



Regence

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

1800 Ninth Avenue
PO Box 21267
Seattle, WA 98111-3267

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Dear BHT Member Group:

Each year, federal and state laws require us to send certain notices to all of our members. While not all of the notices may be relevant to every member, they do apply to all member contracts so it is important to review each notice to understand your rights. These notices include, among other things, your rights regarding privacy practices, the claims appeal process, and information regarding the Women's Health and Cancer Rights Act.

To find out more about your benefits, check your claims, learn about medical conditions, research cost and care options, and even be rewarded for making healthy choices, please log on to **myRegence.com**. With **myRegence.com**, you can find all your health-related resources in one place. Registering is easy and secure - simply go to **www.myRegence.com** and have your member number handy.

If you have questions regarding the notices in this document, please contact us at 1 (888) 367-2112.

Thank you for being a Regence member. We appreciate the opportunity to provide you with the highest quality health care coverage.

Sincerely,

Joanne S. Gholston
VP of Customer Service
Regence BlueShield

Enclosures: Disclosure Notice Document

Breast Reconstruction (medical plans only)

Health plans are required by federal law to inform you upon enrollment and annually thereafter about the presence of a breast reconstruction benefit in your plan. This update includes such information, along with information regarding the Act described below.

The Women's Health and Cancer Rights Act of 1998 established federal standards for the coverage of breast reconstruction following a mastectomy. This law requires that health plans that include coverage for mastectomy must also include coverage of the following (in a manner determined in consultation with the attending physician and the member):

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas

Benefits for reconstructive surgery may be subject to annual deductibles, if any, and coinsurance consistent with those established for other benefits. Health plans and employers may not deny a member eligibility to enroll in or to renew coverage solely for the purpose of avoiding coverage of breast reconstruction following a mastectomy. If you would like more information regarding your cancer rights, contact your Plan Administrator.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We, at Regence BlueShield, know you value your privacy. That is why we are committed to the confidentiality and security of your personal information. We maintain physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of your personal information.

We collect personal information, such as your name, contact information, and health information, from you, your health care providers, and other insurers that provide you coverage. We are required by law to maintain the privacy of this protected health information and to explain our legal duties and privacy practices. We provide the protections and apply the practices described in this notice to all personal information that we maintain, including personal information of former members who are no longer covered by us. We hope this notice will clarify our responsibilities to you and give you an understanding of your rights. We abide by the notice that is currently in effect. This notice is in effect as of April 1, 2006.

Your Rights

Inspection and Copies. You have the right to request an inspection or copies of protected health information that we maintain about you in a "designated record set" except psychotherapy notes and information that we compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding. A "designated record set" is a group of records that is used to administer your health benefits, including enrollment information and claims. We may limit the information that you can inspect or copy if we have reason to believe that it's necessary to protect you or another person from harm. If we limit your right to inspect or copy, you can ask for a review of that decision.

Amendment. If you believe that protected health information we maintain about you in a designated record set is inaccurate or incomplete, you have the right to request an amendment to correct or complete the information. You must submit your request in writing and explain the reason for the amendment. If the amendment is made, we will make reasonable efforts to inform others, including people you identify, that the information has been amended and we will use our best efforts to include the amendment with any future disclosure. We may decline to amend information under certain circumstances. This is likely to occur if we did not create the original record. If we decline to amend the information, you have the right to submit a statement of disagreement. You should know that we are allowed to attach a rebuttal statement in response to your statement of disagreement.

Notice. You have the right to receive a paper copy of this notice upon request.

Accounting. You have the right to request a list of certain disclosures of protected health information. The list will not include disclosures made for treatment, payment, or health care operations. It also will not include disclosures

made pursuant to an authorization, made prior to six years before the date of the request, incidental disclosures, disclosures made for national security or intelligence, disclosures made to a correctional facility or disclosures made prior to April 14, 2003. The list will include the date of any accountable disclosure, to whom that disclosure was made, a brief description of the information disclosed, and the purpose for that disclosure (provided this information is known to us). We will supply this list free of charge once a year at your request. If you request an accounting more than once in a 12-month period, we may charge a reasonable fee.

Special Handling. You have the right to request restrictions on our use or disclosure of protected health information in addition to the restrictions imposed by law. We are not required to agree to your request and we may be unable to do so. If we do agree, we will comply with your request except in the case of emergency. You also have the right to request that we communicate with you in confidence. We will make every effort to accommodate your request if it is reasonable and you provide an alternate means to communicate. You should know that redirecting communication may not prevent others on your policy from discovering that you sought medical care. Accumulated deductibles and co-payment information may reveal that you obtained services. In addition, historic claims reports may include services which were obtained during the time communications were redirected.

