR YEAR BENEFITS RENEW

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

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

Medical Benefits

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

All covered benefits are subject to the limitations, exclusions and provisions of this plan. To be covered, medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Also, a Provider practicing within the scope of his or her license must render the service. Please see the Definitions Section in the back of this Summary Plan Description for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

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

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

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

In-Network (Combined Preferred and Participating Providers)

Per Claimant: \$3,500

Per Family: \$10,500

Out-of-Network (Nonparticipating Providers)

Per Claimant: \$10,500

Per Family: \$31,500

COPAYMENTS AND COINSURANCE

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

CALENDAR YEAR DEDUCTIBLES

In-Network (Combined Preferred and Participating Providers)

Per Claimant: \$500

Per Family: \$1,500

Out-of-Network (Nonparticipating Providers)

Per Claimant: \$1,000

Per Family: \$3,000

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

- In-Network (Preferred) Office Visits;
- In-Network (Preferred) Outpatient Laboratory and Radiology services;
- Emergency Room services;
- In-Network (Preferred and Participating) Preventive Care and Immunizations; or
- Vision Benefits (Pediatric Vision and Adult Vision).

PREVENTIVE CARE AND IMMUNIZATIONS

Benefits will be covered under this Preventive Care and Immunizations benefit, not any other provision in this Summary Plan Description, if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Service Task Force (USPSTF), the Health Resources and Services Administration (HRSA), or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC). In the event any of these bodies adopts a new or revised recommendation, this Plan has up to one year before coverage of the related services must be available and effective under this benefit. For a list of services covered under this

benefit, please visit www.Regence.com or contact Customer Service at 1 (866) 240-9580. You can also visit the HRSA Web site at: <http://www.hrsa.gov/womensguidelines/> for women's preventive services guidelines, and the USPSTF Web site at: <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm> for a list of A and B preventive services. NOTE: Covered Services that do not meet this criteria will be covered the same as any other Illness or Injury.

Preventive Care

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

The Plan covers preventive care services provided by a professional Provider or facility. Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care, routine immunizations and routine health screenings. Also included is Provider counseling for tobacco use cessation and Generic Medications prescribed for tobacco use cessation. See the Prescription Medication Benefits Section in this Summary Plan Description for a description of how to obtain Generic Medications. Coverage for all such services is provided only for preventive care as designated above (which designation may be modified from time to time).

Immunizations - Adult

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

The Plan covers immunizations for adults according to, and as recommended by, the USPSTF and the CDC.

Immunizations -Childhood

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

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

OFFICE VISITS - ILLNESS OR INJURY

In-Network	In-Network	Out-of-Network
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After \$25 Copayment per visit, the Plan pays 100% of the Allowed Amount.	Payment: After Deductible, the Plan pays 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers office visits for treatment of Illness or Injury. The Copayment applies to visits in the office, home or Hospital outpatient department, and for surgical procedures performed in the office. All other professional services performed in the office, not billed as an office visit, or that are not related to the actual visit (separate facility fees billed in conjunction with the office visit for example) are not considered an office visit under this benefit.

Therapeutic Injections

The Plan covers allergy shots, therapeutic injections and related supplies when given in a professional Provider's office.

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

OTHER PROFESSIONAL SERVICES

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

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

Medical Services

The Plan covers professional services, second opinions and supplies, including the services of a Provider whose opinion or advice is requested by the attending Provider, that are generally recognized and accepted non-surgical procedures for diagnostic or therapeutic purposes in the treatment of Illness or Injury. Services and supplies also include those to treat a congenital anomaly for Claimants up to age 26 and foot care associated with diabetes, as well as dental and orthodontic services that are for the treatment of craniofacial anomalies and are Medically Necessary to restore function. A "craniofacial anomaly" is a physical disorder, identifiable at birth, that affects the bony structures of the face or head, including, but not limited to, cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome. Coverage is not provided under this benefit for the treatment of temporomandibular

joint disorder or developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth.

Diabetes Management Associated with Pregnancy

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

Professional Inpatient

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

Radiology and Laboratory

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

Diagnostic Procedures

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

Surgical Services

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

Women's Examinations

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

AMBULANCE SERVICES

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

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

APPROVED CLINICAL TRIALS

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

Definitions

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

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is a study or investigation:

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

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

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

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

BLOOD BANK

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

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

DENTAL HOSPITALIZATION

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

The Plan covers inpatient and outpatient services and supplies for hospitalization for Dental Services (including anesthesia), if hospitalization in an ambulatory surgical center or Hospital is necessary to safeguard Your health. Benefits are not available for services received in a dentist's office.

DETOXIFICATION

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

The Plan covers Medically Necessary detoxification.

DIABETES SUPPLIES AND EQUIPMENT

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

DIABETIC EDUCATION

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

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

DURABLE MEDICAL EQUIPMENT

In-Network	In-Network	Out-of-Network
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: One wig per Calendar Year per Claimant who has lost all of his or her hair from disease.		

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Claimant's home. Examples include wigs, oxygen equipment and wheelchairs. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

In-Network	In-Network	Out-of-Network
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After \$250 Copayment per visit, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum. This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	Payment: After \$250 Copayment per visit, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum. This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.	Payment: After \$250 Copayment per visit, the Plan pays 80% of the Allowed Amount and You pay balance of billed charges. Your 20% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum. This Copayment applies to the facility charge and is waived when You are admitted directly from the emergency room to the Hospital or any other facility on an inpatient basis.

The Plan covers emergency room services and supplies, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. Emergency room services do not need to be pre-authorized. If admitted to a participating or nonparticipating Hospital directly from the emergency room, services will be covered at the Category 1 benefit level. However, You may be billed for balances beyond any Deductible, Copayment and/or Coinsurance. See the Hospital Care benefit in this Medical Benefits Section for coverage of inpatient Hospital admissions.

FAMILY PLANNING

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

The Plan covers certain professional Provider contraceptive services and supplies not covered under the Preventive Care and Immunizations benefit, including, but not limited to, vasectomy. See the Prescription Medication Benefits Section for coverage of prescription contraceptives.

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

GENETIC TESTING

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

HEARING AIDS

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

The Plan covers hearing aids only for Beneficiaries under 19 years of age, or for a spouse enrolled in an accredited educational institution, when necessary for the treatment of hearing loss. For the purpose of this benefit, hearing aid means any nondisposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device. This coverage does not include routine hearing examinations or the cost of batteries or cords.

HOME HEALTH CARE

In-Network	In-Network	Out-of-Network
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 180 visits per Claimant per Calendar Year		

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

HOSPICE CARE

In-Network	In-Network	Out-of-Network
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 180 inpatient or outpatient respite care days per Claimant Lifetime		

The Plan covers hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a patient and

any family members who are caring for a patient, who is experiencing a life threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of a patient and his or her family during the final stages of illness. Respite care: The Plan covers respite care to provide continuous care of the Claimant and allow temporary relief to family members from the duties of caring for the Claimant. Respite days that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services. Durable Medical Equipment associated with hospice care is covered under the Durable Medical Equipment benefit in this Summary Plan Description.

HOSPITAL CARE - INPATIENT, OUTPATIENT AND AMBULATORY SERVICE FACILITY

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

The Plan covers the inpatient and outpatient services and supplies of a Hospital or the outpatient services and supplies of an Ambulatory Service Facility for Injury and Illness (including services of staff Providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. See the Emergency Room benefit in this Medical Benefits Section for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

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

IMMUNIZATIONS - ADULT (NON PREVENTIVE)

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

The Plan covers immunizations for adults that are not covered under the Preventive Care and Immunizations benefit. Covered expenses do not include immunizations if the Claimant receives them only for purposes of travel, occupation or residence in a foreign country.

