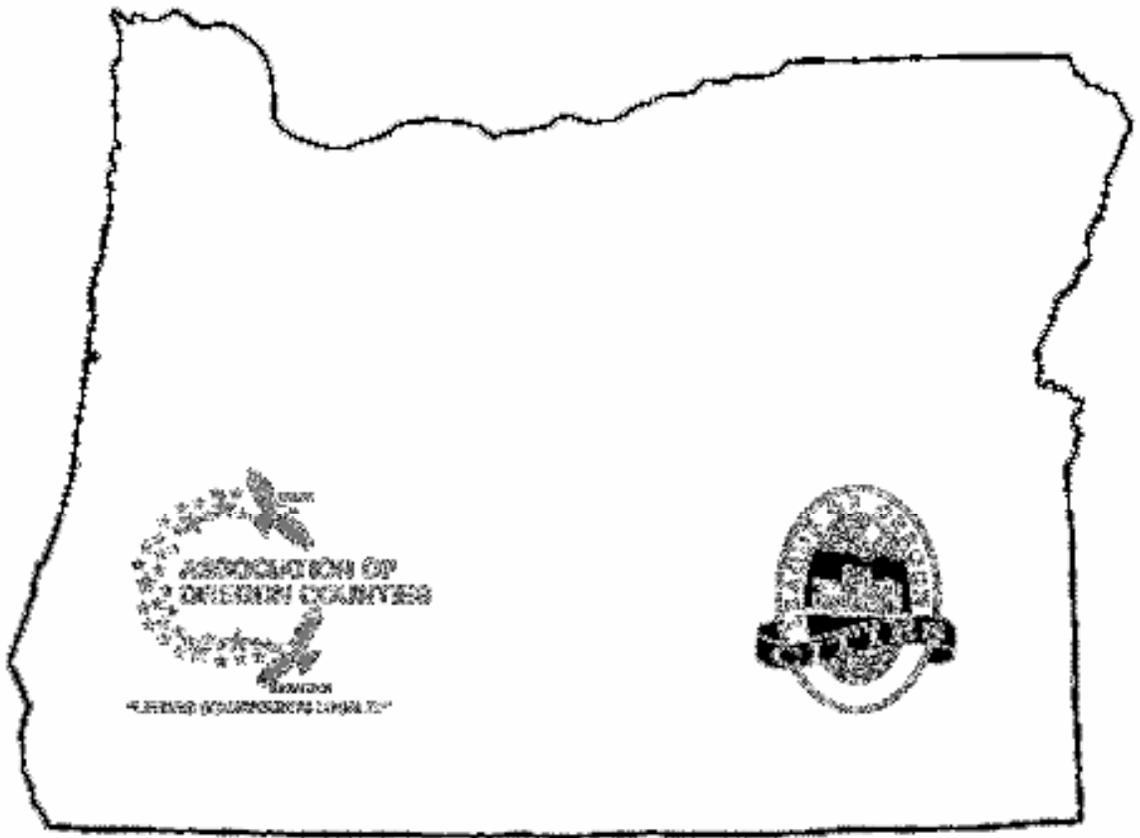




**Employee Benefit Plan with Family Protection**



**Plan I-B PPP Rx2**  
**Effective August 1, 2007**



# **CIS Employee Benefits**

PLAN I-B PPP RX2



On behalf of City County Insurance Services (CIS), it is a pleasure to transmit this booklet explaining the group medical plan benefits for CIS covered employees and dependents.

CIS makes group health insurance programs available to Oregon cities, counties, and associated groups as a special service for their employees and dependents. The CIS Employee Benefits group plans bring together a large number of employees under a single insurance pool to take advantage of the expanded purchasing power and reduced administrative costs, allowing CIS to provide excellent benefit options in relation to cost.

Since the establishment of the cities' trust (EBS Trust) in 1958 and the counties' trust (AOCIT) in 1960, the scope of benefits has been revised from time to time to meet the needs of participating entities. Periodic plan adjustments have been made to offset increasing health care costs, to keep pace with trends in health care services, and to provide greater flexibility by providing additional plan options.

The CIS Trustees are taking a proactive approach to increasing health care costs by offering you programs and services that 1) can help you stay healthy, and 2) that help you use the health care system more effectively. The CIS *Healthy Benefits* program provides a health action guide, a health information website, a self-care book, health care information and resources, and "lifestyle" and "disease management" programs. We encourage you to take advantage of these free programs available to you through *Healthy Benefits*. For more information on the programs and how to access them, log on to [www.cisbenefits.org](http://www.cisbenefits.org). Additionally, you and your covered dependents have access to EASE, the employee assistance program, to help you with work issues or personal concerns.

The CIS medical plans also include an error reward system for those who find errors in your medical bills. If you find a bill overcharge and call the mistake to the attention of your provider so that the proper adjustments are made, you can receive a reward for correcting the mistake. This means that you need to take the time to examine your medical bills to assure they accurately reflect the services you received.

Please take time to read this booklet carefully to understand all the benefits and conditions. You can be a wiser consumer of health care services if you make the effort to understand your health care plan and how it operates.

Noel Klein  
Executive Director  
City County Insurance Services



---

**BENEFITS BOOKLET**

---

Regence BlueCross BlueShield of Oregon  
100 SW Market Street  
PO Box 1271  
Portland, OR 97207-1271  
[www.or.regence.com](http://www.or.regence.com)

**To: All Eligible Employees**

This group health plan is provided to **you** and **your** dependents through Regence BlueCross BlueShield of Oregon.

This **benefits booklet** describes benefits effective August 1, 2007, or the date after that on which **your** coverage became effective.

Date Prepared: May 8, 2007

File No. 096000003



---

**TABLE OF CONTENTS**

---

<b>INTRODUCTION .....</b>	<b>1</b>
<b>REWARD FOR ERROR DETECTION.....</b>	<b>1</b>
<b>WHO IS ELIGIBLE .....</b>	<b>1</b>
Employees.....	2
Dependents .....	2
Newly Acquired Dependents .....	3
Special Enrollment.....	5
<b>ENROLLING ON THE GROUP ORIGINAL EFFECTIVE DATE .....</b>	<b>6</b>
<b>HOW TO ENROLL AFTER THE GROUP ORIGINAL EFFECTIVE DATE.....</b>	<b>6</b>
When You First Become Eligible .....	6
Enrolling New Dependents .....	6
Open Enrollment.....	6
Transferring From One Plan To Another During Selection Period .....	7
<b>WHEN GROUP COVERAGE BEGINS.....</b>	<b>7</b>
<b>WHEN GROUP COVERAGE ENDS .....</b>	<b>7</b>
Contract Termination .....	8
Termination By Enrolled Employee .....	8
If You Die.....	8
If Your Dependents Lose Eligibility .....	8
If You Lose Eligibility .....	9
If You Retire.....	12
Rescinding Coverage .....	13
<b>CONTINUATION OF COVERAGE (COBRA).....</b>	<b>13</b>
<b>PORTABILITY HEALTH BENEFIT PLANS .....</b>	<b>17</b>
Eligibility For A Portability Plan .....	17
How To Apply For A Portability Plan.....	18
Portability Health Benefit Plan Options.....	19
<b>DEFINITIONS .....</b>	<b>19</b>
<b>SUMMARY OF BENEFITS.....</b>	<b>24</b>
Maximum Lifetime Benefit .....	24
Calendar Year Deductible .....	24
Percentage We Pay For Covered Expenses .....	25
Additional Accident Benefit.....	25
Women's Health And Cancer Rights .....	26