Complaints. You have the right to submit a complaint if you believe we have violated your privacy rights. To submit a complaint, write to: The Regence Group, Privacy Office, P.O. Box 1071, Mailstop E12B, Portland, OR 97207 or call our Customer Service department at the phone number provided at the end of this notice. You also have the right to submit a complaint to the Secretary of the U.S. Department of Public Health & Human Services. Be assured that we will not retaliate against you for submitting a complaint.

Permitted Uses and Disclosures

To administer health benefits, we collect, use and disclose protected health information for a variety of purposes:

Treatment. We may disclose protected health information to a health care provider in order for the provider to treat you. We may also use or disclose protected health information in an effort to provide preventive health, early detection, and case management programs.

Payment. We may use or disclose protected health information for payment purposes, including to adjudicate claims, issue Explanation of Benefits, or coordinate benefits with other entities responsible for paying your claims.

Health Care Operations. We may use or disclose protected health information to facilitate operations, including underwriting, customer service, and detection or prevention of fraud or abuse.

Business Associates. Occasionally, we contract with business associates to perform insurance-related functions on our behalf. We may disclose protected health information to these business associates in order to allow them to perform these functions. They also may collect, use or disclose protected health information on our behalf. We contractually obligate our business associates to provide the same privacy protections that we provide.

Plan Sponsors and Group Health Plans. If you are enrolled in a group health plan, we may disclose protected health information to the group health plan or plan sponsor to facilitate administration of the plan. For example, we supply enrollment lists so that premiums can be paid appropriately.

As Permitted or Required by Law. We use or disclose protected health information as permitted or required by law. For example, some laws require that we disclose protected health information to your personal representatives or to certain government agencies.

Public Health Activities. We may disclose protected health information for public health activities. These activities include prevention and control of disease, activities performed by coroners, activities performed by organ or tissue donation and transplantation services, activities performed by the Food and Drug Administration, medical research, research intended to improve the health care system, activities necessary to avert a serious threat to the health or safety of a person, and activities relating to workers' compensation benefits.

Health Oversight. We may disclose protected health information to health oversight agencies. These agencies are authorized by law to conduct audits; perform inspections and investigations; license health care providers, insurers and facilities; and to enforce regulatory requirements. These agencies include: State Commissioner of Insurance, State Board of Medicine, and the U.S. Department of Labor.

Health Related Services. We may use protected health information to provide information about treatment alternatives or other health related benefits or services that may be of interest to you. This may include enhancements to your health plan and health related products or services available only to health plan members that add value to, but are not a part of, your benefit plan.

Legal Proceedings. We may disclose protected health information in the course of a judicial or administrative proceeding, and in response to a court order, subpoena, discovery request, or other lawful process.

Law Enforcement. We may disclose protected health information to law enforcement officials in response to an administrative subpoena, a warrant, or an administrative request intended to identify or locate a suspect, victim, or witness. We also may disclose protected health information for the purpose of reporting a crime on our premises.

Military and National Security. We may disclose protected health information to armed forces personnel for military activities and to authorized federal officials for national security and intelligence activities.

Correctional Institution. If you are an inmate, we may disclose protected health information to your correctional institution for treatment purposes or to ensure the safety of yourself and others.

Marketing. We do not use or disclose protected health information for marketing purposes without your authorization. However, we may communicate with you face-to-face about products or services that may interest you or we may send you a promotional gift of nominal value.

Others Involved in Your Health Care. We may disclose protected health information to personal representatives such as appointed guardians, executors, conservators, and in many cases parents of minor children, as well as to attorneys in fact when a valid power of attorney exists. In addition, if you give us verbal permission or if your permission can be implied (for example, while you are unconscious during an emergency), we may disclose protected health information to family members or others who call on your behalf. This permission is valid only for a limited time. If you want to authorize on-going disclosures to family members or friends, you must submit written authorization.

Authorizations. You may give us written authorization to use protected health information or disclose protected health information about yourself to anyone for any purpose. An authorization remains valid for two years unless the authorization states otherwise or you revoke it. You may revoke an authorization at any time by submitting a written revocation, but a revocation will not affect any use or disclosure permitted by the authorization while it was in effect. An authorization is required for us to use or disclose your protected health information for purposes other than those described in this notice.

Future Changes

We reserve the right to change our privacy practices and this notice at any time without advance notice. If we make a material change to our privacy practices, we will send a new, updated notice. The new notice will apply to all protected health information in our possession, including any information created or received before the revised notice became effective.

