PUBLIC EMPLOYEES'

PEBB

BENEFIT BOARD

Regence BlueCross BlueShield of Oregon

Member Handbook

for Employees & Dependents
and
Non-Medicare Eligible Retirees & Dependents

Regence BlueCross BlueShield of Oregon

An Independent Licensee of the Blue Cross and Blue Shield Association

Effective January 1, 2008

Oregon
John A. Kitzhaber, M.D., Governor

Public Employees' Benefit Board
775 Court Street, NE
Salem, OR 97301-3802
(503) 373-1102
FAX (503) 373-1654

TO: State Employees and Non-Medicare Eligible Retirees

FROM: Public Employees' Benefit Board (PEBB)

The benefits described on the following pages were designed to provide you and your dependents with the best possible medical care at competitive rates. In addition, this medical plan offers a variety of activities that help contain the rising cost of medical insurance.

Should you require additional information concerning this medical plan or any other topic related to your medical insurance, please contact the insurance company at (503) 220-3849 or 1-800-826-9813, or PEBB at (503) 373-1102, 1-800-788-0520 (outside Salem), or via e-mail at inquiries.pebb@state.or.us.

If more than one year has lapsed since the effective date of your member handbook, benefits may have changed. In all cases, benefits will be administered in accordance with the governing plan documents, insurance contracts or applicable Federal and State regulations.

INTRODUCTION

The following pages are the booklet, a written description of the terms of the group health care benefit plan that this booklet describes.

Please read this booklet as soon as you get it. It will tell you how the plans work. You'll then be able to obtain all the benefits to which you're entitled and avoid delays in processing your claims.

This booklet is designed to explain the benefits and other provisions of the plan clearly and completely. This booklet is part of the group policy between Regence BlueCross BlueShield of Oregon (an independent licensee of the Blue Cross and Blue Shield Association) and the Public Employees' Benefit Board.

Throughout this booklet, we use the term ''insured employee'' to refer to the employee or retiree. The terms ''insured dependents'' and ''family members'' are used interchangeably to refer to your spouse, domestic partner, and eligible children. The term ''you'' applies to the insured employee or retiree and insured family members unless we indicate otherwise.

A special feature of your coverage is its ''hold harmless'' clause. Basically, this clause guarantees you that participating providers will not charge you beyond the fee upon which we base our payment. Of course, any applicable coinsurance or copay will continue to apply. Physicians who are not participating, however, may bill you for any balances over the maximum allowable charge.

This booklet describes benefits effective January 1, 2008, or the date after that on which your coverage became effective.

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DEFINITIONS

The following are definitions of some important terms used in this employee plan description. Other terms are defined where they are first used in the text.

Illness means a disease or bodily disorder.

Injury means a personal bodily injury to you or your insured dependent caused directly and independently of all other causes by external, violent, and accidental means.

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.

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 this contract. Mental Disorders that accompany an excluded diagnosis are covered.

Mental health and chemical dependency services means medically necessary outpatient, residential, partial hospital or inpatient services provided by an approved licensed facility or licensed individuals who meet our credentialing requirements 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 care services, and court ordered treatment (unless the treatment is determined by us to be medically necessary). Mental health and chemical dependency services do not include:

- educational programs for drinking drivers;
- voluntary mutual support groups, such as Alcoholics Anonymous; and
- family education or support groups.

Residential care is care in a licensed residential facility, hospital, or other facility which provides an organized full-day or part-day program of treatment and is licensed or approved for the particular level of care for which reimbursement is being sought by the Oregon Mental Health Division (or the equivalent agencies, if the services are provided outside Oregon).

A preexisting condition is a condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received within the

six-month period before the enrollment date. Your coverage has no waiting periods or exclusions for preexisting conditions.

An emergency medical condition means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

Emergency medical screening exam means the medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an emergency medical condition.

Emergency services means those services and supplies furnished by a facility to the extent they are required for the stabilization of a patient who is experiencing an emergency medical condition.

Enrollment date means, for individuals who apply during their initial period of eligibility, your or your enrolled dependent's effective date of coverage or the first day of any group eligibility waiting period applicable to you or your dependent, whichever is earlier. For all others (i.e. including those who applied as late enrollees or during a special enrollment or open enrollment period), enrollment date means the effective date of coverage.

An insured dependent or family member is an eligible dependent, spouse, or domestic partner of an insured employee or retiree whose application is accepted by Regence BlueCross BlueShield of Oregon and who is insured by this policy.

An insured employee or retiree is an employee or retiree of the group whose application is accepted by Regence BlueCross BlueShield of Oregon and who is insured by this policy.

An insured member is an insured dependent or an insured employee or retiree.

A Preferred facility is a hospital, skilled nursing facility, or special facility that has an effective Preferred Provider Plan contract with Regence BlueCross BlueShield of Oregon to provide services and supplies to the insured individuals under this policy.

Preferred professional provider means a professional provider who has an effective Preferred Provider Plan contract with Regence BlueCross BlueShield of Oregon to provide services and supplies to the insured individuals under this policy.

Contracting agency means any of the following with whom Regence BlueCross BlueShield of Oregon has contracted to provide services and supplies to the insured individuals under this policy:

- home health care agency;

- home infusion therapy agency; and
- hospice care program.

Contracting durable medical equipment supplier means a supplier of durable medical equipment with whom we have contracted to provide services and supplies to insured individuals.

Maximum allowable charge means the contracted amount for listed services and supplies provided by a participating facility, participating professional provider, preferred facility, preferred professional provider, a contracting agency, or a contracting durable medical equipment supplier, or the billed amount, whichever is less.

Annual out-of-pocket maximum means the maximum dollar amount of coinsurance or copayments you could pay for eligible charges in a calendar year. The amount of the annual out-of-pocket maximum is shown in the SUMMARY OF BENEFITS.

Reasonable amount means an amount, determined by us according to: a proprietary database on medical/dental billings; or use of pharmacy or Medicare data, which is usual (not more than the provider's normal charge) and customary (falls within the range of average charges for a service or supply billed by most providers or vendors for the same or similar service or supply in the service area).

Health benefit plan means any hospital-medical-surgical expense policy or certificate issued by insurers including health care service contractors and health maintenance organizations, and includes any benefit plan provided by a multiple employer welfare arrangement or by another benefit arrangement, as defined in the federal Employee Retirement Income Security Act of 1974 as amended (ERISA).

You or your means the insured employee, retiree, or dependent.

A special feature of your coverage is its ‘‘hold harmless’’ clause. Basically, this clause guarantees you that participating providers will not charge you beyond the fee upon which we base our payment. Of course, any applicable coinsurance will continue to apply. Physicians who are not participating, however, may bill you for any balances over the maximum allowable charge.

ELIGIBLE CHARGES

Subject to the terms of this policy, eligible charges means the following when incurred for the services and supplies (including medications) listed in the following sections and when medically necessary for diagnosis and/or treatment of an illness or injury:

- the contracted amount for listed services and supplies provided by a participating facility, participating professional provider, preferred facility, preferred professional provider, a contracting agency, or a contracting durable medical equipment supplier;

- the reasonable charge for listed services and supplies provided by a nonparticipating facility;

- the billed amount for listed services received from a nonparticipating professional provider, or the contracted amount for a participating professional provider for the same service, whichever is less;

- the billed amount for listed services and supplies provided by an agency other than a contracting agency for home health care, home infusion therapy, or palliative hospice care or the contracted amount for a contracting agency for the same service or supply, whichever is less;

- the billed amount for listed services and supplies provided by a durable medical equipment supplier that is not a contracting durable medical equipment supplier or the contracted amount for a contracting durable medical equipment supplier for the same service or supply, whichever is less;

- the billed amount for listed services and supplies, or the contracted amount that would have been paid to a participating professional provider for the same service or supply, whichever is less, rendered by a nonparticipating professional provider located in any of the following counties in the state of Oregon: Baker, Crook, Curry, Deschutes, Gilliam, Grant, Harney, Jackson, Jefferson, Josephine, Klamath, Lake, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa and Wheeler.

- the reasonable amount for services and supplies provided by all other categories of providers that are neither participating nor nonparticipating (ambulance providers and non-DME suppliers for example).

For emergency services only (excluding ambulance transportation), we pay a nonpreferred professional provider the same percentage of benefits as we would have paid a preferred professional provider for a similar service.

In addition, if your or your insured dependent's medical condition necessitates emergency services at a nonpreferred facility, we pay the same percentage of benefits we would have paid for a similar service or supply at a preferred facility. However, after receiving covered emergency services at a nonpreferred facility, we can require you to transfer to a preferred facility as soon as your medical condition safely permits. Payment for eligible charges for a nonpreferred facility for care beyond the date we reasonably determine you can be safely transferred will revert back to the percentage payable for a nonpreferred facility.

Preferred and participating providers will not charge you or your insured dependents for any balances beyond any coinsurance amount for eligible charges. Facilities and professional providers that do not have a preferred or participating contract with us, however, may bill you for any balances over the maximum allowable charge in addition to any coinsurance amount.

Example Of How Benefits Are Paid - Nonparticipating Professional Provider

Nonparticipating professional provider's charge for a service:	$50.00
Amount allowed to a participating professional provider for the same service (the contracted amount):	$45.00
Amount considered an eligible charge for the nonparticipating professional provider's charge would be: (nonparticipating professional provider's charge, not to exceed a participating professional provider's contracted amount for the same service)	$45.00

How That Eligible Charge Would Be Paid

Policy coinsurance: (our responsibility is 70%, your responsibility is 30%)	70%
Amount we would pay to the nonparticipating professional provider:	$31.50
Amount you would pay to the nonparticipating professional provider:	$18.50
Total	$50.00

Difference Between Participating And Nonparticipating Professional Provider Payment

If the $50 charge had been for a visit to a participating professional provider, our payment to that provider would have been: (70% of the contracted amount)	$31.50
Your responsibility would have been:	$13.50

The above is only an example. It assumes that you or your insured dependent has not met the annual out-of-pocket maximum amount. Not all eligible charges are subject to the annual out-of-pocket maximum. The actual benefits of the plan may vary. Read the SUMMARY OF BENEFITS thoroughly to determine how your benefits under the plan are paid.

Medical Necessity

Medically necessary means health care services or supplies that a professional 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 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 practicing in relevant clinical areas and any other relevant factors.

Participating Providers

The important difference between the benefits for participating and preferred professional providers and nonparticipating and nonpreferred professional providers is the balance you may be required to pay. Participating and preferred professional providers will not charge you or your dependents any balances for eligible charges over any applicable coinsurance amount required under your plan. Nonparticipating and nonpreferred providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

Ask your professional provider if he or she is a participating or preferred Regence BlueCross BlueShield of Oregon provider. You can also get a list of participating and preferred professional providers from any Regence BlueCross BlueShield of Oregon office or the PEBB office, or access on-line via the PEBB website.

IMPORTANT NOTE: It is extremely important to use participating and preferred facilities and participating and preferred professional providers in order to receive the maximum benefits available under this plan.

Preauthorization

Preauthorization is a tool we use to find the most appropriate and cost-effective level of medical care for our members. Many types of treatment may be available for certain conditions; the preauthorization process helps your physician work together with you or your insured dependent, other providers, and Regence BlueCross BlueShield of Oregon to determine the treatment that best meets your or your insured dependent's medical needs. This teamwork helps save thousands of dollars in premiums each year, which translates into savings for you.

Preauthorization refers to the process by which we determine that a proposed service or supply (including medications) is medically necessary and provide approval for it before it is rendered.

What Needs To Be Preauthorized

Some services and supplies (as may be described in this benefits booklet) must be preauthorized before we will consider paying the claim. These services and supplies are listed on our Focused Notification List which we give to our providers twice a year. Note that we do not preauthorize services or supplies which are not included on our Focused Notification List.

Preauthorization By Contracting Providers -- Providers that have contracted with us know how the preauthorization process works and will normally request preauthorization, if necessary, for your or your insured dependent's proposed service or supply.

Preauthorization By Noncontracting Providers -- Your or your insured dependent's provider knows how this process works and will normally request preauthorization, if necessary, for your or your insured dependent's proposed service or supply. However, if you or your insured dependent receives care from a provider with whom we have not contracted, you or your insured dependent may be liable for charges we deny because the service or supply is not medically necessary. Avoid that risk by asking your or your insured dependent's provider to contact our Preauthorization Department. Please note that for treatment of chemical dependency conditions and/or mental health conditions, providers with whom we have not contracted are bound by law to follow our preauthorization requirements the same as providers with whom we have contracted.

Preauthorization Process
When we receive a preauthorization request from you or your insured dependent, or your or your insured dependent's provider, we will notify you or the provider of our decision within 15 days of our receipt of the preauthorization request. However, this 15-day period may be extended an additional 15 days in the following situations:

- When we cannot reach a decision due to circumstances beyond our control, we will notify you or the provider within the initial 15-day period that the extension is necessary, including an explanation of why the extension is necessary and when we expect to reach a decision.

- When we cannot reach a decision due to lack of information, we will notify you or the provider within the initial 15-day period that the extension is necessary, including a specific description of the additional information needed and an explanation of why it is needed. You or your provider must provide us with the requested information within 45 days of receiving the request for additional information. Once we receive the needed information, we will notify you of our decision within 48 hours after you supplied it to us or at the end of the period we allowed you to supply the needed information to us.

Our Preauthorization Department may be reached by phone or mail at:

Mail: Regence BCBSO Preauthorization Department
PO Box 1271, E-9B
Portland, OR 97201-1271

Telephone: Portland area: (503) 525-6593
Toll-free: 1-800-824-8563

To preauthorize care for transplants:

Mail: PO Box 1271, E-9B
Portland, OR 97207-1271

Telephone: Portland: (503) 226-8783
Toll-free: 1-800-560-0749
Fax: (503) 226-8754

If we approve a preauthorization request from a provider, we are bound to cover the authorized service or supply as follows:

If your or your insured dependent's coverage terminates within five business days of the preauthorization date, we will cover the preauthorized service or supply if the service or supply is actually incurred within those five business days regardless of the termination date unless we are aware the coverage is about to terminate and we disclose this information in our written preauthorization. In that case, we will only cover the preauthorized service or supply if incurred prior to termination.

If your or your insured dependent's coverage terminates later than five business days after the preauthorization date, but before the end of 30 calendar days, no services incurred after termination will be covered even if preauthorized.

If coverage remains in effect for at least 30 calendar days after the preauthorization, we will cover the preauthorized service or supply if incurred within the 30 calendar days.

When counting the days described above, day one will begin on the calendar or business day after we preauthorize the service or supply.

Comprehensive Case Management

Comprehensive case management is a program administered by us which is designed to provide early detection and intervention in cases of serious illness or injury with the potential for major continuing claims expense. We will, at our sole discretion, identify appropriate cases, evaluate recommended treatment plans, and propose alternative benefits.

Alternative benefits means payment for services or supplies which are not otherwise benefits of the contract, but which we believe to be medically necessary and cost effective. We will not cover alternative benefits until we have determined, at our sole discretion, to do so, and have received agreement in writing on the specific terms and conditions for payment signed by an enrollee or an enrollee's legal representative. The fact that we pay alternative benefits for an enrollee shall not obligate us to pay such benefits for other enrollees, nor shall it obligate us to pay continued or additional alternative benefits for the same enrollee. Benefits for alternative benefits are covered expenses for all purposes under this contract.

Medical Bill Audit

Enrollment in one of the Regence BlueCross BlueShield of Oregon (Regence BCBSO) plans makes you eligible for a medical bill audit incentive. If you find an overcharge on your medical bill and convince the hospital or medical provider to correct it, you will be rewarded with up to 50 percent of the amount of the error. There is a minimum reward of $25 (error of $50) and a maximum reward of $100 (error of $200 or greater). To collect your reward, you must submit copies of the following: 1) original bill showing error, 2) your Regence BCBSO Claims Processing Report, and 3) a completed PEBB Medical Bill Audit Claim Form (including the hospital or medical provider's acknowledgment of the error). Submit your claim(s) to the Public Employees' Benefit Board, 775 Court Street NE, Salem, OR 97301. Claim forms may be obtained by calling PEBB at (503) 373-1102 or 1-800-788-0520 (outside Salem). This program may be changed or discontinued without notice.

Coverage Outside The United States

Regence BlueCross BlueShield of Oregon provides coverage for medically necessary health care services received outside the United States. You may be required to pay for services when they are performed. It is important that you obtain the most itemized billing possible, and ask to have bills written in a foreign language translated into English. If this is not possible, the bills will be translated by Regence BlueCross BlueShield of Oregon. Reimbursement for services received in a foreign country is based on the rate of exchange in effect on the date the service was provided.

Once you have returned to the United States, forward these bills to our office and include your group and identification numbers. Claims for all types of health care services must be submitted within one year of the date of service.

Out-Of-Area Claims Service - BlueCard Program

All Blue Cross and Blue Shield licensees ("Plans") participate in the BlueCard Program. This Program benefits insured individuals who incur eligible charges outside our service area. Not all claims incurred outside of our service area, dental claims for example, are processed through the BlueCard Program.

Under BlueCard, when you or an insured dependent incurs eligible charges within the geographic area served by another BlueCross and/or BlueShield Plan, we will remain responsible for meeting our obligations under the policy. The local Blue Plan will only be responsible for providing such services as contracting with its participating providers and handling the interaction with those providers according to BlueCard policies.

When you or an insured dependent receives covered health care services outside our service area from a provider who has a participating contract with the local Blue Cross and/or Blue Shield Plan and the claim is processed through BlueCard, the amount you pay for eligible charges is usually calculated on the lower of:

- the actual billed charges; or

- the negotiated price that the local Blue Cross and/or Blue Shield Plan passes on to us.

Often, this “negotiated price” will consist of a simple discount. But, sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, or other nonclaims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your provider or a group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Plan to use a basis for calculating your liability for eligible charges that does not reflect the entire savings realized, or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the usual BlueCard Program method noted above or require a surcharge, we would then calculate your liability for any covered health care services using the methods outlined by the applicable state statute in effect at the time you or your insured dependent received care.

Emergency Care

You and your insured dependents are covered for emergency medical screening exam expenses (see DEFINITIONS Section) under the various sections of this policy without preauthorization.

Should you or your insured dependent experience an emergency medical condition, you or your insured dependent should seek medical attention from the nearest appropriate facility (physician's office, clinic setting, urgency care center, or hospital emergency room), or call 911.