Biofeedback Therapy.....	26
Waiting Periods .....	26
Open Enrollment.....	26
<b>HOW YOUR PLAN WORKS .....</b>	<b>31</b>
<b>PREAUTHORIZATION .....</b>	<b>31</b>
<b>BENEFITS .....</b>	<b>33</b>
When Benefits Are Available.....	34
Deductibles.....	34
Once The Deductible Is Satisfied .....	35
Restoration Of Benefits .....	36
Deductible, Stop-Loss, And Out-Of-Pocket Maximum Renewal.....	36
Care Management/Alternative Benefits.....	36
Emergency Care.....	36
<b>COVERED EXPENSES.....</b>	<b>37</b>
<b>HOSPITAL CARE.....</b>	<b>39</b>
Hospital Inpatient Care .....	39
Number Of Inpatient Hospital Days Covered.....	40
Skilled Nursing Facility Care.....	40
Inpatient Rehabilitative Hospital Care.....	41
Newborn Nursery Care .....	41
If Benefits Under This Contract Change.....	41
Hospital Outpatient Care .....	41
Outpatient Rehabilitative Care.....	42
Special Facility Care .....	42
<b>PROFESSIONAL PROVIDER SERVICES.....</b>	<b>43</b>
Home Or Office Visits .....	43
Cancer Screening.....	43
Annual Women's Examinations.....	43
Physician's Visits In The Hospital .....	44
Surgery.....	44
Contraceptive Services.....	45
Radium, Radioisotope, And X-Ray Therapy.....	45
Diagnostic X-Rays And Laboratory Services .....	45
Immunizations .....	46
Therapeutic Injections .....	46
Mental Health And Chemical Dependency Services .....	46
Maternity Care .....	47
Women's Health And Cancer Rights .....	47
Special Dental Care.....	47
Chiropractic Care.....	48
Additional Accident Benefit.....	48

<b>OTHER COVERED EXPENSES .....</b>	<b>48</b>
Home Health Care.....	48
Home Infusion Therapy .....	49
Palliative Hospice Care .....	50
Ambulance Transportation .....	52
Supplies, Appliances, Medications, And Durable Medical Equipment.....	52
Outpatient Diabetic Instruction .....	54
<b>GENERAL LIMITATIONS.....</b>	<b>55</b>
Biofeedback Therapy.....	55
Transplants.....	55
Medicare.....	60
<b>GENERAL EXCLUSIONS .....</b>	<b>61</b>
<b>PRESCRIPTION MEDICATION BENEFITS.....</b>	<b>68</b>
Prescription Medication Benefits Replace Contract Benefits.....	68
Definitions.....	68
How To Use The Prescription Medication Benefit .....	70
Amount Payable .....	70
Maximum Out Of Pocket Expense .....	72
Grace Period .....	72
Mail Order Benefit.....	72
Limitations .....	73
Exclusions .....	75
Prior Authorization .....	77
General Provisions .....	77
Contract Terms Apply.....	78
<b>CONTRACT AND CLAIMS ADMINISTRATION.....</b>	<b>80</b>
Right Of Reimbursement And Subrogation .....	80
Coordination Of Benefits .....	82
Disclosure Of Health Information.....	87
Benefits Are Not Transferable .....	87
Hold Harmless In The Event Of Nonpayment .....	87
You Must Submit Health Information.....	88
We Are Not Responsible For The Quality Of Health Care .....	88
Claims Recoveries.....	88
Submission And Payment Of Claims.....	88
Member Appeals And Grievance Process.....	91
Replacing Earlier Contract.....	94
Medication Rebate.....	94
Out-Of-Area Claims Service - BlueCard® Program .....	95
<b>DISCLOSURE STATEMENT - PATIENT PROTECTION ACT.....</b>	<b>96</b>
<b>GENERAL PROVISIONS .....</b>	<b>103</b>

No Waiver..... 103  
Governing Law ..... 104  
Choice Of Forum ..... 104  
Representations Are Not Warranties..... 104  
Relationship To Blue Cross And Blue Shield Association ..... 104  
**SPECIAL BEGINNINGS®..... 105**

---

## INTRODUCTION

---

The following pages are the **benefits booklet**, a written description of the terms of the group health care benefit plan that this **benefits booklet** describes. If the **contract** and the **benefits booklet** differ, the **contract** will prevail. For a copy of the **contract**, consult City County Insurance Services (CIS).

**The legal document that governs in all cases and sets forth the plan in full is the contract between Regence BlueCross BlueShield of Oregon and City County Insurance Services. If you have any questions or want further explanation of the terms of this contract, contact your employer's group insurance administrator, the CIS Employee Benefits staff, or Regence BlueCross BlueShield of Oregon.**

This **benefits booklet** replaces any plan description, booklet, or certificate previously issued by **us** and makes it void.

Throughout this **benefits booklet** the terms **you** and **your** mean the **enrolled employee**. The term **enrollee** means **you** or an **enrolled dependent**. The terms **we**, **us**, and **our** refer to Regence BlueCross BlueShield of Oregon. The term CIS means City County Insurance Services. The term **group** refers to the individual member organizations who participate in City County Insurance Services.

---

## REWARD FOR ERROR DETECTION

---

If **you** find an overcharge on **your** medical bill and **you** convince **your** medical provider to correct it after **you** have received **your** claims processing report from **us**, **you** will be rewarded up to 50 percent of the amount of the error. There is a minimum reward of \$25 (error of \$50 or more) and a maximum reward of \$250 (error of \$500 or greater). To collect **your** reward send copies of: (1) original bill showing the error (2) **your** claims processing report (EOB), and (3) a credit slip from the provider acknowledging that **you** called the error to their attention; to CIS Employee Benefits, 1212 Court Street NE, Salem, Oregon 97301.

---

## WHO IS ELIGIBLE

---

This section describes who is eligible to enroll under the **contract** and when that eligibility becomes effective. Please be aware that the date **you** or **your enrolled dependent** becomes eligible may be different than the date coverage begins. See the provisions in HOW TO ENROLL AFTER THE GROUP ORIGINAL EFFECTIVE DATE and WHEN GROUP COVERAGE BEGINS.

---

## Employees

**You** become eligible to apply for coverage on the date **you** have worked for the **group** long enough to satisfy any required group eligibility waiting period as long as **you** meet the eligibility criteria described in the **contract**.

Ask **your** employer's group insurance administrator to tell **you** the length of employment required before **your** benefits become effective. They could, for example, not go into effect until the first of the month following 30, 60, or 90 days of employment. Also, **you** should check to determine if **your** spouse and dependents are eligible for coverage.

