BridgeSpan Standard Silver Plan EPO OHSU Plus

Individual Group Number: 39000201

2019 Medical Benefit

NONDISCRIMINATION NOTICE

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

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

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

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

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Customer Service
1-855-857-9943 (TTY: 711)

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

Customer Service
Civil Rights Coordinator
M/S CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-855-857-9943, (TTY: 711)
Fax: 1-888-309-8784
CS@BridgeSpanHealth.com

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

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

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

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

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-857-9943 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-857-9943 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-857-9943 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-857-9943 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-857-9943 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-857-9943 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-857-9943 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-857-9943（TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-855-857-9943 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-855-857-9943 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-857-9943 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-857-9943 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-857-9943 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-855-857-9943 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-855-857-9943 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-857-9943 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-857-9943 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-857-9943 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-855-857-9943 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-857-9943 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-857-9943 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-855-857-9943 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-857-9943 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-857-9943 (رقم هاتف الصم والبكم TTY: 711)

Introduction

BridgeSpan Health Company

Street Address:
2890 E. Cottonwood Parkway
Salt Lake City, UT 84121

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

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

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

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

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

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

As You read this Policy, please keep in mind that references to "You" and "Your" refer to both the Policyholder and Enrolled Dependents. The terms "We," "Us" and "Our" refer to BridgeSpan Health Company and the term "Policyholder" means a person who is enrolled for coverage under a BridgeSpan Health Company health insurance Policy, and whose name appears on the records of BridgeSpan Health Company as the individual to whom this Policy was issued. Policyholder does not mean a dependent under this Policy. Other terms are defined in the Definitions Section at the back of this Policy or where they are first used and are designated by the first letter being capitalized.

POLICY
This Policy is a Health Benefit Plan for individuals and their families. This Policy

describes benefits effective **January 1, 2019**, for the Policyholder and Enrolled Dependents. This Policy provides the evidence and a description of the terms and benefits of coverage. This Policy, including Your application, endorsements and attached papers constitutes the entire contract. This Policy replaces any policy, plan description or certificate previously issued by Us and makes it void.
BridgeSpan Health Company agrees to provide benefits for Medically Necessary services as described in this Policy, subject to all of the terms, conditions, exclusions and limitations in this Policy, including endorsements affixed hereto. This agreement is in consideration of the premium payments hereinafter stipulated and in further consideration of the application and statements currently on file with Us and signed by the Policyholder for and on behalf of the Policyholder and/or any Enrolled Dependents listed in this Policy, which are hereby referred to and made a part of this Policy.

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

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008
This coverage complies with the Mental Health Parity and Addiction Equity Act of 2008.

ESSENTIAL HEALTH BENEFITS
This coverage complies with the essential health benefits in the following ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services including chronic disease management; and pediatric services, including vision care.

RISK-SHARING ARRANGEMENTS WITH PROVIDERS
This plan includes "Risk-Sharing Arrangements" with Providers who render services to the Insureds of this plan. Under a Risk-Sharing Arrangement, the Providers that are responsible for delivering health care services are subject to some financial risk or reward for the services they deliver. See the definition of Risk-Sharing Arrangement in the Definitions section. Additional information on Our Risk-Sharing Arrangements is available upon request by calling Customer Service at the number listed below.

NOTICE OF PRIVACY PRACTICES
BridgeSpan Health Company has a Notice of Privacy Practices that is available by calling Customer Service or visiting the Web site listed below.

CONTACT INFORMATION
If You have questions, would like to learn more about Your coverage or would like to request written or electronic information regarding any other plan that We offer, talk with one of Our Customer Service representatives. Phone lines are open Monday-Friday 5

a.m. – 8 p.m. and Saturday 8 a.m. – 4:30 p.m. Pacific Time.

Customer Service: 1 (855) 857-9943
(TTY: 711)

Or visit Our Web site at: **bridgespanhealth.com**

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

Vision Service Plan. For vision Provider and benefit questions, call Vision Service Plan at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance), Monday-Friday 5 a.m. - 8 p.m. Saturday 7 a.m. - 8 p.m., and Sunday 7 a.m. - 7 p.m. You may also visit VSP's Web site at **www.vsp.com**.

Christopher G. Blanton
President
BridgeSpan Health Company

Thomas J. Hartford
Secretary
BridgeSpan Health Company

Using Your BridgeSpan Standard Silver Plan EPO OHSU Plus Policy

YOUR PARTNER IN HEALTH CARE

BridgeSpan Health Company is pleased that You have chosen Us as Your partner in health care. It's important to have continued protection against unexpected health care costs. Thanks to the purchase of BridgeSpan Standard Silver Plan EPO OHSU Plus Policy, You have coverage that's affordable and provided by a partner You can trust in times when it matters most. Your vision coverage is provided by Us, in collaboration with Vision Service Plan Insurance Company (VSP), which coordinates the provision of benefits and claims processing for this plan.

BridgeSpan Standard Silver Plan EPO OHSU Plus provides You with great benefits that are quickly accessible and easy to understand, thanks to broad access to Providers and innovative tools. With BridgeSpan Standard Silver Plan EPO OHSU Plus health care coverage, You will discover more personal freedom to make informed health care decisions, as well as the assistance You need to navigate the health care system.

You may change Your Plan if You experience a qualifying event described under the special enrollment provision. Beyond this, You cannot change Your Plan until the next open enrollment period.

EXCLUSIVE PROVIDERS

Except for those Covered Services (Ambulance Services, Blood Bank and Emergency Room) specified for Out-of-Network Providers in the Medical Benefits Section, BridgeSpan Standard Silver Plan EPO OHSU Plus requires that You receive Covered Services from In-Network Providers.

For services under the Gene Therapy and Adoptive Cellular Therapy benefit to be covered, services must be received at a Center of Excellence identified by Us for the particular therapy.

To receive care at the lowest amount of out-of-pocket expense, You must receive Covered Services from Your network (In-Network). Receiving Covered Services from Your network (In-Network) means You will not be billed for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

Out-of-Network Providers include those Providers who have contracted with Us but are outside Your network, and Providers outside Your state of residence but inside Your network.
You can go to **bridgespanhealth.com** for further Provider network information for Your medical benefits.

ADDITIONAL MEMBERSHIP ADVANTAGES

When You purchased BridgeSpan Standard Silver Plan EPO OHSU Plus, You were provided with more than just great coverage. You also acquired BridgeSpan Health Company membership, which offers additional valuable services. The advantages of BridgeSpan Health Company membership include access to discounts on select items and services, personalized health care planning information, health-related events and innovative health-decision tools, as well as a team dedicated to Your personal health care needs. You also have access to **bridgespanhealth.com**, an interactive

environment that can help You navigate Your way through health care decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE INDIVIDUAL POLICY, BUT ARE NOT INSURANCE.**

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

  - view recent claims, benefits, and coverage;
  - find a contracting Provider;
  - participate in online wellness programs and use tools to estimate upcoming healthcare costs;
  - discover discounts on select items and services*;
  - identify Participating Pharmacies;
  - find alternatives to expensive medicines;
  - learn about prescriptions for various Illnesses; and
  - compare medications based upon performance and cost, as well as discover how to receive discounts on prescriptions.

*NOTE: If You choose to access these discounts, You may receive savings on an item or service that is covered by this Policy, that also may create savings or administrative fees for Us. **ANY SUCH DISCOUNTS OR COUPONS ARE COMPLEMENTS TO THE INDIVIDUAL POLICY, BUT ARE NOT INSURANCE**.

Table of Contents

Understanding Your Benefits

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

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

MAXIMUM BENEFITS

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

OUT-OF-POCKET MAXIMUM

You can meet the In-Network Out-of-Pocket Maximum by payments of Deductible, Copayments and/or Coinsurance as specifically indicated in the Medical Benefits Section. An Insured's payment of any Deductible, Copayment and/or Coinsurance for Covered Services listed in the Medical Benefits Section will apply toward the In-Network Out-of-Pocket Maximum amount. Any amounts You pay for non-Covered Services or amounts in excess of the Allowed Amount do not apply toward the Out-of-Pocket Maximum. Further, any reduction in Your Copayment and/or Coinsurance for Prescription Medications resulting from the use of a drug manufacturer coupon does not count toward the Out-of-Pocket Maximum. You will continue to be responsible for amounts that do not apply toward the Out-of-Pocket Maximum, even after You reach this Policy's Out-of-Pocket Maximum.

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

The Family Out-of-Pocket Maximum for a Calendar Year is satisfied when two or more Family members' Deductibles, Copayments and Coinsurance for Covered Services for that Calendar Year total and meet the Family's Out-of-Pocket Maximum amount. However, no one Insured will be required to meet more than the individual Out-of-Pocket Maximum amount toward the Family Out-of-Pocket Maximum in a Calendar Year.

Periodically, We may make payments to, or receive payments or refunds from, In-Network Providers under Risk-Sharing Arrangements We have with them. As stated below, those payments do not affect Your Copayments, Coinsurance, or Deductibles, and consequently also do not affect Your Out-of-Pocket Maximums. See the definition of Risk-Sharing Arrangement in the Definitions section.

COPAYMENTS
A Copayment means a fixed dollar amount that You must pay directly to a provider of services or supplies, including medications or, each time You receive a specified service or medication (as applicable). The Copayment will be the lesser of the fixed dollar amount or the Allowed Amount for the service or medication. Refer to the Medical Benefits Section to understand what Copayments You are responsible for.

Periodically, We may make payments to, or receive payments or refunds from, In-Network Providers under Risk-Sharing Arrangements We have with them, however, those payments do not affect Your Copayments.

PERCENTAGE PAID UNDER THIS POLICY (COINSURANCE)
Once You have satisfied any applicable Deductible and any applicable Copayment, We pay a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When Our payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). Your Coinsurance will be based upon the lesser of the billed charges or the Allowed Amount. The percentage We pay varies, depending on the kind of service or supply You received and who rendered it.

We do not reimburse Providers for charges above the Allowed Amount. An In-Network Provider will not charge You for any balances for Covered Services beyond Your Deductible, Copayment and/or Coinsurance amount. We do not cover services provided by Out-of-Network Providers, except as specified in the Medical Benefits Section. For eligible Covered Services received from an Out-of-Network Provider, the Out-of-Network Provider may bill You for any balances over Our payment level in addition to any Deductible, Copayment and/or Coinsurance amount. See the Definitions Section for descriptions of Providers.

Periodically, We may make payments to, or receive payments or refunds from, In-Network Providers under Risk-Sharing Arrangements We have with them, however, those payments do not affect Your Coinsurance, which is calculated from the billed charges or Allowed Amount. See the definitions of Allowed Amount and Risk-Sharing Arrangement in the Definitions section.

DEDUCTIBLES
We will begin to pay benefits for Covered Services in any Calendar Year only after an Insured satisfies the Calendar Year In-Network Deductible. An Insured satisfies the In-Network Deductible by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible. An Insured's Deductible amount, if any, paid toward Covered Services that show under the Provider "All" will apply toward the In-Network Deductible amount.

The Family Calendar Year Deductible is satisfied when two or more covered Family members' Allowed Amounts for Covered Services for that Calendar Year total and meet the Family Deductible amount. However, no one Insured will be required to meet more than the individual Deductible amount toward the Family Deductible in a Calendar Year.

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

not count toward the Deductible.

Periodically, We may make payments to, or receive payments or refunds from, In-Network Providers under Risk-Sharing Arrangements We have with them, however, those payments do not affect Your Deductible, which is calculated from Allowed Amounts. See the definitions of Allowed Amount and Risk-Sharing Arrangement in the Definitions section.

HOW CALENDAR YEAR BENEFITS RENEW

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

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

Medical Benefits

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

All covered benefits are subject to the limitations, exclusions and provisions of this Policy. In some cases, We may limit benefits or coverage to a less costly and Medically Necessary alternative item. To be covered, medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). Also, a Provider practicing within the scope of his or her license must render the service. Please see the Definitions Section in the back of this Policy for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

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

NOTE: If You choose to access new medical supplies, equipment and devices through Our Web site, We may receive administrative fees or similar compensation from the Commercial Seller and/or You may receive discounts or coupons for Your purchases. **ANY SUCH DISCOUNTS OR COUPONS ARE A COMPLEMENT TO THE INDIVIDUAL POLICY, BUT ARE NOT INSURANCE**.

A Health Intervention may be medically indicated or otherwise be Medically Necessary, yet not be a Covered Service in this Policy.

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

CALENDAR YEAR OUT-OF-POCKET MAXIMUM
In-Network
Per Insured: $2,350
Per Family: $4,700

Out-of-Network
Not applicable

COPAYMENTS AND COINSURANCE
Copayments and Coinsurance are listed in the tables for Covered Services for each

applicable benefit.

CALENDAR YEAR DEDUCTIBLES
In-Network
Per Insured: $850
Per Family: $1,700

Out-of-Network
Not applicable

You do not need to meet any Deductible before receiving benefits for:
- In-Network Preventive Care and Immunizations;
- In-Network Office or Urgent Care Facility Visits - Illness or Injury;
- In-Network Diabetes Management Associated with Pregnancy;
- In-Network medical colonoscopy associated with positive fecal test;
- In-Network Biofeedback;
- In-Network outpatient Cardiac Rehabilitation;
- In-Network Diabetic Education;
- In-Network outpatient Habilitative Services;
- In-Network outpatient office / psychotherapy visits for Mental Health or Substance Use Disorder Services;
- In-Network Nutritional Counseling;
- In-Network Pediatric Vision services;
- In-Network outpatient Rehabilitative Services;
- In-Network Reproductive Health Care Services; and
- In-Network Telehealth.