INFERTILITY TESTING

In-Network	In-Network	Out-of-Network
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount. Your 50% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount. Your 50% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

The Plan covers services and supplies limited to infertility testing for the sole purpose of diagnosing infertility. This benefit is provided to enrolled employees and spouses only.

KIDNEY DIALYSIS – OUTPATIENT

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

When Your Physician recommends kidney dialysis, You must first contact the Claims Administrator to begin Case Management and activate Your enrollment. Services related to kidney dialysis received prior to enrolling are not covered expenses under the Plan. Once enrolled, the Plan covers professional services, supplies, medications, labs, and facility fees related to outpatient kidney dialysis. Expenses that are applied toward the Deductible and services received prior to enrollment will be applied against the Maximum Benefit limit on these services.

Covered Services include, but are not limited to, hemodialysis, peritoneal dialysis, and hemofiltration. Covered Services also include the first 42 treatments received to complete the first Treatment Period, as calculated from the initial kidney dialysis treatment. See the Supplemental Kidney Dialysis in this benefit for coverage after the first 42 treatments in the first Treatment Period. If more than 42 treatments are necessary in the first Treatment Period prior to Medicare coverage enrollment, the Claims Administrator must be contacted to approve the additional treatment and document Your progress until Your dialysis benefits have begun with Medicare. For the purposes of this benefit, "Treatment Period" means the beginning and end of the dialysis treatment cycle prescribed by Your Physician.

The Plan will pay regular Plan benefits when services are rendered outside the country.

Supplemental Kidney Dialysis – Outpatient

For any subsequent outpatient kidney dialysis beyond the first Treatment Period, the Plan will provide additional supplemental coverage as described here. This Supplemental Kidney Dialysis benefit covers 150% of the current Medicare reimbursement amount, not subject to any Deductible, for the same or similar services as provided under the Kidney Dialysis benefit.

In addition, a Claimant with end stage renal disease (ESRD) is eligible to have Medicare Part B premiums reimbursed by the Plan as an eligible Plan expense for the duration of the Claimant's ESRD treatment, as long as the Claimant continues to be enrolled under Medicare Part B and continues to be eligible for coverage under this Plan (proof of payment of the Medicare Part B premium will be required prior to reimbursement).

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

MATERNITY CARE

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

The Plan covers prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy, and related conditions for all female Claimants. There is no limit for the mother's length of inpatient stay. Where the mother is attended by a Provider, the attending Provider will determine an appropriate discharge time, in consultation with the mother. See the Newborn Care benefit in this Summary Plan Description to see how the care of Your newborn is covered. Coverage also includes termination of pregnancy for all female Claimants. When provided by a preferred or participating Provider, any Copayments, Coinsurance, and Deductible do not apply to Medically Necessary Covered Services for management of a female Claimant's diabetes from the date she conceives through six weeks postpartum for each pregnancy.

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

MEDICAL FOODS (PKU)

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

The Plan covers medical foods for inborn errors of metabolism including, but not limited to, formulas for Phenylketonuria (PKU). Other services and supplies such as office visits and formula to treat severe intestinal malabsorption are otherwise covered under the appropriate provision in this Medical Benefits Section.

MENTAL HEALTH OR CHEMICAL DEPENDENCY SERVICES

In-Network	In-Network	Out-of-Network
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
<p>Payment: After Deductible,* the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.</p> <p>*The Deductible does not apply to outpatient services. For office visits, after \$25 Copayment per visit, the Plan pays 100% of the Allowed Amount.</p>	<p>Payment: After Deductible,* the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.</p> <p>*The Deductible does not apply to outpatient services. For office visits, after \$25 Copayment per visit, the Plan pays 100% of the Allowed Amount.</p>	<p>Payment: After Deductible,* the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.</p> <p>*The Deductible does not apply to outpatient services.</p>

The Plan covers inpatient and outpatient Mental Health and Chemical Dependency Services for treatment of Mental Health or Chemical Dependency Conditions.

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Mental Health or Chemical Dependency Services benefit:

Chemical Dependency Conditions means substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Chemical dependency 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. Chemical dependency does not include addiction to or dependency on tobacco, tobacco products, or foods.

Chemical Dependency or Mental Health Services mean Medically Necessary outpatient services, residential care, partial hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled Nursing Facility services (unless the services are provided by a licensed behavioral health provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is determined to be Medically Necessary).

Mental Health Conditions means Mental Disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association except as otherwise excluded under the Plan. Mental Disorders that accompany an excluded diagnosis are covered.

NEURODEVELOPMENTAL THERAPY

In-Network	In-Network	Out-of-Network
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
<p>Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.</p>	<p>Payment: After Deductible, the Plan pays 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.</p>	<p>Payment: After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.</p>
<p>Inpatient limit: unlimited</p> <p>Outpatient limit: 25 visits per Claimant per Calendar Year for all outpatient neurodevelopmental therapy services</p>		

The Plan covers physical therapy, occupational therapy or speech therapy services to restore or improve function, for a pervasive developmental disorder, for a Claimant age 17 and under. For the purpose of this benefit, "pervasive developmental disorder" means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability, or mental retardation. Outpatient neurodevelopmental therapy visits that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services.

NEWBORN CARE

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

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

NUTRITIONAL COUNSELING

In-Network	In-Network	Out-of-Network
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: three visits per Claimant Lifetime (diabetic education and counseling is not subject to this limit). Nutritional counseling visits for these services that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services.		

ORTHOTIC DEVICES

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

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

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

PEDIATRIC VISION

The Plan covers benefits for vision care for Claimants under the age of 19. Covered Services must be rendered by a Physician or optometrist practicing within the scope of his or her license. Please note that the BlueCard Program detailed in the Claims Administration Section does not apply to vision hardware benefits provided under this Pediatric Vision benefit. The Plan will pay benefits under this Pediatric Vision benefit, not any other provision in this Summary Plan Description, if a service or supply is covered under both.

Vision Examination

In-Network	In-Network	Out-of-Network
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: The Plan pays 100% of the Allowed Amount.	Payment: The Plan pays 100% of the Allowed Amount.	Payment: The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.
Limit: one routine eye examination per Claimant per Calendar Year		

Vision Hardware

In-Network and Out-of-Network
Provider: All
Payment: The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.
Lenses limit: one pair of lenses (two lenses) per Claimant per Calendar Year
Frames limit: one standard frame per Claimant per Calendar Year
Contacts limit: contacts may be selected instead of frames and lenses

The Plan covers hardware including frames, contacts and lenses. Coverage is limited to frames and lenses or contacts, but not both in a Calendar Year period. Separate charges for fittings, prism lens and any hardware not Medically Necessary will not be covered.

PROSTHETIC DEVICES

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

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

REHABILITATION SERVICES

In-Network	In-Network	Out-of-Network
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Inpatient limit: 30 days per Claimant per Calendar Year Outpatient limit: 25 visits per Claimant per Calendar Year		

The Plan covers inpatient and outpatient rehabilitation services (physical, occupational and speech therapy services only) and accommodations as appropriate and necessary to restore or improve lost function caused by Injury or Illness. You will not be eligible for both the Neurodevelopmental Therapy benefit and this benefit for the same services for the same condition. Rehabilitation services that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services.