Contacting Us

You may reach us during regular business hours by calling our Customer Service department at 1 (888) 367-2112. For more information about this notice or to file a written privacy-related complaint, you may write to: Privacy Official, The Regence Group, P.O. Box 1071, MS E12B, Portland, OR 97207.

Newborns' and Mothers' Health Protection Act (medical plans only)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under

federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). State law may permit even longer lengths of stay.

Notice of Preexisting Condition Exclusion Period (medical plans only)

This plan imposes a preexisting condition exclusion period. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion period applies only where there was a recommendation or receipt during the plan's look-back period of medical advice, diagnosis, care, or treatment for the condition (under federal law, the look-back period can be no longer than six months). Generally, the look-back period ends the day before your coverage becomes effective. However, if you have a waiting period for coverage, the look-back period ends the day before the waiting period begins. For fully-insured group plans, this preexisting condition exclusion period may not exceed 9 months for groups of 2-50 or 3 months for groups of 51+ from your enrollment date, according to state and/or federal law.

A preexisting condition exclusion does not apply to a child who becomes covered on a group or individual health plan within 60 days after birth, adoption, or placement for adoption, unless a period of at least 63 consecutive days without creditable coverage has elapsed. A preexisting condition exclusion cannot apply to pregnancy on a group health plan. If you need to confirm the exclusion period applicable to your health coverage, please give us a call using the contact information shown below.

You can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage. Under federal law, you are allowed a credit against the exclusion period for the combined amount of prior creditable coverages that you have had, except that, if you have had a break in coverage of 63 days or more, no credit is given for any creditable coverages prior to that break. Alternatively, under state law, if you had coverage at the time you applied for this plan and that coverage terminated no more than 90 days before you applied, you are allowed credit against this plan's exclusion period.

To reduce the exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have from previous plans (or from plans that were in force at the time of your enrollment in this plan). If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the preexisting condition exclusion and creditable coverage should be directed to: Regence BlueShield, P.O. Box 1271 MS C7A, Portland, OR 97207 or by calling 1 (888) 367-2112.

Appeals Process

If you or your Representative (any representative authorized by you) has a concern regarding a claim denial or other action by us under the contract and wishes to have it reviewed, you may appeal. There are two levels of appeal, as well as additional voluntary appeal levels you may pursue. Certain matters requiring quicker consideration qualify for a level of expedited appeal and are described separately later in this section.

APPEALS

Appeals can be initiated through either written or verbal request. A written request can be made by sending it to us at: Regence BlueShield, P.O. Box 1271 MS C7A, Portland, OR 97207. Verbal requests can be made by calling us at 1 (888) 367-2112.

Each level of appeal, including expedited appeals, must be pursued within 180 days of your receipt of our determination (or, in the case of the first level, within 180 days of your receipt of our original adverse decision that you are appealing). If you don't appeal within this time period, you will not be able to continue to pursue the appeal process and may jeopardize your ability to pursue the matter in any forum. When we receive an appeal request, we will send a written acknowledgement and information describing the entire appeal process and your rights.

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

First-Level Appeals

First-level appeals are reviewed by an employee or employees who were not involved in the initial decision that you are appealing. In appeals that involve issues requiring medical judgment, the decision is made by our staff of health care professionals. A written notice of the decision will be sent within 14 days of receiving the appeal unless we notify you that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond 30 days of the request for appeal, without your informed written consent. For appeals involving a post-service investigational issue, a written notice of the decision will be sent within 20 working days of receipt of the appeal and within five working days of the decision being made. For all other 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 (including a pre-service investigational procedure) we will send a written notice of the decision within 14 days of receipt of the appeal.

Panel-Level (Second-Level) Appeals

Second-level appeals are reviewed by a panel who were not involved in, or subordinate to anyone involved in, the first-level decision. You or your representative, on your behalf, will be given a reasonable opportunity to personally appear or participate via telephone, video conference or other technology and/or to provide written materials. A written notice of the decision will be sent within 14 days of receiving the appeal unless we notify you that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond 30 days of the request for appeal, without your informed written consent. For appeals involving a post-service investigational issue, a written notice of the decision will be sent within 20 working days of receipt of the appeal and within five working days of the decision being made. For all other 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 (including a pre-service investigational procedure) we will send a written notice of the decision within 14 days of receipt of the appeal.