---

## Dependents

If **you** are married, **your** legal spouse is eligible for coverage. So is **your** qualified domestic partner and **your** or **your** qualified domestic partner's unmarried children if they are under age 23 and are dependent on **you** or **your** qualified domestic partner for full or partial support (at least 50 percent of the child's support).

**Please note:** Some **groups** offer only same sex domestic partnership coverage. Check with **your group's** administrator to determine if opposite sex coverage applies to **your group**.

**Your** domestic partner is eligible to apply for coverage provided that all of the qualifying conditions are met:

- each domestic partner is at least 18 years of age;
- the domestic partners share a close personal relationship and are responsible for each other's common welfare;
- the domestic partners share the same permanent residence with the intent to continue doing so indefinitely;
- the domestic partners are jointly financially responsible for basic living expenses including food, shelter, and medical expense;
- neither domestic partner is legally married to anyone else, nor has had another qualifying domestic partnership within the six months immediately prior to enrollment; and
- the domestic partners are not related by blood closer than would bar marriage in the state they reside in.

The following are considered children:

- **your, your** spouse's, or **your** qualified domestic partner's natural child;
- **your, your** spouse's, or **your** qualified domestic partner's adopted child, a child placed for adoption with **you** or **your** qualified domestic partner, a stepchild living in **your** home, or a nonresident stepchild if there is a qualified medical child support order that requires the spouse or **your** domestic partner to provide health insurance coverage; and
- children related to **you** or **your** qualified domestic partner by blood or marriage for whom **you** are the legal guardian (**you** will need to provide a court order showing legal guardianship).

If **you** have a child who is incapable of self-support because of a physical, mental, or developmental disability, that child may be eligible to remain enrolled even though he or she is over 23. To be eligible the child must be covered by the plan at the time of his/her 23rd birthday and the disability must have occurred prior to that date. Exception: new hires may add a disabled child over 23 if the child was disabled prior to his/her 23rd birthday. **You** must certify to **us** that these conditions have been met.

NOTE: **Enrollees** may obtain from CIS, without charge, a copy of the procedures governing qualified medical child support order determinations.

---

## Newly Acquired Dependents

This provision describes when **your** newly acquired or eligible dependents become eligible to apply for coverage. See WHEN GROUP COVERAGE BEGINS for a description of when coverage will normally begin for other than newborn or adopted children.

### New Spouse

If **you** marry while **you** are enrolled under the **contract**, **your** spouse becomes eligible to apply for coverage under this **contract** on the date of the marriage. Enrollment must be completed within 31 days of the marriage. Coverage will actually begin on the date of marriage. The eligibility requirements for **your** new stepchildren are explained later in this provision.

### Qualified Domestic Partner

If **you** establish a qualified domestic partnership **your** domestic partner and his or her eligible dependents become eligible to apply for coverage under this **contract** within 31 days of initial eligibility. When enrollment for coverage is submitted to **us**, it must be accompanied by a completed Certificate of Domestic Partnership. Coverage becomes effective first of

the month following receipt of certificate.

#### Newborn Children

**We** may provide coverage for the first 31 days after **your** or **your enrolled dependent's** baby is born. This coverage is provided as long as **we** receive both enrollment to add the newborn child and any required additional premium. The newborn must be eligible under the terms of the **contract**. In the case of a newborn of a male dependent, proof of paternity must also be provided.

To add the newborn child, enrollment to add the child must be completed and any additional premium from the date of birth must be sent to **us** within 31 days of birth. If **you** do not enroll the child and/or do not pay any additional premium within the required time period, the child's coverage will terminate retroactive to the date of birth. If this happens, **you** may enroll the child later only as a late enrollee, except as described under Special Enrollment.

#### Adopted Children

**We** may provide coverage for the first 31 days following the date **your** adopted child is placed with **you** for the purpose of adoption. **Placement** means **you** assumed and retained a legal obligation for at least 50 percent of the child's support in anticipation of adoption. This coverage is provided as long as **we** receive both enrollment to add the adopted child and any required additional premium. The child must be eligible under the terms of the **contract**.

To add the adopted child, enrollment to add the child must be completed and any additional premium from the date of **placement** must be sent to **us** within 31 days of **placement**. If **you** do not enroll the child and/or do not pay any additional premium within the required time period, the child's coverage will terminate retroactive to the date of **placement**. If this happens, **you** may enroll the child later only as a late enrollee, except as described under Special Enrollment.

#### Stepchildren

Once **you** are covered, stepchildren are eligible if they are under 23 years of age and are financially dependent upon **you** for support (at least 50 percent of the child's support). Stepchildren must reside with **you** or can be a nonresident stepchild if there is a qualified medical child support order that requires **your** spouse to provide health insurance coverage.

If **you** wish to enroll your stepchildren, **you** must complete enrollment listing the child as a dependent. The enrollment must be completed within 31 days of the date **you** assumed financial responsibility for the child. The child's coverage will be effective on the first of the month following that date.

Exception: Stepchildren added as the result of marriage are eligible for coverage on the date of marriage as long as all other enrollment and eligibility requirements are met.

PLEASE NOTE: In regard to all dependents, if **you** do not enroll them within the period in which they are eligible, **you** must wait until the next open enrollment period before they can be enrolled under the plan, unless there is a situation that allows a special enrollment.

---

## Special Enrollment

An eligible individual will not be considered a late enrollee in the following situations:

- If **you** and/or **your** eligible dependents lose coverage under another group **health benefit plan** or health insurance due to:
  - the exhaustion of federal COBRA or Oregon state continuation;
  - the loss of eligibility (including legal separation, divorce, annulment, death, termination of employment or reduction in hours, or exhaustion of lifetime maximum on total benefits); or
  - the employer contributions were terminated.

In all of the above situations, **you** and/or **your** eligible dependents become eligible for coverage under this **contract** on the date the other coverage ends. Note that loss of eligibility does not include a loss because **you** or **your** eligible dependent failed to pay premiums in time or termination of coverage because of fraud.

- If **you** declined coverage when **you** were first eligible and **you** subsequently marry, **you** become eligible for coverage under this **contract** on behalf of **yourself**, **your** spouse, and any eligible dependent children on the date of marriage.
- If **you** declined coverage when **you** were first eligible and **you** subsequently acquire a new dependent child by birth, adoption, or **placement** for adoption, **you** become eligible for coverage under this **contract** along with **your** eligible spouse and eligible dependent children including the newly acquired child on date of the birth, adoption, or **placement**.
- A spouse and/or dependent child for whom **you** declined coverage becomes eligible for coverage under this **contract** on the date a court has issued an order for **you** to provide such coverage.

- If **you** and/or **your** eligible dependents enroll during an open enrollment period under the **contract**, if any. If the **contract** does have an open enrollment period, it will be shown in the SUMMARY OF BENEFITS.
- If **you** and/or **your** eligible dependents are employed by an employer who offers multiple health benefit plans and **you** and/or **your** eligible dependents enroll during an open enrollment period under the **contract**, if any. If the **contract** does have an open enrollment period, it will be shown in the SUMMARY OF BENEFITS.

---

## ENROLLING ON THE GROUP ORIGINAL EFFECTIVE DATE

---

All eligible employees and dependents whose enrollment is completed and premiums **we** have accepted will become **enrollees** under the **contract**.