REPAIR OF TEETH

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

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

SKILLED NURSING FACILITY (SNF) CARE

In-Network	In-Network	Out-of-Network
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: 100 inpatient days per Claimant per Calendar Year		

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

TELEMEDICINE

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

The Plan covers telemedicine (video communication) services between a Physician, the patient and a consulting Practitioner. This includes Medically Necessary telemedicine health services provided in connection with diabetes.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

In-Network	In-Network	Out-of-Network
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount. Your 50% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 50% and You pay 50% of the Allowed Amount. Your 50% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 50% of the Allowed Amount and You pay balance of billed charges. Your 50% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

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

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

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

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

TOBACCO USE CESSATION

In-Network	In-Network	Out-of-Network
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: \$500 per Claimant Lifetime		

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

TRANSPLANTS

In-Network	In-Network	Out-of-Network
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: After Deductible, the Plan pays 80% and You pay 20% of the Allowed Amount. Your 20% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% and You pay 40% of the Allowed Amount. Your 40% payment will be applied toward the Out-of-Pocket Maximum.	Payment: After Deductible, the Plan pays 60% of the Allowed Amount and You pay balance of billed charges. Your 40% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.
Limit: Donor expenses limited to \$10,000 per Claimant per transplant when services are received from Out-of-Network Nonparticipating Providers only.		

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

Donor Organ Benefits

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

Transplant Waiting Period

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

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

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

Creditable coverage means any of the following: group coverage (including self-funded plans); individual insurance coverage; S-CHIP; Medicaid; Medicare; CHAMPUS/Tricare; Indian Health Service or tribal

organization coverage; state high-risk pool coverage; Federal Employee Health Benefit Plan coverage; and public health plans (including foreign government and US government plans).

Creditable coverage is determined separately for each Claimant.

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

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

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

Prescription Medication Benefits

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

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

CALENDAR YEAR DEDUCTIBLES

Not applicable

PRESCRIPTION MEDICATION CALENDAR YEAR OUT-OF-POCKET MAXIMUM

Not applicable

COPAYMENTS AND COINSURANCE

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

For Prescription Medications from a Pharmacy

- | |
|--|
| • \$20 for each Generic Medication |
| • \$40 for each Brand-Name Medication on the Formulary |
| • \$60 for each Brand-Name Medication not on the Formulary |

For Prescription Medications from a Mail-Order Supplier

- | |
|---|
| • \$30 for each Generic Medication. |
| • \$60 for each Brand-Name Medication on the Formulary. |
| • \$90 for each Brand-Name Medication not on the Formulary. |

COVERED PRESCRIPTION MEDICATIONS

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

- diabetic supplies (including test strips, glucagon emergency kits, insulin and insulin syringes, but not insulin pumps and their supplies), when obtained with a Prescription Order (insulin pumps and their supplies are covered under the Durable Medical Equipment benefit);
- Brand-Name Medications for tobacco use cessation when obtained with a Prescription Order (limited to \$500 per Claimant Lifetime);
- Prescription Medications;
- certain preventive medications (including, but not limited to, aspirin, fluoride, iron and Generic Medications for tobacco use cessation) according to, and as recommended by, the USPSTF, when obtained with a Prescription Order;
- women's contraception methods as recommended by the HRSA;
- immunizations for adults and children according to, and as recommended by, the CDC;
- Self-Administrable Cancer Chemotherapy Medication; and
- Self-Administrable Prescription Medications (including, but not limited to, Self-Administrable Compound and Injectable Medications).

You are not responsible for any applicable Copayment when You fill prescriptions at a Participating Pharmacy for specific strengths or quantities of medications that are specifically designated as preventive medications, women's contraceptives, or for immunizations, as specified above. For a list of such medications, please visit the Claims Administrator's Web site at **www.Regence.com** or contact Customer Service at 1 (866) 240-9580. NOTE: The applicable Copayment as listed in this Prescription Medication Benefits Section will apply when You fill preventive medications and immunizations that meet the above criteria, at a Nonparticipating Pharmacy.

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

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

Your Plan identification card enables You to participate in this Prescription Medication program, so You must use it to identify Yourself at any Pharmacy. If You do not identify Yourself as a Claimant through Regence BlueCross BlueShield of Oregon, a Participating Pharmacy or Mail-Order Supplier may charge You more than the Covered Prescription Medication Expense. You can find Participating Pharmacies and a Pharmacy locator on the Claims Administrator's Web site at **www.Regence.com**, or by contacting Customer Service at 1 (866) 240-9580.

Claims Submitted Electronically

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

Claims Not Submitted Electronically

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

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

Mail-Order

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

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

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

PREAUTHORIZATION

Preauthorization may be required so that a determination that a Prescription Medication is Medically Necessary can be made before it is dispensed. The Claims Administrator publishes a list of those medications that currently require preauthorization. You can see the list on their Web site at **www.Regence.com**, or call Customer Service at 1 (866) 240-9580. In addition, participating Providers,

including Pharmacies, are notified which Prescription Medications require preauthorization. The prescribing Provider must provide the medical information necessary to determine Medical Necessity of Prescription Medications that require preauthorization.

Coverage for preauthorized Prescribed Medications begins on the date the Claims Administrator preauthorizes them. If Your Prescription Medication requires preauthorization and You purchase it before the Claims Administrator preauthorizes it or without obtaining the preauthorization, the Prescription Medication may not be covered, even if purchased from a Participating Pharmacy.

LIMITATIONS

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

Maximum 30-Day or Greater Supply Limit

- **Injectable Medications and 30-Day Supply.** The largest allowable quantity for Self-Administrable Injectable Medications purchased from a Pharmacy or Mail-Order Supplier, is a 30-day supply. The Copayment for Self-Administrable Injectable Medications purchased from a Mail-Order Supplier will be the same as if the medication was purchased from and the claim was submitted electronically by a Pharmacy.
- **Mail-Order and 90-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Mail-Order Supplier is a 90-day supply. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities. Self-Administrable Injectable Medications are limited to a 30-day supply as indicated above.
- **Pharmacy and 30-Day Supply.** Except as specifically provided below, a 30-day supply is the largest allowable quantity of Prescription Medication that You may purchase from a Pharmacy and for which a single claim may be submitted. A Provider may choose to prescribe or You may choose to purchase, some medications in smaller quantities.
- **Pharmacy and 90-Day Supply.** The largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Pharmacy is the smallest multiple-month supply packaged by the manufacturer for dispensing by Pharmacies. The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The maximum supply covered for these products is a 90-day supply (even if the packaging includes a larger supply). The Copayment is based on each 30-day supply within that multiple-month supply.

Maximum Quantity Limit

For certain Prescription Medications, the Claims Administrator establishes maximum quantities other than those described previously. This means that, for those medications, there is a limit on the amount of medication that will be covered during a period of time. The Claims Administrator uses information from the United States Food and Drug Administration (FDA) and from scientific publications to establish these maximum quantities. When You take a Prescription Order to a Participating Pharmacy or request a Prescription Medication refill and use Your Plan identification card, the Pharmacy will let You know if a quantity limitation applies to the medication. You may also find out if a limit applies by contacting Customer Service at 1 (866) 240-9580. The Plan does not cover any amount over the established maximum quantity, except if it is determined the amount is Medically Necessary. The prescribing Provider must provide medical information in order to establish whether the amount in excess of the established maximum quantity is Medically Necessary.

Refills

The Plan will cover refills from a Pharmacy when You have taken 75 percent of the previous prescription. Refills obtained from a Mail-Order Supplier are allowed after You have taken 65 percent of the previous Prescription Order. If You choose to refill Your Prescription Medications sooner, You will be responsible for the full costs of these Prescription Medications and these costs will not count toward any Out-of-Pocket Maximum. If You feel You need a refill sooner than allowed, a refill exception will be considered at the Claims Administrator's discretion on a case-by-case basis. You may request an exception by calling Customer Service at 1 (866) 240-9580.

If You receive maintenance medications for chronic conditions, You may qualify for the Claims Administrator's prescription refill synchronization which allows refilling Prescription Medications on the same day of the month. For further information on prescription refill synchronization, please call Customer Service at 1 (866) 240-9580.