SUMMARY OF BENEFITS

This section is a summary of the benefits of the plan. It states at what percentages eligible charges are paid and describes any annual out-of-pocket maximum amounts. It also states benefit maximums applicable to the coverage. You may also be responsible for payment of part of the premium for coverage under the plan. Check with your plan administrator for information on any required premium contribution. The sections following this SUMMARY OF BENEFITS spell out the benefits and the conditions, limitations, and exclusions of the plan in detail.

We have contracted with professional providers and facilities to provide services and supplies to insured employees and their insured family members under this plan. Your provider directory lists which panel of providers applies to your benefits under the plan. This listing of participating providers is available to you, at no cost, upon enrollment or at any other time from your plan administrator or from us on our website at www.or.regence.com or through our Customer Service Department.

PPO Plan

This plan includes a percentage coinsurance amount each time you receive a covered service. Active full and part-time employees, retirees, insured family members, COBRA participants and self pay individuals may be enrolled in this plan.

PPO Part-Time And Retiree Plan

This plan includes a percentage coinsurance amount each time you receive a covered service. Part-time employees receiving less than a full time state contribution, retirees, and their insured family members may be enrolled in this plan.

Eligible Charges

All services must be medically necessary and all payments are based on eligible charges for such services and supplies (see definition on page 3).

Eligible Charges - Designated Rural Counties

For insured employees and their insured family members residing and receiving care in designated rural counties, claims for eligible charges will be processed at the preferred level of benefits, regardless of whether the provider rendering the service or supply is a preferred, nonpreferred or nonparticipating provider. In order for this benefit to apply, you must reside in one of the following counties in the state of Oregon: Baker, Crook, Curry, Deschutes, Gilliam, Grant, Harney, Jackson, Jefferson, Josephine, Klamath, Lake, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa and Wheeler. All services must be medically necessary and all payments are based on eligible charges for such services and supplies (see definition on page 3).

HOW BENEFITS ARE PAID

PPO Plan Out-of-Pocket Maximum

Preferred Provider (including Rural County Residents)

- 85 percent of eligible expenses until $1,000 out-of-pocket per person/$3,000 out-of-pocket per family has been incurred each calendar year.*

- 100 percent of eligible expenses after $1,000 out-of-pocket per person/$3,000 out-of-pocket per family has been incurred each calendar year.*

Nonpreferred Provider

- 70 percent of eligible expenses until $2,000 out-of-pocket per person/$6,000 out-of-pocket per family has been incurred each calendar year.*

- 100 percent of eligible expenses after $2,000 out-of-pocket per person/$6,000 out-of-pocket per family has been incurred each calendar year.*

*Not all expenses accrue to the annual out-of-pocket maximum amount. Expenses that do not accrue to the annual out-of-pocket maximum may include, but are not limited to, the following:

- prescription medication copayments or coinsurance;

- alternative care coinsurance;

- VSP vision examination copayments or any amounts over $160 for eyewear for the PPO Plan;

- any coinsurance for hearing examinations or amounts over $4,000 for hearing aids;

- coinsurance amounts for infertility services; and

- any amounts over the maximum allowable charge when a nonparticipating professional provider's services are used.

PPO Part-Time And Retiree Plan Out-of-Pocket Maximum

Preferred Provider (including Rural County Residents)

- 50 percent of the first $1,000 of eligible expenses per person/$3,000 per family each calendar year.*

- 80 percent of eligible expenses until a $2,000 out-of-pocket per person/$6,000 out-of-pocket per family has been incurred each calendar year.*

- 100 percent of eligible expenses after $2,000 out-of-pocket per person/$6,000 out-of-pocket per family has been incurred each calendar year.*

Nonpreferred Provider

- 50 percent of eligible expenses until $4,000 out-of-pocket per person/$12,000 out-of-pocket per family has been incurred each calendar year.*

- 100 percent of eligible expenses after $4,000 out-of-pocket per person/$12,000 out-of-pocket per family has been incurred each calendar year.*

*Not all expenses accrue to the annual out-of-pocket maximum amount. Expenses that do not accrue to the annual out-of-pocket maximum may include, but are not limited to, the following:

- prescription medication copayments or coinsurance (the Prescription Medication Program has its own $1,000 annual out-of-pocket maximum amount);

- alternative care coinsurance;

- any coinsurance for hearing examinations or amounts over $4,000 for hearing aids;

- coinsurance amounts for infertility services; and

- any amounts over the maximum allowable charge when a nonparticipating professional provider's services are used.

Copayment/Coinsurance

This is the amount you must pay for services received as described in the SUMMARY OF BENEFITS. Copayment is a flat dollar amount. Coinsurance is a percentage of eligible charges.

Maximum Lifetime Benefit

The maximum lifetime benefit is $2,000,000 per covered member.

How Long Coverage Lasts

Each person's coverage lasts until your group's agreement with Regence BlueCross BlueShield of Oregon ends, or until the $2,000,000 lifetime maximum of benefits is used up, whichever comes first.

Restoration Of Benefits

If you or one of your insured dependents receives medical benefits under this policy, the amount of those benefits up to $25,000 will be restored each January 1 to your or your insured dependent's maximum lifetime benefit.

Stop-Loss And Out-Of-Pocket Maximum Renewal

Stop-loss and out-of-pocket maximum provisions are calculated on a calendar year basis (January 1 to December 31). This policy also renews each calendar year, therefore stop-loss and out-of-pocket maximums renew each January 1.

BENEFITS FOR PPO PLAN

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (amount you pay based on eligible charges)	NONPREFERRED PROVIDER COVERAGE (amount you pay based on eligible charges)
Hospital inpatient care	15% of semi-private room rate for unlimited days	30% of semi-private room rate for unlimited days
Medical care in skilled nursing facility in lieu of hospital	15% of semi-private room rate for up to 180 days per calendar year	30% of semi-private room rate for up to 180 days per calendar year
Hospital intensive care or isolation unit	15%	30%
Other hospital charges	15%	30%
Hospitalization for rehabilitation	30 days per calendar year at 15%	30 days per calendar year at 30%
Hospital outpatient care	15%	30%
Care in outpatient birthing center	15%	30%
Hospital emergency room**	15%	30%
Outpatient rehabilitation (refer to page 28 for limitations on this benefit)	15% (60 visits maximum per calendar year)	30% (60 visits maximum per calendar year)
Surgeon	15%	30%
Assistant surgeon	15%	30%
Anesthesiologist	15%	30%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** Emergency benefits (excluding ambulance transportation) will be reimbursed at the Preferred level as long as treatment meets the criteria of a true emergency medical condition. See page 1.

Benefits for PPO Plan *(continued)*

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (amount you pay based on eligible charges)	NONPREFERRED PROVIDER COVERAGE (amount you pay based on eligible charges)
Surgical supplies	15%	30%
Preadmission testing	15%	30%
Physician visits in hospital, home, or office for illness or injury	15%	30%
Maternity care professional services	15%	30%
Contraceptive services	15%	30%
Well-baby care	0% (see page 31)	30% (see page 31)
Immunizations	0% (see page 32)	0% (see page 32)
Durable medical equipment (we cover medically necessary durable medical equipment and supplies)	15% (see page 37)	30% (see page 37)
Therapeutic injections	15%	30%
Chemotherapy	15%	30%
Annual women's examinations	$10 per visit (see page 32)	30% (see page 32)
Routine periodic health appraisals**	0% (see page 31 for frequency schedule)	30% (see page 31 for frequency schedule)

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** Routine periodic health appraisals may not be eligible annually. See frequency schedule on page 31.

Benefits for PPO Plan *(continued)*

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (amount you pay based on eligible charges)	NONPREFERRED PROVIDER COVERAGE (amount you pay based on eligible charges)
Diagnostic x-ray and laboratory tests related to routine periodic health appraisals**	0%	30%
Diagnostic x-ray and laboratory tests (not including Pap smears and mammograms)	15%	30%
Pap smears and mammograms	0%	30%
Scan and interpretation fee for Magnetic Resonance Imaging Services	15% (see page 33)	30% (see page 33)
X-ray, radioisotopic, and radium therapy	15%	30%
Infertility services: artificial insemination (includes related or supporting x-ray and laboratory services)	50%	50%
Outpatient diabetic instruction	0%	0%
Outpatient diabetic supplies	0%	0%
Home health care (maximum 180 visits per calendar year)	15%	30%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** Routine periodic health appraisals may not be eligible annually. See frequency schedule on page 31.

Benefits for PPO Plan *(continued)*

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (amount you pay based on eligible charges)	NONPREFERRED PROVIDER COVERAGE (amount you pay based on eligible charges)
Palliative hospice care	0%	0%
Home infusion therapy	15%	30%
Treatment of mental illness		
- Inpatient	15% (see page 33)	30% (see page 33)
- Residential	15% (see page 33)	30% (see page 33)
- Outpatient	15% (see page 33)	30% (see page 33)
Treatment of alcohol and medication abuse		
- Inpatient	15% (see page 33)	30% (see page 33)
- Residential	15% (see page 33)	30% (see page 33)
- Outpatient	15% (see page 33)	30% (see page 33)
Hearing examination	15% every 12 months (see page 32)	30% every 12 months (see page 32)
Hearing aid	10% up to $4,000 maximum allowance every 4th year (see page 32)	10% up to $4,000 maximum allowance every 4th year (see page 32)
Ambulance service to the nearest hospital (up to 500 miles per calendar year) **	15% (see page 34)	30% (see page 34)
Blood or blood plasma	15%	30%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

**Your coverage pays eligible charges based on community standards for local ground transportation as determined by Regence BlueCross BlueShield of Oregon.

Benefits for PPO Plan *(continued)*

OTHER COVERED EXPENSES	Amount You Pay Based On Eligible Charges
Vision care Vision services are provided through Vision Service Plan (VSP).	Not Covered
Chiropractic care*	30%
Naturopathic care*	30%
Acupuncturist care*	30%
Prescription medications (see page 67) NOTE: There is no copayment for covered diabetic supplies obtained either at the pharmacy or through a mail order supplier.	Pharmacy (34-day supply): $5 generic; $15 preferred; Greater of $50 or 50% nonpreferred (plus difference between generic and brand for multisource brands Mail Order (90-day supply): $12.50 generic; $37.50 preferred; Greater of $125 or 50% nonpreferred (plus difference between generic and brand for multisource brands
Surgical treatment of morbid obesity	Subject to plan limitations (see page 41)

* Alternative care providers may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance. The patient is responsible for those balances.

BENEFITS FOR PPO PART-TIME AND RETIREE PLAN

THIS PLAN PAYS 50 PERCENT OF THE FIRST $1,000 OF ELIGIBLE EXPENSES INCURRED FROM PREFERRED AND NONPREFERRED PROVIDERS PER PERSON/$3,000 PER FAMILY EACH CALENDAR YEAR. BENEFITS ARE THEN PAID AS INDICATED IN THE FOLLOWING SUMMARY:

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):	NONPREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):
Hospital inpatient care	20% of semi-private room rate for unlimited days	50% of semi-private room rate for unlimited days
Medical care in skilled nursing facility in lieu of hospital	20% of semi-private room rate for up to 180 days per calendar year	50% of semi-private room rate for up to 180 days per calendar year
Hospital intensive care or isolation unit	20%	50%
Other hospital charges	20%	50%
Hospitalization for rehabilitation	30 days per calendar year at 20%	30 days per calendar year at 50%
Hospital outpatient care	20%	50%
Care in outpatient birthing center	20%	50%
Hospital emergency room**	20%	50%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** Emergency benefits (excluding ambulance transportation) will be reimbursed at the Preferred level as long as treatment meets the criteria of a true emergency medical condition. See page 1.

Benefits for PPO Part-Time and Retiree Plan *(continued)*

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):	NONPREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):
Outpatient rehabilitation (refer to page 28 for limitations on this benefit)	20% (60 visits maximum per calendar year)	50% (60 visits maximum per calendar year)
Surgeon	20%	50%
Assistant surgeon	20%	50%
Anesthesiologist	20%	50%
Surgical supplies	20%	50%
Preadmission testing	20%	50%
Physician visits in hospital, home, or office for illness or injury	20%	50%
Maternity care professional services	20%	50%
Contraceptive services	20%	50%
Well-baby care	0% (see page 31)**	50% (see page 31)
Immunizations	0% (see page 32)**	50% (see page 32)

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** These benefits are paid 100% and are not subject to the initial 50% of $1,000 requirement when services are rendered by preferred professional providers.

Benefits for PPO Part-Time and Retiree Plan *(continued)*

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):	NONPREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):
Durable medical equipment (we cover medically necessary durable medical equipment and supplies)	20% (see page 37)	50% (see page 37)
Therapeutic injections	20%	50%
Chemotherapy	20%	50%
Annual women's examinations	$10 per visit (see page 32)**	50% (see page 32)
Routine periodic health appraisals***	0% (see page 31 for frequency schedule)**	50% (see page 31 for frequency schedule)
Diagnostic x-ray and laboratory tests related to routine periodic health appraisals***	0%**	50%
Diagnostic x-ray and laboratory tests (not including Pap smears and mammograms)	20%	50%
Pap smears and mammograms	0%**	50%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** These benefits are paid 100% and are not subject to the initial 50% of $1,000 requirement when services are rendered by preferred professional providers.

*** Routine periodic health appraisals may not be eligible annually. See frequency schedule on page 31.

Benefits for PPO Part-Time and Retiree Plan *(continued)*

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):	NONPREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):
Scan and interpretation fee for Magnetic Resonance Imaging Services	20% (see page 33)	50% (see page 33)
X-ray, radioisotopic, and radium therapy	20%	50%
Infertility services: artificial insemination (includes related or supporting x-ray and laboratory services)	50%	50%
Outpatient diabetic instruction	0%	0%
Outpatient diabetic supplies	0%	0%
Home health care (maximum 180 visits per calendar year)	20%	50%
Palliative hospice care	0%	0%
Home infusion therapy	20%	50%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

Benefits for PPO Part-Time and Retiree Plan *(continued)*

TYPE OF CARE OR SUPPLIES*	PREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):	NONPREFERRED PROVIDER COVERAGE (You pay 50% of first $1,000 then amount shown below, based on eligible charges):
Treatment of mental illness		
- Inpatient	20% (see page 33)	50% (see page 33)
- Residential	20% (see page 33)	50% (see page 33)
- Outpatient	20% (see page 33)	50% (see page 33)
Treatment of alcohol and medication abuse		
- Inpatient	20% (see page 33)	50% (see page 33)
- Residential	20% (see page 33)	50% (see page 33)
- Outpatient	20% (see page 33)	50% (see page 33)
Hearing examination	15% every 12 months (see page 32)	50% every 12 months (see page 32)
Hearing aid	10% up to $4,000 maximum allowance every 4th year (see page 32)	10% up to $4,000 maximum allowance every 4th year (see page 32)
Ambulance service to the nearest hospital (up to 500 miles per calendar year)**	20% (see page 34)	50% (see page 34)
Blood or blood plasma	20%	50%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** Your coverage pays eligible charges based on community standards for local ground transportation as determined by Regence BlueCross BlueShield of Oregon.

Benefits for PPO Part-Time and Retiree Plan *(continued)*

OTHER COVERED EXPENSES	Amount You Pay Based On Eligible Charges
Vision care	Not Covered
Chiropractor care*	50%
Naturopathic care*	50%
Acupuncturist care*	50%
Prescription medications (see page 67) NOTE: There is no copayment for covered diabetic supplies obtained either at the pharmacy or through a mail order supplier.	Pharmacy (34-day supply) $10 generic 20% preferred Greater of $50 or 50% nonpreferred (plus difference between generic and brand for multi-source brands) Mail Order (90-day supply) $25 generic $62.50 preferred $125 nonpreferred (plus difference between generic and brand for multi-source brands)
Surgical treatment of morbid obesity	Subject to plan limitations (see page 41)

* Alternative care providers may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance. The patient is responsible for those balances.

WHAT KINDS OF SERVICES AND SUPPLIES ARE COVERED

NOTE: Throughout this section, the term ‘‘physician’’ means:

- doctor of medicine or osteopathy;
- podiatrist;
- a dentist (doctor of medical dentistry or doctor of dental surgery, or a denturist), but only for treatment of accidental injuries as described under the Special Dental Care benefit;
- psychologist;
- nurse practitioner;
- direct entry midwives;
- Christian Science practitioner;
- licensed counselor;
- acupuncturist*;
- naturopath*;
- chiropractor*;
- registered physical, occupational, speech, or audiological therapist;
- registered nurse or licensed practical nurse, but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services which nurses customarily bill patients;
- licensed professional counselor and licensed marriage and family therapist;
- audiologists; and
- licensed clinical social worker.

* Eligible charges for services of an acupuncturist, a naturopath, and/or a chiropractor will be paid as shown in the SUMMARY OF BENEFITS, subject to plan exclusions listed in the GENERAL EXCLUSIONS Section.

The patient must personally see the provider for the billed services in order for us to pay benefits. Each of these providers must act within the scope of a valid license.

The term ‘‘professional provider’’ does not include any other class of provider not named previously, and no benefit of the policy will be paid for their services.

Care When You Are Admitted To A Hospital Or Skilled Nursing Facility

If a physician orders you admitted to a hospital or skilled nursing facility, we will pay a percentage of the eligible charge based on the daily semi-private room charge.

The semi-private room charge normally includes the cost of meals and general nursing care. We'll also pay the percentage shown in the SUMMARY OF BENEFITS for most other hospital services and supplies that are necessary for treatment and ordinarily furnished by the hospital.
If your physician orders you hospitalized in an isolation area or intensive care unit, we'll pay the percentage of the charge listed in the SUMMARY OF BENEFITS.

Please note, skilled nursing facility admissions are limited to a maximum of 180 days per admission.

Preauthorization
We strongly recommend that you or your enrolled dependent contact our Preauthorization Department before receiving skilled nursing facility care. The Preauthorization provision in the CONTRACT AND CLAIMS ADMINISTRATION Section describes the preauthorization process.

Rehabilitative Hospital Care

Eligible charges are limited to 30 days of rehabilitative care each calendar year for an inpatient stay in a hospital that has a specialized department for providing such care. However, for treatment required following head or spinal cord injury, or for treatment of a cerebral vascular accident (stroke), the limit may be increased to 60 days per calendar year. These benefits will continue only as long as you or your insured dependent requires the full rehabilitative team approach and services can only be provided on an inpatient basis. In order to be an eligible charge, rehabilitative services must be part of a physician's formal written program to improve and restore lost function following illness or injury. The services must be consistent with the condition that is being treated. We will cover neurodevelopmental therapy for children age six years and under when such services are for maintenance of a child whose condition would otherwise deteriorate without the service.