Furthermore, You do not need to meet the Deductible when You fill Covered Prescription Medications.

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

Provider: In-Network	Provider: Out-of-Network
Payment: We pay 100% of the Allowed Amount.	**Payment:** Not Covered

We cover preventive care services provided by a professional Provider or facility. Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care, routine immunizations and routine health screenings. Also included is Provider counseling for tobacco use cessation and medications prescribed for tobacco use cessation. See the Prescription Medications benefit in this Policy for a description of how tobacco use cessation medications are covered. Coverage for all such services is provided only for preventive care as designated above (which designation may be modified from time to time). Covered expenses do not include immunizations if the Insured receives them only for purposes of travel, occupation or residence in a foreign country.

We cover one new non-Hospital grade breast pump (including its accompanying supplies) per pregnancy at the In-Network benefit level when obtained from a Provider (including a Durable Medical Equipment supplier). Alternatively, a comparable new breast pump may be obtained from an approved Commercial Seller in lieu of a Provider. Benefits for a comparable new breast pump obtained from an approved Commercial Seller will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible breast pumps, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, please visit Our Web site or contact Customer Service.

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

OFFICE OR URGENT CARE FACILITY VISITS – ILLNESS OR INJURY

	Provider: In-Network	Provider: Out-of-Network
Primary Physician or Practitioner	**Payment:** After $15 Copayment per visit, We pay 100% of the Allowed Amount.	**Payment:** Not Covered
Specialist	**Payment:** After $30 Copayment per visit, We pay 100% of the Allowed Amount.	**Payment:** Not Covered
Urgent Care Facility	**Payment:** After $40 Copayment per visit, We pay 100% of the Allowed Amount.	**Payment:** Not Covered

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

OTHER PROFESSIONAL SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

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

Medical Services and Supplies

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

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

Additionally, We cover some Medically Necessary supplies (for example, compression stockings, active wound care supplies and sterile gloves) that are new and obtained from an approved Commercial Seller. Benefits for eligible new supplies will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible new medical supplies, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, please visit Our Web site or contact Customer Service.

Breast, Pelvic and Pap Smear Examinations
We cover breast, pelvic and Pap smear examinations not covered under the Preventive Care and Immunizations benefit.

Diabetes Management Associated with Pregnancy
We cover management of a pregnant Insured's diabetes from the date of conception through six weeks postpartum (for each pregnancy) that is Medically Necessary and a Covered Service not subject to the Copayments, Coinsurance or Deductible.

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

Medical Colonoscopy
We cover medical colonoscopy (and all associated services, such as anesthesia and pathology) performed as a result of a positive fecal test for an Insured age 50 or older not subject to the Copayments, Coinsurance, or Deductible. Preventive colonoscopies are covered under the Preventive Care and Immunizations benefit. All other colonoscopies, including for those Insureds at high-risk, are also covered subject to the Deductible, Copayment and/or Coinsurance.

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

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

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

Therapeutic Injections
We cover therapeutic injections and related supplies when given in a professional Provider's office.

A selected list of Self-Administrable Injectable Medications is covered under the Prescription Medications benefit.

AMBULANCE SERVICES

Provider: All
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

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

AMBULATORY SURGICAL CENTER

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

We cover outpatient services and supplies of an Ambulatory Surgical Center (including services of staff Providers) for Injury and Illness.

APPROVED CLINICAL TRIALS

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

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

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

- Approved or funded by one or more of:
  - The National Institutes of Health (NIH), the CDC, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid or a cooperative group or center of any of those entities;

- Or, a cooperative group or center of the Department of Defense (DOD) or the Department of Veteran's Affairs (VA);
- A qualified non-governmental research entity identified in guidelines issued by the NIH for center approval grants; or
- The VA, DOD, or Department of Energy, provided it is reviewed and approved through a peer review system that the Department of Health and Human Services has determined both is comparable to that of the NIH and assures unbiased review of the highest scientific standards by qualified individuals without an interest in the outcome of the review; or

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

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

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

BIOFEEDBACK

Provider: In-Network	Provider: Out-of-Network
Payment: After $15 Copayment per visit, We pay 100% of the Allowed Amount.	**Payment:** Not Covered
Limit: ten visits for migraine headaches or urinary incontinence combined per Insured Lifetime	

We cover biofeedback to treat migraine headaches or urinary incontinence. We do not cover biofeedback for other conditions. Biofeedback visits that are applied toward the Deductible, if any, will be applied against the Maximum Benefit limit on these services.

BLOOD BANK

Provider: All
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment of the Allowed Amount will be applied toward the Out-of-Pocket Maximum.

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

CARDIAC REHABILITATION

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After $15 Copayment per visit, We pay 100% of the Allowed Amount.	**Payment:** Not Covered
Limit: 36 outpatient visits per Insured Lifetime	

We cover Medically Necessary phase I (inpatient) and phase II (short-term outpatient) cardiac rehabilitation services associated with a cardiac rehabilitation exercise program. We do not cover phase III (long-term outpatient) services. Outpatient cardiac rehabilitation visits that are applied toward the Deductible, if any, will be applied against the Maximum Benefit limit on these services.

CHILD ABUSE MEDICAL ASSESSMENT

We cover Child Abuse Medical Assessments including those services provided by an Oregon Community Assessment Center in conducting a Child Abuse Medical Assessment of a child enrolled on this plan subject to the Deductible, Coinsurance and/or Copayments and Maximum Benefits, if any, as specified in the Medical Benefits in this Policy. The services include, but are not limited to, a forensic interview and Mental Health treatment.

Definitions

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

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

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

DENTAL HOSPITALIZATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

We cover inpatient and outpatient services and supplies for hospitalization for Dental Services (including anesthesia), if hospitalization in an Ambulatory Surgical Center or Hospital is necessary to safeguard Your health.

DETOXIFICATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

We cover Medically Necessary detoxification.

DIABETES SUPPLIES AND EQUIPMENT

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

NOTE: In-Network coverage of diabetes supplies is not subject to any Copayments, Coinsurance, or Deductible.

DIABETIC EDUCATION

Provider: In-Network	Provider: Out-of-Network
Payment: We pay 100% of the Allowed Amount.	**Payment:** Not Covered

We cover services and supplies for diabetic self-management training and education. Nutritional therapy is covered under the Nutritional Counseling benefit.

DIALYSIS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

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

DURABLE MEDICAL EQUIPMENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered
Limit: one pair of glasses (frames and lenses) or contact lenses per Insured per Calendar Year to correct visual defect due to severe medical or surgical problem such as stroke, neurological disease, trauma or eye surgery other than refractive procedures. **Limit:** one synthetic wig per Insured per Calendar Year. For reimbursement, You must submit a Prescription Order from Your Provider and an itemized purchase receipt indicating the type of wig and the charges for it. You will be reimbursed at the In-Network benefit level.	

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness or Injury and is appropriate for use in the Insured's home. Examples include insulin pumps and insulin pump supplies, oxygen equipment and wheelchairs. Wigs, glasses or contact lenses that are applied toward the Deductible, if any, will be applied against the Maximum Benefit limit on these services. Durable Medical Equipment is not covered if it serves solely as a comfort or convenience item.

Additionally, We cover new Durable Medical Equipment that is obtained from an approved Commercial Seller. Benefits for eligible new Durable Medical Equipment will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible new Durable Medical Equipment, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, please visit Our Web site or contact Customer Service.

EMERGENCY ROOM (INCLUDING PROFESSIONAL CHARGES)

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** After In-Network Deductible, We pay 90% of the Allowed Amount and You pay balance of billed charges. Your 10% payment of the Allowed Amount will be applied toward the In-Network Out-of-Pocket Maximum.

We cover emergency room services and supplies, including outpatient charges for patient observation and medical screening exams that are required for the stabilization of a patient experiencing an Emergency Medical Condition. For the purpose of this benefit, "stabilization" means to provide Medically Necessary treatment: 1) to assure, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during, or to result from, the transfer of the Insured from a facility; and 2) in the case of a covered Insured, who is pregnant, to perform the

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

GENE THERAPY AND ADOPTIVE CELLULAR THERAPY

Provider: Centers of Excellence	Provider: All Other Providers
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

We cover gene therapies and/or adoptive cellular therapies and associated Medically Necessary Covered Services, if You fulfill Medical Necessity criteria and receive Your therapy from a Provider expressly identified by Us as a Center of Excellence for that therapy. Contact Customer Service for a current list of covered gene therapies and cellular therapies and/or to identify a Center of Excellence, as the lists are subject to change.

Travel Expenses

We reimburse travel expenses (limited to transportation, food, and lodging) for You and a companion (or two companions if You are under age 19) to a combined maximum of $7,500 per course of treatment, when You receive covered gene therapy and/or adoptive cellular therapy at a Center of Excellence. Reimbursable transportation includes only commercial airfare, commercial train fare, or documented auto mileage (calculated per IRS allowances) to the treatment area and local ground transportation to and from treatment within that area during the course of treatment. Keep documentation of Your travel expenses to submit for reimbursement.

GENETIC TESTING

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

HABILITATIVE SERVICES

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered
Limit: 30 days per Insured per Calendar Year (up to 60 days per Calendar Year for head or spinal cord Injury).	

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After $15 Copayment per visit, We pay 100% of the Allowed Amount.	**Payment:** Not Covered
Limit: 30 visits combined per Insured per Calendar Year (up to 30 additional visits per condition may be considered for treatment of neurologic conditions when criteria for supplemental services are met).	

We cover inpatient and outpatient habilitative services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services) and are not services for a Mental Health Condition or Substance Use Disorder. Examples include therapy for a child who is not walking or talking at the expected age. These services and devices may include physical and occupational therapy, speech-language pathology and other services and devices for people with disabilities in a variety of inpatient or outpatient settings.

Habilitative services for Mental Health Conditions or Substance Use Disorders are not subject to a visit limit. Such services are covered under the Mental Health or Substance Use Disorder Services benefit.

Habilitative services that are applied toward the Deductible, if any, will be applied against the Maximum Benefit limit on these services.

HEARING AIDS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

We cover services and supplies for hearing aids and hearing assistive technology systems in accordance with state and federal law when necessary for the treatment of hearing loss. For the purposes of this benefit, "hearing aid" means any nondisposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument

or device. "Hearing assistive technology systems" means devices used with or without hearing aids or cochlear implants to improve the ability of a user with hearing loss to hear in various listening situations, such as being located a distance from a speaker, in an environment with competing background noise or in a room with poor acoustics or reverberation. Hearing aids, services and supplies that are applied toward any Deductible will be applied against any Maximum Benefit limit on these services. This coverage does not include routine hearing examinations or the cost of cords. Please contact Customer Service for specific coverage requirements and limitations.

HOME HEALTH CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

We cover home health care when provided by a licensed agency or facility for home health care. Home health care includes all services for patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility. Durable Medical Equipment associated with home health care services is covered under the Durable Medical Equipment benefit in this Policy.

HOSPICE CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered
Limit: 30 inpatient or outpatient respite care days per Insured Lifetime (limited to a maximum of five consecutive respite days at a time.)	

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

HOSPITAL CARE – INPATIENT AND OUTPATIENT

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

We cover inpatient and outpatient services and supplies of a Hospital for Injury and Illness (including services of staff Providers billed by the Hospital). Room and board is limited to the Hospital's average semiprivate room rate, except where a private room is determined to be necessary. If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. However, an Out-of-Network Provider may bill You for balances beyond any Deductible, Copayment and/or Coinsurance. Please contact Customer Service for further information and guidance. See the Emergency Room benefit in this Medical Benefits Section for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

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

MATERNITY CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

We cover prenatal and postnatal maternity (pregnancy) care, childbirth (vaginal or cesarean), complications of pregnancy and related conditions. There is no limit for the mother's length of inpatient stay. Where the mother is attended by a Provider, the attending Provider will determine an appropriate discharge time, in consultation with the mother. See the Newborn Care benefit in this Medical Benefits Section to see how the care of Your newborn is covered. When provided by an In-Network Provider, any Copayments, Coinsurance, and Deductible do not apply to Medically Necessary Covered Services for management of a pregnant Insured's diabetes from the date of conception through six weeks postpartum for each pregnancy.
Certain services such as screening for gestational diabetes, breastfeeding support, supplies and counseling are covered under Your Preventive Care benefit.

Surrogacy

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

You or any other person or entity occurs after the termination of Your coverage under the Policy).

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

Definitions
In addition to the definitions in the Definitions Section, the following definition applies to this Maternity Care benefit:

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

MEDICAL FOODS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

We cover medical foods for inborn errors of metabolism including, but not limited to, formulas for Phenylketonuria (PKU). For the purpose of this benefit, "medical food" means a food which is formulated to be consumed or administered orally or enterally under the supervision of a Physician. Medical foods are intended for specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. Other services and supplies such as office visits and formula to treat severe intestinal malabsorption are otherwise covered under the appropriate provision in this Medical Benefits Section.

MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

Outpatient Office / Psychotherapy Visits

Provider: In-Network	Provider: Out-of-Network
Payment: After $15 Copayment per visit, We pay 100% of the Allowed Amount.	**Payment:** Not Covered

Other Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

We cover inpatient and outpatient Mental Health and Substance Use Disorder Services, including Applied Behavioral Analysis (ABA) therapy services and gender-affirmation services. Benefits include physical therapy, occupational therapy or speech therapy provided for treatment of a Mental Health Condition.

Definitions

In addition to the definitions in the Definitions Section, the following definitions apply to this Mental Health or Substance Use Disorder Services benefit:

Applied Behavioral Analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human social behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior. ABA therapy services must be provided by a licensed Provider qualified to prescribe and perform ABA therapy services. Providers must submit individualized treatment plans and progress evaluations.

Habilitative means health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services and devices may include physical and occupational therapy, speech-language pathology and other services and devices for people with disabilities in a variety of inpatient or outpatient settings.

Mental Health and Substance Use Disorder Services mean Medically Necessary outpatient services, residential care, partial hospital program or inpatient services provided by a licensed facility or licensed individuals with the exception of Skilled

Nursing Facility services (unless the services are provided by a licensed behavioral health provider for a covered diagnosis), home health services and court ordered treatment (unless the treatment is determined by Us to be Medically Necessary). These services include Habilitative services for Mental Health Conditions or Substance Use Disorders.

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

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

NEWBORN CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

We cover services and supplies, under the newborn's own coverage, in connection with nursery care for the natural newborn or newly adoptive child of the Policyholder or Policyholder's spouse. The newborn child must be eligible and enrolled as explained later in the Who Is Eligible, How to Apply and When Coverage Begins Section. There is no limit for the newborn's length of inpatient stay. For the purpose of this benefit, "newborn care" means the medical services provided to a newborn child following birth including well-baby Hospital nursery charges, unless otherwise covered under the Preventive Care and Immunizations benefit.

NUTRITIONAL COUNSELING

Provider: In-Network	Provider: Out-of-Network
Payment: We pay 100% of the Allowed Amount.	**Payment:** Not Covered

ORTHOTIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

We cover benefits for the purchase of braces, splints, orthopedic appliances and orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body.

Additionally, We cover some orthotic devices that are new and obtained from an approved Commercial Seller. Benefits for eligible new orthotic devices will be covered up to the In-Network benefit level, with reimbursement based on the lesser of either the amount paid to an In-Network Provider or the retail market value. To verify eligible new orthotic devices, find an approved Commercial Seller, instructions for claiming benefits or for additional information on Covered Services, please visit Our Web site or contact Customer Service.

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

PEDIATRIC VISION

We cover benefits for vision care for Insureds under the age of 19. Coverage will be provided for an Insured until the last day of the monthly period in which the Insured turns 19 years of age. Covered Services must be rendered by a Physician or optometrist practicing within the scope of his or her license. We will pay benefits under this Pediatric Vision benefit, not any other provision in this Policy, if a service or supply is covered under both.

Accessing Providers

Your Pediatric Vision benefit allows You to control Your out-of-pocket expenses. You control Your out-of-pocket expenses by choosing a "VSP Doctor."

- **VSP Doctor.** You choose to see a VSP Doctor and save the most in Your out-of-pocket expenses. Choosing this provider option means You will not be billed for balances beyond the Allowed Amount.
- **Out-of-Network Provider.** You choose to see an Out-of-Network Provider that does not have a contract with VSP and You are responsible for all expenses.

Vision Examination

Provider: VSP Doctor	Provider: Out-of-Network
Payment: We pay 100% of the Allowed Amount.	**Payment:** Not Covered
Frequency Period: once every Calendar Year	

We cover one professional complete medical eye examination or visual analysis, including:

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

Contact Lens Evaluation and Fitting Examination

Provider: VSP Doctor	Provider: Out-of-Network
Payment: We pay 100% of the Allowed Amount.	**Payment:** Not Covered
Frequency Period: once every Calendar Year	

We cover services and supplies for one contact lens evaluation and fitting examination.

Lenses

Provider: VSP Doctor	Provider: Out-of-Network
Payment: We pay 100% of the Allowed Amount.	**Payment:** Not Covered
Frequency Period: once every Calendar Year	

Lenses limit: one pair of standard lenses which include the following in either glass or plastic:

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

Contacts limit: in lieu of eyeglasses, one of the following elective contact lens types may be chosen:

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

Contact lenses are available once every Calendar Year in lieu of all other lenses and frame benefits. When You receive contact lenses, You will not be eligible for any lenses and/or frames again until the next Calendar Year.

An annual supply of Necessary Contact Lenses is covered if You have a specific condition for which contact lenses provide better visual correction.

Frames

Provider: VSP Doctor	Provider: Out-of-Network
Payment: We pay 100% of the Allowed Amount.	**Payment:** Not Covered
Frequency Period: once every Calendar Year	

We cover one frame from a VSP Doctor. Covered frames from a VSP Doctor are

limited to the Otis & Piper Eyewear Collection. Frames from a VSP Doctor that are not from the Otis & Piper Collection are not covered, and You will pay the full cost of the frame minus any discount. Refer to the Discounts provision for information on discounts for non-covered materials from a VSP Doctor.

Low Vision Benefit
In addition to the Pediatric Vision benefits described above, We cover low vision benefits for Insureds if vision loss is sufficient enough to prevent reading and performing daily activities. If You fall within this category (check with Your Provider), You will be entitled to professional services as well as ophthalmic materials, subject to the frequency and benefit limitations of these Low Vision Benefits. Consult Your VSP Doctor for more details.

Supplemental Testing

Provider: VSP Doctor	Provider: Out-of-Network
Payment: We pay 100% of the Allowed Amount.	**Payment:** Not Covered
Frequency Period: every two Calendar Years	

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

Supplemental Aids

Provider: VSP Doctor	Provider: Out-of-Network
Payment: We pay 100% of the Allowed Amount.	**Payment:** Not Covered
Frequency Period: every two Calendar Years	

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

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

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

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

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

Limitations
- 20 percent discount applies only when a complete pair of glasses is dispensed.
- Discounts do not apply to sundry items, for example, contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

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

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

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

Corrective Vision Treatment of an Experimental Nature

Costs for Services and/or Supplies Exceeding Benefit Allowances

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

Orthoptics or Vision Training: Except as provided under the Low Vision benefit, We do not cover orthoptics or vision training and any associated supplemental testing.

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

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

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

Two Pair of Glasses in Lieu of Bifocals

Definitions
In addition to the definitions in the Definitions Section, the following definitions apply to

only this Pediatric Vision benefits section:

Allowed Amount means the amount that VSP Doctors (see definition of "VSP Doctor" below) have contractually agreed to accept as payment in full for a service or supply. Charges in excess of the Allowed Amount and charges from an Out-of-Network Provider (see definition of "Out-of-Network Provider" below) are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, please contact Us.

Benefit Authorization means VSP has approved benefits for You.

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

Frequency Period is the number of Calendar Years, usually one or two, that must pass before benefits renew.

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

Out-of-Network Provider means a Provider who is not a VSP Doctor. We do not cover services provided by Out-of-Network Providers.

Provider means a Physician, Practitioner or other individual or organization which is duly licensed to provide vision services.

VSP Doctor means an optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials to Insureds in accordance with the provisions of this coverage.

GENERAL INFORMATION

Freedom of Choice of Provider

Nothing contained in this Policy is designed to restrict You in selecting the Provider of Your choice for vision care.

Submission of Claims and Reimbursement

When You visit a VSP Doctor, the VSP Doctor will submit the claim directly to VSP for payment.

PRESCRIPTION MEDICATIONS

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

Benefits under this Prescription Medications benefit are not subject to the Deductible. You are responsible for paying the following Copayment and/or Coinsurance amounts (at the time of purchase, if the Pharmacy submits the claim electronically). (See below for information on claims that are not submitted electronically and for information on maximum quantities.) Your Copayment and/or Coinsurance will be applied toward the In-Network Out-of-Pocket Maximum.

Copayments and/or Coinsurance do not apply to diabetes supplies and Medically Necessary Prescription Medications for management of a pregnant Insured's diabetes from the date of conception through six weeks postpartum for each pregnancy or for women's contraceptive methods that are not covered under the Preventive Care and Immunizations benefit.

For Self-Administrable Cancer Chemotherapy Medication, Your Coinsurance is the same as Your medical In-Network Coinsurance.

Your Prescription Medication is eligible for a discount if filled at a Preferred Pharmacy. Discounts are $5 off the Copayment or 5% off the Coinsurance. Your cost share will not be lower than $0. Preferred Specialty Medications and Specialty Medications are not eligible for this discount.

For Prescription Medications from a Participating Pharmacy

• $10 for each Preferred Generic Medication on the Drug List
• 25% for each Generic Medication on the Drug List
• $25 for each Preferred Brand-Name Medication on the Drug List
• 50% for each Brand-Name Medication on the Drug List
• 40% for each Preferred Specialty Medication on the Drug List
• 50% for each Specialty Medication on the Drug List

For Prescription Medications from a Participating Mail-Order Supplier

• $20 for each Preferred Generic Medication on the Drug List
• 20% for each Generic Medication on the Drug List
• $50 for each Preferred Brand-Name Medication on the Drug List
• 45% for each Brand-Name Medication on the Drug List

Drug List Changes

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

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

Drug List Exception Process

Non-Drug List medications are not routinely covered under this Prescription Medications benefit; however, a Prescription Medication not on the Drug List may be covered under

certain circumstances. Non-Drug List means those self-administered Prescription Medications not listed in the Drug List on Our Web site.

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

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

The specific medication policy criteria to determine if a Prescription Medication not on the Drug List is Medically Necessary are available on Our Web site. You or Your Provider may request prior authorization by calling Customer Service, or by completing and submitting the form available on Our Web site.

Once Preauthorization has been approved, the Prescription Medication not on the Drug List will be available for coverage at the Substituted Medication Copayment and/or Coinsurance level determined by Your benefit and will count toward any Deductible or Out-of-Pocket Maximum.

Covered Prescription Medications
Benefits under this Prescription Medications benefit are available for the following:

- diabetic supplies (including test strips, glucagon emergency kits, insulin syringes, but not insulin pumps or continuous glucose monitors and their supplies), when obtained with a Prescription Order (insulin pumps or continuous glucose monitors and their supplies are covered under the Durable Medical Equipment benefit);
- Prescription Medications;
- certain preventive medications (including, but not limited to, aspirin, fluoride, iron, and medications for tobacco use cessation, except for Brand-Name Medications not on the Drug List) according to, and as recommended by, the USPSTF, HRSA, and CDC when obtained with a Prescription Order;
- FDA-approved women's prescription and over-the-counter (if presented with a Prescription Order) contraception methods as recommended by the HRSA. These include female condoms, diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide, spermicide, oral contraceptives (combined pill, mini pill, and extended/continuous use pill), contraceptive patch, vaginal ring, contraceptive shot/injection, and emergency contraceptives (both levonorgestrel and ulipristal acetate-containing products);
- immunizations for adults and children according to, and as recommended by, the USPSTF, HRSA and CDC;
- Specialty Medications;
- certain Prescription Medications that are administered by Your Provider as determined by the Pharmacy and Therapeutics (P&T) Committee;
- Self-Administrable Cancer Chemotherapy Medication; and
- Self-Administrable Prescription Medications (including, but not limited to,

Self-Administrable Injectable Medications).

You are not responsible for any applicable Deductible, Copayment and/or Coinsurance when You fill prescriptions at a Participating Pharmacy for specific strengths or quantities of medications that are specifically designated as preventive medications, women's contraceptives, or for immunizations, as specified above. For a list of such medications, please visit Our Web site or contact Customer Service. Also, if Your Provider believes that Our covered preventive medications, including women's contraceptives, are medically inappropriate for You, You may request a coverage exception for a different preventive medication by contacting Customer Service.

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

Nonparticipating Pharmacies are not covered under Your Prescription Medications benefit.

For any Specialty Medication for which the FDA has not restricted distribution to certain Providers, if a Participating Pharmacy demonstrates the ability to provide the same level of services (i.e., special handling, provider coordination, and/or patient education) as a Specialty Pharmacy and accepts all Specialty Pharmacy network terms, then that Specialty Medication from that Participating Pharmacy will be eligible for coverage.

Your member card enables You to participate in this Prescription Medication program, so You must use it to identify Yourself at any Pharmacy. If You do not identify Yourself as Our Insured, a Participating Pharmacy, Specialty Pharmacy or Mail-Order Supplier may charge You more than the Covered Prescription Medication Expense. You can find Participating Pharmacies and a Pharmacy locator on Our Web site or by contacting Customer Service.

Claims Submitted Electronically
You must present Your member card at a Participating Pharmacy for the claim to be submitted electronically. You must pay any required Deductible, Copayment and/or Coinsurance at the time of purchase.

Claims Not Submitted Electronically
When a claim is not submitted electronically, You must pay for the Prescription Medication in full at the time of purchase. For reimbursement, simply complete a Prescription Medication claim form and mail the form and receipt to Us. We will reimburse You based on the Covered Prescription Medication Expense, less any applicable Deductible, Copayment and/or Coinsurance that would have been required had the medication been purchased from and submitted electronically by a Participating Pharmacy. We will send payment directly to You.