Prescription Medications Dispensed by Excluded Pharmacies

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

EXCLUSIONS

In addition to the exclusions in the General Exclusions Section, the following exclusions apply to this Prescription Medication Benefits Section:

Acne Medication

Prescription Medications for the treatment of acne in Claimants over age 39.

Biological Sera, Blood or Blood Plasma

Cosmetic Purposes

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

Devices or Appliances

Devices or appliances of any type, even if they require a Prescription Order (coverage for devices and appliances may otherwise be provided under the Medical Benefits Section).

Foreign Prescription Medications

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

Growth Hormones

Growth hormones, unless they are preauthorized under the Plan.

Insulin Pumps and Pump Administration Supplies

Coverage for insulin pumps and supplies is provided under the Medical Benefits Section.

Medications That Are Not Self-Administrable

Coverage for these medications may otherwise be provided under the Medical Benefits Section.

Nonprescription Medications

Medications that by law do not require a Prescription Order and which are not included in the definition of Prescription Medications, shown below, unless specifically defined by the Claims Administrator.

Prescription Medications Dispensed in a Facility

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

Prescription Medications for Treatment of Infertility

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

Prescription Medications Not within a Provider's License

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

Prescription Medications without Examination

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

Professional Charges for Administration of Any Medication

DEFINITIONS

In addition to the definitions in the Definitions Section, the following definitions apply to this Prescription Medication Benefits Section:

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

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

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

Formulary means the Claims Administrator's list of selected Prescription Medications. The Claims Administrator established and routinely reviews and updates the Formulary. It is available on the Claims Administrator's Web site at **www.Regence.com**, or by calling Customer Service at 1 (866) 240-9580. Medications are reviewed and selected for inclusion in the Formulary by an outside committee of providers, including Physicians and Pharmacists.

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

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

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

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

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

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

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

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

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

Adult Vision Benefits

In this section, You will learn how Your vision coverage works for Claimants age 19 and older. The explanation includes information about Maximum Benefits, Covered Services and payment. Covered Services are those services required for the diagnosis or correction of visual acuity and must be rendered by a Physician or optometrist practicing within the scope of his or her license.

All terms and conditions of the Summary Plan Description apply to this Adult Vision Benefits Section, except as otherwise noted. However, the BlueCard Program detailed in the Claims Administration Section does not apply to vision hardware benefits provided under this Adult Vision Benefits Section. The Plan will pay benefits under this Adult Vision Benefits Section, not any other provision of the Summary Plan Description, if a service or supply is covered under both.

VISION EXAMINATION

In-Network	In-Network	Out-of-Network
Provider: Preferred	Provider: Participating	Provider: Nonparticipating
Payment: The Plan pays 100% of the Allowed Amount.	Payment: The Plan pays 100% of the Allowed Amount.	Payment: The Plan pays 100% of the Allowed Amount and You pay balance of billed charges.
Limit: one routine eye examination per Claimant per Calendar Year		

The Plan covers one routine vision examination.

VISION HARDWARE

In-Network and Out-of-Network
Provider: All
Payment: The Plan pays 100%
Limit: \$250 per Claimant per Calendar Year

The Plan covers hardware including frames, contacts and all lenses and tints. Separate charges for fittings will not be covered under the Plan.

Care Management Programs

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

CASE MANAGEMENT

Receive one-on-one help and support in the event You have a serious or sudden Illness or Injury. An experienced, compassionate case manager will serve as Your personal advocate during a time when You need it most. Your case manager is a licensed health care professional who will help You understand Your treatment options, show You how to get the most out of Your available Plan benefits and work with Your Physician to support Your treatment plan.

To learn more or to make a referral to case management, please call 1 (866) 543-5765.

CASE MANAGED KIDNEY DIALYSIS AND SUPPLEMENTAL KIDNEY DIALYSIS

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

To learn more or to make a referral to case management, please call 1 (866) 240-9580.

REGENCE CONDITION MANAGER

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

To learn more, please call 1 (866) 543-5765.

General Exclusions

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

PREEXISTING CONDITIONS

This coverage does not have an exclusion period for preexisting conditions.

SPECIFIC EXCLUSIONS

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

Alternative Care

The Plan does not cover alternative care, including, but not limited to, acupuncture and spinal manipulations.

Applied Behavioral Analysis treatment by any Provider for any condition

Conditions Caused By Active Participation In a War or Insurrection

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

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

The treatment of any Claimant's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Cosmetic/Reconstructive Services and Supplies

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

- to treat a congenital anomaly for Claimants up to age 26;
- to restore a physical bodily function lost as a result of Injury or Illness; or
- related to breast reconstruction following a Medically Necessary mastectomy, to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights provision.

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

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

Counseling in the Absence of Illness

Except as provided in this Summary Plan Description or as required by law, the Plan does not cover counseling in the absence of Illness (for example, educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; Employee Assistance Program ("EAP") services, except as provided under the EAP Section, if applicable; wilderness programs; premarital or marital counseling; and family counseling (however family counseling will be covered when the identified patient is a child or an adolescent with a covered diagnosis and the family counseling is part of the treatment when Mental Health Services are covered benefits under the Plan)).

Custodial Care

Non-skilled care and helping with activities of daily living.

Dental Services

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

Expenses Before Coverage Begins or After Coverage Ends

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

Fees, Taxes, Interest

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

Government Programs

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

Growth Hormone Therapy

Except as provided under the Prescription Medication Benefits Section in this Summary Plan Description, the Plan does not cover growth hormone therapy.

Hearing Care

Except as provided under the Hearing Aids and Other Professional Services benefits in this Summary Plan Description, the Plan does not cover hearing care, routine hearing examinations, programs or treatment for hearing loss, including, but not limited to, hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them.

Infertility

Except as provided under the Infertility Testing benefit in this Summary Plan Description, the Plan does not cover treatment of infertility, except to the extent Covered Services are required to diagnose such condition. Non-covered treatment includes, but not limited to, all assisted reproductive technologies (for example, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception) and fertility drugs and medications.

Investigational Services

Except as provided under the Approved Clinical Trials benefit, Investigational treatments or procedures (Health Interventions) and services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). Also excluded are any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section in this Summary Plan Description.

Mental Health Treatment For Certain Conditions

The Plan will not cover Mental Health Conditions for diagnostic codes 302 through 302.9 found in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders for all ages, except diagnostic codes 302.85 and 302.6. Additionally, the Plan will not cover any "V code" diagnoses except the following when Medically Necessary: parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger and bereavement for children five years of age or younger. "V code" means codes for additional conditions that may be a focus of clinical attention as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders that describes Relational Problems, Problems Related To Abuse Or Neglect or other issues that may be the focus of assessment or treatment. This would include, but is not limited to, such issues as occupational or academic problems.

Motor Vehicle Coverage and Other Insurance Liability

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

Non-Direct Patient Care

Services that are not direct patient care, including charges for:

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

Non-Duplication of Medicare

When, by law, this coverage would not be primary to Medicare had You properly enrolled in Medicare when first eligible, benefits will be reduced to the extent that those benefits are or would have been provided by any part of Medicare (for example, Part A, B, C or D), regardless of whether or not You choose to accept those benefits. In addition, if You are eligible for Medicare, You or Your Provider will not be paid for any part of expenses incurred if Your Provider has opted out of Medicare participation.

Obesity or Weight Reduction/Control

Except as may be specifically provided in this Summary Plan Description, the Plan does not cover medical treatment, medication, surgical treatment (including reversals), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions.

Orthognathic Surgery

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

Over-the-Counter Contraceptives

Except as provided under the Prescription Medication Benefits Section in this Summary Plan Description, the Plan does not cover over-the-counter contraceptive supplies and oral contraceptives.