VOLUNTARY EXTERNAL APPEAL - IRO

A voluntary appeal to an Independent Review Organization (IRO) is available only after you have exhausted all of the applicable non-voluntary levels of appeal, or if we have failed to provide you with a first-level or panel-level appeal decision within the timeframes given and the issue on appeal addresses one of the following:

- Medical Necessity;
- determination that the treatment is investigational; or
- treatment of a preexisting condition and the benefit denial is based in whole or in part on a medical review determination by the plan.

We coordinate voluntary external appeals, but the decision is made by an Independent Review Organization (IRO) at no cost to you. We will provide the IRO with the appeal documentation. A written notice of the IRO's decision will be sent to you within 30 days of receipt of your request. Choosing the voluntary external appeal as the final level to determine an appeal will be binding in accordance with the IRO's decision and this section.

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

EXPEDITED APPEALS

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

- the application of regular appeal timeframes on a pre-service or concurrent care claim could jeopardize your life, health or ability to regain maximum function, or
- according to a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the disputed care or treatment.

Panel-Level (First-Level) Expedited Appeal

The first-level expedited appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the appeal decision. First-level expedited appeals are reviewed by a panel who were not involved in, or subordinate to anyone involved in, the initial denial determination. You or your Representative, on your behalf, will be given the opportunity (within the constraints of the expedited appeals timeframe) to participate via telephone and/or provide written materials. A verbal and written notice of the decision will be provided to you and your representative as soon as possible after the decision, but no later than 72 hours of receipt of the appeal.

Voluntary Expedited Appeal - IRO

If you disagree with the decision made in the panel-level appeal and you or your representative reasonably believes that preauthorization remains clinically urgent (pre-service), you may request a voluntary expedited appeal to an IRO. The criteria for a voluntary expedited appeal to an IRO are the same as described above for non-urgent IRO review.

We coordinate voluntary expedited appeals, but the decision is made by an IRO at no cost to you. In order to have the appeal decided by an IRO, you must sign a waiver granting the IRO access to medical records. We will provide the IRO with the appeal documentation. 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. Choosing the voluntary external appeal as the final level to determine an appeal will be binding in accordance with the IRO's decision and this section.

The voluntary expedited appeal by an IRO is optional and you should know that other forums may be used as the final level of expedited appeal to resolve a dispute you have with us, including, but not limited to, civil action under Section 502(a) of ERISA, where applicable.

INFORMATION

If you have any questions about the appeal process outlined here, you may contact our Customer Service department at 1 (888) 367-2112 or you can write to our Customer Service department at the following address: Regence BlueShield, P.O. Box 1271 MS C7A, Portland, OR 97207.

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

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

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

Independent Review Organization (IRO) is an independent physician review organization which acts as the decision-maker for voluntary external appeals and voluntary expedited external 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.

Medical Director means for purposes of the appeal process only, a physician employed by, or consulted by, us. The Medical Director will reserve the right, if not appropriately qualified to review a particular procedure, to consult with an outside practitioner with specialty in the medical condition/procedure involved in the review.

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

Pre-Service means any claim for benefits under the contract 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 the Appeal. The Representative may be your personal Representative or a treating provider. It may also be another party, such as a family member, as long as you or your legal guardian authorize in writing, disclosure of personal information for the purposes of the Appeal. No authorization is required from the parent(s) or legal guardian of a member who is an unmarried and dependent child and is less than 13 years old. For expedited Appeals only, a health care professional with knowledge of your medical condition is recognized as your Representative. Even if you have previously designated a person as your Representative for a previous matter, an authorization designating that person as your Representative in a new matter will be required (but redesignation is not required for each Appeal level). If no authorization exists and is not received in the course of the Appeal, the determination and any personal information will be disclosed to you, your personal Representative or treating provider only.

Post-Sale Disclosure Statement: Health Care Patient Bill of Rights (Form Number WW1109DDIS)

This Q & A summarizes many of the terms and conditions of our plans and supplements your member benefits booklet. **Please note:** As you read this information, keep in mind that the references to "you" refer to both you *and* your enrolled dependents (if applicable), unless specifically noted otherwise.

What additional information can I get from Regence BlueShield upon request?

- Any documents or other information referred to in the contract or benefit brochure.
- Annual accounting of all payments made by the company which have been counted against any payment limitations, visit limitations, or other overall limitations under the plan.

What is Regence BlueShield's accreditation status with national managed care accreditation organizations, including effectiveness performance using HEDIS? Is the HEDIS data published and how can I access HEDIS data?

Regence BlueShield has not sought NCQA accreditation. As a result, HEDIS rates are not reported to Quality Compass. However, HEDIS reporting is mandated by government programs contracts. (Medicaid) HEDIS rates are reported annually to DSHS/HCA, per contract requirements. This data is publicly reported. HEDIS data is reported as aggregate data by product. Individual providers and members remain confidential. Some large employee groups may also require HEDIS measurements.