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

To buy Prescription Medications through the mail, simply send all of the following items

to a Mail-Order Supplier at the address shown on the prescription mail-order form available on Our Web site (which also includes refill instructions):

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

Preauthorization
Preauthorization may be required so that We can determine that a Prescription Medication is Medically Necessary before it is dispensed. We publish a list of those medications that currently require preauthorization. If You have any questions regarding the list of medications that require preauthorization, You can contact Customer Service or You can view the list on Our Web site. In addition, We notify participating Providers, including Pharmacies, which Prescription Medications require preauthorization. The prescribing Provider must provide the medical information necessary to determine Medical Necessity of Prescription Medications that require preauthorization.

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

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

- **Maximum 30-Day or Greater Supply Limit**
  - **Self-Administrable Cancer Chemotherapy Medications and 30-Day Supply.** The largest allowable quantity for Self-Administrable Cancer Chemotherapy Medication purchased from a Participating Pharmacy or Specialty Pharmacy, is a 30-day supply. A Self-Administrable Cancer Chemotherapy Medication that is a Specialty Medication, must be filled at a Specialty Pharmacy (the first fill is not allowed at a Participating Pharmacy).
  - **Specialty Medications and 30-Day Supply.** The largest allowable quantity for a Specialty Medication purchased from a Specialty Pharmacy, is a 30-day supply. The first fill is allowed at a Participating Pharmacy. Additional fills must be provided at a Specialty Pharmacy. However, some Specialty Medications must have the first and subsequent fills at a Specialty Pharmacy. For more information on those medications, please visit Our Web site or contact Customer Service. Specialty Medications are not allowed through mail-order.
  - **Prescription Contraceptives and 3-Month Supply.** The largest allowable quantity for the first fill of a prescription contraceptive purchased from a Participating Pharmacy or Mail-Order Supplier, is a three-month supply (which may be dispensed in a Provider's office, if available). After the first fill, a 12-month supply is allowed for subsequent fills of the same contraceptive. The Copayment and/or Coinsurance is based on each 30-day supply from a Participating Pharmacy and each 90-day supply from a Mail-Order Supplier.
  - **Mail-Order and 90-Day Supply.** The largest allowable quantity of a Prescription Medication purchased from a Mail-Order Supplier is a 90-day supply. A Provider

may choose to prescribe or You may choose to purchase, some medications in smaller quantities.

- **Participating Pharmacy or Preferred Pharmacy and 90-Day Supply.** The largest allowable quantity of Prescription Medication purchased from a Participating Pharmacy or Preferred Pharmacy is a 90-day supply. A Provider may choose to prescribe, or You may choose to purchase, some medications in smaller quantities. The Copayment and/or Coinsurance is based on each 30-day supply.
- **Participating Pharmacy and 90-Day Multiple-Month Supply.** Except for prescription contraceptives, the largest allowable quantity of a covered Prescription Medication that is packaged exclusively in a multiple-month supply and is purchased from a Participating Pharmacy is the smallest multiple-month supply packaged by the manufacturer for dispensing by Pharmacies. The availability of that supply at a given Pharmacy or time is not a factor in identifying the smallest multiple-month supply. The maximum supply covered for these products is a 90-day supply (even if the packaging includes a larger supply). The Copayment and/or Coinsurance is based on each 30-day supply within that multiple-month supply.

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

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

- **Refills**
  We will cover refills from a Pharmacy when You have taken 75 percent of the previous prescription (however, Schedule II or III controlled substance medications may be refilled only after You have taken 85 percent of the previous prescription). Refills obtained from a Mail-Order Supplier are allowed after You have taken all but 20 days of the previous Prescription Order. If You choose to refill Your Prescription Medications sooner, You will be responsible for the full costs of these Prescription Medications and these costs will not count toward Your Deductible (if applicable) or Out-of-Pocket Maximum. If You feel You need a refill sooner than allowed, a refill exception will be considered at Our discretion on a case-by-case basis. You may request an exception by calling Customer Service.

  If You receive maintenance medications for chronic conditions, You may qualify for

Our prescription refill synchronization which allows refilling Prescription Medications from a Pharmacy on the same day of the month. For further information on prescription refills or refill synchronization, please call Customer Service.

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

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

Biological Sera, Blood or Blood Plasma

Brand-Name Medications not on the Drug List: Except as provided through the Drug List Exception Process in this Prescription Medications benefit, We do not cover Prescription Medications as defined below for Brand-Name Medications that are not on the Drug List also defined below.

Bulk Powders: Except for those included on Our Drug List that are presented with a Prescription Order, We do not cover bulk powders.

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

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

Diagnostic Agents: Except for diagnostic agents that may otherwise be provided under this Medical Benefits Section, We do not cover medications used to aid in diagnosis rather than treatment.

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

General Anesthetics: Coverage may otherwise be provided under this Medical Benefits Section.

Insulin Pumps and Pump Administration Supplies: Coverage for insulin pumps and

supplies is provided under the Durable Medical Equipment benefit.

Medical Foods: Coverage for these products may otherwise be provided under this Medical Benefits Section.

Medications That Are Not Self-Administrable: Coverage for these medications may otherwise be provided under this Medical Benefits Section or as specifically indicated in this Prescription Medications benefit.

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

Prescription Medications Dispensed by a Nonparticipating Pharmacy

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

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

Prescription Medications Not Approved by the FDA

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

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

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

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

Professional Charges for Administration of Any Medication

Repackaged Medications, Institutional Packs and Clinic Packs

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

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

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

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

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

Pharmacy means any duly licensed outlet in which Prescription Medications are dispensed. A Participating Pharmacy or Preferred Pharmacy means either a Pharmacy with which We have a contract or a Pharmacy that participates in a network for which We have contracted to have access. Participating or Preferred Pharmacies have the capability of submitting claims electronically. To find a Participating Pharmacy or Preferred Pharmacy, please visit Our Web site or contact Customer Service. A Nonparticipating Pharmacy means a Pharmacy with which We neither have a contract nor have contracted access to any network it belongs to. Nonparticipating Pharmacies may not be able to or choose not to submit claims electronically.

Pharmacy and Therapeutics (P&T) Committee means an officially chartered group of practicing Physicians and Pharmacists, all of whom are free from conflict of interest of drug manufacturers and the majority of whom are free from conflict of interest of Your coverage, who review the medical and scientific literature regarding medication use and provide input and oversight of the development of the Drug List and medication policies.

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

Preferred Generic Medication and Generic Medication means a Prescription Medication that is equivalent to a Brand-Name Medication and is listed in widely accepted references (or specified by Us) as a Generic Medication. For the purpose of this definition, "equivalent" means the FDA ensures that the Generic Medication has the same active ingredients, meets the same manufacturing and testing standards, and is as safe and as effective as the Brand-Name Medication. Medications available only

from one source (also referred to as "single source") are not considered Generic Medications. If listings in widely accepted references are conflicting or indefinite about whether a Prescription Medication is a generic or Brand-Name Medication, We will decide.

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

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

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

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

Specialty Pharmacy means a Pharmacy that specializes in the distribution and medication management services of high cost injectables and Specialty Medications. To find a Specialty Pharmacy, please visit Our Web site or contact Customer Service.

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

PROSTHETIC DEVICES

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

We cover prosthetic devices for functional reasons to replace a missing body part,

including artificial limbs, external or internal breast prostheses following a Mastectomy and maxillofacial prostheses. Prosthetic devices or appliances that are surgically inserted into the body are otherwise covered under the appropriate facility provision (Hospital inpatient care or Hospital outpatient and Ambulatory Surgical Center care) in this Medical Benefits Section. We will cover repair or replacement of a prosthetic device due to normal use or growth of a child.

REHABILITATIVE SERVICES

Inpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered
Limit: 30 days per Insured per Calendar Year (up to 60 days per Calendar Year for head or spinal cord Injury).	

Outpatient Services

Provider: In-Network	Provider: Out-of-Network
Payment: After $15 Copayment per visit, We pay 100% of the Allowed Amount.	**Payment:** Not Covered
Limit: 30 visits combined per Insured per Calendar Year (up to 30 additional visits per condition may be considered for treatment of neurologic conditions when criteria for supplemental services are met).	

We cover inpatient and outpatient rehabilitation services (physical, occupational and speech therapy services) and accommodations as appropriate and necessary to restore or improve lost function caused by Injury or Illness that is not a Mental Health Condition or Substance Use Disorder. (Rehabilitative services for mental diagnosis are not subject to a visit limit and are covered under the Mental Health or Substance Use Disorder Services benefit.) Rehabilitative services include neurodevelopmental therapy for neurological conditions that are not a Mental Health Condition or Substance Use Disorder (e.g. failure to thrive in newborn, lack of physiological development in childhood) and maintenance services if significant deterioration of an Insured's condition would result without the service. Rehabilitation services that are applied toward the Deductible, if any, will be applied against the Maximum Benefit limit on these services.

REPAIR OF TEETH

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

We cover services and supplies for treatment required as a result of damage to or loss

of sound natural teeth when such damage or loss is due to an Injury.

REPRODUCTIVE HEALTH CARE SERVICES

Provider: In-Network	Provider: Out-of-Network
Payment: We pay 100% of the Allowed Amount.	**Payment:** Not Covered

We cover reproductive health care services and supplies, including abortion, voluntary vasectomy and screening for pregnancy that are not covered under the Preventive Care and Immunizations benefit.

SKILLED NURSING FACILITY (SNF) CARE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered
Limit: 60 inpatient days per Insured per Calendar Year	

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

TELEHEALTH

Provider: In-Network	Provider: Out-of-Network
Payment: After $15 Copayment per visit, We pay 100% of the Allowed Amount.	**Payment:** Not Covered

We cover telehealth (live audio-only communication, audio and video communication and store and forward services, as permitted by law) between the patient and an In-Network Provider.

For the purpose of this benefit:

"Audio-only communication" is a secure telephonic communication. Audio-only communication is covered if there is a previously established patient-Provider relationship. An audio-only communication must take the place of an in-person visit that would be billable by the Provider.

"Store and forward technology" is secure one-way electronic transmission (sending) of a patient’s medical information from an originating site to a Provider at a distant site, which is later used by the Provider for diagnosis and medical management of the patient. Store and forward technology does not include telephone, fax or e-mail

communication.

"Store and forward services" are the Provider's diagnosis and medical management of the patient that result from the use of store and forward technology. You must have engaged in a live (in-person or synchronous audio and video communication) visit with Your Provider before engaging in subsequent, related store and forward services with that Provider. Coverage of store and forward services is limited to the services We have specifically contracted with that Provider to provide.

TELEMEDICINE

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

We cover telemedicine (audio and video communication, including synchronous two-way interactive video conferencing) services between the patient at an originating site and a consulting Practitioner. We also cover store and forward technology. For the purpose of this benefit, "store and forward technology" is a secure one-way electronic transmission (sending) of a patient's medical information from an originating site to a Provider at a distant site, which is later used by the Provider for diagnosis and medical management of the patient. Store and forward technology does not include telephone, fax or e-mail communication. Originating sites include facilities such as Hospitals, rural health clinics, Physician's offices and community mental health centers. This benefit includes Medically Necessary telemedicine health services provided in connection with diabetes.

TOBACCO USE CESSATION

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

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

TRANSPLANTS

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 90% and You pay 10% of the Allowed Amount. Your 10% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

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

NOTE: Gene therapy and adoptive cellular therapy are covered under the Gene Therapy and Adoptive Cellular Therapy benefit and not under this Transplant benefit.

Donor Organ Benefits
We cover donor organ procurement costs if the recipient is covered for the transplant under this Policy. Procurement benefits are limited to selection, removal of the organ, storage, and transportation of the surgical harvesting team and the organ.

General Exclusions

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

SPECIFIC EXCLUSIONS
We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**. However, these exclusions will not apply with regard to an otherwise Covered Service for: 1) a preventive service as specified under the Preventive Care and Immunizations benefit and the Prescription Medications benefit in the Medical Benefits Section; or 2) services and supplies furnished in an emergency room for stabilization of a patient.

Activity Therapy
We do not cover creative arts, play, dance, aroma, music, equine or other animal-assisted, recreational or similar therapy, sensory movement groups and wilderness or adventure programs.

Assisted Reproductive Technologies
We do not cover any assisted reproductive technologies including, but not limited to, cryogenic or other preservation, storage and thawing (or comparable preparation) of egg, sperm or embryo; in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception, or associated surgery, drugs, testing or supplies, regardless of underlying condition or circumstance.

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

Complementary Care
We do not cover complementary care, including, but not limited to, acupuncture and chiropractic spinal manipulations.

Conditions Caused By Active Participation In a War or Insurrection
The treatment of any condition caused by or arising out of an Insured's active participation in a war in the service of a non-United States nation-state or similar entity or in an insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services
The treatment of any Insured's condition that the Secretary of Veterans Affairs determines to be a service-connected disability incurred, that is a disability in performance of service in the uniformed services of the United States or to be aggravated such service.

Cosmetic/Reconstructive Services and Supplies
Cosmetic and/or reconstructive services and supplies, except as necessary:

- to correct a congenital anomaly;
- to correct a craniofacial anomaly;

- to restore a physical bodily function lost as a result of Injury or Illness;
- for one attempt to correct a scar or defect that resulted from an accidental Injury or treatment for an accidental Injury (more than one attempt is covered if Medically Necessary); or
- for one attempt to correct a scar or defect on the head or neck that resulted from a surgery (more than one attempt is covered if Medically Necessary).