Personal Comfort Items

Items that are primarily for comfort, convenience, cosmetics, environmental control or education. For example, telephones, televisions, air conditioners, air filters, humidifiers, whirlpools, heat lamps and light boxes are not covered.

Physical Exercise Programs and Equipment

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

Private-Duty Nursing

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

Reversals of Sterilizations

Services and supplies related to reversals of sterilization.

Riot, Rebellion and Illegal Acts

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

Routine Foot Care**Self-Help, Self-Care, Training or Instructional Programs**

Except as may be specifically provided in the Summary Plan Description, the Plan does not cover self-help, non-medical self-care, training programs, including:

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

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

Services and Supplies Provided by a Member of Your Family

Services and supplies provided to You by a member of Your immediate family. For purposes of this provision, "immediate family" means parents, spouse, children, siblings, half-siblings, parent-in-law, child-in-law, sibling-in-law, half-sibling-in-law, or any relative by blood or marriage who shares a residence with You.

Services and Supplies That Are Not Medically Necessary

Except for preventive care benefits provided in this Summary Plan Description, the Plan does not cover services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

Sexual Dysfunction

Except for counseling services provided by covered, licensed Practitioners when Mental Health Services are covered benefits in this Summary Plan Description, the Plan does not cover services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause.

Sexual Reassignment Treatment and Surgery

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

Third-Party Liability

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

Tobacco Addiction Treatment

Except as specifically provided in this Summary Plan Description, the Plan does not cover treatment of tobacco addiction and supportive items for addiction to tobacco, tobacco products or nicotine substitutes.

Travel and Transportation Expenses

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

Vision Care

Except as specifically provided in this Summary Plan Description, the Plan does not cover routine eye exam and vision hardware.

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

Work-Related Conditions

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

Claims Administration

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

PREAUTHORIZATION

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

Preauthorization is performed to ensure that the medical services You receive are aligned with evidence based criteria and to determine whether the requested service meets the Claim Administrator's Medical Necessity criteria. Preauthorization also ensures that services or supplies You receive are safe, effective, and appropriate, with the goal of helping You obtain the most out of Your health plan benefits and receiving the right care, at the right time, and in the right place.

Contracted Providers may be required to obtain preauthorization from the Claims Administrator in advance for certain services provided to You. Non-contracted Providers are not required to obtain preauthorization from the Claims Administrator in advance for services. You, however, may be liable for costs if You elect to seek services and those services are not considered Medically Necessary and/or not covered under this Plan. You may request that a non-contracted Provider preauthorize services on Your behalf to determine Medical Necessity prior to the services being rendered.

A comprehensive list of services and supplies that must be preauthorized may be obtained from the Claims Administrator by visiting the Claims Administrator's Web site at:

https://www.regence.com/web/regence_provider/pre-authorization or by calling 1 (866) 240-9580.

Preauthorization requests should be faxed by Your Provider to the Claims Administrator at 1 (877) 663-7526.

Timeframe for Response

You will be notified in writing within 15 calendar days of the Claims Administrator's receipt of the preauthorization request whether the request has been approved, denied, or if more information is needed to make a determination.

When More Information is Needed to Make a Determination

Additional information requested by the Claims Administrator must be received within 45 calendar days of the date on the letter requesting information. The Claims Administrator will notify You in writing of the determination within 15 calendar days of receipt of additional information or within 15 calendar days of the end of the 45 day period if no additional information is received.

If You or Your Physician believes that waiting for a determination under the standard time frame could place Your life, health, or ability to regain maximum function in serious jeopardy, Your Physician should notify the Claims Administrator by phone or fax as a shorter time frame for response may apply.

Preauthorization does not guarantee payment. The Claim Administrator's reimbursement policies may affect how claims are reimbursed, and payment of benefits is subject to all Plan provisions, including eligibility for benefits at the time of services.

PLAN IDENTIFICATION CARD

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

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

If You lose Your card, or if it gets destroyed, You can get a new one by simply calling the Claims Administrator's Customer Service department at: 1 (866) 240-9580. You can also view or print an image of Your Plan identification card by visiting the Claims Administrator's Web site at **www.Regence.com** on

Your PC or mobile device. If the Agreement terminates, Your Plan identification card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

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

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

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

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

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

Calendar Year and Plan Year

The Deductible and Out-of-Pocket Maximum provisions are calculated on a Calendar Year basis. The Agreement is renewed, with or without changes, each Plan Year. A Plan Year is the 12-month period following either the Agreement's original effective date or subsequent renewal date. A Plan Year may or may not be the same as a Calendar Year. When the Agreement is renewed on other than January 1 of any year, any Deductible or Out-of-Pocket Maximum amounts You satisfied before the date the Agreement renews will be carried over into the next Plan Year. If the Deductible and/or Out-of-Pocket Maximum amount increases during the Calendar Year, You will need to meet the new requirement minus any amount You already satisfied under the previous Agreement during that same Calendar Year.

Timely Filing of Claims

Written proof of loss must be received within one year after the date of service for which a claim is made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof within the time required will not invalidate or reduce any claim. A claim that is not filed in a timely manner will be denied unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. You may, however, appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner.

Freedom of Choice of Provider

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

In-Network Claims

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

In-Network Reimbursement

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

Out-of-Network (Nonparticipating Provider) Claims

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

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

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

Out-of-Network (Nonparticipating Provider) Reimbursement

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

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

Reimbursement Examples by Category

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

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

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

- In-Network (Preferred): the Plan would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:

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

- In-Network (Participating): the Plan would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:

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

- Amount the Plan pays (80% of the \$4,000 Allowed Amount):	\$3,200
- Amount You pay (20% of the \$4,000 Allowed Amount and the \$1,000 difference between the billed charges and the Allowed Amount):	\$1,800
- Total:	\$5,000

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

Ambulance Claims

When You or Your Provider forwards a claim for ambulance services to the Claims Administrator, it must show where the patient was picked up and where he or she was taken. It should also show the date of service, the patient's name and the patient's group and identification numbers. Payment for Covered Services will be paid directly to the ambulance service Provider.

Claims Determinations

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

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

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

Claims Processing Report

You will be told how a claim has been acted on via a form called a claims processing report. Claims under the Plan may be denied or accumulated toward satisfying any Deductible. If all or part of a claim is denied, the reason for the denial will be stated on the claims processing report. The claims processing report will also include instructions for filing an Appeal if You disagree with the action.

OUT-OF-AREA SERVICES

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever You obtain health care services outside of the Claims Administrator's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between the Claims Administrator and other Blue Cross and Blue Shield Licensees.

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

BlueCard Program

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

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

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

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

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

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

Negotiated National Account Arrangements

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

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

Nonparticipating Providers Outside the Claims Administrator's Service Area

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

BLUECARD WORLDWIDE®

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

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

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

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

NONASSIGNMENT

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

CLAIMS RECOVERY

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

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

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS

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

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

- an insurance carrier or group health plan;

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

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

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

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

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

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

LIMITATIONS ON LIABILITY

In all cases, You have the exclusive right to choose a health care Provider. Neither the Plan nor the Claims Administrator is responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since neither the Plan nor the Claims Administrator provides any health care services, neither can be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither employees nor agents of the Plan and the Claims Administrator.

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

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

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

Coverage under the Plan will not be provided for any medical (or dental and vision, if applicable) or Prescription Medication expenses You incur for treatment of an Injury or Illness if the costs associated with the Injury or Illness may be recoverable from any of the following:

- a third-party;
- workers' compensation; or
- any other source, including automobile medical, personal injury protection ("PIP"), automobile no-fault, homeowner's coverage, commercial premises medical coverage or similar contract or insurance, when the contract or insurance is either issued to, or makes benefits available to You, whether or not You make a claim under such coverage.