---

## HOW TO ENROLL AFTER THE GROUP ORIGINAL EFFECTIVE DATE

---

If **you** are enrolling for coverage to begin after **your group's** original effective date under this **contract**, the following section explains how to enroll **yourself** and **your** eligible dependents.

---

### When You First Become Eligible

**You** must complete enrollment for **yourself** and any dependents **you** want enrolled within 31 days before or after the **normal effective date** (see WHEN GROUP COVERAGE BEGINS on next page).

---

### Enrolling New Dependents

**You** can obtain coverage for newly acquired or newly eligible dependents, other than newborn or adopted children, by completing enrollment within 31 days before or after the **normal effective date** (see WHEN GROUP COVERAGE BEGINS).

To continue coverage for a newborn or adopted child beyond the first 31 days, **you** have to complete enrollment and submit any applicable premium within 31 days after the child is born or the date of **placement** listing the child as a dependent.

---

### Open Enrollment

Except as provided in the Special Enrollment provision, an employee and/or dependent who wishes to enroll under the **contract** but who did not enroll when he or she was first eligible may apply for coverage during the Open Enrollment period shown in the SUMMARY OF BENEFITS section. **You** must complete enrollment on behalf of all dependents to be

enrolled. **We** must receive all enrollments and premiums with the **group's** regular monthly payment before the end of the Open Enrollment period.

---

### Transferring From One Plan To Another During Selection Period

If **you** and/or **your** eligible dependents are transferring directly to this **contract** from another CIS **alternative health benefit plan** on the yearly anniversary of the **contract**, or on another date designated by **us** (the selection period), **you** will not be subject to the late enrollment requirements of the **contract**. **You** must complete enrollment on behalf of all dependents **you** want enrolled. CIS must receive all enrollments and premiums by the end of the selection period. The enrollments must be completed and premiums must be sent to **us** with CIS's regular monthly payment.

**You** and/or **your** eligible dependents will be considered eligible to enroll under this **contract** on the date **you** move out of a CIS **alternative health benefit plan's** service area or the date a CIS **alternative health benefit plan** in which **you** are enrolled ends operation.

---

### WHEN GROUP COVERAGE BEGINS

If **we** receive **your** and/or **your enrolled dependents'** enrollment, including premium, within the allowed time (see HOW TO ENROLL AFTER THE GROUP ORIGINAL EFFECTIVE DATE on the previous page), the date coverage under the **contract** begins (the **normal effective date**) for **you** and/or **your** eligible dependents (other than newborn or adopted children\*) will be the first of the month following the date **you** or **your enrolled dependent** became eligible to apply for coverage.

\* See Newborn Children And Adopted Children in the Newly Acquired Dependents provision. The exception is if **you** are enrolling **yourself** along with **your** eligible dependents according to the Special Enrollment provision when **you** declined coverage when **you** were first eligible and **you** subsequently acquire a new dependent child by birth, adoption, or **placement** for adoption. In this case, **your** and **your enrolled dependents' normal effective date** will be the date of birth, adoption, or **placement** as long as **you** complete enrollment and submit the premium within the allowed time.

---

### WHEN GROUP COVERAGE ENDS

The following paragraphs describe the situations when coverage will end for **you** and **your enrolled dependents**.

---

## Contract Termination

If the **contract** is terminated by CIS or **your** employer, coverage ends for **you** and **your enrolled dependents** on the date the **contract** terminates. However, if **you** or one of **your enrolled dependents** is in the **hospital** on the day the **contract** terminates, **we** will continue to provide benefits for that hospitalization until **you** or **your enrolled dependent's** discharge from the **hospital** or the benefits under this **contract** have been exhausted, whichever comes first. That is the only situation in which **we** will cover an expense incurred while **you** or **your** dependents are not enrolled under this **contract**.

---

## Termination By Enrolled Employee

**You** may end **your** coverage or coverage for any **enrolled dependent** at open enrollment or, consistent with an IRS-qualified event and CIS policies, by giving **us** notice through CIS. Coverage will end on the last day of the monthly period through which premiums are paid. If **you** end **your** own coverage, coverage for **your** dependents also ends.

---

## If You Die

If **you** die, coverage for **your enrolled dependents** ordinarily ends on the last day of the monthly period in which **your** death occurs. However, it may be possible for **your enrolled dependents** to continue coverage under this **contract** according to the CONTINUATION OF COVERAGE Section of this **benefits booklet**.

---

## If Your Dependents Lose Eligibility

Coverage ordinarily ends for **your** enrolled spouse on the last day of the monthly period in which a divorce or annulment is final, or in the case where the decree is appealed, the date the divorce or annulment would have been final but for the appeal.

Coverage for a domestic partner ordinarily ends on the last day of the monthly period in which the qualified domestic partnership ends, which will occur, for purposes of insurance, when any of the qualifying conditions listed under the Dependents provision in the WHO IS ELIGIBLE Section are no longer being met. **You** are required to give notice of such a change within 31 days of the change by submission of a Statement of Termination of Domestic Partnership to the **group** plan administrator.

Coverage ordinarily ends for an enrolled child on the last day of the monthly period in which the child is no longer eligible according to the terms of the **contract**. When **your enrolled dependent** child reaches the maximum age for eligibility under the **contract**, coverage ordinarily

ends on the last day of the month in which the child reaches the limiting age.

It may be possible for **your** ineligible dependents to continue coverage under this **contract** according to the CONTINUATION OF COVERAGE Section of this **benefits booklet**. These dependents may also be entitled to coverage under a **portability plan** when their group coverage ends as explained in the PORTABILITY HEALTH BENEFIT PLANS Section.

---

## If You Lose Eligibility

If **you** are no longer eligible as explained in the following paragraphs, **your** and **your enrolled dependents'** coverage ordinarily ends on the last day of the monthly period in which **your** eligibility ends. However, it may be possible for **you** and/or **your enrolled dependents** to continue coverage under this **contract** according to the CONTINUATION OF COVERAGE Section of this **benefits booklet**. **You** also may be entitled to coverage under a **portability plan** as explained in the PORTABILITY HEALTH BENEFIT PLANS Section.

### Family And Medical Leave

If **your group** grants **you** a leave of absence under the Family and Medical Leave Act of 1993 (FMLA - generally applicable to public employers of any size), the following rules will apply:

- **You** and **your enrolled dependents** will remain eligible to be enrolled under the **contract** during the FMLA leave.
- If **you** and/or **your enrolled dependents** elect not to remain enrolled during the leave, **you** (and/or **your enrolled dependents**) will be eligible to be reenrolled under the **contract** on the date **you** return from the FMLA leave. In order to reenroll after **you** return from an FMLA leave, **you** must complete enrollment just as if **you** were a newly eligible employee.

In this situation, if **you** reenroll within the required time, all of the terms and conditions of the **contract** will resume at the time of reenrollment as if there had been no lapse in coverage. **You** (and/or **your enrolled dependents**) will receive credit for any exclusion period served prior to the FMLA leave and **you** will not have to re-serve any group eligibility waiting period under this **contract**, although **you** and/or **your enrolled dependents** will receive no exclusion period credits for the period of noncoverage.