Breast reconstruction following a Medically Necessary Mastectomy, is covered to the extent required by law. For more information on breast reconstruction, see the Women's Health and Cancer Rights notice in this Policy.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance and that are not Medically Necessary.

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

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

Counseling in the Absence of Illness
Except as provided in this Policy or as required by law, We do not cover counseling in the absence of Illness.

Custodial Care
We do not cover non-skilled care and helping with activities of daily living.

Dental Services
Except as provided in this Policy, We do not cover Dental Services provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

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

Family Counseling
We do not cover family counseling unless the patient is a child or adolescent with a covered diagnosis, and the family counseling is part of the treatment.

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

Government Programs
Benefits that are covered, or would be covered in the absence of this Policy, by any federal, state or government program, except for facilities that contract with Us and except as required by law, such as for cases of medical emergency or for coverage

provided by Medicaid. We do not cover government facilities outside the Service Area.

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

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

Illegal Services, Substances and Supplies
We do not cover services, substances, and supplies that are illegal as defined under state or federal law.

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

Infertility
Except to the extent Covered Services are required to diagnose such condition, We do not cover treatment of infertility, including, but not limited to, surgery, fertility drugs and medications.

Investigational Services
Except as provided under the Approved Clinical Trials benefit, We do not cover Investigational treatments or procedures (Health Interventions), services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). We also exclude any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section in this Policy.

Motor Vehicle Coverage and Other Available Insurance
Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to an Insured, whether or not the Insured makes a claim under such coverage. Further, the Insured is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, We will provide benefits according to this Policy.

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

- appointments scheduled and not kept ("missed appointments");
- preparing or duplicating medical reports and chart notes;

- preparing itemized bills or claim forms (even at Our request); and
- visits or consultations that are not in person, except as provided under the Telehealth and Telemedicine benefits.

Non-Emergency Services While Outside the United States or BridgeSpan Service Area

Obesity or Weight Reduction/Control
Except as required by law, such as for Preventive Care and Immunizations, We do not cover medical treatment, medication, surgical treatment (including revisions, reversals, and treatment of complications), programs or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis or psychological conditions.

Orthognathic Surgery
Except for orthognathic surgery due to an Injury, sleep apnea or congenital anomaly (including craniofacial anomalies), We do not cover services and supplies for orthognathic surgery. By "orthognathic surgery," We mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones.

Over-the-Counter Contraceptives
Except as provided under the Prescription Medications benefit in this Policy, We do not cover over-the-counter contraceptive supplies unless approved by the FDA and prescribed by a Provider.

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

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

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

Reversals of Sterilizations
Services and supplies related to reversals of sterilization.

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

Routine Foot Care

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

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

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

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family. For purposes of this provision, "immediate family" means:

- You and Your parents, parents' spouses or Eligible Domestic Partners, spouse or Eligible Domestic Partner, children, stepchildren, siblings and half-siblings;
- Your spouse's or Eligible Domestic Partner's parents, parents' spouses or Eligible Domestic Partners, siblings and half-siblings;
- Your child's or stepchild's spouse or Eligible Domestic Partner; and
- any other of Your relatives by blood or marriage who shares a residence with You.

Services and Supplies That Are Not Medically Necessary
Except for preventive care benefits provided in this Policy, We do not cover services and supplies that are not Medically Necessary for the treatment of an Illness or Injury.

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

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

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

Temporomandibular Joint (TMJ) Disorder Treatment
Services and supplies provided for temporomandibular joint (TMJ) disorder treatment.

Therapies, Counseling, and Training
We do not cover educational, vocational, social, image, milieu, or marathon group therapy; premarital or marital counseling; IAP services; and job skills or sensitivity training.

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

Travel and Transportation Expenses
Travel and transportation expenses other than covered Ambulance Services and travel expenses specified in the Gene Therapy and Adoptive Cellular Therapy benefit in this Policy.

Travel Immunizations
Immunizations for purposes of travel, occupation or residency in a foreign country.

Varicose Veins Treatment
Except when there is associated venous ulceration or persistent or recurrent bleeding from ruptured veins, We do not cover treatment of varicose veins.

Vision Care
Except as provided in this Policy, We do not cover routine eye exam, vision hardware, visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism and reversals or revisions of surgical procedures which alter the refractive character of the eye.

Work Injury/Illness
When You have filed a claim with workers' compensation and Your work-related Injury or Illness has been accepted by workers' compensation, We do not cover any services and supplies arising out of that accepted work-related Injury or Illness. Subject to applicable state or federal workers' compensation law, We do not cover services and supplies received for work-related Injuries or Illnesses where You and Your Enrolled Dependent(s) fail to file a claim for workers' compensation benefits. The only exception is if You and Your Enrolled Dependent(s) are exempt from state or federal workers' compensation law.

Policy and Claims Administration

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

PREAUTHORIZATION

Contracted Providers

Contracted Providers may be required to obtain preauthorization from Us in advance for certain services provided to You. You will not be penalized if the contracted Provider does not obtain those approvals from Us in advance and the service is determined to be not covered under this Policy.

Non-Contracted Providers

Non-contracted Providers are not required to obtain preauthorization from Us in advance for Covered Services. You may be liable for costs if You elect to seek services from non-contracted Providers and those services are not considered Medically Necessary and not covered in this Policy. You may request that a non-contracted Provider preauthorize outpatient services on Your behalf to determine Medical Necessity prior to the service being rendered.

We will not require preauthorization for Emergency Room services or other services and supplies which by law do not require preauthorization.

If We do preauthorize a service or supply (from a contracted or non-contracted Provider), We are bound to cover it as follows:

- If Your coverage terminates within five business days of the preauthorization date, We will cover the preauthorized service or supply if the service or supply is actually incurred within those five business days, regardless of the termination date, unless We are aware the coverage is about to terminate and We disclose this information in Our written preauthorization. In that case, We will only cover the preauthorized service or supply if incurred before termination.
- If Your coverage terminates later than five business days after the preauthorization date, but before the end of 30 calendar days, We will not cover services incurred after termination even if the services were preauthorized.
- If coverage remains in effect for at least 30 calendar days after the preauthorization, We will cover the preauthorized service or supply if incurred within the 30 calendar days.

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

MEMBER CARD

When You, the Policyholder, enroll with Us, You will receive a member card. It will include important information such as Your identification number and Your name.

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

If You lose Your card, or if it gets destroyed, You can get a new one by contacting Customer Service. You can also view or print an image of Your member card by visiting

Our Web site on Your PC or mobile device. If coverage under this Policy terminates, Your member card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT
When claims reimbursement is due, We decide whether to pay You, the Provider or You and the Provider jointly. We may make benefit payments for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child. If a person entitled to receive payment under this 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 when We believe that person is equitably entitled to the payment. A payment made in good faith under this provision will fully discharge Us to the extent of the payment.

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

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

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

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

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

Out-of-Network Provider Claims
We do not cover services provided by Out-of-Network Providers, except as specifically noted in the Medical Benefits Section. In order for Us to pay for eligible Covered Services received from an Out-of-Network Provider, You or the Out-of-Network Provider must first send Us a claim. Be sure the claim is complete and includes the following information:

- an itemized description of the services given and the charges for them;

- the date treatment was given;
- the diagnosis; and
- the patient's name and the group and identification numbers.

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

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

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

Reimbursement Examples by Provider
Here is an example of how Your selection of In-Network or Out-of-Network Providers affects Our payment to Providers and Your cost sharing amount. For purposes of this example, let's assume We pay 70 percent of the Allowed Amount for In-Network Providers, 0 percent for Out-of-Network Providers for non-covered services, and 50 percent of the Allowed Amount for Out-of-Network Providers for eligible Covered Services. The benefit table from the Medical Benefits Section (or other benefits section) would appear as follows:

Provider: In-Network	Provider: Out-of-Network
Payment: After Deductible, We pay 70% and You pay 30% of the Allowed Amount. Your 30% payment will be applied toward the Out-of-Pocket Maximum.	**Payment:** Not Covered

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

- In-Network Provider: We would pay 70 percent of the Allowed Amount and You would pay 30 percent of the Allowed Amount, as follows:
  - Amount In-Network Provider must "write-off" (that is, cannot charge You for): $1,000
  - Amount We pay (70% of the $4,000 Allowed Amount): $2,800
  - **Amount You pay** (30% of the $4,000 Allowed Amount): **$1,200**
  - Total: $5,000
- Out-of-Network Provider (non-Covered Services): We would pay 0 percent of the benefits not covered and You would pay 100 percent of the billed charges, as follows:

- Amount We pay (0% of the $5,000 billed charge): $0
- **Amount You pay** (100% of the $5,000 billed charge): **$5,000**
- Total: $5,000

- Out-of-Network Provider (eligible Covered Services): We would pay 50 percent of the Allowed Amount. (For purposes of this example, We assume $4,000 also is the Reasonable Charge upon which the Out-of-Network Provider's Allowed Amount is based. The Reasonable Charge can be lower than the In-Network Allowed Amount.) Because the Out-of-Network Provider does not accept the Allowed Amount, You would pay 50 percent of the Allowed Amount, plus the $1,000 difference between the Out-of-Network Provider's billed charges and the Allowed Amount, as follows:

  - Amount We pay (50% of the $4,000 Allowed Amount): $2,000
  - **Amount You pay** (50% of the $4,000 Allowed Amount and the $1,000 difference between the billed charges and the Allowed Amount): **$3,000**
  - Total: $5,000

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

Ambulance Claims
When You or Your Provider forwards a claim for ambulance services to Us, it must show where the patient was picked up and where he or she was taken. It should also show the date of service, the patient's name and the patient's identification number. We will send Our payment for Covered Services directly to the ambulance service Provider.

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

- When We cannot take action on the claim due to circumstances beyond Our control, We will notify You within the initial 30-day period that an extension is necessary. This notification includes an explanation of why the extension is necessary and when We expect to act on the claim.
- When We cannot take action on the claim due to lack of information, We will notify You within the initial 30-day period that the extension is necessary. This notification includes a specific description of the additional information needed and an explanation of why it is needed.

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

Claims Processing Report
We will tell You how We have acted on a claim. We use a form called a claims processing report. We may pay claims, deny them or accumulate them toward

satisfying any Deductible. If We deny all or part of a claim, the reason for Our action will be stated on the claims processing report. The claims processing report will also include instructions for filing an appeal or Grievance if You disagree with the action.

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

CLAIMS RECOVERY
If We pay a benefit to which You or Your Enrolled Dependent was not entitled, or if We pay a person who is not eligible for benefits at all, We reserve the right to recover the payment from the person We paid or anyone else who benefited from it, including a Provider of services. Our right to recovery includes the right to deduct the mistakenly paid amount from future benefits We would provide the Policyholder or any of his or her Enrolled Dependents, even if the mistaken payment was not made on that person's behalf.

We regularly work to identify and recover claims payments that should not have been made (for example, claims that are the responsibility of another, duplicates, errors, fraudulent claims, etc.). We will credit all amounts that We recover, less Our reasonable expenses for obtaining the recoveries, to the experience of the pool under which You are rated. Crediting reduces claims expense and helps reduce future premium rate increases.

This Claims Recovery provision in no way reduces Our right to reimbursement or subrogation. Refer to the other-party liability provision in this Policy and Claims Administration Section for additional information.

LEGAL ACTION
No action at law or in equity will be brought to recover under this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND MEDICAL RECORDS
It is important to understand that Your personal health information may be requested or disclosed by Us. This information will be used for the purpose of facilitating health care treatment, payment of claims or business operations necessary to administer health care benefits; or as required by law.

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

- an insurance carrier or group health plan;
- any other institution providing care, treatment, consultation, pharmaceuticals or

supplies;
- a clinic, Hospital, long-term care or other medical facility; or
- a Physician, dentist, Pharmacist or other physical or behavioral health care Practitioner.

Health information requested or disclosed by Us may include, but is not limited to:

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

We are required by law to protect Your personal health information, and must obtain prior written authorization from You to release information not related to routine health insurance operations. A Notice of Privacy Practices is available by visiting Our Web site or contacting Customer Service.

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

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

LIMITATIONS ON LIABILITY

In all cases, You have the exclusive right to choose a health care Provider. We are not responsible for the quality of health care You receive, since all those who provide care do so as independent contractors. Since We do not provide any health care services, We cannot be held liable for any claim or damages connected with Injuries You suffer while receiving health services or supplies provided by professionals who are neither Our employees nor agents.

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

In addition, We will not be liable to any person or entity for the inability or failure to procure or provide the benefits in this Policy by reason of epidemic, disaster or other cause or condition beyond Our control.

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

As used herein, the term "third-party," means any party that is, or may be, or is claimed to be responsible for Illness or Injuries to You. Such Illness or Injuries are referred to as

"third-party Injuries." Third-party includes any party responsible for payment of expenses associated with the care or treatment of third-party Injuries.

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

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

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

By accepting benefits under this Policy, You also specifically acknowledge Our right of reimbursement. This right of reimbursement attaches when We have paid benefits due to third-party Injuries and You or Your representative have recovered any amounts from a third-party. By providing any benefit under this Policy, We are granted an assignment of the proceeds of any settlement, judgment or other payment received by You to the extent of the full cost of all benefits provided by Us. Our right of reimbursement is cumulative with and not exclusive of Our subrogation right and We may choose to exercise either or both rights of recovery.