Newborn Nursery Care

We cover routine nursery care of a well-newborn infant under the newborn's own coverage. However, this benefit does not cover professional provider charges for well-baby care except as may be specifically provided elsewhere in the contract, nor does it cover pediatric standby charges for vaginal delivery.

Please Note: Benefits for the covered expenses of an ill or injured newborn are paid under the other provisions of this contract.

If Benefits Under This Contract Change
If benefits under this contract change while you or an enrolled dependent is in the hospital, covered expenses will be based on the benefits in effect when the stay began. The same rule applies to stays in other kinds of medical facilities.

Care In A Special Facility

Your inpatient hospital benefit can be used for services provided in an approved non-hospital facility that offers specialized care, such as a birthing center. We pay benefits for eligible charges in these facilities as an alternative to your inpatient hospital benefit.

Your Benefits Won't Change While You Are Hospitalized

If your plan's benefits change while you are in the hospital, we'll cover your entire hospital stay at the level of benefit that was in effect when you were admitted. The same rule applies to stays in other kinds of medical facilities.

Hospital Outpatient Care (Other Than Emergency Room)

We will pay eligible charges as listed in the SUMMARY OF BENEFITS for eligible services and supplies you receive in the outpatient department. Examples include:

- surgery; and
- x-ray, radium, and radioisotope therapy.

Outpatient Rehabilitation

We cover up to 60 sessions each calendar year for rehabilitative services provided by a professional provider to a patient who is not confined to a hospital. Rehabilitative services are physical, occupational, speech, or audiological therapy services necessary to restore or improve lost function caused by illness or injury. Rehabilitative services also include neurodevelopmental therapy for children up to age 18 when such services are for maintenance of a child whose condition would otherwise significantly deteriorate without the service. In order for us to cover any therapy, it must be part of a written plan of treatment prescribed by a physician.

Eligible charges do not include more than one session of any one kind of rehabilitation on one day. Nor do they include rehabilitative care provided in the patient's home and covered under the Home Health Care benefit, recreational or educational therapy, self-help or training, or treatment of psychotic or psychoneurotic conditions.

Physician Bills For Surgery

The surgery benefit applies to the physician's fee for operations as well as for treatment of dislocations and fractures.

Eligible charges for surgery (operative and cutting procedures), including treatment of fractures, dislocations, and burns are covered as follows:

- the primary surgeon;
- the assistant surgeon;
- the anesthesiologist or certified anesthetist;
- surgical supplies, such as sutures and sterile set-ups, when surgery is performed in the physician's office; and
- colonoscopy, sigmoidoscopy, and barium enemas.

When more than one surgical procedure is performed through the same incision during a single operative session, benefits will be payable on only the major procedure.

For bilateral procedures or procedures performed through different incisions in a single operative session, we will pay as follows:

- for the first procedure, the covered expense will be paid as stated in the SUMMARY OF BENEFITS;
- for the second procedure, the covered expense will be reduced by 50 percent and the remainder paid as stated in the SUMMARY OF BENEFITS; and
- for any subsequent procedures, the covered expense will be reduced by 75 percent and the remainder paid as stated in the SUMMARY OF BENEFITS.

Assistant Surgeon

Your coverage will pay eligible charges shown in the SUMMARY OF BENEFITS for the services of an assistant surgeon.

Anesthesiologist

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS for the services of a professional anesthesiologist.

Surgical Supplies

Your plan pays eligible charges as shown in the SUMMARY OF BENEFITS for surgical supplies, such as suture kits and sterile setups.

Physician Visits In The Hospital

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS for visits by your physician during your hospital or skilled nursing facility stay unless you are recuperating from surgery. If that is the case, your doctor's visits will probably be included in his or her surgical fee. Visits by a consulting specialist will be paid for eligible charges as shown in the SUMMARY OF BENEFITS.

Physicians' Home And Office Visits

Your coverage provides benefits for physicians' home and office visits for eligible charges shown in the SUMMARY OF BENEFITS.

Therapeutic Injections

We cover therapeutic injections, such as allergy shots, when given in a professional provider's office, except when comparable results can be obtained safely with home self-care or through oral use of a prescription medication.

Vitamin and mineral injections are not covered unless medically necessary for treatment of a specific medical condition.

Covered expenses under this therapeutic injection benefit apply only to administrative charges. Medicine charges for serum, vaccine, or mixture in connection with the therapeutic injection are not part of this benefit, but may be paid under the other provisions of the policy, subject to any deductible and/or coinsurance.

Chemotherapy Medications/Infusion

We cover chemotherapy medication which requires infusion, not subject to the deductible or coinsurance. Charges for the administration of such medication will be reimbursed under the applicable professional or facility benefit. Oral chemotherapy medication is covered under the prescription medication benefit of this contract.

Acupuncture, Chiropractic, And Naturopathic Care

Acupuncture therapy, care received from chiropractors, and/or naturopathic care may be approved for services within the scope of the provider's license. Eligible providers of acupuncture are doctors of medicine or osteopathy or registered acupuncturists.

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS.

Coinsurance amounts you are responsible for do not apply toward the annual out-of-pocket maximum amount.

Exclusions
Nutritional supplements are not covered (see Vitamins And Fluoride exclusion in the GENERAL EXCLUSIONS Section). Procedures and tests that are not medically necessary and/or are investigational are not covered (see Experimental Or Investigational Services provision of the GENERAL EXCLUSIONS Section). Diagnoses which are considered plan exclusions (see GENERAL EXCLUSIONS Section) such as obesity, smoking cessation, are ineligible for coverage.

Preventive Care Benefits

Preventive care benefits are provided under four categories: periodic screening, well-baby care, routine periodic health appraisals, and immunizations. The benefit we pay is based upon the diagnosis that the doctor puts on your bill. If the diagnosis shows that the purpose of your care was preventive, then this benefit will be applied instead of any other benefit. If the diagnosis shows that care was for treatment of an illness or injury, regular policy benefits will be applied instead of preventive care benefits. If a claim has two diagnoses, we will pay claims on the diagnosis that will give you the higher benefit. However, we will pay benefits based on one diagnosis only.

Well-Baby Care Including Periodic Screening
We will pay eligible charges as listed in the SUMMARY OF BENEFITS for routine periodic health appraisals and periodic screening of your insured dependent children under two years of age. **For insured dependents two years of age and over, see Routine Periodic Health Appraisals information**.

We will pay for standard hospital exams at birth plus eight well-baby visits the first two years of life. Examinations include related laboratory tests and x-ray examinations.

Routine Periodic Health Appraisals
We will pay eligible charges as listed in the SUMMARY OF BENEFITS for routine periodic health appraisals based on a rolling schedule that follows:

Age 2 - 18	Once every 36 months
Age 19 - 34	Once every 60 months
Age 35 - 59	Once every 24 months
Age 60 and over	Once every 12 months

Routine periodic health appraisals include routine physical examinations, physical examinations required for school and/or to participate in athletics according to the schedule noted above, physician charges, and related laboratory and x-ray tests (handling fees are not covered).

Included in the above examinations are prostate cancer screening examinations including a digital rectal examination and a prostate-specific antigen test for men age 50 or older, or as determined by the treating physician for men of any age who are at high risk for prostate cancer.

Commercial Driver's License Examinations
Employment related Commercial Driver's License (CDL) examinations for the insured state employee only are covered under this routine periodic health appraisal provision. This benefit includes the urinalysis required with the initial examination, but does not include additional urinalysis testing that may be required by the employer.

Annual Women's Examinations
Annual women's breast, pelvic, and Pap smear examinations are covered once every calendar year. However, more frequent examinations will be covered if medically necessary and recommended by the woman's health care provider. By breast examination, we mean a complete and thorough exam of the breast for women age 18 or older, including but not limited to a clinical breast examination, performed by a health care provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer. Except for Pap smears and mammograms, which are paid according to this Annual Women's Examinations benefit, any covered expenses for laboratory and x-ray procedures that accompany the examination will be covered according to the Diagnostic X-Rays And Laboratory Services provision. Note that routine mammographic breast screening will be covered according to the following schedule:

- Age 35 - 40, one mammogram in that period; and
- Age 40 and above, one mammogram per calendar year.

More frequent mammograms will be covered if medically necessary and recommended by the woman's health care provider.

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS.

Immunizations
We will pay as listed in the SUMMARY OF BENEFITS for immunizations and inoculations regardless of your or your insured dependent's age. Immunizations for purposes of travel are eligible.

Hearing Examinations And Hearing Aids
We will pay eligible charges as listed in the SUMMARY OF BENEFITS for one hearing examination every 12 months. We will also allow for the purchase of hearing aids once every four years up to a maximum of $4,000. The benefit period will be calculated using the same four calendar year period for all PEBB members beginning January 1, 2008, and renews every 4 years. The $4,000 is an accumulative amount over this period and is not a one time benefit.

Exclusions
Routine examinations and immunizations for the purpose of employment, insurance, or licensing are not covered except CDL coverage as described above.

Mental Health And Chemical Dependency Services

We will cover mental health and chemical dependency services under the various sections of the contract the same as illness. Covered expenses for residential care for treatment of mental health conditions, however, is limited for you and for each of your enrolled dependents to 45 days per calendar year.

Women's Health And Cancer Rights

If you or your insured dependent is receiving benefits in connection with a mastectomy and you or your insured dependent, in consultation with the attending physician, elects breast reconstruction, we will provide coverage for:

reconstruction of the breast on which the mastectomy was performed;

surgery and reconstruction of the other breast to produce a symmetrical appearance; and

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

Reconstruction benefits are subject to the same provisions as any other benefit provided under this plan (e.g., coinsurance, and annual out-of-pocket maximums).

Diagnostic X-Rays And Laboratory Tests

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS for diagnostic x-rays and laboratory tests ordered by a physician. The x-rays or tests must be related to the treatment of an illness or injury, except that we will pay the laboratory charges for administration of the following diagnostic tests when ordered by a physician:

- Pap smears*;
- mammograms*; and
- hemocult

* Eligible charges for Pap smears and mammograms are paid at the percentage shown in the SUMMARY OF BENEFITS.

Preadmission testing performed on an outpatient basis is covered in full.

Magnetic Resonance Imaging (MRI) is an imaging device used as a diagnostic tool for certain internal conditions. Benefits for the eligible charges of this service will be provided just as if this policy had no Preferred provider provision unless the facility or professional provider rendering the service has a special Preferred MRI contract with us. In that case, benefits will be paid at the Preferred provider level.

X-Ray, Radium, And Radioisotope Therapy

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS for x-ray, radium, and radioisotope therapy. Eligible charges for these therapies other than for professional services are also covered under the hospital outpatient benefit of this plan.

Ambulance Benefits

Your coverage pays eligible charges based on community standards as determined by Regence BlueCross BlueShield of Oregon for local ground transportation by state certified ambulance up to 500 miles per calendar year. This is for transportation to the nearest hospital that has facilities to give the necessary treatment. Certified air ambulance transportation will be covered if it is medically necessary, based on usual and customary or reasonable charges. Emergency benefits, excluding ambulance transportation, will be reimbursed at the Preferred level as long as treatment meets the criteria of a true emergency medical condition (see page 1).

We will send our payment for covered expenses directly to the ambulance service provider, unless you have already paid them, in which case we will pay you directly.

Infertility Services

Covered infertility services will be limited to artificial insemination, including services related to or supporting artificial insemination, when medically necessary, subject to a 50 percent coinsurance. Infertility medications, in vitro and in vivo fertilization, including services related to or supporting in vitro fertilization, GIFT, ZIFT, reversals of voluntary sterilization and procedures we determine to be experimental or investigational in nature will not be covered.

Coinsurance amounts you are responsible for do not apply toward the annual out-of-pocket maximum amount.

Outpatient Diabetic Instruction

(This benefit is not subject to any copayment or coinsurance provisions of the policy.)

Services and supplies used in outpatient diabetes self-management programs as described here are covered under this policy when they are provided by a health care professional or by a credentialed or accredited diabetic education program for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes. For the purposes of this benefit, a health care professional means a physician, registered nurse, nurse practitioner, certified diabetes educator, or licensed dietitian with demonstrated expertise in diabetes. We will waive any required copayment and pay 100 percent of the billed charges for one outpatient diabetes self-management program of assessment and training after diagnosis, including up to three hours per year of assessment and

training when there is a material change of condition. Diabetic medications, supplies, and equipment not included in the charge for the outpatient diabetes self-management program are covered elsewhere under the policy.

The benefits paid for diabetic instruction under this policy do not apply to the annual out-of-pocket maximum.

Maternity Benefit

We will pay eligible charges shown in the SUMMARY OF BENEFITS for maternity care.

To the extent this policy provides coverage for maternity care, we will not limit benefits for the mother and her newborn's length of inpatient stay (beginning with the time of admission) to less than 48 hours for a normal delivery and 96 hours for a cesarean section. However, the attending physician in consultation with the mother may decide on an early discharge. Such hospitalization does not need to be preauthorized.

Contraceptive Services

Eligible charges for certain professional provider contraceptive services are covered, including but not limited to vasectomy, tubal ligation, and insertion of IUD or Norplant (the actual prescription contraceptive may be covered elsewhere under the policy).

Home Health Care

Home health care services and supplies as described in this section when provided by a home health care agency for a patient who is homebound. By ''homebound'' we mean that the condition of the patient is such that there exists a general inability to leave home. If the patient does leave home, the absences must be infrequent, of short duration and mainly for receiving medical treatment. A home health care agency is a licensed public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy in the patient's home.

We will cover up to 180 intermittent medically necessary home health care visits per calendar year. A ''visit'' must be for intermittent care of not more than two hours in duration. Home health care services must be ordered by a physician and be provided by and require the training and skills of one of the following providers:

- a registered or licensed practical nurse;
- a physical, occupational, speech, or respiratory therapist; or
- a licensed social worker.

Note that this home health care benefit does not include home care services provided as part of a hospice treatment plan or ongoing hourly shift care in the home. See the ''Palliative Hospice Care'' benefit for a description of those benefits.

Maximum visits -- There is a two-visit maximum allowed in any one day for the services of a registered or licensed practical nurse. The maximum visits allowed for each other classification of home health care provider is one visit per day.

Preauthorization -- If home health care is provided by an agency other than a contracting agency, we strongly urge you to contact our Preauthorization Department before receiving such care. See ‘‘Preauthorization’’ subsection for a description of the preauthorization process.

Special Dental Care

Your plan covers treatment of accidental injury to natural teeth or a fractured jaw if the treatment is given by a physician or dentist. Natural teeth are healthy teeth, teeth that have been restored to a sound condition, or teeth that have been replaced by a fixed or removable partial denture or bridge. Diagnosis must be made within six months of the injury and benefits will be available for treatment provided within 12 months of the injury except when completion is delayed due to healing time following medically necessary surgery. The injury must be one that occurred while you or your insured dependent was enrolled under this policy. For purposes of this Special Dental Care benefit, injury does not include accidents that occur during eating, biting, or chewing.

Orthognathic surgery is not reimbursable as a benefit for temporomandibular joint (TMJ). Because TMJ is not directly related to the tooth or supporting services, we consider TMJ to be medical treatment. TMJ medical therapy services are limited to the examination, x-rays, physical therapy, TMJ splint, and surgical procedures appropriate for TMJ. Services directly related to the tooth or supporting structure are considered dental procedures even when provided to a patient diagnosed with TMJ. Examples of these services include occlusal equilibration, full mouth reconstruction, orthodontia services, and dentures.

Medications

Your coverage pays for the following medically necessary medications when required by standard treatment practices for the treatment of an illness or injury:

- nonprescription elemental enteral formula for home use when ordered by the patient’s physician as long as:
  - the formula is medically necessary for the treatment of severe intestinal malabsorption; and
  - the formula comprises the sole or an essential source of the patient’s nutrition;
- **medical foods**, such as PKU formula, for treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which there exists medically standard methods of

diagnosis, treatment, and monitoring. Medical foods means foods that are:

- formulated to be consumed or administered enterally under the supervision of a physician;
- specifically processed or formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts;
- for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients, or have other specific nutrient requirements as established by medical evaluation; and
- essential to optimize growth, health, and metabolic homeostasis.

Charges for diagnosis, treatment, and monitoring of the disorder requiring medical foods are covered elsewhere in the policy.

Durable Medical Equipment And Supplies

Your coverage pays eligible charges as shown in the SUMMARY OF BENEFITS for medically necessary artificial eyes, limbs, and appliances when required by standard treatment practices.

The term durable medical equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is appropriate for use in the insured person's home. Examples include oxygen equipment and wheelchairs. Durable medical equipment may not serve solely as a comfort or convenience item.

Deluxe equipment with mechanical or electrical features such as motor-driven wheelchairs and chair lifts, usually serve as convenience items. They are generally not eligible for benefits unless medical necessity can be established from diagnosis and treatment. However, if medical necessity is established and preauthorization is granted, we will cover motor-driven wheelchairs and seat-lift mechanisms.

Environmental modifications such as wheelchair ramps or elevators for the home, and devices and equipment used for environmental control or to enhance the environmental setting such as air conditioners, humidifiers, air filters, and portable whirlpool pumps, are not considered durable medical equipment under this policy and are not covered.

We cover the following durable medical equipment and supplies:

- casts, trusses, limb or back braces, crutches, and orthotics (must be custom made; casting charges included);
- artificial limbs, prosthetics, orthotics, eyes, and maxillofacial prosthetic devices (maxillofacial prosthetic devices must be medically necessary for the restoration and management of head and facial

structures that cannot be replaced by living tissue, are defective due to disease, trauma, or developmental deformity to control or eliminate infection and pain and restore facial configuration and function);

- rental (not to exceed the reasonable purchase price if the item can be purchased) of a wheelchair, hospital-type bed, or other durable medical equipment. If your physician thinks you will need the equipment long enough for the rental costs to exceed the purchase price, your coverage will be applied toward the purchase price; and

- other supplies including:

  - contraceptive devices;

  - nonself-administered injectable medications; and

  - outpatient diabetic supplies, such as glucose monitors, insulin pumps, infusion sets and reservoir syringes

- up to a maximum 90-day supply at any one time.

Palliative Hospice Care

We cover palliative hospice care as described in this section when provided by a Medicare or state certified hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day, that uses an interdisciplinary team of personnel to provide palliative and supportive services to a patient-family unit experiencing a life threatening disease with a limited prognosis. A patient-family unit is the patient and any family members who are caring for the patient. These services include acute, respite and home care to meet the physical, psychosocial, and special needs of a patient-family unit during the final stages of illness and dying.

Palliative hospice care means medical services provided by a hospice care program that alleviate symptoms or afford temporary relief of pain but are not intended to effect a cure. If palliative hospice care is elected by the patient, then he or she is not eligible for any other benefits for active treatment of the terminal illness.