- In all events, **your** and **your enrolled dependents'** rights under the FMLA will be determined by the Family and Medical Leave Act of 1993 and its regulations.

- If **you** are on leave for an FMLA-qualifying reason, **you** remain eligible under the **contract** only for a period equivalent to FMLA leave and may not also continue coverage under a non-FMLA leave.

#### Leave Of Absence

If **you** are granted a non-FMLA leave of absence by **your group**, **you** can continue coverage for up to three months. Premiums must be paid to **your** employer in order to maintain coverage during a leave of absence.

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

#### Workers' Compensation Claim

If **you** are no longer eligible due to an **illness** or **injury** for which **you** have filed a Workers' Compensation claim, **you** can continue coverage after **your** eligibility ends, or until **you** obtain full-time employment with another employer, whichever happens first. **You** must pay **your** premium to **your** employer on a timely basis in order to maintain coverage during this period.

If **you** qualify for continued coverage under this provision and under the Continuation of Coverage (COBRA) provision, the two continuation periods begin at the same time and run concurrently.

#### Strike Or Lockout

If **you** are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, **your** coverage can be continued for up to six months. **You** must pay the full premium, including any part usually paid by **your** employer, directly to **your** employer.

If **you** qualify for continued coverage under this provision and under the Continuation of Coverage (COBRA) provision, the two continuation periods begin at the same time and run concurrently.

#### Uniformed Services Employment And Reemployment Rights Act

If **you** are covered under this **plan** when **you** are called to active duty by or join any of the armed forces of the United States of America and **you** qualify for reemployment rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA), **you** may continue coverage under the **plan** for **yourself** and any of **your** enrolled dependents for up to 24 months or the period of uniformed service leave,

whichever is shorter. **You** must pay any required premium contributions toward the cost of the coverage during the leave. If the leave is less than 30 days, the contribution rate will be the same as is paid by active employees. If the leave is 30 days or longer, the required contribution will not exceed 102 percent of the full cost of active employee coverage (that is, employee and employer contributions).

If **you** are entitled to any other continuation of coverage provisions of the **contract**, this coverage and that other continuation of coverage will run concurrently and **you** will be entitled to the coverage that is of most benefit to **you**.

Whether or not **you** elect continuation coverage under USERRA, coverage under the **contract** as an active employee may be reinstated on the first day **you** return to active employment with the **group** if **you** are released under honorable conditions and **you** return to employment:

- on the first full business day following completion of **your** military service for a leave of 30 days or less;
- within 14 days of completing **your** military service for a leave of 31 to 180 days; or
- within 90 days of completing **your** military service for a leave of more than 180 days (a reasonable amount of travel time or recovery time for an **illness** or **injury** determined by the Veterans' Administration of the United States (VA) to be service connected will be allowed).

When coverage as an active employee under this **plan** is reinstated, all provisions and limitations of the **plan** will apply to the extent that they would have applied if **you** had not taken **your** military leave and **your** coverage under the **plan** had been continuous. **You** do not have to reserve any group eligibility waiting period and the period of **your** military leave will be credited toward any **preexisting condition** exclusion period. (These waivers of limitations do not provide coverage for any **illness** or **injury** caused or aggravated by **your** military service, as determined by the VA.) For complete information regarding **your** rights under the USERRA, contact **your** employer.

#### Termination Of Employment

If **your** employment terminates, **your** coverage will ordinarily end for **you** and all **enrolled dependents** on the last day of the month during which employment ends.

#### Reenrolling After Layoff

If **you** are rehired and return to active work within six months of being laid off, **you** and any previously **enrolled dependents** may reenroll under the

**contract** on the date **you** are rehired, regardless of any lapse in coverage.

**Your group** must notify **us** that **you** are being rehired following a layoff and the necessary premiums for **your** coverage must be paid.

All **contract** provisions will resume at the time **you** reenroll whether or not there was a lapse in **your** coverage. Any exclusion period not completed at the time the employee was laid off must be satisfied. However, the period of **your** layoff will be counted toward the exclusion period. At the time **you** are rehired, **you** do not have to re-serve any group eligibility waiting period required by this **contract**.

## If You Retire

If **you** are retired and non-Medicare eligible, **you** and **your enrolled dependents** are eligible to continue coverage under the **contract** after retirement as long as **you** apply for coverage within 60 days from the end of active coverage, and if all of the following conditions are met:

- **you** must have received, be receiving, or be eligible to receive benefits from PERS (Public Employee Retirement System) or any other retirement plan offered by the **group**; and
- **you** may change to a different plan option within the same insurance carrier (if offered by the employer) at retirement or during open enrollment.

### Dependent Eligibility Requirements

A qualified dependent enrolled under the **contract** at the time **you** retire is eligible to continue coverage under this **contract** as **your** dependent. However, a new spouse or domestic partner, or new dependent children acquired after retirement are eligible to enroll within 31 days of their initial eligibility.

### When You Lose Retiree Eligibility

If **you** are retired, **your** coverage will end on the last day of the month prior to the date **you** become eligible for Medicare. Some employers continue coverage for Medicare-eligible enrollees. Check with **your** employer to determine if this coverage applies to **your group**.

### When Your Dependents Lose Eligibility If You Are Retired

If **you** are retired, coverage for **your** spouse will end on the last day of the monthly period that he or she turns 65, is granted a decree of divorce or annulment, or on the last day of the month prior to the date he or she becomes eligible for Medicare, whichever happens first. Some employers continue coverage for Medicare-eligible enrollees. Check with **your** spouse's employer to determine if this coverage applies to **your group**.

Eligibility will end for a dependent child of an early retired employee on the last day of the month in which the child is otherwise no longer considered to be a dependent as defined in the **contract**, or voluntarily terminates enrollment, either individually or through the early retiree.

An incapacitated dependent child, as defined in the **contract** may remain covered past age 23 as long as at least one parent (the early retiree or spouse) continues to be enrolled.

#### Death of an Early Retiree

If **you** are an early retiree and die, **your** coverage for **your enrolled dependents** may be continued as long as **your enrolled dependents** are eligible under this **contract**.

#### Voluntary Termination Of Retiree Coverage

If **you** and/or **your enrolled dependents** voluntarily terminate retiree coverage under this **contract**, reenrollment under this **contract** will not be possible. If retiree voluntarily terminates coverage, coverage for all family members ends.

### **Rescinding Coverage**

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

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

### **CONTINUATION OF COVERAGE (COBRA)**

The CIS group health plans are subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA. This section will automatically cease to be effective when federal law requiring continuation of eligibility for coverage no longer applies to the group health plan.

Under certain circumstances, **you** and/or **your enrolled dependents** may have the right to continue coverage beyond the time coverage would ordinarily have ended. The following rights and obligations regarding

continuation of coverage are governed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. In the event of any conflict between this Continuation of Coverage provision and COBRA, COBRA shall govern.

**You** have the right to elect continuation of coverage if **you** would otherwise lose coverage because of a reduction in hours of employment or termination of employment (for reasons other than gross misconduct).