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

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

- By accepting or claiming benefits, You agree that We are entitled to reimbursement of the full amount of benefits that We have paid out of any settlement or recovery from any source. This includes any judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Injury or Illness for

which We have provided benefits.

- You or Your representative agree to give Us a first-priority lien on any recovery, settlement, judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with third-party Injuries provided by Us (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- Further, You agree to pay, as the first priority, from any recovery, settlement, judgment or other source of compensation, any and all amounts due to Us as reimbursement for the full cost of all benefits associated with third-party Injuries paid by Us (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).
- Our rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration award or judgment or other characterization of the recovery by the Insured and/or any third-party or the recovery source. We are entitled to reimbursement from the first dollars received from any recovery. This applies regardless of whether:

  - the third-party or third-party's insurer admits liability;
  - the health care expenses are itemized or expressly excluded in the recovery; or
  - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered in this Policy.

- We will not reduce Our reimbursement or subrogation due to Your not being made whole. Our right to reimbursement or subrogation, however, will not exceed the amount of recovery.
- By accepting benefits under this Policy, You or Your representative agree to notify Us promptly (within 30 days) and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to third-party Injuries sustained by You.
- You and Your representative must cooperate with Us and do whatever is necessary to secure Our rights of subrogation and reimbursement under this Policy. We may require You to sign and deliver all legal papers and take any other actions requested to secure Our rights (including an assignment of rights to pursue Your claim if You fail to pursue Your claim of recovery from the third-party or other source). If We ask You to sign a trust agreement or other document to reimburse Us from the proceeds of any recovery, You will be required to do so as a condition to advancement of any benefits.
- You must agree that nothing will be done to prejudice Our rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by Us. You will also cooperate fully with Us, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify Us of any facts that may impact Our right to reimbursement or subrogation, including, but not necessarily limited to, the following:

  - the filing of a lawsuit;
  - the making of a claim against any third-party;
  - scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to

be involved in any settlement conferences or mediations); or
- intent of a third-party to make payment of any kind to Your benefit or on Your behalf and that in any manner relates to the Injury or Illness that gives rise to Our right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).

- You and/or Your agent or attorney must agree to serve as constructive trustee and keep any recovery or payment of any kind related to Your Illness or Injury which gave rise to Our right of subrogation or reimbursement segregated in its own account, until Our right is satisfied or released.
- In the event You and/or Your agent or attorney fails to comply with any of these conditions, We may recover any such benefits advanced for any Illness or Injury through legal action.
- Any benefits We have provided or advanced are provided solely to assist You. By paying such benefits, We are not acting as a volunteer and are not waiving any right to reimbursement or subrogation.

We may recover the full cost of all benefits paid by Us under this Policy without regard to any claim of fault on Your part, whether by comparative negligence or otherwise. No court costs of attorney fees may be deducted from Our recovery, and We are not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by You to pursue Your claim or lawsuit against any third-party. In the event You or Your representative fail to cooperate with Us, You shall be responsible for all benefits paid by Us in addition to costs and attorney's fees incurred by Us in obtaining repayment.

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 Recovery provision still applies.

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

- You must notify Us in writing within five days of any of the following:
  - filing a claim;
  - having the claim accepted or rejected;
  - appealing any decision;
  - settling or otherwise resolving the claim; or
  - any other change in status of Your claim.
- We will expedite preauthorization during the interim period before workers' compensation initially accepts or denies Your work-related injury or occupational disease.
- If the entity providing workers' compensation coverage denies Your claim as a non-compensable workers' compensation claim and You have filed an appeal, We may advance benefits for Covered Services if You agree to hold any recovery

obtained in a segregated account for Us.

Fees and Expenses
We are not liable for any expenses or fees incurred by You in connection with obtaining a recovery. However, You may request that We pay a proportional share of attorney's fees and costs at the time of any settlement or recovery to otherwise reduce the required reimbursement amount to less than the full amount of benefits paid by Us. We have discretion whether to grant such requests.

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

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

Benefits Subject to this Provision
All of the benefits provided in this Policy are subject to this Coordination of Benefits provision.

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

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

- An expense or portion of an expense not covered by any of Your involved plans.
- The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room, unless one of Your involved plans provides coverage for private Hospital rooms.
- When this coverage restricts coordination of benefits to certain types of coverage or benefits, any expenses for other types of coverage or benefits. See the Benefits Subject to this Provision paragraph, above, for restrictions on the types of coverage or benefits to which coordination applies.
- Any amount by which a Primary Plan's benefits were reduced because You did not comply with that plan's provisions regarding second surgical opinion or precertification of services or failed to use a preferred provider (except, if the Primary Plan is a closed panel plan and does not pay because a nonpanel provider is used, the Secondary Plan (if it is not a closed panel plan) shall pay as if it were the Primary Plan).
- A Primary Plan's deductible, if the Primary Plan is a high-deductible health plan as defined in the Internal Revenue Code and We are notified both that all plans covering a person are high-deductible health plans and that the person intends to

contribute to a health savings account in accordance with the Internal Revenue Code.
- An expense that a provider is prohibited by law or contract from charging You.

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

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

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

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

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

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

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

Other Plan does not include:

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

- A state plan under Medicaid, or a governmental plan that, by law, provides benefits that are excess to those of private insurance or other nongovernmental coverage.

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

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

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

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

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

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

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

If a court decree specifies that Your parent is responsible for Your health care expenses or health care coverage and that parent's plan has actual knowledge of that term of the decree, the plan of that parent is primary to the plan of Your other parent. If the parent with that responsibility has no coverage for You, but that parent's spouse does and the spouse's plan has actual knowledge of that term in the decree, the plan of the spouse shall be primary to the plan of Your other parent. If benefits have been paid or provided by a plan before it has actual knowledge of the term in the court decree, these rules do not apply until that plan's next contract Year.

If a court decree awards joint custody of You without specifying that one of Your parents is responsible for Your health care expenses or health care coverage, a plan that covers You as the dependent of Your parent whose Birthday occurs earlier in the Year will be

primary over a plan that covers You as the dependent of Your parent whose Birthday occurs later in the Year. If both parents have the same Birthday, the plan of the parent who has been covered by his or her plan longer shall be primary to the plan of the other parent. If the Other Plan does not contain this dependent rule, the Other Plan's dependent rule will govern.

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

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

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

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

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

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

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

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

that of a multiple employer plan).

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

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

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

Primary Health Plan Benefits
When, in accordance with the order of benefit determination, this coverage is the Primary Plan, We will pay the benefits in this Policy as if no Other Plan exists.

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

We will calculate the benefits that We would have paid for a service if this coverage were the Primary Plan. We will compare the Allowable Expense in this Policy 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, or
- the benefits that We would have paid for the service if this coverage were the Primary Plan.

Deductibles, Coinsurance and Copayments, if any, in this Policy will be used in the calculation of the benefits that We would have paid if this were the Primary Plan, but they will not be applied to the unpaid charges You owe after the Primary Plan's payment. Our payment therefore will be reduced so that it, when combined with the Primary Plan's payment, does not exceed the higher (highest) Allowable Expense among the involved plans and We will credit toward any Deductible in this Policy any amount that would have been credited to the Deductible if this coverage had been the only plan.

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

Nothing contained in this Coordination of Benefits provision requires Us to pay for all or

part of any service that is not covered under this coverage. Further, in no event will this Coordination of Benefits provision operate to increase Our payment over what We would have paid in the absence of this Coordination of Benefits provision.

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

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

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

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

Appeal Process

NOTE: For Pediatric Vision benefits, We have delegated certain activities, including appeals, to VSP, though We retain ultimate responsibility over these activities. For the purpose of appeals for Pediatric Vision benefits, references to "We", "Us" and "Our" in this Appeal Process Section refer to VSP.

A written request can be made by sending it to VSP at: Vision Service Plan, Attention: Complaint and Grievance Unit, P.O. Box 997100, Sacramento, CA 95899-7100. Verbal requests can be made by calling VSP's Customer Service department at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance).

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

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

Our Grievance process is designed to help You resolve Your complaint or concern and to allow You to appeal an Adverse Benefit Determination. We offer one internal level of appeal of Our Adverse Benefit Determinations. We also offer an external appeal with an Independent Review Organization (IRO) for some of Our Adverse Benefit Determinations if You remain dissatisfied with Our Internal Appeal decision. Please see External Appeal - IRO later in this section for more information.

An Internal Appeal, including an internal expedited appeal, must be pursued within 180 days of Your receipt of Our Adverse Benefit Determination. If You don't appeal within this time period, You will not be able to continue to pursue the appeal process and may jeopardize Your ability to pursue the matter in any forum.

Internal appeals, including internal expedited appeals, are reviewed by an employee or employees who were not involved in, or subordinate to anyone involved in, the initial decision that You are appealing. In appeals that involve issues requiring medical judgment, the decision is made by Our staff of health care professionals. You or Your Representative may submit written materials supporting Your appeal, including written testimony on Your behalf. For Post-Service appeals, a written notice of the decision will be sent within 30 days of receipt of the appeal. For appeals involving a Pre-Service preauthorization of a procedure, We will send a written notice of the decision within 30 days of receipt of the appeal.

If You or Your treating Provider determines that Your health could be jeopardized by waiting for a decision under the regular appeal process, You or Your treating Provider may specifically request an expedited appeal. Please see Expedited Appeals later in this section for more information.

You are entitled to receive continued coverage of the disputed item or service pending the conclusion of the Internal Appeal process. However, You will be responsible for any amounts We pay for the item or service during this time should You not prevail.

You may contact Us either in writing or verbally with a Grievance or to request an

appeal. For pediatric vision, a written request can be made by sending it to VSP at: Vision Service Plan, Attention: Complaint and Grievance Unit, P.O. Box 997100, Sacramento, CA 95899-7100. For all other benefits under this plan, a written request can be made by sending it to BridgeSpan at: Appeals Coordinator, BridgeSpan Health Company, P.O. Box 1408, Lewiston, ID 83501 or facsimile 1 (888) 496-1542. Verbal requests can be made by calling Customer Service. We will acknowledge receipt of a Grievance or an appeal within seven days of receiving it.

An Adverse Benefit Determination may be overturned by Us at any time during the Appeal process if We receive newly submitted documentation and/or information which establishes coverage, or upon the discovery of an error the correction of which would result in overturning the Adverse Benefit Determination.

EXTERNAL APPEAL - IRO

You have the right to an external review by an Independent Review Organization (IRO). An appeal to an IRO is available only after You have exhausted the Internal Appeal process (or we have mutually agreed to waive exhaustion, You are deemed to have exhausted the Internal Appeal process because We failed to strictly comply with state and federal requirements for Internal Appeals, or You request expedited external appeal at the same time You request expedited Internal Appeal). An external appeal, including an external expedited appeal, must be pursued within 180 days of Your receipt of Our Internal Appeal decision (or, if sooner, the mutual waiver or any deemed exhaustion of the Internal Appeal process). **We are bound by the decision of the IRO and may be penalized by the Oregon Division of Financial Regulation if We fail to comply with the IRO's decision. You have the right to sue Us if the decision of the IRO is not implemented**.

The issue being submitted to the IRO for external review must be a dispute over an Adverse Benefit Determination We have made concerning whether a course or plan of treatment is:

- Medically Necessary;
- experimental or Investigational;
- part of an active course of treatment for purposes of continuity of care;
- delivered in an appropriate health care setting at the appropriate level of care; or
- whether an exception to Our Drug List should be granted.

We coordinate external appeals, but the decision is made by an IRO at no cost to You. We will provide the IRO with the appeal documentation. You may submit additional information to the IRO within five business days after You receive notice of the IRO's appointment. The IRO will make its decision within 30 days after You apply for external review. Written notice of the IRO decision will be sent to You by the IRO within five days of the decision. Choosing an external appeal as the final level to determine an appeal will be binding, except to the extent other remedies are available under state or federal law.

External review can be initiated through either written or verbal request. For pediatric vision, a written request can be made by sending it to VSP at: Vision Service Plan, Attention: Complaint and Grievance Unit, P.O. Box 997100, Sacramento, CA 95899-7100. For all other benefits under this plan, a written request can be made by sending it to BridgeSpan at: Appeals Coordinator, BridgeSpan Health Company, P.O.

Box 1408, Lewiston, ID 83501. Verbal requests can be made by calling Customer Service. We must notify the Oregon Division of Financial Regulation of Your request by the second business day after We receive it.

You may also initiate an external appeal by submitting Your request to the Oregon Division of Financial Regulation at P.O. Box 14480, Salem, OR 97309-0405.

In order to have the appeal decided by an IRO, You must sign a waiver granting the IRO access to medical records that may be required to be reviewed for the purpose of reaching a decision on the external appeal.

If You want more information regarding IRO review, please contact Our Customer Service department. You can also contact the Oregon Division of Financial Regulation by calling (503) 947-7984 or the toll-free message line at 1 (888) 877-4894; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: **http://dfr.oregon.gov/gethelp/Pages/file-a-complaint.aspx**; or by E-mail at: **cp.ins@oregon.gov**.