In order to qualify for palliative hospice care, the patient's physician must certify that the patient is terminally ill with a life expectancy of six months or less if the illness runs its normal course.

Levels of Care -- Palliative hospice care benefits are limited to the following treatment settings:

- routine home care;

- continuous home care;

- inpatient respite care; and

- inpatient hospice care.

Additionally, eligible charges for palliative hospice care include the following when provided under one of the previously listed levels of care:

- durable medical equipment;
- medications, including infusion therapy;
- care by any member of the hospice interdisciplinary team; and
- any other supplies required for the palliative hospice care.

Exclusions -- In addition to the exclusions listed in the GENERAL EXCLUSIONS Section, expenses for the following services and supplies are not covered:

- care that is not palliative;
- services provided to other than the terminally ill patient, including charges for bereavement counseling for the insured employee, retiree, or insured dependents, except when provided and billed by the hospice care program;
- pastoral and spiritual counseling;
- services performed by family members or volunteer workers;
- homemaker or housekeeping services, except by home health aides as ordered by a hospice treatment plan;
- supportive environmental materials, including but not limited to, hand rails, ramps, air conditioners and telephones;
- normal necessities of living, including but not limited to food, clothing and household supplies;
- food services, such as ‘‘Meals on Wheels’’;
- separate charges for reports, records or transportation;
- legal and financial counseling services;
- services and supplies not included in a hospice treatment program or not specifically set forth as a hospice benefit; and
- services and supplies in excess of the stated maximums or services and supplies provided more than six months after the initial date of covered palliative hospice care, unless specifically approved by us.

Preauthorization -- If palliative hospice care is provided by an agency other than a contracting agency, we strongly urge you to contact our

Preauthorization Department before receiving such care. See ‘‘Preauthorization’’ subsection for a description of the preauthorization process.

Home Infusion Therapy

We cover home infusion therapy services and supplies as described in this section when they are medically necessary and are required for administration of a home infusion therapy regimen when ordered by a physician and provided by an accredited home infusion therapy agency.

Limited Services -- Home infusion therapy is limited to the following:

- aerosolized pentamidine;
- intravenous medication therapy;
- total parenteral nutrition:
- enteral nutrition (under certain circumstances);
- hydration therapy;
- intravenous/subcutaneous pain management;
- terbutaline infusion therapy;
- SynchroMed pump management;
- IM/SC bolus/push medications; and
- blood product administration.

Additionally, eligible charges include only the following medically necessary services and supplies:

- solutions, medications, pharmaceutical additives;
- pharmacy compounding and dispensing services;
- durable medical equipment;
- ancillary medical supplies;
- nursing services associated with:
  - patient and/or alternative care giver training;
  - visits necessary to monitor intravenous therapy regimen;
  - emergency services;

- administration of therapy; and

- collection, analysis and reporting of the results of laboratory testing services required to monitor response to therapy.

Preauthorization -- If home infusion therapy is provided by an agency other than a contracting agency, we strongly urge you to contact our Preauthorization Department before receiving such therapy. See ''Preauthorization'' subsection for a description of the preauthorization process.

Surgical Treatment Of Morbid Obesity

The plan will only cover the Roux-en-Y gastric bypass and Laparoscopic Adjustable Gastric Banding (Lap-Band) for the treatment of morbid obesity, and only when the criteria defined below are met. No other surgical procedures are covered by the plan, including, but not limited to, other gastric banding, vertical banded gastroplasty, mini-gastric bypass (gastric bypass using a Billroth II type of anastomosis), distal gastric bypass (long-limb gastric bypass), biliopancreatic bypass, and biliopancreatic bypass with duodenal switch.

The Roux-en-Y gastric bypass and complications as a result of this procedure may be covered for the treatment of morbid obesity when surgery and all related pre- and post-surgical care is performed in a Center of Excellence recognized by Regence BlueCross BlueShield of Oregon for the performance of such a procedure and when all of the following criteria are met:

1. BMI $\geq$ 35mg/k² with a diagnosis of diabetes; or BMI 40mg/k² with any comorbid condition; or BMI $\geq$ 50mg/k² with or without comorbid conditions.

2. A presurgical work-up is completed that includes all of the following:

   - dietary counseling and education;

   - medical evaluation;

   - psychological evaluation.

3. Weight loss of >5% over the 6 months prior to surgery.

LIMITATIONS APPLICABLE TO YOUR PLAN

A few limitations (affecting benefits for medications, maternity care, and nursing services, for instance) have already been listed. In addition, there are several general limitations that apply to your plan. They are described in the following paragraphs.

Biofeedback Therapy

Eligible charges for biofeedback therapy services are limited to treatment of tension headaches or migraine headaches.

Transplants

Benefits for services and supplies (including medications) rendered in connection with a transplant, including pretransplant procedures such as ventricular assist devices (VADs), organ or tissue harvesting (donor costs), post-operative care (including antirejection medication treatment), and transplant related infusion chemotherapy for cancer are limited as described here.

A covered transplant means a medically necessary transplant of one of the following organs or tissues only and no others:

- heart;
- heart/lung or lung;
- liver;
- kidney;
- pancreas;
- small bowel;
- small bowel/liver;
- autologous hematopoietic stem cells whether harvested from bone marrow or peripheral blood when determined to be medically necessary;
- allogeneic or syngeneic hematopoietic stem cells whether harvested from bone marrow, peripheral blood, or from any other source when determined to be medically necessary; and
- other transplants determined by us to be a medically necessary transplant since this booklet was issued. You may obtain a copy of any current transplant medical policy by contacting our Customer Service Department or over the internet at www.or.regence.com.

Donor costs means all costs, direct and indirect (including program administration costs), incurred in connection with:

- medical services required to remove the organ or tissue from either the donor's or the self-donor's body;
- preserving it;
- transporting it to the site where the transplant is performed; and
- related and unrelated donor search costs.

A **transplant** means a procedure or a series of procedures by which an organ or tissue is either:

- removed from the body of one person (called a donor) and implanted in the body of another person (called a recipient); or
- removed from and replaced in the same person's body (called a self-donor).

For purposes of this limitation, the term ''transplant'' includes a ventricular assist device (VAD) when used as a bridge to a heart transplant for a patient who is suffering from severe congestive heart failure, is in imminent risk of dying before a heart is available, and has been approved as a heart transplant candidate. In addition, in treatment of cancer, the term ''transplant'' includes any infusion chemotherapy and related course of treatment which the transplant supports.

For purposes of this limitation, the term ''transplant'' does not include transplant of blood or blood derivatives (except hematopoietic stem cells), or cornea. These services are considered as nontransplant related and are covered elsewhere in the policy.

Benefits
Benefits for a Covered Transplant are payable as follows:

Facility Benefits. We will waive any otherwise applicable coinsurance of the policy and pay 100 percent of the Contracted Amount for Facility Transplant Services for a Covered Transplant performed at a Contracting Transplant Facility. Payments of the Contracted Amount at 100 percent do not accumulate toward the stop-loss amount (the point at which coinsurance is no longer payable) under the policy.

Payments of the Contracted Amount at 100 percent do not accumulate towards the annual out-of-pocket maximum amount (the point at which coinsurance is no longer payable) under the policy.

We pay 60 percent of reasonable charges towards the cost of Facility Transplant Services for a Covered Transplant performed at other than a Contracting Transplant Facility. Any deductible amount under the contract shall apply but the percentage of payment (60 percent) will remain the same

throughout the calendar year. These payments do not accumulate toward the stop-loss amount under the policy.

The exception to the above facility benefits payment schedule is when the Covered Transplant is for a ventricular assist device (VAD), in which case we pay facility expenses according to the benefits for facilities under the policy.

Professional Provider Benefits. We will pay for Professional Provider Transplant Services according to the benefits for professional providers under the policy.

Benefits for Donor Costs. If the recipient or self-donor is insured under this policy, we will pay up to a maximum of $8,000 per Covered Transplant for Donor Costs. If the donor is insured under this policy and the recipient is not, we will not pay toward Donor Costs. Complications and unforeseen effects of the donation will be covered as any other illness under the terms of the policy if the donor or self-donor is insured under the policy.

Benefits for Anti-Rejection Medications. For anti-rejection medications following the Covered Transplant, we will pay according to the benefits for prescription medications, if any, under the policy.

Limited Waiver of Policy Maximum Benefit. If the expenses of a Transplant at a Contracting Transplant Facility would cause an insured person to exceed his or her lifetime maximum benefit under the policy, we will waive the lifetime limit to the extent such expenses for Facility and Professional Provider Transplant Services and Donor Costs exceed the limit. This waiver will not apply to the cost of anti-rejection medications, a Transplant at a noncontracting facility or to any subsequent Transplants.

Preauthorization
All transplant procedures must be preauthorized for type of transplant and be medically appropriate according to criteria established by us.

All transplant procedures must be preauthorized for type of transplant and be medically necessary according to criteria in The Regence Group medical policy.

Preauthorization is a part of the benefit administration of the policy and is not a treatment recommendation. The actual course of medical treatment you or your insured dependent chooses remains strictly a matter between you or your insured dependent and your or your insured dependent's physician.

Preauthorization Procedures
To preauthorize a transplant procedure, your or your insured dependent's physician must contact our Preauthorization Department before the transplant admission. Preauthorization should be obtained as soon as possible after you or your insured dependent has been identified as a possible transplant candidate. See the Preauthorization provision in the ELIGIBLE CHARGES Section for a description of the preauthorization process.

Only written approval from us on a proposed transplant will constitute preauthorization. If time is a factor, preauthorization will be made by telephone followed by written confirmation.

24-Month Exclusionary Period
No benefits for Covered Transplants will be payable during the first 24 months an individual is insured under this policy except as follows:

- the 24-month exclusion period will not apply if the insured person or self-donor has been continuously covered under this policy since birth; or

- we will reduce the duration of the 24-month exclusion period by the amount of your or your insured dependent's combined periods of prior creditable coverage if the most recent period of creditable coverage ended within 63 days of your or your enrolled dependent's enrollment date. Creditable coverage means any of the following coverages:

- group coverage (including FEHBP and Peace Corp);

- individual coverage (including student health plans);

- Medicaid;

- Medicare;

- CHAMPUS/Tricare;

- Indian Health Service or tribal organization coverage;

- plans of a state, the US, a foreign country, or a political subdivision of one of these;

- state high risk pool coverage; and

- public health plans.

Prior creditable coverage is determined separately for each insured person. However, if benefits for the transplant would not have been payable under the previous coverage for any reason, no credits for such prior creditable coverage will be given under this policy toward the 24-month exclusion period. The insured person is responsible for furnishing evidence of the terms of transplant coverage under the previous coverage.

Exclusions
In addition to the exclusions listed in the GENERAL EXCLUSIONS Section, we will not pay for the following:

- any transplant procedure that has not been preauthorized;

- any transplant performed outside of the United States;

- purchase of any organ or tissue;

- donor or organ procurement services and costs incurred outside the United States, unless specifically approved by us;

- donation related services or supplies provided to an insured donor if the recipient is not insured under this policy and eligible for Transplant benefits. This exclusion does not apply to complications or unforeseen infections resulting from the donation of tissue;

- services or supplies for any Transplant not specifically named as covered including the Transplant of animal organs or artificial organs; and

- infusion chemotherapy with autologous, allogeneic or syngeneic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered.

GENERAL EXCLUSIONS

We will not pay for the following:

Treatment Prior To Enrollment: Services or supplies you or an insured dependent received before you were first insured by this policy.

Treatment After Insurance Ends: Services or supplies you or an insured dependent receives after your insurance coverage under this policy ends. The only exception is that when you or an insured dependent is in the hospital on the day the insurance ends, we will continue to pay toward eligible charges for that hospitalization until your discharge from the hospital or your benefits have been exhausted, whichever comes first.

Services Provided By A Member Of Your Immediate Family

Treatment Not Medically Necessary: Services or supplies that are not medically necessary for the treatment of an illness or injury (See page 5).

The Following Services And Supplies: We do not cover the following services and supplies:

- routine tests and screening procedures, except as specifically listed (see page 31);
- treatment for corns and calluses, removal of nails (except complete removal), and other routine foot care;
- eye examinations, the fitting, provision or replacement of eyeglasses;
- orthoptics (eye exercises);
- telephone consultations that are not in conjunction with the Free & Clear Quit For Life, CareEnhance or AdviCare Programs, missed appointments, completion of claim forms, or completion of reports requested by Regence BlueCross BlueShield of Oregon in order to process claims;
- self-help or training programs including, but not limited to court-ordered treatment, those to provide general fitness, wilderness experience programs; also included are those programs that teach a person how to use durable medical equipment (not including prosthetics or orthotics) or how to care for a family member;
- instruction programs, including, but not limited to, those to learn to self-administer medications or nutrition, except as specifically provided for under the ‘‘Outpatient Diabetic Instruction’’ benefit of this policy;
- appliances or equipment primarily for comfort, convenience, cosmetics, environmental control, or education, such as air

conditioners, humidifiers, air filters, whirlpools, heat lamps, or tanning lights;

- private duty nursing, including ongoing hourly shift care in the home, or personal items such as telephones, televisions, and guest meals in a hospital or skilled nursing facility; and

- speech therapy unless it is to improve or restore lost function due to illness or injury.

Treatment For Obesity Or Weight Control: Except as specifically provided under the Surgical Treatment Of Morbid Obesity provision (page 41). This exclusion includes any treatment of obesity and complications related to non-covered medical and surgical treatments of obesity, even if you or your insured dependent has other medical conditions related to or caused by obesity. Exclusions include, but are not limited to, diet programs except as specifically provided under the Surgical Treatment of Morbid Obesity provision, exercise programs, behavior modification programs, hypnosis, biofeedback, neurolinguistic programming, guided imagery, and other forms of relaxation training as well as subliminal suggestion used to modify eating behavior.

Surgery To Alter Refractive Character Of The Eye: Surgical procedures which alter the refractive character of the eye, including, but not limited to, radial keratotomy, keratomileusis (LASIK), keratoprosthesis, and other surgical procedures of the refractive keratoplasty type. Additionally, reversals or revisions of surgical procedures which alter the refractive character of the eye and complications of all of these procedures are excluded.

Orthodontic Treatment

Massage Or Massage Therapy: Except as may be provided by a physical therapist or licensed chiropractor. Massage therapists are not eligible providers.

Orthopedic Shoes Or Arch Supports

Cosmetic/Reconstructive Services And Supplies: Services and supplies (including medications) rendered for cosmetic or reconstructive purposes, including complications resulting from cosmetic or reconstructive surgery, except as follows:

- if the surgery is performed to correct a functional disorder or as the result of an accidental injury;

- if the surgery is performed for correction of congenital anomalies in children under age 18; or

- the surgery is related to breast reconstruction following a mastectomy necessary because of illness or injury in accordance with the Women's' Health And Cancer Rights benefit.

‘‘Cosmetic’’ means services and supplies that are applied to normal structures of the body primarily for the purpose of improving or changing appearance or enhancing self-esteem.

‘‘Reconstructive’’ means services, procedures and surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

Orthognathic Services: Repair, surgical alteration, or reconstruction of the upper or lower jaw in the absence of significant dysfunction, including but not limited to when used for altering or improving bite or for improvement of appearance. However, orthognathic services may be covered if the services are medically necessary because of significant dysfunction due to illness, injury, congenital anomaly, or developmental anomaly.

Orthognathic surgery is not reimbursable as a benefit for temporomandibular joint (TMJ). Because TMJ is not directly related to the tooth or supporting services, we consider TMJ to be medical treatment. TMJ medical therapy services are limited to the examination, x-rays, physical therapy, TMJ splint, and surgical procedures appropriate for TMJ. Services directly related to the tooth or supporting structure are considered dental procedures even when provided to a patient diagnosed with TMJ. Examples of these services include occlusal equilibration, full mouth reconstruction, orthodontia services, and dentures.

Infertility Medications, In Vitro and In Vivo Fertilization: Including services related to or supporting in vitro fertilization, reversal of sterilization procedures, or GIFT and ZIFT procedures.

Dental Examinations And Treatments: Except as specifically provided in the ‘‘Special Dental Care’’ and/or, if applicable, the ‘‘Covered Dental Expenses’’ or ‘‘Dental Benefits’’ section of the policy. For the purposes of this exclusion, the term ‘‘dental examinations and treatment’’ means services or supplies provided to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures, including services or supplies rendered to repair defects which have developed because of tooth loss and services or supplies rendered to restore the ability to chew.

Physical Exercise Programs: Even though they may be prescribed for a specific condition.

Counseling Or Treatment In The Absence Of Illness: For example, educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; EAP services; wilderness programs; premarital or marital counseling; 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).

Sexual Dysfunction: Services and supplies (including drugs) for or in connection with sexual dysfunction regardless of cause, except for counseling services provided by covered, licensed mental health practitioners.

Sexual Reassignment Treatment and Surgery: Treatment, surgery or counseling services for sexual reassignment.

Mental Health Treatment For Certain Conditions: We will not cover treatment of paraphilias no matter the age of the enrollee. Additionally, we 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. By "V code," we mean diagnosis codes as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR) that describe 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.

Custodial Care: Including routine nursing care and rest cures; and hospitalization for environmental change.

Developmental/Learning Disabilities: Developmental and learning disabilities for your insured dependent age 18 years or older.

Counseling Or Treatment In The Absence Of Illness: Including individual or family counseling or treatment for marital, social, behavioral, family, occupational, or religious problems; or treatment of ‘‘normal’’ transitional response to stress.

Experimental Or Investigational Services: Treatments, procedures, equipment, medications, devices, and supplies (hereafter called services) which are, in our judgment, experimental or investigational for the specific illness or injury of the insured employee or insured family member receiving services are excluded. Services which support or are performed in connection with the experimental or investigational services are also excluded. For purposes of this exclusion, experimental or investigational services include, but are not limited to, any services which at the time they are rendered and for the purpose and in the manner they are being used:

- have not yet received final US Food and Drug Administration (FDA) approval for other than experimental, investigational, or clinical testing. However, if a medication is prescribed for other than its FDA approved use and the medication is recognized as effective for the use for a particular diagnosed condition, benefits for the medication when so used will not be excluded under this exclusion. To be considered effective for other than its FDA approved use, the Oregon Health Resources Commission must have determined that the medication is effective for the treatment of that condition; or

- are determined by us to be in an experimental and/or investigational status. The following will be considered in making the determination whether the service is in an experimental and/or investigational status:

  - whether there is sufficient scientific evidence to permit conclusions concerning the effect of the services on health outcomes. "Scientific evidence" consists of:

  - well-designed and well-conducted clinical trials documenting improved health outcomes published in peer reviewed medical (or dental) literature. Peer reviewed medical (or dental) literature means a US scientific publication which requires that manuscripts be submitted to acknowledged experts inside or outside the editorial office for their considered opinions or recommendations regarding publication of the manuscript. Additionally, in order to qualify as peer reviewed medical (or dental) literature, the manuscript must actually have been reviewed by acknowledged experts before publication; and

  - evaluations by national professional medical (or dental) organizations, national consensus panels or other national technology evaluation bodies which have published a technology assessment or practice guideline based on peer reviewed medical (or dental) literature;

  - whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;

  - whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects;

  - whether the scientific evidence improves health outcomes as much or more than established alternatives;

  - whether any improved health outcome from the service is attainable outside investigational settings; and

  - the advice of participating professional providers medical (or dental).