Advancement of Benefits

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

- By accepting or claiming benefits, You agree that the Plan is entitled to reimbursement of the full amount of benefits paid out of any settlement or recovery from any source. This includes any judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for which benefits under the Plan have been provided.
- In addition to the Plan's right of reimbursement, the Claims Administrator may choose instead to achieve the Plan's rights through subrogation. The Claims Administrator is authorized, but not obligated, to recover any benefits paid under the Plan directly from any party liable to You, upon mailing of a written notice to the potential payer, to You or to Your representative.
- The Plan's rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration award or judgment or other characterization of the recovery by the Claimant and/or any third-party or the recovery source. The Plan is entitled to reimbursement from the first dollars received from any recovery. This applies regardless of whether:
 - the third-party or third-party's insurer admits liability;
 - the health care expenses are itemized or expressly excluded in the recovery; or
 - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered under the Plan.
- Reimbursement or subrogation under the Plan will not be reduced due to Your not being made whole.
- You may be required to sign and deliver all legal papers and take any other actions requested to secure the Plan's rights (including an assignment of rights to pursue Your claim if You fail to pursue Your claim of recovery from the third-party or other source). If You are asked to sign a trust agreement or other document to reimburse the Plan from the proceeds of any recovery, You will be required to do so as a condition to advancement of any benefits.
- You must agree that nothing will be done to prejudice the Plan's rights and that You will cooperate fully with the Claims Administrator, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify the Claims Administrator of any facts that may impact the right to reimbursement or subrogation, including, but not necessarily limited to, the following:
 - the filing of a lawsuit;
 - the making of a claim against any third-party;
 - scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
 - intent of a third-party to make payment of any kind to Your benefit or on Your behalf and that in any manner relates to the Injury or Illness that gives rise to the Plan's right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).
- You and/or Your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to Your benefit or on Your behalf that in any manner relates to the Injury or Illness giving rise to the Plan's right of reimbursement or subrogation, until the Plan's right is satisfied or released.
- In the event You and/or Your agent or attorney fails to comply with any of these conditions, any such benefits advanced for any Illness or Injury may be recovered through legal action.
- Any benefits provided or advanced under the Plan are provided solely to assist You. By paying such benefits, neither the Plan nor the Claims Administrator is acting as a volunteer and is not waiving any right to reimbursement or subrogation.

Motor Vehicle Coverage

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

Workers' Compensation

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

- You must notify the Claims Administrator in writing within five days of any of the following:
 - filing a claim;
 - having the claim accepted or rejected;
 - appealing any decision;
 - settling or otherwise resolving the claim; or
 - any other change in status of Your claim.
- If the entity providing workers' compensation coverage denies Your claim and You have filed an appeal, benefits may be advanced for Covered Services if You agree to hold any recovery obtained in a segregated account for the Plan.

Fees and Expenses

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

Future Medical Expenses

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

COORDINATION OF BENEFITS

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

Benefits Subject to this Provision

All of the benefits described in this Summary Plan Description are subject to this Coordination of Benefits provision.

Definitions

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

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

- An expense or portion of an expense not covered by any of Your involved plans.
- The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room, unless one of Your involved plans provides coverage for private Hospital rooms.
- When this Plan restricts coordination of benefits to certain types of coverage or benefits, any expenses for other types of coverage or benefits. See the Benefits Subject to this Provision paragraph, above, for restrictions on the types of coverage or benefits to which coordination applies.

- Any amount by which a Primary Plan's benefits were reduced because You did not comply with that plan's provisions regarding second surgical opinion or precertification of services or failed to use a preferred provider (except, if the Primary Plan is a closed panel plan and does not pay because a nonpanel provider is used, the Secondary Plan (if it is not a closed panel plan) shall pay as if it were the Primary Plan).
- A Primary Plan's deductible, if the Primary Plan is a high-deductible health plan as defined in the Internal Revenue Code and the Claims Administrator is notified both that all plans covering a person are high-deductible health plans and that the person intends to contribute to a health savings account in accordance with the Internal Revenue Code.
- An expense that a provider is prohibited by law or contract from charging You.

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

Birthday, for purposes of these coordination of benefits provisions, means only the day and month of birth, regardless of the year.

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

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

Group-type Coverage is a coverage that is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group, including blanket coverage. Group-type Coverage does not include an individually underwritten and issued guaranteed renewable coverage, even if the coverage is purchased through payroll deduction at a premium savings to the covered person.

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

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

Other Plan does not include:

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

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

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

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

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

Order of Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Primary Health Plan Benefits

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

Secondary Health Plan Benefits

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

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

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

Deductibles, Coinsurance and Copayments under this Plan will be used in the calculation of the benefits that would have been paid if this were the Primary Plan, but they will not be applied to the unpaid charges

You owe after the Primary Plan's payment. This Plan's payment therefore will be reduced so that it, when combined with the Primary Plan's payment, does not exceed the higher (highest) Allowable Expense among the involved plans and any amount that would have been credited to the Deductible if this Plan had been the only plan will be credited toward any Deductible under this Plan.

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

Appeal Process

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action under the Plan and wishes to have it reviewed, You may Appeal. There is one level of Appeal. Certain matters requiring quicker consideration qualify for a level of expedited Appeal and are described separately later in this section.

APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to the Claims Administrator at: Attn: Appeals, Regence BlueCross BlueShield of Oregon, P.O. Box 2998, Tacoma, WA 98401-2998 or facsimile 1 (877) 663-7526. Verbal requests can be made by calling the Claims Administrator at 1 (866) 240-9580.

Appeals, except voluntary external review, must be pursued within 180 days of Your receipt of the Claims Administrator's 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.

If Your health could be jeopardized by waiting for a decision under the regular Appeal process, an expedited Appeal may be requested. Please see Expedited Appeals later in this section for more information.

Appeals

Appeals are reviewed by a Claims Administrator employee or employees who were not involved in the initial decision that You are appealing. In Appeals that involve issues requiring medical judgment, the decision is made by the Claims Administrator's staff of health care professionals. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, the Claims Administrator will send a written notice of the decision within 14 days of receipt of the Appeal.

CIVIL ACTION

You may be required to exhaust certain appeals before pursuing civil action. See Your Plan Administrator for details.

EXPEDITED APPEALS

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

- the application of regular Appeal timeframes on a Pre-Service or concurrent care claim could jeopardize Your life, health or ability to regain maximum function; or
- according to a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

Panel-Level Expedited Appeal

The expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. Expedited Appeals are reviewed by a panel of Claims Administrator's employees who were not involved in, or subordinate to anyone involved in, the initial denial determination. You, or Your Representative on Your behalf, will be given the opportunity (within the constraints of the expedited Appeals timeframe) to provide written materials. A 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. A written notification of the decision will be mailed to You within three calendar days of the verbal notification.

Further Appeals

If You have exhausted all possible levels of Appeal described here, You may contact Your Plan Administrator for possible continuation of the appeals process at the following address: PEHT, c/o Rico Bocala, USI NW, 700 NE Multnomah St, #1300, Portland, OR 97232.

INFORMATION

If You have any questions about the Appeal process outlined here, You may contact the Claims Administrator's Customer Service department at: 1 (866) 240-9580 or You can write to the Claims Administrator's Customer Service department at the following address: Regence BlueCross BlueShield of Oregon, P.O. Box 2998, Tacoma, WA 98401-2998 or facsimile 1 (877) 663-7526.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

Appeal means a written or verbal request from a Claimant or, if authorized by the Claimant, the Claimant's Representative, to change a previous decision made under the Plan concerning:

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

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

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

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

Who Is Eligible, How to Enroll and When Coverage Begins

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

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS

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

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

Employees

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

Dependents

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

See Your employer's Human Resources department to determine if non-certified domestic partners are covered.

Dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your Oregon-Certified Domestic Partner. Oregon-Certified Domestic Partnership means a contract, in accordance with Oregon law, entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon.
- Your (or Your spouse's or Your Eligible Domestic Partner's) child who is under age 26 and who meets any of the following criteria:
 - Your (or Your spouse's or Your Eligible Domestic Partner's) natural child, step child, adopted child or child legally placed with You (or Your spouse or Your Eligible Domestic Partner) for adoption;
 - a child for whom You (or Your spouse or Your Eligible Domestic Partner) have court-appointed legal guardianship; and
 - a child for whom You (or Your spouse or Your Eligible Domestic Partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).
- Your (or Your spouse's or Your Eligible Domestic Partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of developmental disability or physical handicap that began before his or her 26th birthday, if You complete and submit the Claims Administrator's affidavit of dependent eligibility form, with written evidence of the child's incapacity, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:
 - he or she is a Beneficiary immediately before his or her 26th birthday; or
 - his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on group coverage since that birthday.

The Claims Administrator's affidavit of dependent eligibility form is available by visiting their Web site at **www.Regence.com**, or by calling their Customer Service department at: 1 (866) 240-9580.

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request to the Plan Sponsor. Request for enrollment of a new child by birth, adoption or placement for adoption must be made within 60 days of the date of birth, adoption or placement for adoption. Request for enrollment of all other newly eligible dependents must be made within 30 days of the dependent's attaining eligibility. Coverage for such dependents will begin on their Effective Dates (which, for a new child by birth, adoption or placement for adoption, is the date of birth, adoption or placement for adoption, if enrolled within the specified 60 days).

SPECIAL ENROLLMENT

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

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

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

- You and/or Your eligible dependents lose coverage under another group or individual Health Benefit Plan due to one of the following:
 - an employer's contributions to that other plan are terminated;
 - exhaustion of federal COBRA or any state continuation; or
 - loss of eligibility, for instance, due to legal separation, divorce, termination of domestic partnership, death, termination of employment or reduction in hours.
- You involuntarily lose coverage under Medicare, CHAMPUS/Tricare, Indian Health Service or a publicly sponsored or subsidized health plan (other than the Children's Health Insurance Program (CHIP), see below).
- You lose coverage under Medicaid or the Children's Health Insurance Program (CHIP).

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

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

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

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

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

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

ANNUAL ENROLLMENT PERIOD

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

DOCUMENTATION OF ELIGIBILITY

You must promptly furnish or cause to be furnished any information necessary and appropriate to determine the eligibility of a dependent. Such information must be received before enrolling a person as a dependent under the Plan.

When Coverage Ends

This section describes the situations when coverage will end for You and/or Your Beneficiaries. You must notify the Claims Administrator within 120 days of the date on which a Beneficiary is no longer eligible for coverage.

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

AGREEMENT TERMINATION

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

MEMBER EMPLOYER TERMINATION

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

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

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

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

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

NONPAYMENT

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

FAMILY AND MEDICAL LEAVE

If You are granted a non-FMLA leave of absence, You may be able to continue coverage according to Your employer's internal leave policy. Please refer to the institution's Eligibility Insert or contact Human Resources for more information. Payments must be made through the Plan Sponsor in order to maintain coverage during a leave of absence.

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

- You and Your Beneficiaries will remain eligible to be enrolled under the Plan during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
 - in order to care for Your newly born child;

- in order to care for Your spouse, child or parent, if such spouse, child or parent has a serious health condition;
- the placement of a child with You for adoption or foster care; or
- You suffer a serious physical or Mental Health Condition.

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

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

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

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

LEAVE OF ABSENCE

If You are granted a non-FMLA leave of absence, You may be able to continue coverage according to Your employer's internal leave policy. Please refer to the institution's Eligibility Insert or contact Human Resources for more information. Payments must be made through the Plan Sponsor in order to maintain coverage during a leave of absence.

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

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

WHAT HAPPENS WHEN YOUR BENEFICIARIES ARE NO LONGER ELIGIBLE

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

Divorce or Annulment

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

If You Die

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

Dissolution or Annulment of Oregon-Certified Domestic Partnership

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

Loss of Dependent Status

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

OTHER CAUSES OF TERMINATION

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

Fraudulent Use of Benefits

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

Fraud or Misrepresentation in Application

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

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

COBRA Continuation of Coverage

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

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

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

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

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

General Rules

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

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

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

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

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

Notice

The complete details on the COBRA Continuation provisions outlined here are available from Your employer or the Plan Sponsor.

Other Continuation Options

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

Reenrolling After Layoff

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

Strike or Lockout

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

Workers' Compensation Claim

If You are no longer eligible due to an Illness or Injury for which You have filed a Workers' Compensation claim, You can continue coverage for up to six months after Your eligibility ends, or until You obtain full-time employment with another employer, whichever happens first. You must make payment of premiums for the coverage to the Plan Sponsor within its established timeframe in order to maintain coverage during this period. This six months of continued coverage is in lieu of and not in addition to any continuation of coverage provisions of the Plan.

Continuation of Certain Surviving and Former Dependents

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

General Provisions

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

CHOICE OF FORUM

Any legal action arising out of the Plan benefit option described herein must be filed in a court in the state of Oregon.

GOVERNING LAW

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

PLAN SPONSOR IS AGENT

The Plan Sponsor is Your agent for all purposes under the Plan and not the agent of Regence. You are entitled to health care benefits pursuant to the Plan. In the Agreement, the Plan Sponsor agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in the Summary Plan Description. You, through the enrollment form signed by the Participant, and as beneficiaries of the Plan, acknowledge and agree to the terms, provisions, limitations and exclusions described in this Summary Plan Description.

NO WAIVER

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

NOTICES

Any notice to Claimants required in the Plan will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to a Participant will be addressed to the Participant or to the Plan Sponsor at the last known address appearing in the Claims Administrator's records. If the Claims Administrator receives a United States Postal Service change of address form (COA) for a Participant, it will update its records accordingly. Additionally, the Claims Administrator may forward notice for a Participant to the plan administrator or Plan Sponsor if it becomes aware that it doesn't have a valid mailing address for the Participant. Any notice to the Claims Administrator required in the Agreement may be given by mail addressed to: Regence BlueCross BlueShield of Oregon, P.O. Box 30805, Salt Lake City, UT 84130-0805; provided, however that any notice to the Claims Administrator will not be considered to have been given to and received by it until physically received.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

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

REPRESENTATIONS ARE NOT WARRANTIES

In the absence of fraud, all statements You make in an enrollment form will be considered representations and not warranties. No statement made for the purpose of obtaining coverage will void such coverage or

reduce benefits unless contained in a written document signed by You, a copy of which is furnished to You.

WHEN BENEFITS ARE AVAILABLE

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS

If You are receiving benefits in connection with a mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, coverage under the Plan will be provided (subject to the same provisions as any other benefit) for:

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

Definitions

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

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

Allowed Amount means:

- For preferred and participating Providers (see definition of "In-Network (Preferred)" and "In-Network (Participating)" below), the amount that they have contractually agreed to accept as payment in full for a service or supply.
- For nonparticipating Providers (see definition of "Out-of-Network" below) who are not accessed through the BlueCard Program, the amount the Claims Administrator has determined to be Reasonable Charges for Covered Services or supplies. The Allowed Amount may be based upon the billed charges for some services, as determined by the Claims Administrator or as otherwise required by law.
- For nonparticipating Providers (see definition of "Out-of-Network" below) accessed through the BlueCard Program, the lower of the Provider's billed charges and the amount that the Host Blue identifies to the Claims Administrator as the amount on which it would base a payment to that Provider.