If **you** elect COBRA continuation as a result of a reduction of hours of employment or termination of employment (for reasons other than gross misconduct), **your** qualified domestic partner may also elect COBRA continuation.

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

**Your** spouse or domestic partner has the right to choose continuation of coverage if he or she would otherwise lose coverage for any of the following reasons:

- **you** die;
- termination of **your** employment (for reasons other than gross misconduct) or reduction in **your** hours of employment;
- dissolution of marriage (divorce or annulment), legal separation from **you**, or termination of domestic partnership; or
- **you** become entitled to Medicare.

**Your enrolled dependent** child has the right to continuation of coverage if coverage would otherwise be lost for any of the following reasons:

- **you** die;
- termination of **your** employment (for reasons other than gross misconduct) or reduction in **your** hours of employment;
- **you** and **your** spouse dissolve your marriage (divorce or annulment), legally separate, or **your** domestic partnership terminates; or
- **you** become entitled to Medicare; or
- the child loses eligibility as a dependent under the **contract**.

A natural born child or a child placed for adoption with **you** who is properly enrolled under the terms of the **contract** during the continuation period shall be considered a qualified beneficiary.

#### Notification Responsibilities

**You** or **your enrolled dependent** has the responsibility to inform CIS's plan administrator in writing of a divorce, annulment, legal separation, termination of domestic partnership, or a child losing dependent status within 60 days of the date of the event. CIS has the responsibility to notify CIS's plan administrator of the employee's death, termination of employment, reduction in hours, Medicare eligibility.

#### Once Notification Is Given

When CIS's plan administrator is notified that one of these events has happened, the plan administrator will in turn notify **you** or **your enrolled dependent** that **you** or **your enrolled dependent** has the right to elect continuation of coverage. Under this provision, **you** or **your enrolled dependent** has 60 days from the date coverage would otherwise be lost because of one of the events described previously or 60 days from the date of notification from the plan administrator, whichever is later, to elect continuation. Failure to elect continuation within that period will cause group health plan coverage to end as it normally would under the terms of the **contract**.

#### Available Coverage

The coverage for continuation of coverage is required to be the same as that provided to similarly situated employees and their **enrolled dependents**.

#### Making Monthly Payments

**You** or **your enrolled dependent** is responsible for the full cost of continuation unless **your group** has specific provisions to pay for this coverage under special circumstances. Check with **your group's** plan administrator or personnel office to find out if there are any such policies. Please note that for qualified beneficiaries whose coverage is extended beyond 18 months due to disability, **we** will charge 148 percent of the regular monthly premium in addition to the 2 percent administration fee CIS may charge. Premium for continuation of coverage must be paid to CIS on a timely basis within 31 days of CIS's Premium Due Date. The only exception is the premium payment for the period preceding the election which may be made up to 45 days from the date of election, however premiums must be paid back to the point **you** became eligible. Premium for those on continuation must be submitted to **us** each month with CIS's regular monthly premium payment in order to maintain continuation of coverage.

#### How Long Continued Coverage Lasts

Coverage may be continued as follows:

- For termination of employment or reduction of hours, continuation may last for up to 18 months. However, there is one exception. It applies when a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time prior to or during the first 60 days of continuation coverage. In that situation, each qualified beneficiary may have up to a total of 29 months of continuation, but only if the Social Security Administration makes the determination within the first 18 months of that continuation period and the qualified beneficiary notifies the plan administrator both within that 18-month period and within 60 days of the determination. Thereafter, if there is a final determination of nondisability, the qualified beneficiary must so notify the plan administrator within 31 days. The extended continuation will end the month that begins more than 31 days from the final determination that the qualified beneficiary is no longer disabled.
- For death, dissolution of marriage, annulment, **your** legal separation, or termination of domestic partnership, continuation may last for up to 36 months.

However, there is a special Oregon statute that allows a spouse who is age 55 or over at the time coverage would otherwise end due to the death, dissolution of marriage, annulment, or legal separation to remain enrolled beyond 36 months until covered by another group health plan or until age 65, whichever happens first. **Enrolled dependent** children of the spouse may remain enrolled with the spouse beyond 36 months as long as they are otherwise eligible under the **contract**.

- For a dependent child ceasing to be eligible as a dependent under the plan, continuation may last for up to 36 months.
- If **you** become entitled to Medicare thereby causing a loss of coverage for **enrolled dependents**, continuation will last for up to 36 months.
- In the case of multiple qualifying events (a qualifying event followed by one or more qualifying events), a qualified beneficiary shall upon proper notice to the plan administrator of the succeeding qualifying event, continue for up to 36 months from the date the original continuation began. However, if **you** are an active employee with **enrolled dependents** and **you** become entitled to Medicare, the period of continuation for **your enrolled dependents** for any subsequent qualifying event may be continued until the later of:
  - 36 months from the date of Medicare entitlement; or

- the end of any other continuation period to which an **enrollee** is entitled.

#### Termination

Notwithstanding the previous statements, in all situations, continuation under this **contract** will end for a person on the last day of the monthly premium payment period in which any of the following occurs, whichever happens first:

- premium for a person on continuation is not paid to CIS or to **us** on a timely basis;
- after electing continuation a person becomes covered under any other group plan. However, coverage under another plan will not cause continuation to end so long as the other plan excludes or limits coverage for a preexisting condition of a qualified beneficiary in accordance with federal law;
- after electing continuation a person becomes entitled to Medicare; or
- the applicable period of continuation ends.

In addition, continuation will end on the day the **contract** terminates, or, if applicable, the day the **group** withdraws from participation under the **contract**. However, continuing coverage may still be available under the succeeding plan unless CIS no longer provides a group health plan for any of its employees.

---

## **PORTABILITY HEALTH BENEFIT PLANS**

---

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

---

### **Eligibility For A Portability Plan**

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

- have terminated coverage or been terminated from coverage due to loss of eligibility;

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

---

### How To Apply For A Portability Plan

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

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

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

---

## Portability Health Benefit Plan Options

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

- a prevailing cost plan, which includes benefit coverages and premiums that are prevalent in the Oregon group health insurance market; and
- a low cost plan, which emphasizes affordability for eligible individuals.

For information regarding the individual portability coverage, a special representative in **our** Customer Service Department is available to answer **your** questions.

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

---

## DEFINITIONS

The following definitions of important terms used in this **benefits booklet** will appear throughout the **contract** in bold face (darkened text). Other terms are defined, and bold-faced, where they are first used in the text of the **contract**.

The **contract** means the agreement between CIS and **us** that contains all of the terms of the coverage. This **benefits booklet** is by reference part of the **contract**.

**Plan Administrator** means **your** employer or CIS.

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

An **alternative health benefit plan** means an optional health plan offered to CIS's eligible employees as an alternative to the benefits of this **contract**. **Alternative health benefit plans** would include CIS's health maintenance organization (an HMO qualified under 1310(a) of the U.S. Public Health Services Act).

**Enrollment date** means, for individuals who apply during their initial period of eligibility, **your** or **your enrolled dependent's** effective date of coverage or the first day of any group eligibility waiting period applicable to **you** or **your** dependent, whichever is earlier. For all others (i.e.

including those who applied as late enrollees or during a special enrollment or open enrollment period), **enrollment date** means the effective date of coverage.