AN EXPERIMENTAL OR INVESTIGATIONAL SERVICE IS NOT MADE ELIGIBLE FOR BENEFITS BY THE FACT THAT OTHER TREATMENT IS CONSIDERED BY YOUR DOCTOR TO BE INEFFECTIVE OR NOT AS EFFECTIVE AS THE SERVICE OR THAT THE SERVICE IS PRESCRIBED AS THE MOST LIKELY TO PROLONG LIFE.

Service-Related Conditions: The treatment of any condition caused by or arising out of service in the armed forces of any country.

Work-Related Conditions: Services or supplies for treatment of illness or injury arising out of or in the course of employment or self-employment for

wages or profit. The only exception would be if you or your insured dependent is exempt from state or federal workers' compensation law.

Services Otherwise Available: A category that includes:

- services or supplies for which payment could be obtained in whole or in part if you or your dependent had applied for payment under any city, county, state, or federal law, except for Medicaid coverage;

- services and supplies you could have received in a hospital or program operated by a government agency or authority; unless reimbursement under this policy is otherwise required by law;

- charges for services and supplies your or your dependent cannot be held liable because of an agreement between the provider rendering the service and another third party payor which has already paid for such service or supply; and

- services or supplies for which no charge is made, or for which no charge is normally made in the absence of insurance.

Charges Over Usual And Customary Or Reasonable: Any charge over the usual and customary or reasonable charge for services or supplies.

Standby Charges When The Provider Renders No Actual Treatment To The Patient.

Benefits Not Stated: Services and supplies not specifically described as benefits under this policy.

Care Of Inmates: Services and supplies you or your insured dependent receives while in the custody of any state or federal law enforcement authorities or while in jail or prison.

Growth Hormones: Growth hormone conditions other than growth hormone deficiency in:

- children or growth failure in children secondary to chronic renal insufficiency prior to transplant; or

- adults, with a destructive lesion of the pituitary or peripituitary, or as a result of treatment such as cranial irradiation, or surgery.

Growth hormone for the treatment of these listed conditions is covered when our medical policy criteria are met (preauthorization is required).

Impotence Medications: Any medication therapy for the treatment of impotence regardless of cause.

Prescription Medications: For prescription medication plan exclusions, see page 75.

BENEFITS TO BE PAID BY OTHER SOURCES

Situations may arise in which health care expenses are also covered by a source other than Regence BlueCross BlueShield of Oregon. If so, we won't provide benefits that duplicate the other coverage.

Right Of Reimbursement And Subrogation

PLEASE NOTE: In the following Section the terms you and your also include your insured dependents.

We will exclude any medical (or dental, 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 a third party or through workers' compensation or from any other source. This includes first party payer payments for any automobile personal injury protection or medical payments and uninsured or underinsured motorist coverages. We may choose, at our discretion, reimbursement or subrogation as a means to recovery.

If you have a potential right of recovery for illness or injuries for which a third party may have legal responsibility, we may advance benefits pending the resolution of the claim upon the following conditions:

- By accepting or claiming benefits, you agree that we are entitled to reimbursement of the full amount of benefits that we have paid out of any settlement or recovery from any source, including any judgment, settlement, disputed claim settlement, uninsured motorist payment, or any other recovery related to the injury or illness for which we have provided benefits.

  This right applies without regard to the characterization as payment for medical expenses, or other designation of the recovery by you and/or any third party or the recovery source. Our right to reimbursement, however, will not exceed the amount of recovery.

- We may require you to sign and deliver all legal papers and take any other actions we may ask to secure our rights (including an assignment of rights to pursue your claim if you fail to pursue your claim). If we ask you to sign a trust agreement or other document to reimburse us from the proceeds of any recovery, you will be required to do so as a condition to advancement of any benefits. If benefits were paid before the agreement is signed, you agree to reimburse us for these upon receipt of recovery in any form from or on behalf of a third party.

- You must agree that you will do nothing to prejudice our rights and will cooperate fully with us, including signing any documents within the required time and providing prompt notice of any settlement. You must notify us of any facts that may impact our right to reimbursement or subrogation, including but not necessarily limited to the following:

- the filing of a lawsuit,
- the making of a claim against any third party;
- scheduling of settlement negotiations (including but not necessarily limited to a minimum of 21 days advance notice of the date, time, location, and participants to be involved in any settlement conferences or mediations); and
- intent of a third party to make payment of any kind to your benefit or on your behalf which is in any manner related to the injury or illness which gives rise to our right of reimbursement or subrogation (notification of a minimum of 5 business days prior to the settlement is required).

You must acknowledge that we are authorized but not obligated to recover directly from any third party any benefits paid from any party liable to you upon mailing of a written notice to the potential payer, to you, or to your representative.

We are entitled to reimbursement from the first dollars received from any recovery and we will not reduce our lien due to you not being made whole. We shall not be liable for any expenses or fees you incur in connection with obtaining a recovery. You, however, may request us to pay a proportional share of attorney's fees and costs at the time of any settlement or recovery or to otherwise reduce the required reimbursement amount to less than the full amount of benefits we paid. We have discretion whether to grant such requests.

Advancement of payment for otherwise excluded benefits or review of a request for attorney fees depends on whether or not your attorney has funds sufficient to satisfy our asserted lien in a client trust account, until such lien is satisfied or released. In the event you and/or your agent or attorney fails to comply with the terms of these provisions, we may recover any benefits advanced for any illness or injury resulting from the action or omission of a third party through legal action.

If you incur health care expenses for treatment of the illness or injury after receiving a recovery, we will exclude benefits for otherwise covered expenses until the total amount of health expenses incurred after the recovery exceeds the net recovery amount.

Please contact our Customer Service Department to obtain third party reimbursement forms and to obtain additional information.

Motor Vehicle Coverage: If you are involved in a motor vehicle accident, you may have rights both under motor vehicle insurance coverage and against a third party who may be responsible for the accident. In that case, this Right Of Reimbursement And Subrogation provision still applies.

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

- You must notify us in writing within five days of filing a workers' compensation claim.

- If the entity providing workers' compensation coverage denies your or your insured dependent's claims and you have filed an appeal, we may advance benefits for covered expenses if you or your insured dependent agrees to hold any recovery obtained in trust for us.

Medicare

In certain situations, this policy is primary to Medicare. This means that when you or your insured dependent is insured in Medicare and this policy at the same time, we pay benefits for eligible charges first and Medicare pays second. Those situations are:

- when you or your insured spouse is age 65 or over and by law Medicare is secondary to your employer group health plan;

- when you or your insured dependent incurs eligible charges for kidney transplant or kidney dialysis and by law Medicare is secondary to your employer group health plan; and

- when you or your insured dependent is entitled to benefits under Section 226(b) of the Social Security Act (Medicare disability) and by law Medicare is secondary to your employer group health plan.

In all other instances, we will not cover any part of a covered expense to the extent that covered expense is actually paid or would have been paid under Medicare Part A or B had you or your insured dependent properly applied for benefits. Furthermore, when we are paying secondary to Medicare, we will not pay any part of expenses a Medicare-eligible insured member incurs from providers who have opted out of Medicare participation.

Coordination Of Benefits

This provision applies when you have health care coverage under more than one plan. This means that 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 the contract and those of the other plan will be coordinated in accordance with the provisions of this provision. Please note that in the following section the terms you and your also include your enrolled dependents.

Benefits Subject To This Provision
All of the benefits provided under the contract 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 provision:

Allowable expense means, with regard to services that are covered in full or part by the contract 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 the contract 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 contracting provider (except, if the primary plan is a closed panel plan and does not pay because a nonpanel provider is used, the secondary plan (if it is not a closed panel plan) shall pay as if it were the primary plan).

- A primary plan's deductible, if the primary plan is a high-deductible health plan as defined in the Internal Revenue Code and we are notified both that all plans covering a person are high-deductible health plans and that the person intends to contribute to a health savings account in accordance with the Internal Revenue Code.

- An expense that a provider is prohibited by law or contract from charging you.

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

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

Claim determination period means a calendar year. However, a claim determination period does not include any time when you were not enrolled under the contract.

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

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

Other plan means any of the following with which the contract coordinates benefits:

- Group and blanket health insurance and prepayment coverage.
- Group, blanket, individual, and franchise health maintenance organization 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:

- Hospital indemnity coverage or other fixed indemnity coverage.
- School accident-type coverage that covers students for accidents only, including athletic injuries, either on a twenty-four 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 an other 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 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.

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 the you were eligible under the second within 24 hours after the first ended. The start of a new plan does not include:

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

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

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

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

Primary Health Plan Benefits
When, in accordance with the order of benefit determination, this coverage is the primary plan, we will pay the benefits of the contract 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 the contract, the benefits of the contract will be calculated as follows:

We will calculate the benefits that we would have paid for a service if the contract were the primary plan. We will compare the allowable expense under the contract for that service to the allowable expense for it under the other plan(s) by which you are covered. We will pay the lesser of:

- the unpaid charges for the service, up to the higher (highest) allowable expenses among the involved plans, and

- the benefits that we would have paid for the service if the contract were the primary plan.

Deductibles, coinsurance and copayments under the contract will be used in the calculation of the benefits that we would have paid if this were the primary plan, but they will not be applied to the unpaid charges you owe after the primary plan's payment. Our payment therefore will be reduced so that it, when combined with the primary plan's payment, does not exceed the higher (highest) allowable expense among the involved plans and we will credit toward any Deductible under the contract any amount that would have been credited to Deductible if the contract had been the only plan.

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

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

Right to Receive and Release Needed Information
Certain facts are needed to apply coordination of benefits provisions. We have the right to decide which facts we need. We may get needed facts from, or give them to, any other organization or person as permitted by law, and need not tell or get the consent of any person to do this. You will promptly furnish to us any information necessary or appropriate to administer this coordination of benefits provision. Receipt of such information by us will be a condition precedent to Our obligation to provide benefits under the plan.

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

Right of Recovery
If we provide benefits to or on behalf of you in excess of the amount that would have been payable under the contract by reason of your coverage under any other plan(s), we will be entitled to recover from you, your assignee or beneficiary, or from the other plan(s) upon request.

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

This provision applies when you or your enrolled dependent has health care coverage under more than one plan.

Claims Recoveries

If we mistakenly make a payment for you or your insured dependent to which you or your insured dependent is not entitled, or if we pay a person who is not eligible for payments at all, we have the right to recover the payment from the person we paid or anyone else who benefited from it, including a provider of services. Our right to recovery includes the right to deduct the amount paid by mistake from future benefits we would provide for you or any of your insured dependents even if the mistaken payment was not made on that person’s behalf.

We regularly engage in activities to identify and recover claims payments which should not have been paid (for example, claims which are the responsibility of another, duplicates, errors, fraudulent claims, etc.). We will

credit to your group's experience or the experience of the pool under which your group is rated all amounts that we recover, less our reasonable expenses in obtaining the recoveries.

HOW TO FILE A CLAIM

We process claims as we receive them. The date we receive a claim may not be the date the service or supply is rendered.

You must submit claims within one year of the time you receive services or supplies for us to pay benefits. Claims submitted beyond that date are not eligible for benefits. If circumstances beyond your control prevent you from submitting a claim within one year, the time period will be extended to 30 days beyond the time you reasonably could have submitted the claim.

We have the sole right to decide whether to pay benefits to you, to the provider of services, or to you and the provider jointly. If a person entitled to receive payment under the policy has died, is a minor or is incompetent, we may pay the benefits (up to $1,000) to a relative by blood or marriage of that person who we believe is equitably entitled to the payment. A payment made in good faith under this provision will fully discharge Regence BlueCross BlueShield of Oregon to the extent of the payment.

If we receive an inquiry regarding a properly submitted claim and we believe that you expect a response to that inquiry, we will respond to the inquiry within 30 days of when we first received it.

Please submit medical and/or vision claims to your local Blue Cross and/or Blue Shield plan. Call your local plan for questions or claims. Send all claims to:

PO Box 30805
Salt Lake City, UT 84130-0805

Hospital Charges

If you or a dependent is hospitalized in one of our participating hospitals, all you need to do is present your Regence BlueCross BlueShield of Oregon identification card to the admitting office. In most cases, the hospital will bill us directly for the entire cost of the hospital stay. We'll pay the hospital and send you copies of our payment record. The hospital will then bill you for any of the charges that weren't covered by your Regence BlueCross BlueShield of Oregon benefits.

Sometimes, however, the hospital will ask you, at the time of discharge, to pay amounts that might not be covered by your benefits. If this happens, you must pay these amounts yourself. You will, of course, be reimbursed if any of the charges you pay are covered by your Regence BlueCross BlueShield of Oregon plan.

The same procedure will apply if you or a family member is hospitalized outside our service area (Oregon and Clark County, Washington) in a hospital that has an agreement with the local Regence BlueCross BlueShield

of Oregon plan. Your claim will be processed by the Blue Cross plan serving that area and your benefits will be provided by that plan.

When The Hospital Bills You

You will be billed for inpatient care you or a dependent receives in a nonparticipating hospital, and for outpatient care you receive in any hospital outside our service area. In order to claim your benefits for these charges, send a copy of the bill to us, and be sure it includes all of the following information:

- the name of the insured person who was treated;
- your name and your group and identification numbers;
- a description of the symptoms that were observed or a diagnosis; and
- a description of the services and the dates on which they were given.

If you have already paid for the services or supplies, please note that fact boldly on the billing.

The same procedure should be followed with bills for hospital or physician care you receive outside the United States. Reimbursement will be made at the current rate of exchange at the time of service.

Physicians' Charges

Your physician may bill charges directly to us. If not, you may send physician bills to us yourself. Be sure the physician uses his or her billing form and includes on the bill:

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

If you have already paid for the services and supplies, please note that fact boldly on the billing.

If the treatment is for an accidental injury, include a statement explaining the date, time, place, and circumstances of the accident when you send us the physician's bill.

Filing A Lawsuit

Any legal action arising out of this policy and filed against us by an insured person or any third party must be filed within three years of the time written proof of loss is required to be furnished under this policy.

Other Health Care Charges

As we explained previously in the description of benefits, your Regence BlueCross BlueShield of Oregon plan will pay for certain other health care expenses. Bills should be forwarded to us as you receive them. Or you may send them to us at regular intervals -- for example, once a month. *Again, if you have already paid for the services and supplies, please note that fact boldly on the billing*.

Prescription Medication Rebates

Regence BlueCross BlueShield of Oregon participates in arrangements with medication manufacturers which allow us to receive rebates based, among other things, on the volume of certain prescription medications purchased on behalf of insured individuals. Any rebates we receive from medication manufacturers are credited directly or indirectly to the group to reduce prescription medication claims expense and thereby help reduce future premium rate increases. We will withhold a percentage of the total rebate to cover our costs of collecting and administering the rebate program.

Appliances

By this term, we mean things such as artificial limbs, crutches, and wheelchairs. Bills for any of these items should include a complete description of the appliance and the reason it is needed. If your doctor wrote a prescription for the appliance, this should also be included with your claim. Always include your group and identification numbers and the patient's name.

Ambulance Service

Bills for ambulance service must show where the patient was picked up and where he or she was taken. They should also show the date of service, the patient's name and group and identification numbers. We will send our payment for covered expenses directly to the ambulance service provider, unless you have already paid them, in which case we will pay you directly.

Claim Determinations

Within 30 days of our receipt of a claim, we will notify you of the action we have taken on it, adverse or not. However, this 30-day period may be extended by an additional 15 days in the following situations:

- When we cannot take action on the claim due to circumstances beyond our control, we will notify you within the initial 30-day period that the extension is necessary, including an explanation of why the extension is necessary and when we expect to act on the claim.

- When we cannot take action on the claim due to lack of information, we will notify you within the initial 30-day period that the extension is necessary, including a specific description of the additional information needed and an explanation of why it is needed. You must provide us with the requested information within 45 days of receiving the request for additional information. If we do not receive the requested information to process the claim within the 45 days we have allowed, we will deny the claim.

Claims Processing Reports

We will report to you on the action we take on a claim on a form called a Claims Processing Report.

If we deny all or part of a claim, the reason for our action will be stated on the Claims Processing Report. The Claims Processing Report will also include instructions to file an appeal or grievance if you disagree with the action we have taken on your or your insured dependent's claim.

When Benefits Are Available

The expense of a service is incurred on the day the service is rendered and the expense of a supply is incurred on the day the supply is delivered to the patient.

There are two exceptions to this rule. One is when you are in the hospital on the day coverage ends. In this case, we will continue to pay toward eligible charges for that hospitalization until discharge from the hospital or until your benefits have been exhausted, whichever comes first.

We have the sole right to decide whether to pay benefits to you, to the provider of services, or to you and the provider jointly. If a person is entitled to receive payment under the policy has died, is a minor or is incompetent, we may pay the benefits (up to $1,000) to a relative by blood or marriage of that person who we believe is equitably entitled to the payment. A payment made in good faith under this provision will fully discharge Regence BlueCross BlueShield of Oregon to the extent of the payment.

Out-of-Area Claims Service - BlueCard Program

All Blue Cross and Blue Shield Plans participate in a national program called the BlueCard Program. This national program benefits insured individuals who incur eligible charges outside our service area. Not all claims incurred outside of our service area, dental claims for example, are processed through the BlueCard Program.

Under BlueCard, when you or an insured dependent incurs eligible charges within the geographic area served by another BlueCross and/or BlueShield Plan, we will remain responsible for meeting our obligations under the policy. The local Blue Plan will only be responsible for providing such services as contracting with its participating providers and handling the interaction with those providers according to BlueCard policies.