How do I, if necessary, consult a provider other than my Personal/Primary Care Provider (PCP)?

PCPs are not required on Innova, Engage, Activate, Regence HSA 2.0, Preferred or Traditional plans. Members on Selections plans may go outside the Selections Network to a Selections, Preferred Plan, or participating provider in the "extended network," however, out-of-pocket costs may be higher. All care must be coordinated by the member's Personal Care Provider for the member to qualify for the highest level of benefits, with the exception of self-referral benefits and for emergency services.

Descriptions of and justifications for provider compensation programs.

Regence BlueShield does not employ the physicians within the Regence network. Physicians are contracted to provide services on a fee-for-service basis and are paid from fee schedules for the services provided.

What procedures may require prior authorization from Regence BlueShield and how do I obtain that authorization?

Prior authorization, also known as preauthorization, is the process we use to determine the medical necessity of a service before it is rendered. Contact our Customer Service department at the phone number on the back of your 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 your 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.

Description of any reimbursement or payment arrangements between the company and a provider or network.

Regence BlueShield reimburses physicians and other providers using the Resource Based Relative Value Scale, (RBRVS). Reimbursement conversion factors are reviewed and updated annually. Hospitals are reimbursed using Diagnostic Related Groups, (DRGs). DRG weights and conversion factors are reviewed and updated periodically as hospital contracts are renewed. These reimbursement methodologies are based on national standards for reimbursement as developed and maintained by the Centers for Medicare and Medicaid Services, (CMS). Commercial reimbursement for provision of healthcare services is almost always based on these methods, both locally and nationally.

What is the plan's appeal / grievance process, including appeals / grievances for claim or service denial and for dissatisfaction with care?

For the most up to date copy of the plan's appeal / grievance process, visit our Web site at www.myRegence.com.

What are the limitations and exclusions to my medical benefit plan?

The following list is representative of the limitations and exclusions to the benefit plans we offer. It is not a complete list. For a complete list, see your group contract and/or member booklet. The following services and supplies are not covered or are limited:

- Acupuncture for smoking cessation

- Benefits covered by government programs
- Charges for services or supplies that are above the allowed amount, except as required by law for emergencies
- Charges that in the absence of the plan there would be no obligation to pay
- Cosmetic surgery and supplies (including drugs) and the treatment of any direct or indirect complications of such surgery, except: 1) when related to an illness or injury; 2) for congenital anomalies; 3) for reconstructive breast surgery following mastectomies to the extent required under federal and state law
- Custodial care
- Dental services except as provided under the Repair of Teeth and Hospitalization for Dental Services benefits (*Preferred, Selections, & Traditional plans only*)
- Dental services (*Innova, Engage, Activate & Regence HSA Healthplan 2.0 plans only*)
- Eyeglasses and contact lenses and the fitting, except for the first intraocular lenses following cataract surgery (optional Vision Hardware or Vision Care benefit is available)
- Hearing aids
- Investigational services or supplies
- In-vitro fertilization, artificial insemination, embryo transfer, or other artificial means of conception, including any expenses for fertility drugs
- Marital counseling; family counseling, except as specified in the Mental Disorders or Mental Health Services benefit
- Over-the-counter contraceptive supplies and devices
- Private duty nursing or hourly nursing charges
- Routine eye exams, except on Selections plans (Optional Vision Care benefit including exams available on *Traditional, Preferred, Innova, Engage, Activate, & Regence HSA Healthplan 2.0 plans*)
- Services or supplies covered by auto insurance, personal injury protection insurance, homeowner insurance, or commercial premises coverage
- Services or supplies not medically necessary for illness, injury, or physical disability
- Services provided by a family member
- Surgery (including reversals), treatment, programs, or supplies that are intended to result in weight reduction, regardless of diagnosis
- Surgery or treatment for sexual dysfunction/impotence or transsexualism
- Treatment of any condition caused by or resulting from active participation in the armed forces in a war or insurrection
- Treatment of any condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States
- Visual analysis, therapy, training, or orthoptics
- Visits or consultations that are not in person, including but not limited to any telephone, Internet, or other electronic communication (except telemedicine in remote locations, as approved by the Company (*Preferred, Selections and Traditional plans only*) and except where otherwise provided under the Telemedicine benefit of the *Innova, Engage, Activate & Regence HSA Healthplan 2.0 plans*), whether initiated by the member or the member's provider.