Exercise of Your right to IRO review is at Your option. Alternatively, You may use another forum as the final level of appeal.

EXPEDITED APPEALS
An expedited appeal is available in clinically urgent situations if:

- the Adverse Benefit Determination concerns an admission, the availability of care, a continued stay, or a health care service for a medical condition for which You received emergency services, and You have not yet been discharged from a health care facility;
- a Provider with whom You have an established clinical relationship certifies in writing and provides supporting documentation that the ordinary time period for external review would seriously jeopardize Your life or health or Your ability to regain maximum function; or
- according to a Physician with knowledge of Your medical condition, the regular appeals time frame would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

Internal Expedited Appeal
Internal expedited appeals can be initiated through either written or verbal request. For pediatric vision, a written request can be made by sending it to VSP at: Vision Service Plan, Attention: Complaint and Grievance Unit, P.O. Box 997100, Sacramento, CA 95899-7100. For all other benefits under this plan, a written request can be made by sending it to BridgeSpan at: Appeals Coordinator, BridgeSpan Health Company, P.O. Box 1408, Lewiston, ID 83501. Verbal requests can be made by calling Customer Service.

The internal expedited appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the appeal decision. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the expedited appeal time frame) to provide written materials, including written testimony on Your behalf. Verbal notice of the decision will be provided to You

and Your Representative as soon as possible after the decision, but not later than 72 hours after receipt of the expedited appeal. This will be followed by written notification within three days of the verbal notice.

External Expedited Appeal - IRO
If You disagree with the decision made in the internal expedited appeal, You may request an external expedited appeal to an IRO if:

- the Adverse Benefit Determination concerns an admission, the availability of care, a continued stay, or a health care service for a medical condition for which You received emergency services, and You have not yet been discharged from a health care facility;
- a Provider with whom You have an established clinical relationship certifies in writing and provides supporting documentation that the ordinary time period for external review would seriously jeopardize Your life or health or Your ability to regain maximum function; or
- according to a Physician with knowledge of Your medical condition, the regular appeals time frame would subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

The issues an IRO will consider are the same as described in the External Appeal - IRO Section. You may request an external expedited review at the same time You request an internal expedited appeal from Us.

External expedited appeals can be initiated through either written or verbal request. For pediatric vision, a written request can be made by sending it to VSP at: Vision Service Plan, Attention: Complaint and Grievance Unit, P.O. Box 997100, Sacramento, CA 95899-7100. For all other benefits under this plan, a written request can be made by sending it to BridgeSpan at: Appeals Coordinator, BridgeSpan Health Company, P.O. Box 1408, Lewiston, ID 83501. Verbal requests can be made by calling Customer Service. We must notify the Oregon Division of Financial Regulation of Your request by the second business day after We receive it.

You may also request an external expedited appeal by submitting Your request to the Oregon Division of Financial Regulation at P.O. Box 14480, Salem, OR 97309-0405.

We coordinate external expedited appeals, but the decision is made by an IRO at no cost to You. In order to have the expedited appeal decided by an IRO, You must sign a waiver granting the IRO access to medical records that may be required to be reviewed for the purpose of reaching a decision on the expedited appeal. We will provide the IRO with the expedited appeal documentation. You may submit additional information to the IRO no later than 24 hours after the appointment of the IRO. Verbal notice of the IRO's decision will be provided to You and Your Representative as soon as possible after the decision, but no later than within 72 hours of Your request. The IRO decision is binding, except to the extent other remedies are available under state or federal law.

Exercise of Your right to IRO review is at Your option. Alternatively, You may use another forum as the final level of appeal.

INFORMATION
For pediatric vision, if You have any questions about the appeal process outlined here,

You may contact VSP's Customer Service department at 1 (844) 299-3041 (hearing impaired customers call 1 (800) 428-4833 for assistance) or You can write to VSP Customer Service at: Vision Service Plan, Attention: Complaint and Grievance Unit, P.O. Box 997100, Sacramento, CA 95899-7100.

For all other benefits under this plan, if You have any questions about the appeal process outlined here, You may contact BridgeSpan Customer Service or You can write to Customer Service at the following address: BridgeSpan Health Company, P.O. Box 1827, MS CS B32B, Medford, OR 97501-9884.

You also have the right to file a complaint and seek assistance from the Oregon Division of Financial Regulation. Assistance is available by calling: (503) 947-7984 or the toll-free message line at (888) 877-4894; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: **http://dfr.oregon.gov/gethelp/Pages/file-a-complaint.aspx**; or by E-mail at: **cp.ins@oregon.gov**.

You also are entitled to receive from Us, upon request and free of charge, reasonable access to and copies of all documents, records, and other information considered, relied upon, or generated in, or otherwise relevant to, an Adverse Benefit Determination.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

Adverse Benefit Determination means Our denial, reduction or termination of a health care item or service, or Our failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on Our:

- Denial of eligibility for or termination of enrollment;
- Rescission or cancellation of a policy;
- Imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;
- Determination that a health care item or service is experimental, Investigational or not Medically Necessary, effective or appropriate; or
- Determination that a course or plan of treatment that You are undergoing is an active course of treatment for purposes of continuity of care.

Grievance means a submission by You or Your authorized Representative that either is a written or oral request for Internal Appeal or external review (including expedited appeal or review), or is a written complaint regarding:

- health care service availability, delivery, or quality;
- payment, handling, or reimbursement of a health care service claim; or
- contractual matters between You and Us.

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for external appeals and external expedited appeals, through an independent contractor relationship with Us and/or through assignment to Us via state regulatory requirements. The IRO is unbiased and is not controlled by Us.

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

Us.

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

Pre-Service means any claim for benefits in this Policy which We must approve in advance, in whole or in part, in order for a benefit to be paid.

Representative means someone who represents You for the purpose of a Grievance. The Representative may be Your personal Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the purpose of the Grievance. No authorization is required from the parent(s) or legal guardian of an Insured who is an unmarried and dependent child and is less than 13 years old. For expedited appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative. Even if You have previously designated a person as Your Representative for a previous matter, an authorization designating that person as Your Representative in a new matter will be required (but redesignation is not required for a complaint that becomes an appeal or between levels of appeal). If no authorization exists and is not received in the course of the Grievance, the determination and any personal information will be disclosed to You, Your personal Representative or treating Provider only.

Who Is Eligible, How to Apply and When Coverage Begins

Please note that matters concerning eligibility and application for coverage as well as coverage effective dates are determined by the Exchange. Therefore, some, though not all, information concerning these matters is included in this Policy. For additional information, contact the Exchange.

This section details some of the terms of eligibility under this Policy for a Policyholder and his or her dependents. Payment of any corresponding monthly premiums is required for coverage to begin and continue.

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

WHEN COVERAGE BEGINS
Subject to meeting the eligibility requirements as stated in the following paragraphs, and as further determined by the Exchange, You will be entitled to apply for coverage for Yourself and Your eligible dependents through the Exchange. Coverage for You and Your applying eligible dependents will begin on the date assigned by the Exchange.

Residency Requirement
To be eligible for coverage under this Policy, You must meet the residency requirements as determined by the Exchange and provide appropriate documentation as requested.

Policyholder
An applicant must meet the Residency Requirement provision above, enroll through the Exchange and agree to the terms of this Policy. Applicants who are currently enrolled in Medicare, who are incarcerated after adjudication, or who are not lawfully present in the United States are not eligible to apply for coverage. Any application (including statements made on such application) used in establishing coverage will be considered to be a part of this Policy and will be binding on both the applicant and dependents.

Dependents
You may enroll Your eligible dependents by completing the enrollment process for them established by the Exchange. Your newly Eligible Domestic Partner who is not an Oregon-Certified Domestic Partner is eligible for coverage when a domestic partnership is established and an Affidavit of Domestic Partnership is submitted. By "established," We mean the date on which the conditions described below are met. Dependents are limited to the following:

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

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

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

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

- Your (or Your spouse's or Your Eligible Domestic Partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of developmental disability or physical handicap that began before his or her 26th birthday, if the child meets the requirements of a Disabled Dependent as defined in the Definitions Section below, and either:

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

NEWLY ELIGIBLE DEPENDENTS
You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an application through the Exchange, (and, for an Eligible Domestic Partner who is not an Oregon-Certified Domestic Partner, an Affidavit of Domestic Partnership form). Applications for enrollment of a newly eligible dependent must be made within 60 days of the dependent attaining eligibility.

For a new child by birth, adoption or placement for adoption, the effective date of coverage is the date of birth, adoption or placement for adoption if enrolled within the specified 60 days. If the date of birth, adoption or placement for adoption is the first day of a month and the newly eligible dependent is enrolled within the specified 60 days, additional premium, if applicable, will be due for that month (and subsequent months). If the date of birth, adoption or placement for adoption is on a date other than the first day of a month, additional premium, if applicable, will not be prorated for that month. The first additional premium for that child will be due for the month following the

effective date of coverage.

See also the Special Enrollment provision below.

SPECIAL ENROLLMENT
If You and/or Your eligible dependents have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your Eligible Domestic Partner) and any eligible children are eligible to enroll (except as specified otherwise below) for coverage under the Policy within 60 days from the date of the qualifying event:

- If You, Your spouse or Eligible Domestic Partner gain a new dependent child or, for a child, become a dependent child by birth, adoption, placement for adoption or placement as a foster child, as defined in 26 USC 152(f)(1)(C);
- If You, Your spouse or Eligible Domestic Partner gain a new dependent child or, for a spouse or Eligible Domestic Partner or child, become a dependent through marriage or beginning a domestic partnership;
- Unintentional, inadvertent, or erroneous enrollment or non-enrollment resulting from an error, misrepresentation, or inaction by an officer, employee, or agent of the exchange or U.S. Department of Health and Human Services;
- Can adequately demonstrate that a qualified health plan has substantially violated a material provision of its contract with regard to You and/or Your eligible dependents;
- Become newly eligible or newly ineligible for advance payment of premium tax credits or have a change in eligibility for cost-sharing reductions;
- Lose eligibility for group coverage due to: death of a covered employee, an employee's termination of employment (other than for gross misconduct), an employee's reduction in working hours, an employee's divorce or legal separation, an employee's entitlement to Medicare, a loss of dependent child status, or certain employer bankruptcies;
- An individual, not previously lawfully present, gains status as a citizen, national, or lawfully present individual in the U.S.;
- Permanently move to a new Service Area;
- Loss of minimum essential coverage; or
- Other exceptional circumstances as the Exchange may provide.

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

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

OPEN ENROLLMENT PERIOD
The open enrollment period is the period of time, as designated by law, during which You and/or Your eligible dependents may enroll.

DOCUMENTATION OF ELIGIBILITY
You must promptly furnish or cause to be furnished any information necessary and appropriate to determine the eligibility of a dependent. Such information will be required before a person can be enrolled as a dependent under this Policy.

DEFINITIONS SPECIFIC TO WHO IS ELIGIBLE, HOW TO APPLY AND WHEN COVERAGE BEGINS SECTION
Resident means a person who is able to provide satisfactory proof of having residence within the BridgeSpan Health Company Service Area as his or her primary place of domicile for six months or more in a Calendar Year, for the purpose of being an eligible applicant.

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

When Coverage Ends

Please note that matters concerning coverage termination dates are determined by the Exchange. Therefore, some, though not all, information concerning these matters is included in this Policy. For additional information, contact the Exchange.

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

No person will have a right to receive any benefits in this Policy after the date coverage is terminated. Termination of Your or Your Enrolled Dependent's coverage under this Policy for any reason will completely end all Our obligations to provide You or Your Enrolled Dependent benefits for Covered Services received after the date of termination. This applies whether or not You or Your Enrolled Dependent is then receiving treatment or is in need of treatment for any Illness or Injury incurred or treated before or while this Policy was in effect.

GUARANTEED RENEWABILITY AND POLICY TERMINATION
This Policy is guaranteed renewable, at the option of the Policyholder, subject to receipt of the monthly premium according to the requirements established by the Exchange, including any provisions pertaining to a grace period.

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

In addition, if We choose to discontinue offering coverage in the individual market, We will provide 180-days prior written notice to the Oregon Division of Financial Regulation, Policyholder and all Enrolled Dependents.

If this Policy is terminated or not renewed by the Policyholder or Us, coverage ends for You and Your Enrolled Dependents on the date determined by the Exchange. If We terminate this Policy for any reason, We will provide You written notice at least 30 days' prior to the last day of coverage.

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

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE
If You are no longer eligible as explained in the following paragraphs, Your and Your Enrolled Dependents' coverage ends on the date determined by the Exchange.

NONPAYMENT OF PREMIUM AND GRACE PERIOD
You must pay Your portion of premium directly to the Exchange and according to the requirements established by the Exchange including any provisions pertaining to a grace period. Failure to make timely payment of premium to the Exchange will result in

coverage ending for You and all Enrolled Dependents on the date assigned by the Exchange.

If You or Your Enrolled Dependent receives an Advance Premium Tax Credit, We will provide You with coverage for all allowable claims incurred within the first month of a three-month grace period, and We may pend allowable claims in the second and third month of the grace period.

TERMINATION BY YOU
You have the right to terminate this Policy with respect to Yourself and Your Enrolled Dependents by giving written notice to Us at least 14 days prior to the requested termination date.