When you or an insured dependent receives covered health care services outside our service area from a provider who has a participating contract with the local Blue Cross and/or Blue Shield Plan and the claim is processed through BlueCard, the amount you pay for eligible charges is usually calculated on the lower of:

- the actual billed charges; or
- the negotiated price that the local Blue Cross and/or Blue Shield Plan passes on to us.

Often, this ‘‘negotiated price’’ will consist of a simple discount. But sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, or other nonclaims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your provider or a group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered the final price.

Statutes in a small number of states may require the local Blue Cross and/or Blue Shield Plan to use a basis for calculating your liability for eligible charges that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the usual BlueCard program method noted above or require a surcharge, we would then calculate your liability for any covered health care services using the methods outlined by the applicable state statute in effect at the time you or your insured dependent received care.

PRESCRIPTION MEDICATION PROGRAM

This Regence BlueCross BlueShield of Oregon prescription medication plan is administered through a nationwide network of participating pharmacies. Pharmacies that participate in this network submit claims electronically on-line, which are then processed according to your plan benefits.

Your Regence BlueCross BlueShield of Oregon identification card identifies your medical program, and enables you to use the pharmacies that participate in this prescription medication program. If you would like a listing of the participating pharmacies, you may obtain one from your employer or from Regence BlueCross BlueShield of Oregon.

Prescription Medication Benefits

The benefits of this medication plan are described below, and any balances over the maximum amount available under this plan are not eligible for payment under any other provision of the policy.

Definitions

The definitions which appear here apply to this plan.

Brand name medication means a prescription medication that has a patent and is marketed and sold by only one source or is listed in widely accepted references as a brand name medication based on manufacturer and price.

Generic medication means a prescription medication that is an equivalent medication to the brand name medication, is marketed as a therapeutically equivalent and interchangeable product and is listed in widely accepted references as a generic medication or is specified as a generic medication by us. Equivalent medication means the US Food and Drug Administration (FDA) ensures that the generic medication must:

- have the same active ingredients;
- meet the same manufacturing and testing standards; and
- be absorbed into the bloodstream at the same rate and same total amount as the brand name medication.

These requirements ensure that the generic medication has the same effectiveness 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 medication, we will determine whether the prescription medication is a generic or brand name medication.

Brand name medication (single source brand) means a prescription medication that has a current patent and is marketed and sold by limited sources or is listed in widely accepted references as a brand name medication based on manufacturer and price.

Multi-source brand name medication means a brand name medication for which a generic medication may be substituted under the laws and regulations of the state in which the pharmacy dispensing the prescription is located.

Compound medication means two or more medications that are mixed together by the pharmacist. In order to be covered, compound medications must contain, in therapeutic amount, either one federal legend drug or one state restricted drug.

Coinsurance, for purposes of this prescription medication benefit, means any percentage amount you or your insured dependent must pay for a covered prescription medication. Coinsurance or copayment amounts are assessed on each covered prescription medication claim (except for covered diabetic supplies).

Copayment, for purposes of this prescription medication benefit, means any flat dollar amount you or your insured dependent must pay for a covered prescription medication. Coinsurance or copayment amounts are assessed on each covered prescription medication claim (except for covered diabetic supplies).

Covered prescription medication expense means, for participating pharmacies, the amount we have agreed to pay participating pharmacies for a prescription medication. For nonparticipating pharmacies, covered prescription medication expense means the pharmacy's retail price for a prescription medication or the amount we would have paid a participating pharmacy for the same prescription medication, whichever is less. For mail order suppliers, covered prescription medication expenses means the amount we have agreed to pay mail order suppliers for a prescription medication.

Generic medication means a prescription medication that is an equivalent medication to the brand name medication, is marketed and sold by more than one source, and is listed in widely accepted references as a generic medication based on manufacturer and price. Equivalent medication means the Food and Drug Administration (FDA) ensures that the generic medication must:

- have the same active ingredients;
- meet the same manufacturing and testing standards; and
- be absorbed into the bloodstream at the same rate and same total amount

as the brand name medication.

These requirements ensure that the generic medication has the same effectiveness as the brand name medication.

Mail order supplier means a mail order pharmacy that has contracted with us to provide mail order services to insured employees and their insured family members.

Maintenance medication means a prescription medication that we have determined is intended to treat a chronic illness that requires medication therapy for more than 12 continuous months.

A Pharmacist means an individual licensed to dispense prescription medications and counsel a patient about how the medication works and its possible adverse effects.

A Pharmacy means any duly licensed outlet in which prescription medications are regularly compounded and dispensed.

A Participating Pharmacy means a Pharmacy that has signed a participating pharmacy agreement with us and that submits claims electronically on-line at the time of dispensing.

Preferred medication list means a list comprised of generic medications and selected brand name medications, which is established, reviewed, and updated routinely by us.

Prescription medications are medications and biologicals that relate directly to the treatment of an illness or injury and cannot legally be dispensed without a prescription order, and that by law must bear the legend: "Caution - federal law prohibits dispensing without prescription," or which are specifically designated by us. For purposes of this prescription medication benefit, prescription medications also include insulin and diabetic supplies, self-injectable medications, and compound medications. Although insulin and diabetic supplies, do not require a prescription order, they still require a prescription order to be covered under this benefit.

Prescription order is a written prescription or oral request for prescription medications issued by a professional provider who is licensed to prescribe medications.

Self-injectable medication means an outpatient injectable prescription medication intended for self-administration and approved by us for self-injection.

How To Use The Prescription Medication Benefit

At a participating pharmacy, you or your insured dependent is required to present your identification card at the pharmacy in order to have the prescription medication claim submitted by the pharmacy electronically on-line. You or your insured dependent must pay your copayment or coinsurance at the time of purchase.

If you or your insured dependent uses a nonparticipating pharmacy or you or your insured dependent uses a participating pharmacy but the claim is not submitted by the pharmacy electronically on-line, you or your insured dependent must pay for the medication. You then must complete a

Prescription Medication Claim Form and mail the form and receipt to us. How you will be reimbursed is described later.

PPO Plan
You pay a $5 copayment for each generic prescription medication dispensed by a participating pharmacy. Each brand name medication on the preferred medication list dispensed by a participating pharmacy is subject to $15 copayment. Each brand name medication not on the preferred medication list dispensed by a participating pharmacy is subject to a copayment of $50 or 50 percent of the covered prescription medication expense (whichever is greater), plus the difference between generic and brand name for multisource brands.

Please note: No copayment is applied for prescription orders for insulin or covered diabetic supplies.

PPO Part-Time and Retiree Plan
You pay a $10 copayment for each generic prescription medication dispensed by a participating pharmacy. Each brand name medication on the preferred medication list dispensed by a participating pharmacy is subject to a coinsurance of 20% of the covered prescription medication expense. Each brand name medication not on the preferred medication list dispensed by a participating pharmacy is subject to a copayment of $50 or 50 percent of the covered prescription medication expense (whichever is greater), plus the difference between generic and brand name for multisource brands. Once you have paid $1,000 out-of-pocket during the calendar year, your prescription medications will be paid in full.

Please note: No copayment is applied for prescription orders for insulin or covered diabetic supplies.

All Plans
The amount we cover and the amount you must pay depends on whether or not the pharmacy is a participating pharmacy.

- **Participating Pharmacy**
  Eligible charges incurred at a participating pharmacy will be covered at 100 percent, less the copayment or coinsurance depending which plan you are enrolled in for a 34-day supply. You or your insured dependent need only present your identification card to the participating pharmacy and pay any copayment or coinsurance at the time of purchase.

- **Nonparticipating Pharmacy**
  You or your insured dependent must pay a nonparticipating pharmacy the full charge at the time of purchase and then submit a Prescription Medication Claim Form for reimbursement. You will be reimbursed 100 percent of the covered expense less the copayment or coinsurance depending which plan you are enrolled in for a 34-day supply. Payment will be sent directly to the insured employee or retiree.

Maximum Out Of Pocket Expense - PPO Part-Time and Retiree Plan Only

The copayment for prescription medications obtained from a participating pharmacy will be waived during the remainder of a calendar year in which your or your insured dependent's out-of-pocket expenses (copayments and coinsurance) reach $1,000. The out-of-pocket maximum applies separately to each insured employee and their insured family members.

In order for the copayment or coinsurance to be waived, you or your insured dependent must present your identification card to the participating pharmacy at the time of purchase and the participating pharmacy must submit the claim electronically on-line.

Expenses incurred at both participating pharmacies and nonparticipating pharmacies and expenses incurred for mail order prescription medications accumulate toward the out-of-pocket maximum.

Mail Order Benefit

Mail order is an optional method of obtaining maintenance medications under this prescription medication plan. Not all prescription medications are available from the mail order supplier and mail order benefits are available only when prescription medications are dispensed and the claim is submitted electronically on-line by the mail order supplier.

PPO Plan
Under this benefit, you or your insured dependent pays a copayment of $12.50 each time a generic medication is dispensed or refilled by the mail order supplier. You or your insured dependent pays a copayment of $37.50 each time a brand name medication from the preferred medication list is dispensed or refilled by the mail order supplier. Brand name medications not on the preferred medication list are subject to a copayment of $125 or 50 percent of the covered prescription medication expense (whichever is greater), plus the difference between generic and brand name for multisource brands.

Please note: No copayment is applied for prescription orders for insulin or covered diabetic supplies.

PPO Part-Time and Retiree Plan
Under this benefit, you or your insured dependent pays a copayment of $25 each time a generic medication is dispensed or refilled by the mail order supplier. You or your insured dependent pays a copayment of $62.50 each time a brand name medication from the preferred medication list is dispensed or refilled by the mail order supplier. Brand name medications not on the preferred medication list are subject to a copayment of $125, plus the difference between generic and brand name for multisource brands.

Please note: No copayment is applied for prescription orders for insulin or covered diabetic supplies.

How To Obtain Mail Order Medications

To use the mail order plan, you or your insured dependent must send all of the following items to the mail order supplier at the address shown on the prescription mail order form obtained from your group:

- a completed prescription mail order form;
- the original prescription order; and
- the copayment.

Refills
If a prescription order includes refills, they may also be obtained from the mail order supplier. You must complete the ‘‘refill’’ section on the back of the prescription order form, including the mail order supplier’s prescription number, and send it to the mail order supplier along with the copayment. Subsequent mail order prescription refills are available once you have used 75 percent of the supply from the previous mail order prescription.

Regence BlueCross BlueShield of Oregon contracts with two mail order companies:

Postal Prescription Service (PPS)
Postal Prescription Service is a full service mail order pharmacy based in Portland, Oregon, offering you:

- Free standard shipping;
- Convenient hours, 6am – 6pm, Pacific time, Monday – Friday, 9am – 2pm, Saturdays;
- Access to a registered pharmacist during business hours at 1 (800) 552-6694;
- Use of PPS Website after filling one prescription. Visit www.PPSRX.com to;
- Refill your prescription(s);
- Print out new prescription order forms or medical expense forms;
- Review your order status and history;
- Submit prescription transfer requests.

Postal Prescription Services
PO Box 2718
Portland, OR 97208

Walgreens Healthcare Plus (Mail Order Service)

Walgreens offers fully integrated retail and mail service with convenient delivery to your home or office:

- Free shipping;
- Convenient hours, 7am to 7pm. (Central time), Monday – Friday, and 7am to noon, Saturdays;
- 24/7 access via 1 (800) RX-REFILL 1 (800) 797-3345 to place an order, check order status and account balance;
- 24/7 access to a Walgreens representative or pharmacist at 1 (888) 832-5462;
- Online ordering at www.walgreensmail.com or print a form to fax or mail. Walgreens will send you Rx Order Status emails telling you when your order was received, when it ships, and delivery service provider.

You can choose which Walgreens Mail Service facility to have your prescriptions filled. Locations include:

Walgreens Healthcare Plus
PO Box 29061
Phoenix, AZ 85038

Walgreens Healthcare Plus
PO Box 5957
Portland, OR 97228

Walgreens Healthcare Plus
PO Box 628001
Orlando, FL 32862

Exceptions Process For Non-Preferred Brand-Name Medications

A formulary is a list of generic and preferred brand-name prescription drugs covered by your health plan.

What To Do When Your Doctor Prescribes A Drug That Isn't On The Drug List:

- If your doctor prescribes a non-formulary drug to treat your condition, he or she can fax a request to 1(888) 437-1510 or submit a request online at www.regencerx.com.
- Exceptions may be granted if formulary drugs have failed to treat your condition or have caused side effects that made you stop taking them. If an exception is granted, your copayment is the preferred brand level.

- When you get an exception, the copay for the non-preferred drug will not apply to your deductible. (The copay of a preferred brand drug does apply to your deductible.)

Contact us for more information or call 1(800) 643-5918.

Prescription Medication Plan Limitations

The following limitations apply to the benefits of this prescription medication plan:

Maximum Supply
The largest allowable quantity for most outpatient prescription medications purchased from a pharmacy is a 34-day supply. There are no exceptions to the maximum 34-day supply. The provider, however, may choose to prescribe some medications in smaller quantities or you or your insured dependent may wish to purchase some medications in smaller quantities. The amount payable is always based on each dispensing. Some examples of how the maximum 34-day supply works:

- if one tablet per day is prescribed, up to 34 tablets for a 34-day supply will be covered; or

- if one tablet per week is prescribed, up to four tablets for a 34-day supply will be covered.

The largest allowable quantity at one time per prescription medication purchased from the mail order supplier is a 90-day supply. The maximum quantity for self-injectable medications purchased from the mail order supplier is a 30-day supply. The provider, however, may choose to prescribe some prescription medications in smaller quantities or you or your insured dependent may choose to purchase some prescription medications in smaller quantities. The amount payable and copayment is always based on each dispensing. Some examples of how the maximum 90-day supply works:

- if one tablet per day is prescribed, up to 90 tablets for a 90-day supply will be covered; or

- if one tablet per week is prescribed, up to 12 tablets for a 90-day supply will be covered.

Maximum Quantities
For certain medications, we have established a maximum quantity of medication allowed. This means that there is a limit for the amount of medication that will be covered during a period of time. We use information from the US Food and Drug Administration (FDA) and from scientific publications to establish these maximum quantities.

Any amount over the established maximum quantity is not covered, except if we determine the amount is medically necessary. The medication information must be provided by the health care provider who prescribed the medication in order to establish if the amount is medically necessary. Some examples of established maximum quantities include:

- Imitrex (used for migraines) - up to 9 tablets every 34 days;
- Tamiflu (used for flu) - up to one treatment course every 6 months; and
- Diflucan 150 mg (antifungal agent) - up to 2 tablets every 34 days.

When you or your insured dependent take a prescription order to a participating pharmacy or requests a prescription medication refill and an identification card is used, the pharmacy will let you or your insured dependent know if a quantity limitation applies to the medication. To find out in advance whether a limit applies, contact Customer Service (number on the back of your identification card) or check our website at www.or.regence.com.

Prescription Refills
Refills obtained from a pharmacy or the mail order supplier are allowed after 75 percent of the supply from the previous prescription order is used. You or your insured dependent is responsible for the full cost of any prescription medications that are denied at the participating pharmacy for 'refill too soon' due to this quantity limitation.

Prescription Medication Plan Exclusions

In addition to other exclusions of the policy, the following exclusions apply to the benefits of this prescription medication plan:

Non-Prescription Medications
Medications that by law do not require a prescription order and which are not included in our definition of prescription medications.

Contraceptives
Certain contraceptive prescription medications and devices are covered under this prescription medication plan, however, Norplant, surgically inserted contraceptive devices, IUDs, Depo-Provera and other nonself-administered contraceptives are not. These may be covered under other provisions of the policy.

Administration Or Injection Of Medications

Prescription Medications With No Proven Therapeutic Indication

Prescription Medications That Are Not Medically Necessary

Immunization Agents, Biological Sera, Blood Or Blood Plasma

Vitamins And Fluoride
Except those that by law require a prescription order.

Injectable Prescription Medications
Except those defined as self-injectable. Excluded are all injectable prescription medications administered in a physician's office, hospital, outpatient facility, or skilled nursing facility.

Prescription Medications Dispensed In Facility
Prescription medications dispensed to an insured person while a patient in a hospital, skilled nursing facility, nursing home or other health care institution.

Prescription Medications For Weight Loss Or Treatment Of Obesity
Including, but not limited to amphetamines.

Prescription Medications For Treatment Of Infertility

Growth Hormones
Growth hormone conditions other than growth hormone deficiency in:

- children or growth failure in children secondary to chronic renal insufficiency prior to transplant; or

- adults, with a destructive lesion of the pituitary or peripituitary, or as a result of treatment such as cranial irradiation, or surgery.

Growth hormone for the treatment of these listed conditions is covered when our medical policy criteria are met (preauthorization is required). See the Preauthorization provision in the ELIGIBLE CHARGES Section for a description of the preauthorization process.

Prescription Medications For The Treatment Of Impotence Regardless Of Cause

Medications Prescribed For Cosmetic Purposes

Tretinoin (i.e. Retin-A) For Insured Employees And Insured Family Members Age 26 Or Over

Medications Prescribed For Treatment Of Hair Loss Regardless Of Cause
Including but not limited to topical minoxidil.

Renova

Medications Prescribed For Hair Removal Regardless Of Cause
Including but not limited to Vaniqa.

Refills Needed for Stolen, Lost, Spilled Or Destroyed Prescription Medications

Prescription Medications For Which Claims Are Submitted 12 Months Or More After The Date Of Purchase

Any Medication Not Specifically Described As A Benefit Under This Prescription Medication Benefit

Prior Authorization

There are certain prescription medications which must be preauthorized before they will be considered for payment under this prescription medication benefit. Prior authorize and prior authorization mean the process by which we determine that a prescription medication is medically necessary, based on the information provided to us, before it is dispensed. Coverage for medications that have been preauthorized begins on the date we determine that the medication is medically necessary. Any medication that requires prior authorization that is purchased without such prior authorization or is purchased before the date that we determined the medication was medically necessary is not covered under this prescription medication plan, even if purchased from a participating pharmacy.

Participating providers, including participating pharmacies, are notified which prescription medications require prior authorization. The medical information necessary to determine medical necessity for medications that require prior authorization must be provided by the health care provider who is prescribing the medication.

If you or your insured dependent take a prescription order to a participating pharmacy and show your identification card, the pharmacy will let you or your insured dependent know if prior authorization is necessary for the prescription medication. To find out in advance whether a prescription medication requires prior authorization, contact Customer Service (number on back of your identification card) or check our website at www.or.regence.com. For more information on prior authorization, including how we are bound to cover an authorized service or supply, please see Prior Authorization under the ELIGIBLE CHARGES Section.