An **enrolled employee** means either an employee of the **group** whose enrollment is accepted by **us** and who is enrolled under this **contract** or a retired employee who remains enrolled under the **contract** after retirement.

An **enrolled dependent** means an eligible dependent of an **enrolled employee** whose enrollment is accepted by **us** and who is enrolled under this **contract**.

A **calendar year** means the period from January 1 through December 31 each year.

**Illness** means a disease or bodily disorder.

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

**Chemical dependency conditions** means substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Chemical dependency is an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological, or physical adjustment to common problems. Chemical dependency does not include addiction to or dependency on tobacco, tobacco products, or foods.

**Mental health conditions** means Mental Disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association except as otherwise excluded under this **contract**. Mental Disorders that accompany an excluded diagnosis are covered.

**Mental health and chemical dependency services** means **medically necessary** outpatient, residential, partial hospital or inpatient services provided by an approved licensed facility or licensed individuals who meet **our** credentialing requirements with the exception of **skilled nursing facility** services (unless the services are provided by a licensed behavioral health provider for a covered diagnosis), home health care services, and court ordered treatment (unless the treatment is determined by **us** to be **medically necessary**). **Mental health and chemical dependency services** do not include:

- educational programs for drinking drivers;

- voluntary mutual support groups, such as Alcoholics Anonymous; and
- family education or support groups.

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

**Medically necessary** means those services and supplies that are required for diagnosis or treatment of **illness** or **injury** and which, in **our** judgment, are:

- appropriate by treatment setting and level of care in amount, duration, and frequency of care and consistent with the symptoms or diagnosis and treatment of **your** or **your enrolled dependent's** condition;
- appropriate with regard to widely accepted standards of good medical practice;
- not primarily for the convenience of **you** or **your enrolled dependent** or a provider of services or supplies; and
- the least costly of the treatment settings, alternative supplies, or levels of service that can be safely provided to a patient. This means, for example, that care rendered in a **hospital** inpatient setting is not **medically necessary** if it could have been provided in a less expensive setting, such as a **skilled nursing facility** or by a nurse in the patient's home, without harm to the patient.

THE FACT THAT A PROFESSIONAL PROVIDER FURNISHED, PRESCRIBED, ORDERED, RECOMMENDED, OR APPROVED A SERVICE OR SUPPLY DOES NOT, OF ITSELF, MAKE THE SERVICE OR SUPPLY MEDICALLY NECESSARY. WE WILL DETERMINE WHETHER THE SERVICES ARE NECESSARY. WE WILL CONSULT WITH PROFESSIONAL CONSULTANTS, PEER REVIEW COMMITTEES, OR OTHER APPROPRIATE SOURCES FOR RECOMMENDATIONS REGARDING THE NECESSITY OF THE SERVICES OR SUPPLIES RECEIVED BY ENROLLEES.

NOTE: **Medically necessary** care does not include **custodial care**. **Custodial care** refers to care that helps a person conduct activities of daily living and that can be provided by people without medical or paramedical skills; for example, help in bathing, eating, dressing, or getting in or out of bed. This also includes care that is primarily for the purpose of separating a

patient from others or preventing a patient from harming himself or herself.

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

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

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

**Grievance** is a written complaint submitted by or on behalf of an **enrollee** regarding the availability, delivery, or quality of the health care (including **preauthorization** determinations), claims payments, or matters related to the relationship between the **enrollee** and **us**.

A **copayment** means a fixed dollar amount that **you** or **your enrolled dependent** must pay to the provider rendering the service or supply.

A **professional provider** means any of the following for **medically necessary** services which are within the scope of the provider's state license or registry:

- a physician (doctor of medicine or osteopathy);
- a physician's assistant;
- a podiatrist;
- a dentist (doctor of medical dentistry or doctor of dental surgery, or a denturist) but only for treatment of accidental **injuries** as described under the Special Dental Care benefit;
- a psychologist;
- a licensed clinical social worker;
- a certified nurse practitioner;
- a registered physical, occupational, speech, or audiological therapist;

- a registered nurse or licensed practical nurse, but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill patients; or
- a chiropractor, but only for musculoskeletal disorders and limited to 12 office visits per **calendar year**.

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

A **participating** or **preferred professional provider** means a **professional provider** who has an effective participating or preferred contract to provide services and supplies to **enrollees**.

A **participating** or **preferred facility** means a **hospital, skilled nursing facility, or special facility** that has an effective participating or preferred contract to provide services and supplies to **enrollees**.

A **nonparticipating** or **nonparticipating professional provider** means a facility or **professional provider** who does not have an effective participating contract.

A **nonpreferred facility** or **nonpreferred professional provider** means a facility or **professional provider** who does not have an effective preferred contract.

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

A **contracting agency** means any of the following with whom **we** have contracted to provide services and supplies to **enrollees**:

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

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

---

**SUMMARY OF BENEFITS**


---

This section is a summary of the benefits of the **plan**. It states at what percentages **covered expenses** are paid and describes any stop-loss amounts. It also states deductibles or benefit maximums applicable to the coverage. **You** may also be responsible for payment of part of the premium for coverage under the **plan**. Check with **your Plan Administrator** for information on any required premium contribution. The sections following this SUMMARY OF BENEFITS spell out the benefits and the conditions, limitations, and exclusions of the **plan** in detail.

**We** have contracted with **professional providers** and facilities to provide services and supplies to **enrollees** under this **plan**. **Your** provider directory lists which panel of providers applies to **your** benefits under the **plan**. This listing of participating providers is available to **you**, at no cost, upon enrollment or at any other time from **your Plan Administrator** or from **us** on **our** website at [www.or.regence.com](http://www.or.regence.com) or through **our** Customer Service Department.

**IMPORTANT NOTE:** This is a **preferred provider** plan, where **preferred providers** are paid at a higher percentage than **nonpreferred providers** (as noted in the Summary of Benefits). If an **enrollee** sees a **participating provider** that is not preferred, they will not receive the maximum benefit. It is extremely important to use **preferred facilities** and **preferred professional providers** in order to receive the maximum benefits available under this **contract**. Services provided for an **emergency medical condition** (see DEFINITIONS) will be paid at the preferred level of benefits.

---

**Maximum Lifetime Benefit**

per <b>enrolled employee</b> or <b>enrolled dependent</b> :	\$2,000,000
---	-------------

---

**Calendar Year Deductible**

per <b>enrollee</b> :	\$200
total family:	\$600

---

**Calendar Year Stop-Loss Amount**

per <b>enrollee</b> :	\$10,000*
-----------------------	-----------

\*If two family members have met the stop-loss amount, other enrolled family members need only meet any remaining family deductible to have **covered expenses** paid at 100% for the remainder of the **calendar year**.

---

## Percentage We Pay For Covered Expenses

After the deductible is satisfied, **we** pay as explained in the following paragraphs for **covered expenses** incurred for the listed services and supplies.