Coverage will end on the last day of the calendar month following the date We receive such notice so long as premium has been received for the calendar month. However, it may be possible for an ineligible dependent to continue coverage under this Policy according to the provisions below.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE
If Your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), his or her coverage will end on the date assigned by the Exchange. However, it may be possible for an ineligible dependent to continue coverage under this Policy according to the provisions below.

Divorce or Annulment
Eligibility ends for Your enrolled spouse and the spouse's children (unless such children remain eligible by virtue of their continuing relationship to You) on the date assigned by the Exchange.

If You Die
If You die, coverage for Your Enrolled Dependents ends on the date assigned by the Exchange.

Dissolution or Annulment of Oregon-Certified Domestic Partnership
If the contract with Your Oregon-Certified Domestic Partner ends, eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the date assigned by the Exchange.

Policy Continuation
In the event that an Insured shall no longer be eligible due to divorce, annulment, or death of the Policyholder, such Insured may the right to continue the coverage of this Policy.

Termination of Domestic Partnership
If Your domestic partnership other than an Oregon-Certified Domestic Partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet any of the requirements outlined in the definition of a dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the calendar month following the date of termination of the

domestic partnership so long as premium has been received for the calendar month. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence. You may not file another Affidavit of Domestic Partnership within 90 days after a request for termination of a domestic partnership has been received.

Loss of Dependent Status
For an enrolled child who is no longer an eligible dependent due to: 1) exceeding the dependent age limit; 2) disruption of placement before legal adoption and removal from placement; or 3) for any other cause (not described), eligibility ends on the date assigned by the Exchange.

OTHER CAUSES OF TERMINATION
Insureds may be terminated for either of the following reasons:

Fraudulent Use of Benefits
If You or Your Enrolled Dependent engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of material fact in connection with coverage, coverage under this Policy will terminate for that Insured.

Fraud or Misrepresentation in Application
We have issued this Policy in reliance upon all information furnished to Us by You or on behalf of You and Your Enrolled Dependents. In the event of any intentional misrepresentation of material fact or fraud regarding an Insured, We may take any action allowed by law or Policy, including denial of benefits or termination of coverage and may subject the person making the misrepresentation or fraud to prosecution for insurance fraud and associated penalties.

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

MEDICARE SUPPLEMENT
When eligibility under this Policy terminates, You may be eligible for coverage under a Medicare supplement plan through Us as described here.

- If You are eligible for Medicare, You may be eligible for coverage under one of Our Medicare supplement plans. To be eligible for continuous coverage, We must receive Your application within 31 days following Your termination from this Policy. If You apply for a Medicare supplement plan within six months of enrolling in Medicare Part B coverage, We will not require a health statement. After the six-month enrollment period, We may require a health statement. Benefits and premiums under the Medicare supplement plan will be substantially different from this Policy.

General Provisions

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

Premium Payments
Except as required by law, We will not accept payments of premium or other cost-sharing obligations on behalf of an Insured from a Hospital, Hospital system, health-affiliated aid program, healthcare Provider or other individual or entity that has received or may receive a financial benefit related to the Insured's choice of health care. As required by the Centers for Medicare and Medicaid Services (CMS), We will accept premium and cost-sharing payments made on behalf of Insureds by the Ryan White HIV/AIDS Program, other federal and state government programs that provide premium and cost sharing support for specific individuals, Indian Tribes, Tribal Organizations and Urban Indian Organizations.

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

GOVERNING LAW AND BENEFIT ADMINISTRATION
This Policy will be governed by and construed in accordance with the laws of the United States of America and by the laws of the state of Oregon without regard to its conflict of law rules. We are an insurance company that provides insurance to this benefit plan and makes determinations for eligibility and the meaning of terms subject to Insured rights under this benefit plan that include the right to appeal, review by an Independent Review Organization and civil action.

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

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

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

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

If We make a material modification to this Policy including, but not limited to, changes in preventive benefits mandated by the federal Affordable Care Act at any time other than renewal, We will provide You with at least 60 days advance notice.

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

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

NOTICES
Any notice to Insureds required in this Policy will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Insured will be addressed to the Insured and/or the Policyholder at the last known address appearing in Our records. If We receive a United States Postal Service change of address form (COA) for a Policyholder, We will update Our records accordingly. Additionally, We may forward notice for an Insured if We become aware that We don't have a valid mailing address for the Insured. Any notice to Us required in this Policy may be given by mail addressed to: BridgeSpan Health Company, P.O. Box 1271, Portland, OR 97207-1271; provided, however that any notice to Us will not be considered to have been given to and received by Us until physically received by Us.

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

TIME LIMIT ON CERTAIN DEFENSES
After two years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, You made in the application will be used to void this Policy or to deny a claim for health care services commencing after the expiration of the two-year period.

WHEN BENEFITS ARE AVAILABLE
In order for health expenses to be covered in this Policy, they must be incurred while coverage is in effect. Coverage is in effect when all of the following conditions are met:

- the person is eligible to be covered according to the eligibility provisions of this Policy;
- the person has applied and has been accepted for coverage by Us; and
- premium for the person for the current month has been paid by the Policyholder on a timely basis.

The expense of a service is incurred on the day the service is provided and the expense of a supply is incurred on the day the supply is delivered to You.

WOMEN'S HEALTH AND CANCER RIGHTS
If You are receiving benefits in connection with a Mastectomy and You, in consultation with Your attending Physician, elect breast reconstruction, We will provide coverage

(subject to the same provisions as any other benefit) for:

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

Definitions

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

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

Allowed Amount means:

- For In-Network Providers (see definition of "In-Network" below), the amount that they have contractually agreed to accept as payment in full for a service or supply. However, with regard to Providers who have entered Risk-Sharing Arrangements with Us for this plan, the Allowed Amount is the amount they have agreed to accept in initial payment, without regard to any subsequent reward to which they may become entitled or refund or payment for which they may become liable under the Risk-Sharing Arrangement.
- For Out-of-Network Providers (see definition of "Out-of-Network" below), the amount We have determined to be Reasonable Charges for Covered Services or supplies.

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

Ambulatory Surgical Center means a facility or that portion of a facility licensed by the state in which it is located, that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and for whom the expected duration of services does not exceed 24 hours following admission. Ambulatory Surgical Center does not mean: 1) individual or group practice offices of private Physicians or dentists that do not contain a distinct area used for outpatient surgical treatment on a regular and organized basis, or that only provide surgery routinely provided in a Physician's or dentist's office using local anesthesia or conscious sedation; or 2) a portion of a licensed Hospital designated for outpatient surgical treatment.

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

Center of Excellence means a Provider organization certified to deliver a gene therapy (or therapies) that meets or exceeds a set of clinical service and quality standards (including available clinical services, patient selection criteria, and outcome reporting), maintains a set of clinical protocols and certifications required for gene therapy delivery, and maintains or exceeds a foundation of rigorous and sustainable cost controls.

Commercial Seller includes, but is not limited to, retailers, wholesalers or commercial vendors that are not Providers, who are approved to provide new medical supplies, equipment and devices in accordance with the provisions of this coverage.

Covered Service means a service, supply, treatment or accommodation that is listed in

the benefits sections in this Policy.

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

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

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

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

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

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

Enrolled Dependent means a Policyholder's eligible dependent who is listed on the Policyholder's completed application and who has been accepted for coverage under the terms of this Policy by Us.

Exchange means an on-line health insurance marketplace implemented under the Affordable Care Act where consumers can, among other things, purchase health insurance.

Family means a Policyholder and his or her Enrolled Dependents.

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

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

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

health must outweigh the overall harmful effects on health.

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

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

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

In-Network means a Provider that has an effective participating contract with Us that designates him, her or it as a network Provider and who is a member of Your chosen Provider network, to provide services and supplies to Insureds in accordance with the provisions of this coverage. For In-Network Provider reimbursement, You will not be charged for balances beyond any Deductible, Copayment and/or Coinsurance for Covered Services.

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

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

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

In applying the above criteria, We will review Scientific Evidence from well-designed

clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating Physician or Practitioner regarding the Health Intervention.

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

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

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

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

Nonparticipating Facility means an Out-of-Network facility that does not have any effective participating contract with Us or one of Our Affiliates.

Out-of-Network means Providers that are not In-Network. Out-of-Network Providers include those Providers who have contracted with Us but are outside Your network, and Providers outside Your state of residence but inside Your network. We do not cover services provided by Out-of-Network Providers, except as specified in the Medical Benefits Section. For reimbursement of Covered Services from an Out-of-Network Provider, You may be billed for balances over Our payment level in addition to any Deductible, Copayment and/or Coinsurance amount for Covered Services provided inside or outside the area that We serve.

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

Policy is the description of the benefits for this coverage. This Policy is also the agreement between You and Us for a Health Benefit Plan.

Practitioner means an individual who is duly licensed to provide medical or surgical services that are similar to those provided by Physicians. Practitioners include podiatrists who do not meet the definition of Physician, Physician's assistants, psychologists, licensed clinical social workers, certified nurse Practitioners, registered physical, occupational, speech or audiological therapists; registered nurses or licensed practical nurses, (but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill

patients), dentists (doctor of medical dentistry or doctor of dental surgery, or a denturist) and other health care professionals practicing within the scope of their respective licenses.

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

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

Reasonable Charges means an amount determined based on one of the following, as determined by Us:

- 125% of the fee paid by Medicare for the same services or supplies;
- the average amount that In-Network Providers have contractually agreed to accept as payment in full for the same or similar services or supplies in Our Service Area; or
- 40% of the Out-of-Network Provider's billed charges.

Under no circumstances will any fee exceeding 300% of the fee paid by Medicare for the same services or supplies be considered Reasonable Charges.

Risk-Sharing Arrangement means a contractual arrangement with an In-Network Provider under which the Provider assumes financial risk related to aggregate quality, utilization, and/or similar measures of the Provider's (and/or that Provider's and associated Providers') services. Under a Risk-Sharing Arrangement, a Provider may become entitled to payments from Us separate from Allowed Amounts already paid or may become liable to make payments or refunds to Us. Payments under a Risk-Sharing Arrangement, however, are based on aggregate performance data, are not specific to any Insured, and will not change the Allowed Amount or result in adjustment to Your cost-sharing. That is, a Risk-Sharing Arrangement payment to an In-Network Provider will not require an adjustment for You to pay additional cost-sharing corresponding to that additional payment and a Risk-Sharing Arrangement payment or refund from a Provider will not result in an adjustment reducing Your cost-sharing.

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

Service Area means the states of Idaho, Oregon, Utah and Washington.

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

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

Disclosure Statement Patient Protection Act

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

WHAT ARE MY RIGHTS AND RESPONSIBILITIES AS AN INSURED OF BRIDGESPAN HEALTH COMPANY?

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

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

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

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

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

care since he or she is familiar with Your medical history.

HOW WILL I KNOW IF MY BENEFITS CHANGE OR ARE TERMINATED?
If You have an individual Policy, We will send You notification of any benefit changes through the mail. In addition, You can always contact Our Customer Service Department and ask a representative about Your current benefits.

WHAT HAPPENS IF I AM RECEIVING CARE AND MY DOCTOR IS NO LONGER A CONTRACTING PROVIDER?
When a Physician's or Practitioner's (herein Provider) contract ends with Us for any reason, We will give notice to those Insureds that We know, or should reasonably know, are under the care of the Provider of his or her rights to receive continued care (called "continuity of care"). We will send this notice no later than ten days after the Provider's termination date or ten days after the date We learn the identity of an affected Insured, whichever is later. The exception to Our sending the notice is when the Provider is part of a group of Providers and We have agreed to allow the Provider group to provide continuity of care notification to Insureds.

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

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

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

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

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

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

You also have the right to file a complaint and seek assistance from the Oregon Division of Financial Regulation. Assistance is available by calling: (503) 947-7984 or the toll-free message line at (888) 877-4894; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: **http://dfr.oregon.gov/gethelp/Pages/file-a-complaint.aspx**; or by E-mail at: **cp.ins@oregon.gov**.

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

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

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

- the Member Advisory Committee for Insureds;
- the Marketing Advisory Panel for employers; and
- the Provider Advisory Committee for health care professionals.

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

BridgeSpan Health Company ATTN: Vice President, Customer Service, P.O. Box 1827, MS CS B32B, Medford, OR 97501-9884 or send Your comments to Us through Our Web site.

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

WHAT ARE YOUR PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT CRITERIA?

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

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

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

definition of Medically Necessary in the Definitions Section of this Policy.

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

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

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

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

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

WHAT ADDITIONAL INFORMATION CAN I GET FROM YOU UPON REQUEST?

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

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

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

The following information regarding the Health Benefit Plans of BridgeSpan Health Company is available from the Oregon Division of Financial Regulation:

- 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 appeals.
- An annual summary of utilization management policies.
- An annual summary of quality assessment activities.
- An annual summary of scope of network and accessibility of services.

To obtain the mentioned information, You can call the Oregon Division of Financial Regulation at (503) 947-7984 or the toll-free message line at (888) 877-4894; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: **http://dfr.oregon.gov/gethelp/Pages/file-a-complaint.aspx**; or by E-mail at: **cp.ins@oregon.gov**. You can also contact Our Customer Service department.

For more information call Us at 1 (855) 857-9943 or You can write to Us at 2890 East Cottonwood Parkway, Salt Lake City, UT 84121

bridgespanhealth.com