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

Ambulatory Service Facility means a facility, licensed by the state in which it is located, that is equipped and operated mainly to do surgeries or obstetrical deliveries that allow patients to leave the facility the same day the surgery or delivery occurs.

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

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

Claimant means a Participant or a Beneficiary.

Covered Service means a service, supply, treatment or accommodation that is listed in the benefits sections in this Summary Plan Description.

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

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

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

Eligible Domestic Partner means a domestic partner who meets the dependent eligibility requirements in the Who Is Eligible, How to Enroll and When Coverage Begins Section.

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

- placing the Claimant's health, or with respect to a pregnant Claimant, her health or the health of her unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Family means a Participant and his or her Beneficiaries.

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

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following: disease, illness, injury, genetic or congenital anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation; or to maintain or restore functional ability. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

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

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

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

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

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

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

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

- If a medication or device, the Health Intervention must have final approval from the United States Food and Drug Administration as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the use for a particular diagnosed condition, benefits for the medication may be provided when so used. To be considered effective for other than its FDA-approved use, the Oregon Health Evidence Review Commission must have determined that the medication is effective for the treatment of that condition.
- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, Injury or Illness, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- The Scientific Evidence must show that the Health Intervention is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

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

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

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

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

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

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

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

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

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

Practitioner means an individual who is duly licensed to provide medical or surgical services that are similar to those provided by Physicians. Practitioners include podiatrists who do not meet the definition of

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

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.

Reasonable Charges means an amount, determined by the Claims Administrator, that falls within the range of average payments they make to Providers, who have an effective participating contract with them, for the same or similar service or supply in the Claims Administrator's service area.

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

Regence refers to Regence BlueCross BlueShield of Oregon.

Scientific Evidence means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes. However, Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

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

Summary Plan Description (SPD) is a summary of the benefits provided by the Group Health Plan (GHP). A GHP with different benefit plan options may describe them in one SPD or in separate SPDs for each alternative benefit plan option.

Disclosure Statement Patient Protection Act

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You also have the right to file a complaint and seek assistance from the Oregon Insurance Division. Assistance is available by calling: (503) 947-7984 or the toll free message line at 1 (888) 877-4894; by writing to the Oregon Insurance Division, Consumer Protection Unit, 350 Winter Street NE, Salem, OR 97301-3883; through the Internet at: www.insurance.oregon.gov/consumer/tomake.html; or by E-mail at: cp.ins@state.or.us.

HOW CAN I PARTICIPATE IN THE DEVELOPMENT OF THE CLAIMS ADMINISTRATOR'S CORPORATE POLICIES AND PRACTICES?

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

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

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

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

Regence BlueCross BlueShield of Oregon ATTN: Vice President, Customer Service, P.O. Box 1271, MS C7A, Portland, OR 97207-1271 or send Your comments to Us over the internet at: www.Regence.com.

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

WHAT IS THE CLAIMS ADMINISTRATOR'S PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT CRITERIA?

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

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

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

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

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

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

WHAT ADDITIONAL INFORMATION CAN I GET FROM THE CLAIMS ADMINISTRATOR UPON REQUEST?

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

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

WHAT OTHER SOURCE CAN I TURN TO FOR MORE INFORMATION ABOUT REGENCE BLUECROSS BLUESHIELD OF OREGON?

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

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

To obtain the mentioned information, You can call the Oregon Insurance Division at (503) 947-7984 or the toll free message line at 1 (888) 877-4894; by writing to the Oregon Insurance Division, Consumer Protection Unit, 350 Winter Street NE, Salem OR 97301-3883; through the Internet at: **www.insurance.oregon.gov/consumer/tomake.html**; or by E-mail at: **cp.ins@state.or.us**.

Summary Plan Description

The Plan is an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA). For further information regarding ERISA, contact the Plan Sponsor. Note that the terms "You" and "Your" in this Summary Plan Description Section by and large refer to the Participant.

PLAN NAME

Pioneer Educators Health Trust

NAME, ADDRESS AND PHONE NUMBER OF PLAN SPONSOR

Pioneer Educators Health Trust
c/o Rico Bocala
700 NE Multnomah Street, Suite 1300
Portland, Oregon 97232
(503) 299-3401

EMPLOYER IDENTIFICATION NUMBER ASSIGNED FOR THIS PLAN BY THE IRS

35-2198318

PLAN NUMBER

501

TYPE OF PLAN

Welfare Benefit Plan: medical, prescription medication, and vision benefits.

TYPE OF ADMINISTRATION

The processing of claims for benefits under the terms of the Plan are provided through a company contracted by the Plan Sponsor which hereinafter is referred to as the Claims Administrator.

NAME, ADDRESS AND PHONE NUMBER OF THE AGENT FOR SERVICE OF LEGAL PROCESS

Jeff Robertson
Barran Liebman, LLP
601 SW 2nd Avenue
Portland, Oregon 97204
(503) 276-2140

Legal process may also be served upon the Plan Sponsor's address above.

SOURCES OF CONTRIBUTIONS TO THE PLAN

Contributions for plan expenses are obtained from Plan Sponsor and Participants.

FUNDING MEDIUM

Plan Sponsor will maintain an account for the receipt of money and property to fund the Plan, for the management and investment of such funds, and for the payment of Plan benefits and expenses from such funds.

All funds and earnings received by the Plan Sponsor will be applied toward payment of Plan benefits and reasonable expenses of administration of the Plan except to the extent otherwise provided by the Plan documents. The Plan Sponsor may appoint an investment manager or managers to manage (including the power to acquire and dispose of) any assets of the Plan.

Any fiduciary, employee, agent representative, or other person performing services to or for the Plan shall be entitled to reasonable compensation for services rendered and for the reimbursement of expenses properly and actually incurred, unless such person already receives full-time pay from Plan Sponsor.

Enrollees shall look only to the Plan Sponsor's funds for payment of Plan benefits and expenses.

PLAN FISCAL YEAR ENDS ON

This plan is maintained on a calendar year basis from January 1 through December 31.

PLAN TERMINATION PROVISIONS

The Plan Sponsor expects and intends to continue the Plan indefinitely, but reserves its right to end the Plan at any time in its sole discretion. The Plan Sponsor also reserves the right to amend the Plan at any time in its sole discretion.

The Plan Sponsor's decision to end or amend the Plan may be due to changes in federal or state laws governing welfare benefits, the requirements of the IRS or ERISA, or for any other reason. A Plan change may transfer assets and liabilities to another plan or split this plan into two or more parts. If the Plan Sponsor does change or end the Plan, it may decide to set up a different plan providing similar or identical benefits.

If the Plan is terminated, plan participants and beneficiaries will not have any further rights. The amount and form of any final benefit will depend on any contract provisions affecting the Plan, and the Plan Sponsor's decisions.

NOTICE OF ERISA RIGHTS

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

Receive Information About Your Plan And Benefits

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

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

Continue Employer Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

No one, including the Plan Sponsor or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a health and welfare benefit under the Plan or exercising Your rights under ERISA. If Your claim for a health and welfare benefit is denied in whole or in part, You must receive a written explanation of the reasons for the denial. You have the right to have the Plan Sponsor review and reconsider Your claim. Under ERISA, there are steps You can take to enforce these rights. For instance, if You request materials from the Plan and You do not receive them within 30 days, You may file suit in the Federal court. In such case, the court may require the Plan Administrator to provide the material and pay You up to \$110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

Procedures For Filing Claims

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

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

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

Assistance With Your Questions

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

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

www.Regence.com



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

Regence BlueCross BlueShield of Oregon