General Medication Plan Provisions

Right To Examine Records

Regence BlueCross BlueShield of Oregon can require you or your insured dependent to authorize any participating pharmacy furnishing prescription medications under this plan to make available to us information relating to a prescription order or any other records we need in order to approve a claim payment.

Group Coverage Benefits Only

This plan is provided only under group coverage. There is no conversion privilege, nor is this plan available under any nongroup plan.

We Are Not Responsible

We cannot be held liable for any claim or damages connected with illness or injuries suffered by you or your insured dependent arising out of the use of any prescription medication or insulin.

Right To Deny Benefits Or Prescription Orders

We reserve the right to deny benefits for any medication prescribed or dispensed in a manner contrary to normal medical practices. In addition, a pharmacy need not dispense a prescription order which, in the pharmacist's professional judgment, should not be filled.

Utilization Review Program
Included as part of this prescription medication benefit is a medication utilization review program. Utilizing a database of information on each of your prescription medication claims, the program alerts a dispensing pharmacist of potential conflicts in medication therapy, duplicate prescription medications, and overuse before you obtain the prescription medication. Prescription medication claims submitted electronically on-line by a participating pharmacy are analyzed with your active medication profile for potential medication problems. Claims determined to be excessive utilization and therefore not medically necessary will be denied.

Recovery Of Benefits Paid By Mistake
If we mistakenly make a payment for you or your insured dependent, or on your or your insured dependent's behalf, we have the right to recover the payment from you or your insured dependent, not the pharmacy. This includes the right to deduct the amount paid by mistake from future benefits we provide to you, even if the mistaken payment was not made on that person's behalf.

General Medication Plan Provisions
The provisions described in the WHAT KIND OF SERVICES AND SUPPLIES ARE COVERED and ELIGIBILITY Sections of this policy also apply to this prescription medication plan.

MEMBER APPEALS AND GRIEVANCE PROCESS

This procedure is designed to keep lines of communication open and to provide an opportunity for mutual understanding among our enrollees, providers, and us. Grievances and appeals are promptly directed to appropriate individuals within Regence BlueCross BlueShield of Oregon so action can be taken quickly, and on an informal basis if possible. Final decisions may be decided by an independent review organization (IRO), as explained below under the third step in the grievance and appeals process.

If you believe a policy, action, or decision of ours is incorrect, please contact our Customer Service Department. If we cannot resolve your concern to your satisfaction, you (or an individual authorized to represent you in the grievance and appeal process) may file a verbal or written appeal with us within 180 days of the claim denial or other action giving rise to the grievance. The Customer Service contact information is provided below. Failure to appeal within this time period will preclude all further rights to appeal and may jeopardize your right to contest the action in any forum.

If you have concerns regarding a decision, action, or statement by your provider, we encourage you to discuss these concerns with the provider. If you remain dissatisfied after discussing your concern with your provider, you may file a grievance with our Customer Service Department. However, if you would prefer to discuss your concern with us rather than your provider, please contact our Customer Service Department.

First Step – Filing A Grievance

There are three steps to our grievance and appeal process. The first level of review is filing a grievance. You must file your grievance within 180 days of the claim denial or other action giving rise to the grievance by writing us a letter, filling out a grievance form, or by contacting our Customer Service Department by phone. Within five business days of receiving a grievance, we will send you or your representative an acknowledgment letter outlining your issues as well as advising you of your rights. Within 30 calendar days, you or your representative will receive a written decision from our grievance coordinator. For preservice claims, you or your representative will receive a written decision within 14 days of our receipt of your grievance.

Second Step – Filing Second Appeal

If you remain dissatisfied after the initial grievance review, you have the right to file an appeal verbally or in writing within 180 days of receiving a response from us. Within five business days of receiving the appeal, we will send you or your representative an acknowledgment letter. Your issue will be reviewed by someone not previously involved in your case. For clinical issues, a practitioner that specializes in your medical condition or procedure will be involved in the review of your appeal. A panel of representatives will evaluate your case and your appeal coordinator will notify you or your representative of the decision in writing. The written decision will be sent:

- for appeals of preservice (preauthorization) claims, within 14 calendar days of our receiving your appeal; or

- for appeals of postservice claims, within 30 calendar days of our receiving your appeal.

Third Step – Voluntary Appeal - External Independent Review
A voluntary external review is available for certain types of appeals and will be decided by an independent review organization (IRO). Appeals qualifying for external appeal must first have been considered through internal review, unless you and we have mutually agreed to waive that requirement. You or your representative must request a voluntary external appeal in writing or verbally within 180 days of receipt of the written notification of the second appeal decision. An external independent review may not be available in all situations. If you are not sure whether your appeal is eligible for an independent review or you want more information, please contact our Customer Service Department. The Customer Service contact information is provided below. At a minimum, a voluntary external review will be available for the following types of appeals:

- an adverse determination based on medical necessity (cosmetic or out-of-network services, for example);

- an adverse determination for treatment determined as experimental or investigational; or

- for purposes of continuity of care (no interruption of an active course of treatment).

You should know that in order to have the appeal decided by an IRO, you or your enrolled dependent must:

- sign a waiver granting the independent review organization access to medical records; and

- have exhausted all other appeals and grievance opportunities under this contract unless, with your consent, we waive this requirement.

An IRO is not part of the Regence BlueCross BlueShield of Oregon company. The IRO is independent and may be assigned by the Director of Consumer and Business Services (DCBS). You are not responsible for the costs of the independent review.

A written response to your appeal will be sent to you or your representative within 5 days after the IRO makes its determination. We are bound by the decision made by the IRO, even if it conflicts with our definition of medical necessity.

If you want more information regarding external review, please contact our Customer Service Department at (Portland area) (503) 225-5336, or toll-free at (800) 452-7390.

Expedited Procedure
In the event you or your physician reasonably believes a decision denying a preauthorization of a service is clinically urgent and that application of the regular appeal timeframes could jeopardize your life, health, or ability to

regain maximum function, you or your representative may request an Expedited Appeal. Expedited Appeal also is available if a physician with knowledge of your medical condition concludes that application of the regular appeal timeframes to the review of our denial of preauthorization of a service would subject you to severe pain that cannot be adequately managed without the disputed service. The appeal request must be made verbally or in writing within 180 days after you receive notice of the initial written preauthorization denial, should state the need for a decision on an expedited basis, and must include documentation necessary for the appeal decision. The appeal request, including any additional information or comments, must be made to the appeal coordinator. However, if the appeal issue doesn't meet the expedited criteria, the appeal will be handled through the standard appeal process. If the appeal meets the expedited criteria, a verbal notice of the decision will be provided to you or your representative no later than one working day or seventy-two hours of receipt of the request. A written notice will be provided within one working day of the verbal notification. If you are not satisfied with that decision, you may ask for an expedited, second level appeal similar to the Second Step appeal process described above.

How To Contact Us

If you have any questions about the grievance and appeal process outlined here, you may contact our Customer Service Department at (Portland area) (503) 225-5336, or toll-free at (800) 452-7390 or you can write to our Customer Service Department at the following address:

Regence BlueCross BlueShield of Oregon
Customer Service Department
Grievance or Appeal Coordinator, C-7A
PO Box 1271
Portland, OR 97207-1271

Assistance From The Department Of Consumer And Business Services

You also have the right to file a complaint and seek assistance from the director of the DCBS at:

Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, OR 97310

Or call: (503) 947-7984
Toll free message line: (888) 877-4894
Web site: www.cbs.state.or.us/external.ins/
or E-mail: DCBS.INSMAIL@state.or.us

or E-mail: http://www.cbs.state.or.us/external/ins/

Please note that your enrolled dependents also have the right to grievance and appeal as described here.

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 and your insured dependents about the benefits and policies of this health insurance plan.

What Are My Rights And Responsibilities As A Member Of Regence BlueCross BlueShield of Oregon?

No one can deny you or your insured dependent the right to make your own choices. As a member, you and your insured dependents 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 or your insured dependent;
- the medical care necessary to correctly diagnose and treat any covered illness or injury;
- have providers tell you or your insured dependent about the diagnosis, the treatment ordered, the prognosis of the condition, and instructions required for follow-up care;
- know why various tests, procedures, or treatments are done, who the persons are who give them, and any risks you or your insured dependent needs to be aware of;
- refuse to sign a consent form if you or your insured dependent does not clearly understand its purpose, cross out any part of the form you or your insured dependent doesn't want applied to care, or have a change of mind about treatment you or your insured dependent previously approved;
- refuse treatment and be told what medical consequences might result from your or your insured dependent's refusal;
- be informed of policies regarding "living wills" as required by state and federal laws (these kinds of documents explain your or your insured dependent's rights to make health care decisions, in advance, if you or your insured dependent becomes unable to make them);
- expect privacy about care and confidentiality in all communications and in your or your insured dependent's 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 and your insured dependents have a responsibility to:

- tell the provider you or your insured dependent is covered by Regence BlueCross BlueShield of Oregon and show an identification card when requesting health care services;
- be on time for appointments and to call immediately if there is a need to cancel an appointment or if you or your insured dependent will be late. You or your insured dependent is 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 or your insured dependent's condition;
- follow instructions given by those providing health care to you or your insured dependent;
- review this health care booklet to make sure services are covered by the plan;
- make sure services are preauthorized when required by this plan before receiving medical care;
- contact our Customer Service Department if you or your insured dependent believes adequate care is not being received;
- read and understand all materials about your health benefits and make sure family members that are covered under this plan also understand them;
- give an identification card to your insured 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 or your insured dependent experiences an emergency situation, you or your insured dependent should obtain care from the nearest appropriate facility, or dial 911 for help.

If there is any doubt about whether your or your insured dependent's condition requires emergency treatment, you or your insured dependent can always call the provider for advice. The provider is able to assist you or your

insured dependent in coordinating medical care and is an excellent resource to direct you or your insured dependent to the appropriate care since he or she is familiar with your or your insured dependent's 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 policy terminates and your employer does not replace the coverage with another group policy, 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 professional provider's contract with us ends for any reason, we will give notice to those insured that we know, or should reasonably know, are under the care of the provider of their rights to receive continued care (called "continuity of care"). We will send this notice no later than 10 days after the provider's termination date or 10 days after the date we learn the identity of an affected insured individual, whichever is later. The exception to our sending the notice is when the professional provider is part of a group of providers and we have agreed to allow the provider group to provide continuity of care notification to those insured.

When Continuity Of Care Applies

If you or your insured dependent is undergoing an active course of treatment by an in-network professional provider and benefits for that provider would be denied (or paid at a level below the benefit for an out-of-area provider) if the provider's preferred contract with us is terminated or the provider is no longer participating in our preferred provider network, we will continue to pay plan benefits for services and supplies provided by the professional provider as long as:

- you or your insured dependent and the professional provider agree that continuity of care is desirable and you or your insured dependent requests continuity of care from us;
- the care is medically necessary and otherwise covered under the policy;
- you or your insured dependent remains eligible for benefits and insured under the policy; and
- the policy has not terminated.

Continuity of care does not apply if the contractual relationship between the professional provider and us ends in accordance with quality of care provisions of the contract between the provider and us, or because the professional provider:

- retires;

- dies;
- no longer holds an active license;
- has relocated outside of our service area;
- has gone on sabbatical; or
- is prevented from continuing to care for patients because of other circumstances.

How Long Continuity Of Care Lasts

Except as follows for pregnancy care, we will provide continuity of care until the earlier of the following dates:

- the day following the date on which the active course of treatment entitling you or your insured dependent to continuity of care is completed; or
- the 120th day after notification of continuity of care.

If you or your insured dependent becomes eligible for continuity of care after the second trimester of pregnancy, we will provide continuity of care for that pregnancy until the earlier of the following dates:

- the 45th day after the birth;
- the day following the date on which the active course of treatment entitling you or your insured dependent 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 your or your insured dependent 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 MEMBER APPEALS AND GRIEVANCE PROCESS Section of this booklet, including, if applicable, information about filing an appeal through an independent review organization without charge to you.

You and your insured dependents also have the right to file a complaint and seek assistance from the director of the Department of Consumer and Business Services (DCBS). You or your insured dependent can write to the Director of the DCBS at:

Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, OR 97310

or call: (503) 947-7984

or E-mail: http://www.cbs.state.or.us/external/ins/

How Can I Participate In The Development Of Your Corporate Policies And Practices?

Your or your insured dependent's feedback is very important to us. If you or your insured dependent has suggestions for improvements about the plan or our services, we would like to hear from you or your insured dependent.

We have formed several advisory committees -- the Member Advisory Committee for insured employees and their insured family members, the Marketing Advisory Panel for employers, and the Provider Advisory Committee for health care professionals -- to allow participation in the development of corporate policies and to provide feedback. If you or your insured dependent would like to become a member of the Member Advisory Committee, send your or your insured dependent's 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, C-7A
P.O. Box 1271
Portland, OR 97207-1271

Or send your comments to us over the internet at:

www.or.regence.com

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

What Are Your Prior Authorization And Utilization Review Criteria?

Prior authorization, also known as preauthorization, is the process we use to determine the medical necessity of a service before it is rendered. Contact our Customer Service Department at the phone number on the back of your identification card, or ask your or your insured dependent's 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 or your insured dependent, other providers, and us to determine the treatment that best meets your or your insured dependent's 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 and

your insured dependents' assurance that medical services won't be denied because they are not medically necessary.

Utilization review is a process in which we examine services you receive 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 or your insured dependent would like a written summary of information that we may consider in our utilization review of a particular condition or disease. Simply call the Customer Service phone number on the back of your identification card.

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 may access your personal information. Disclosure outside the company is permitted only when necessary to perform functions related to providing your or your insured dependent's coverage and/or when otherwise allowed by law. Note that with certain limited exceptions, Oregon law requires insurers to obtain a written authorization from you or your representative before disclosing personal information. One exception to the need for a written authorization is disclosure to a designee acting on behalf of the insurer for the purpose of utilization management, quality assurance, or peer review.

My Neighbor Has A Question About The Policy That He Has With You And Doesn't Speak English Very Well. Can You Help?

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

What Additional Information Can I Get From You Upon Request?

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

- Rules related to our medication formulary, including information on whether a particular medication is included or excluded from the formulary and information on what medications require preauthorization from Regence BlueCross BlueShield of Oregon.
- Provisions for referrals for specialty care, behavioral health services, and hospital services, and how you may obtain the care or services.
- A copy of 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 your care.

- Information about our prior authorization and utilization review procedures.

What Other Source Can I Turn To For More Information About Your Company?

The following information regarding the health benefit plans of Regence BlueCross BlueShield of Oregon is available from the Oregon Insurance Division:

- The results of all publicly available accreditation surveys.

- A summary of our health promotion and disease prevention activities.

- Samples of the written summaries delivered to policyholders.

- An annual summary of grievances and appeals.

- An annual summary of utilization review policies.

- An annual summary of quality assessment activities.

- An annual summary of scope of network and accessibility of services.

To obtain the mentioned information, write to:

Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, OR 97310

or call: (503) 947-7984

or E-mail: http://www.cbs.state.or.us/external/ins/

ELIGIBILITY

The Public Employees' Benefit Board (PEBB) Eligibility Rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules for detailed information on eligibility and program requirements.

See the PEBB eligibility rules for more information.

NOTICE OF TERMINATION

In the event the group policy is terminated and the insurance coverage is not replaced by the group, we will mail to the group a notice of termination. It is then the duty of the group to send each insured employee or retiree a notice of the termination. The notice will explain the insured employee's or retiree's rights to continuation or conversion of coverage under federal and/or state law. Our notice to the group will be mailed within 10 working days of the policy termination date or, in the event of termination due to nonpayment of premium, the notice will be mailed within 10 working days of expiration of the grace period for payment of premium under the policy. If we fail to give notice as required in this provision, we will waive the premiums and the policy will continue in full force and effect from the end of the 10-day period to the date notice is received by the group. In this case, the period in which an insured person has to apply for continuation or conversion will begin on the date the group receives notice.

RESCINDING COVERAGE

We may rescind your and/or your insured dependent's coverage under this policy from the beginning as never effective or deny a claim at any time for fraud, material misrepresentation, or concealment by you or your insured dependent in obtaining or attempting to obtain benefits under this policy or for knowingly aiding or permitting such actions by another.

If we rescind coverage as described above, we will retain premiums paid as liquidated damages and reserve the right to recover from you or your insured dependent the benefits paid as a result of such wrongful activity that are in excess of the premium payments. In addition, we may deny future enrollment of the group or insured person under any Regence BlueCross BlueShield of Oregon policy or the policy of any of our subsidiaries for a period of up to five years.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

COBRA Notice

This notice includes important information about your rights and obligations under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Under federal COBRA law, the State of Oregon is required to offer covered employees and family members the opportunity for a temporary extension of health coverage (called "Continuation Coverage"). This

Continuation Coverage is offered at group rates when coverage under the medical plan would otherwise end due to certain qualifying events. This notice is intended to inform all plan participants, in a summary fashion, of your potential future options and obligations under the Continuation Coverage provisions. Should an actual qualifying event occur in the future, the COBRA Administrator will send you additional information and the appropriate election notice at that time.

Note that Medicare entitlement, as referred to later in this provision, very seldom causes a loss of coverage, so very rarely triggers COBRA continuation.

The Plan Administrator is the Public Employees' Benefit Board (PEBB) located at 775 Court Street NE in Salem, Oregon. You can contact PEBB at (503) 373-1102 or 1-800-788-0520. COBRA continuation is administered by a third party administrator (TPA).

Continuation Coverage

COBRA coverage is continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. Continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses or domestic partners of employees and dependent children of employees may be qualified beneficiaries.

Qualifying Events For Covered Employee

If you are an employee, you become a qualified beneficiary if you lose eligibility for group coverage for any of the following reasons (qualifying events):

1. A reduction in your hours of employment; or
2. Your employment ends for any reason.

Qualifying Events For Covered Spouse Or Domestic Partner

If you are the covered spouse or domestic partner, you become a qualified beneficiary if you lose eligibility for group coverage for any of the following reasons (qualifying events):

1. Death of the employee;
2. Termination of the employee's employment or reduction in the employee's hours of employment;
3. The employee becomes enrolled in Medicare (Part A, Part B, or both); or
4. Divorce or legal separation from the employee or termination of your domestic partnership.

Qualifying Events For Covered Dependent Children

Your dependent children become qualified beneficiaries if they lose eligibility for group coverage for any of the following reasons (qualifying events):

1. Death of the employee;
2. Termination of the employee's employment or reduction in the employee's hours of employment;
3. The employee becomes enrolled in Medicare (Part A, Part B, or both);
4. The employee's divorce or legal separation, or termination of a domestic partnership; or
5. The child ceases to qualify as a dependent child under PEBB eligibility.

Important Employee, Spouse Or Domestic Partner, And Dependent Notification Requirements

Under the law, the employee or family member is responsible to inform the agency's payroll/personnel office or benefits office within 60 days of the following qualifying events:

1. A divorce;
2. A legal separation;
3. A termination of domestic partnership; or
4. A dependent child losing dependent status under PEBB eligibility.

If this notification is not mailed within the 60 days, rights to Continuation Coverage will be forfeited.

Employer Notification Requirements

When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the COBRA Administrator of the qualifying event within 30 days of the date coverage ends.

Election Period

When the agency payroll/personnel or benefits office receives notification that one of these events has occurred, they will notify the COBRA Administrator. The Administrator will notify qualified beneficiaries by first class mail of their right to choose Continuation Coverage within 14 days. Under COBRA provisions, each individual covered on the active group plan on the day before the qualifying event or any newborn or adopted children added to your policy during the COBRA time period has the right to elect Continuation Coverage. You, your spouse or domestic partner can elect continuation coverage for any combination of individuals who would otherwise lose coverage.

Under the law, you have 60 days from the date you would lose coverage due to a qualifying event or the date on your notification letter; whichever is the later date, to elect Continuation Coverage. The Public Employees' Benefit Board (PEBB) Eligibility Rules allow an employee or covered family member to change their plan choices upon experiencing a qualifying event. This means that not only is the employee or family member given the right to continue coverage under COBRA, but may also choose any medical plan at the time of the COBRA election. If a qualified beneficiary does not elect Continuation Coverage within this period, rights to continue medical insurance will end.

If you choose Continuation Coverage, PEBB is required to offer you coverage that is identical to the coverage provided under the group plan to similarly situated active employees and family members. Should coverage change or be modified for active employees, then the change or modification will be made to your coverage as well. COBRA participants will also be offered an annual open enrollment period. This open enrollment period allows participants to change plans and add or delete eligible dependents. If you add family members, the family members will not be COBRA qualified beneficiaries and will not be permitted to make independent COBRA elections.

Length Of Continuation Coverage

The law requires that you receive the opportunity to maintain Continuation Coverage from the time of the qualifying event for the following periods:

1. Up to 18 months if you qualify due to termination or reduction in working hours;

2. Up to 29 months if you qualify due to termination or reduction in working hours and are deemed disabled by the Social Security Administration at the time of your qualifying event or at any time prior to or during the first 60 days of Continuation Coverage. You must inform the COBRA Administrator within 60 days of receipt of the Social Security disability determination and within the 18-month continuation period to qualify for this extended coverage which will be at an increased premium of up to 150%. Newborns and children placed for adoption must be disabled during the first 60 days after birth or placement to qualify for this extension.

3. Up to 36 months for spouses or domestic partners and dependents after the employee's enrollment in Medicare (if the enrollment is 18 months or less prior to termination of employment or reduction of hours), if you qualify due to Medicare entitlement (enrollment in), death of a covered employee, divorce or legal separation, termination of a domestic partnership, or if you are a dependent child who is no longer eligible to be on the plan.

4. Up to 10 years if you are the spouse or domestic partner of a covered employee and you are 55 years of age or older and qualify due to death of a covered employee, divorce or legal separation, or termination of domestic partnership (ORS 743.600 - 743-602).

However, the law also provides that your Continuation Coverage will end for any of the following reasons:

1. The State of Oregon no longer provides group medical coverage to any of its employees;

2. Any required premium for Continuation Coverage is not paid in a timely manner;

3. A qualified beneficiary becomes covered, after the date of COBRA election, under another group health plan that does not exclude or limit coverage for specific conditions solely because they are pre-existing condition(s) which apply to you or to a covered dependent (this does not apply to CHAMPUS or Tri-Care);

4. A qualified beneficiary becomes covered (after the date of COBRA election) under Medicare.

5. The Social Security Administration no longer considers you disabled under the provision of the disability extension, but COBRA coverage will not terminate earlier than the end of the original 18 month continuation period.

6. A qualified beneficiary notifies the COBRA Administrator they wish to cancel COBRA continuation coverage.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follows.

If you or your family members become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated while the limitation is in effect. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, PEBB may terminate your COBRA coverage.

Eligibility And Premiums

Qualified beneficiaries do not have to show they are insurable to choose Continuation Coverage. However, they must have been covered by the active group plan on the day before the event to be eligible for Continuation Coverage. An exception to this rule is if, while on Continuation Coverage, a baby is born to, adopted, or placed for adoption by a covered employee. The newborn or adopted child can be added to the plan and will gain the rights of all other qualified beneficiaries. The COBRA Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

A qualified beneficiary will have to pay all of the premium plus a 2% administration charge for Continuation Coverage. These premiums will be

adjusted during the continuation period if the active employee premiums change. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, the State of Oregon will charge 150% of the premium during the extended coverage period. Beneficiaries will be billed on a monthly basis for the premiums due. There is a maximum grace period of 30 days for payment of the regularly scheduled premium.

At the end of the 18, 29, or 36 months of continuation coverage, a qualified beneficiary will be allowed to enroll in an individual portability plan provided by the same insurance carrier, as long as portability plans continue to be offered. You may contact the insurance carrier to enroll in a portability plan before, during, or following your COBRA continuation period. To qualify for a portability plan you must make application directly to the medical carrier within 63 days following the end of your Continuation Coverage or any time during your Continuation Period. Coverage on a portability plan will differ from the group plan and may exclude certain conditions or services offered under the group plan. Contact the carrier for further details.

Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Questions

Remember, this notice is simply a summary of your potential future options under COBRA. Should an actual qualifying event occur and it is determined that you are eligible for COBRA, you will be notified of your COBRA rights at that time. If any covered individual does not understand any part of this summary notice or has questions regarding the beneficiaries' obligations, please contact PEBB at:

- (503) 373-1102 or (800) 788-0520 (outside Salem).
- inquiries.pebb@state.or.us
- http://pebb.das.state.or.us

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

CONVERSION TO PORTABILITY HEALTH BENEFIT PLANS

If you or your insured dependents lose eligibility for coverage under this policy, you and/or your insured dependents may be entitled to coverage under one of our portability health benefit plans, or one of our products for Medicare eligible individuals which we are offering at that time. ''Portability health benefit plans'' are health benefit plans for eligible individuals that are required to be offered by all group carriers in Oregon. The purpose of

portability plans is to improve the availability and affordability of health benefit plans for individuals leaving group coverage.

Eligibility For A Portability Plan

To be eligible for one of the portability plans, you or your insured spouse or any eligible dependents must:

- have terminated coverage or been terminated from coverage due to loss of eligibility;
- not be eligible for Medicare coverage or coverage under this policy (except under federal COBRA or Oregon State continuation coverage) or any other health benefit plan;
- have been continuously covered up to the time of termination of coverage under this policy as follows:
  - for at least 180 days under this policy (including federal COBRA or Oregon State continuation coverage) or this policy and one or more prior Oregon group medical insurance contracts; or
  - for at least 18 months of prior credible coverage but less than 180 days of combined Oregon group medical insurance coverage. In that situation, if you or your insured dependent are eligible for either federal COBRA or Oregon State continuation coverage at the time of termination from this policy, you or your insured dependent must enroll on continuation coverage until you or your insured dependent has a total of at least 180 days of continuous Oregon group medical insurance coverage. If you or your insured dependent is not eligible for continuation coverage, this continuation coverage requirement does not apply;
- have been a resident of the State of Oregon at the time coverage under this policy terminated (including any federal COBRA or Oregon State continuation coverage) or within 63 days of such coverage termination; and
- satisfy any other provisions of the portability plan.

How To Apply For A Portability Plan

In order to exercise the right to one of the portability plan options, the person must:

- submit a written application to us;
- apply within 63 days of termination of prior Oregon group medical insurance coverage or at any time during continuation coverage under federal COBRA or Oregon State law; and
- make the required premium payment.

Please note that once you enroll in a portability plan, you may not reenroll under this policy unless you are again eligible for coverage under the policy.

Portability Health Benefit Plan Options

For eligible individuals leaving their group coverage, we offer the following types of portability health benefit plans:

- a ‘‘prevailing cost plan’’, which includes benefit coverages and premiums that are prevalent in the Oregon group health insurance market; and

- a ‘‘low cost plan,’’ which emphasizes affordability for eligible individuals.

For information regarding the individual portability coverage, a special representative in our Member Services department is available to answer your questions.

Telephone: (503)-220-6363
Toll-free: 1-800-777-3168

GENERAL PROVISIONS

The following section explains various provisions concerning the relationship between the group and us.

Group Is The Agent

The group is your and your insured dependent’s agent for all purposes under this policy and not the agent of Regence BlueCross BlueShield of Oregon.

Relationship To Blue Cross And Blue Shield Association

The group on behalf of itself and its insured employees hereby expressly acknowledges its understanding that this policy constitutes a policy solely between the group and Regence BlueCross BlueShield of Oregon, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, and association of independent Blue Cross and Blue Shield Plans (the ‘‘Association’’), permitting Regence BlueCross BlueShield of Oregon to use the Blue Cross and Blue Shield Service Marks in the State of Oregon and a portion of the State of Washington, and that Regence BlueCross BlueShield of Oregon is not contracting as the agent of the Association. The group on behalf of itself and its insured employees further acknowledges and agrees that it has not entered into this policy based upon representations by any person or entity other than Regence BlueCross BlueShield of Oregon and that no person or entity other than Regence BlueCross BlueShield of Oregon shall be held accountable or liable to the group or the insured employees for any of our obligations to the group or the insured employees created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Regence

BlueCross BlueShield of Oregon other than those obligations created under other provisions of this policy.

CUSTOMER SERVICE

The Regence BlueCross BlueShield of Oregon home office in Portland and the branch offices are maintained to meet your servicing needs. Blue Cross and Blue Shield plans are located in cities throughout the United States with additional offices in Puerto Rico, Jamaica, and Canada.

Regence BlueCross BlueShield of Oregon Customer Service hours are 7:30 a.m. to 5:15 p.m.

- From Portland dialing area, call (503) 220-3849.
- From Oregon outside the Portland area, call 1-800-826-9813.

HEALTH PROMOTION PROGRAMS

The descriptions of the following health promotion programs are provided in this member handbook as a convenience. These programs are not insurance. They are a complement to, but do not form a part of, the group health plan.

FREE & CLEAR ® QUIT FOR LIFE™ PROGRAM

Regence BCBSO is excited to offer PEBB members the Free & Clear® Quit For Life™ Program. This program addresses tobacco dependence, through a clinically proven, comprehensive approach to tobacco cessation that treats all 3 aspects of tobacco use: physical addiction, psychological dependence and behavioral patterns. The expert Quit Coaches will create a quit plan just for you that includes:

- One-on-one phone based treatment sessions
- Unlimited toll-free telephone access to Quit Coaches
- A Quit Kit of materials designed to help participants quit tobacco through active self-management
- Recommendations on an direct fulfillment of nicotine replacement therapy, if appropriate
- Information and decision support for bupropion, if appropriate

Free & Clear can be reached at: 1-866-QUIT-4-LIFE (784-8454).

- Hours: Monday – Sunday 5:00 a.m. – 9:00 p.m. Pacific Time
- Hours: Monday – Sunday 6:00 a.m. – 10:00 p.m. Mountain Time
- Hours: Monday – Sunday 7:00 a.m. – 11:00 p.m. Central Time
- Hours: Monday – Sunday 8:00 a.m. – Midnight Eastern Time
- After hours voicemail: All messages returned within 24 hours

Languages Spoken

- Translation services for many languages
- English/Spanish tobacco treatment staff and supervisors
- TTY available 1-877-777-6534

To find out more about the Free & Clear Quit For Life Program, call 1-866-QUIT-4-LIFE (784-8454).

SPECIAL BEGINNINGS®

Special Beginnings® is an optional program providing a coordinated method of prenatal risk assessment and support for expectant mothers, designed to decrease the incidence of pregnancy complications and increase the chances of giving birth to full-term, healthy babies. Participation by the expectant mother (you, your enrolled spouse, or an enrolled dependent female child) is voluntary and confidential, and is offered at no additional cost to you.

Registering for the program is easy: Simply call Regence BlueCross BlueShield of Oregon at 1-888-JOY-BABY (569-2229). After registration, everything the expectant mother needs to participate will be sent directly to your home in a prenatal kit that includes:

- a confidential questionnaire which is used to evaluate the expectant mother's risk for potential problems;
- a pregnancy calendar; and
- an illustrated book on prenatal care.

Other benefits of the program include:

- personalized monitoring of the expectant mother's care throughout the pregnancy, along with 24-hour, toll-free telephone access to registered nurses who are experienced in working with expectant mothers and newborns;
- educational materials based on information provided in the prenatal risk assessment you return to Special Beginnings®;
- referrals to maternity services available in your area; and
- a gift upon completion of the program.

CAREENHANCE®

CareEnhance® Nurse Advice Line is a service brought to you by The Regence Group. This service is designed to give you accurate, reliable answers and get you on the road to recovery as quickly as possible by providing access to a registered nurse **24 hours a day**, **7 days a week**.

Registered nurses can help you understand health issues and treatment options, review specific questions to ask your providers, offer insights into current research on treatments and diagnostic procedures, and explain the risks and benefits of various options.

While nurse advisors cannot necessarily prescribe or give medical advice, they do empower you to make informed decisions and give you the support and information you need to maximize your care.

Call the CareEnhance® Nurse Advice Line at (1-800-267-6729):

- when you're sick, hurt or need health care advice;
- when you're not sure whether to go to the emergency room, see your doctor, or treat your problems at home; or
- if you have health questions about things like medications and medical procedures;

CareEnhance® nurses will help you:

- learn self care for minor illnesses and injuries;
- understand diagnosed conditions;
- discover and evaluate possible benefits and risks of various treatment options; and
- choose the best time and place for care.

You can also logon to http://www.or.regence.com/careenhance for online health care information. Please note that all CareEnhance® calls are confidential.

Don't forget to use your employee ID for access to the nurse line and website.

ADVICARE[SM]

AdviCare[SM] is a series of Disease Management and High-Risk Case Management programs provided to assist members with chronic and other health conditions in managing their health. The program identifies eligible participants and provides personalized contact with a nurse, educational materials, Internet tools, and other services for members.

AdviCare is helpful for people who want to take control of serious health conditions. The program is designed to work with members' schedules and personal health needs. The major objectives of AdviCare are to:

- improve member health status and outcomes;
- enhance patient satisfaction with the overall care experience;
- improve physician satisfaction;
- reduce total health-care costs; and
- reduce employee absenteeism.

Conditions managed with the program are:

- asthma, diabetes, chronic obstructive pulmonary disease, coronary heart disease;
- impact conditions: atrial fibrillation, acid-related stomach disorders, chronic back pain, decubitus ulcers, fibromyalgia, hepatitis C, irritable bowel syndrome, inflammatory bowel disease, osteoarthritis, osteoporosis and urinary incontinence; and
- high-risk case management.

Members receive:

- introductory packet and welcome call;
- conveniently scheduled "care calls" for members that provide individual support based on claims and a clinical assessment;
- self-care goal reminders mailed to members whenever new goals are established;
- nurses available toll-free 24 hours a day, seven days a week;
- mailed reminders about important screening tests and standards of care, and
- an online health risk assessment tool.

For general questions regarding this program you may contact Customer Service from the Portland dialing area at (503) 220-3849 or from Oregon outside the Portland area at 1-800-826-9813. Eligible members with a qualifying condition may also self-refer by calling (866) 782-7241.

REGENCE HEALTH COACH

The Regence Health Coach program provides information and support to avoid health problems or to improve and protect your health. The program is a benefit of your health-insurance policy and is free of charge.

Here is what you will receive from the program:

- An enrollment questionnaire that helps you assess your current health habits.
- A follow-up consultation with one of our health coaches that reviews your enrollment questionnaire and helps you choose a goal or two toward better health. The health coach is there to provide you with educational materials on any health-related subject, and to offer encouragement and support as you work toward meeting your goal(s).
- A free pedometer and walking log.
- Telephone contact from your health coach for ongoing education and support as you are working toward those healthy lifestyle goals.
- Toll-free access to your health coach to address any of your health-related concerns or for continued encouragement and support.
- A $25 gift certificate upon completion of the program.

Why is PEBB participating in this?
We know that making lifestyle changes can prevent some illnesses and diseases. That is why PEBB has partnered with Regence BlueCross BlueShield of Oregon to provide employees and dependents with health coaches, who can help people set and reach goals for a healthier life. Everyone wins – the employee who is healthier, PEBB who has a healthier workforce with less absenteeism and Regence BlueCross BlueShield of Oregon because it costs less to insure healthier people.

Will PEBB or my boss know that I'm participating or will they know what my medical conditions are?
Your participation and your medical information are confidential. PEBB will receive summary reports showing totals only. No individuals are identified.

What if I set a goal and don't reach it?
There are no repercussions if you don't reach your goal. It is a personal goal you set for yourself and your health coach will provide you with materials, encouragement and support to try to help you reach those goals.

Can my family members join?
Anyone who has insurance coverage through PEBB is eligible to enroll.

Is it mandatory?

Enrollment and participation are voluntary. Please consider joining *the Regence Health Coach Program*. What do you have to lose? To enroll, or to ask questions, please call (800) 632-2022, choose menu option 4, then extension 6558.

BACK ON TRACK

Regence is pleased to introduce the *Back on Track* program. A program for employees and adult dependents with back problems brought to you by Regence and PEBB.

If you don't have back pain, you probably know someone who does. That's because 80% of adults have back pain at some point in their lives. In fact, back pain is second only to coughing as a reason for seeing a doctor. Yet, despite being so common, back pain is overwhelmingly misunderstood.

That's why this program is so important.

Back on Track provides information and support to PEBB employees and their adult dependents who experience back problems. Specifically, the program educates you and your family about back pain so you can deal with it in the most effective manner—and understand both the common myths and the facts about back pain.

You have access to a specially trained *Regence Back Health Coach.* You can call the coaching line toll free at 888-277-1544 or TTY for the hearing impaired at 888-277-1582 24 hours a day, seven days a week. Best of all, Regence provides this program at no cost to you!

Call a *Regence Back Health Coach* to:

- Learn about treatment choices and their risks and benefits
- Get an educational video or DVD on a specific back problem
- Go over questions to discuss with your doctor

Or visit our website at www.thedialogcenter.com/backontrack/

Regence
BlueCross BlueShield
of Oregon

An Independent Licensee of the Blue Cross and Blue Shield Association