### Preferred Facilities, Preferred Professional Providers, and Other Covered Expenses

**We** pay 80 percent of **covered expenses** an **enrollee** incurs for **preferred facilities, preferred professional providers**, and Other Covered Expenses for those services listed on the following pages until those **covered expenses** total \$10,000 (the stop-loss amount) in a **calendar year**. Once these **covered expenses** exceed the stop-loss amount, **we** then pay 100 percent of **covered expenses** incurred during the rest of the **calendar year** for that **enrollee**.

### Nonpreferred Facilities and Nonpreferred Professional Providers

**We** pay 60 percent of **covered expenses** an **enrollee** incurs for **nonpreferred facilities and nonpreferred professional providers** for those services listed on the following pages until those **covered expenses** total \$10,000 (the stop-loss amount) in a **calendar year**. Once **covered expenses** for **nonpreferred facilities and nonpreferred professional providers** exceed the stop-loss amount, **we** then cover 100 percent of **covered expenses** incurred during the rest of the **calendar year** for that **enrollee**.

NOTE: **Covered expenses** paid at 100 percent and/or any **copayments** the **enrollee** pays do not accumulate toward the stop-loss amount.

---

## Additional Accident Benefit

We will waive any required deductible for services and supplies **you** or **your enrolled dependent** receives as treatment for an accidental **injury** that occurs while **you** or **your enrolled dependent** is enrolled under this **contract**. Care must be received within 90 days of the **injury**.

---

## Mental Health And Chemical Dependency Services

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

---

**Women's Health And Cancer Rights**

The **plan** covers surgery, reconstruction, prosthesis, and treatment of physical complications of all stages of mastectomy according to the Women's Health And Cancer Rights benefit.

---

**Biofeedback Therapy**

**We** cover certain expenses for biofeedback therapy services. (See Biofeedback Therapy under the GENERAL LIMITATIONS Section for exact qualifications and limitations.)

---

**Waiting Periods**

**Your** coverage has *no waiting periods* before **we** pay benefits for pre-existing conditions.

---

**Open Enrollment**

June and July of each year for an August 1<sup>st</sup> effective date.

---

**MEDICAL BENEFITS**


---

<b>Type of Services or Supplies</b>	<b>Preferred Provider</b> Providers that have a preferred contract with us are paid under this column. This could include a participating provider if they are also preferred.	<b>Nonpreferred Provider</b> Providers that do not have a preferred contract with us are paid under this column. This could include a provider that has a participating (but not preferred) contract with us.
	Based on covered expenses* 80% of first \$10,000 after \$200 deductible, then 100%	Based on covered expenses* 60% of first \$10,000 after \$200 deductible, then 100%
<b>Hospital Inpatient Care</b>  Number of days  Semi-private room  Intensive/coronary care unit  Additional <b>medically necessary hospital</b> services and supplies  Inpatient rehabilitation 30 days (60 days for head or spinal cord injury, or for treatment of stroke, per <b>calendar year</b> )	unlimited  80%/100%  80%/100%  80%/100%  80%/100%	unlimited  60%/100%  60%/100%  60%/100%  60%/100%
<b>Skilled Nursing Facility Care</b>  Number of days per stay  Semiprivate room plus <b>medically necessary</b> ancillary charges	100  80%/100%	100  60%/100%
<b>Hospital Outpatient Care</b>  Surgery  Radium, radioisotope, and x-ray therapy  Chemotherapy  Preadmission testing  Diagnostic x-ray and laboratory  Emergency room	80%/100%  80%/100%  80%/100%  80%/100%  80%/100%  80%/100% after \$100 <b>copayment</b>	60%/100%  60%/100%  60%/100%  60%/100%  60%/100%  60%/100% after \$100 <b>copayment</b>

\* See page 37 for an explanation of covered expenses.

<b>Type of Services or Supplies</b>	<b><u>Preferred Provider</u></b> Providers that have a preferred contract with us are paid under this column. This could include a participating provider if they are also preferred.	<b><u>Nonpreferred Provider</u></b> Providers that do not have a preferred contract with us are paid under this column. This could include a provider that has a participating (but not preferred) contract with us.
	<b>Based on covered expenses* 80% of first \$10,000 after \$200 deductible, then 100%</b>	<b>Based on covered expenses* 60% of first \$10,000 after \$200 deductible, then 100%</b>
<b>Special Facility Care</b>  Birthing center or ambulatory surgery facility	80%/100%	60%/100%
<b>Professional Provider Services</b>  Home or office visits  Annual women's examinations  Visits in <b>hospital</b> consultation in <b>hospital</b>  Surgery: Surgeon, assistant surgeon, anesthesiologist and supplies  Contraceptive services  Radium, radioisotope, and x-ray therapy  Diagnostic x-ray and laboratory tests (not including Pap smears and mammograms)  Pap smears and mammograms  Immunizations for children through age 18  Immunizations age 19 and over  Therapeutic injections, such as allergy shots, when given in the <b>professional provider's</b> office	80%/100%  100% after \$15 <b>copayment</b> , not subject to the deductible  80%/100%  80%/100%  80%/100%  80%/100%  80%/100%  100%, not subject to the deductible  100% after \$5 <b>copayment</b> , not subject to the deductible  80%/100%  80%/100%	60%/100%  100% after \$15 <b>copayment</b> , not subject to the deductible  60%/100%  60%/100%  60%/100%  60%/100%  100%, not subject to the deductible  100% after \$5 <b>copayment</b> , not subject to the deductible  60%/100%  60%/100%

\* See page 37 for an explanation of covered expenses.

<b>Type of Services or Supplies</b>	<b><u>Preferred Provider</u></b> Providers that have a preferred contract with us are paid under this column. This could include a participating provider if they are also preferred.	<b><u>Nonpreferred Provider</u></b> Providers that do not have a preferred contract with us are paid under this column. This could include a provider that has a participating (but not preferred) contract with us.
	<b>Based on covered expenses*</b> 80% of first \$10,000 after \$200 deductible, then 100%	<b>Based on covered expenses*</b> 60% of first \$10,000 after \$200 deductible, then 100%
Maternity  <b>Medically necessary durable medical equipment</b> and supplies which relate directly to the treatment of an <b>illness</b> or <b>injury</b>	80%/100%  80%/100%	60%/100%  60%/100%

\* See page 37 for an explanation of covered expenses.

Type of Services or Supplies	<u>Preferred Provider or Nonpreferred Provider</u> Based on covered expenses *- 80% of first \$10,000 after \$200 deductible, then 100%
<b>Other Covered Expenses</b>  Outpatient rehabilitative care, maximum 30 sessions (60 sessions for head or spinal cord <b>injury</b> or for treatment of stroke) per <b>calendar year</b> **  Chiropractor office visits (for treatment of musculoskeletal disorders only, up to a maximum of 12 visits per <b>calendar year</b> )**  Home health care (maximum 180 days per <b>calendar year</b> )**  Home infusion therapy (as specified)**  Blood and blood plasma**  <b>Palliative hospice care</b> (as specified for six months of care)  Ambulance transportation (up to 500 miles per <b>calendar year</b> )***  Outpatient diabetic instruction (as specified in the <b>benefits booklet</b> )  Transplants  Prescription medications (including mail order)	80%/100%  80%/100%  80%/100%  80%/100%  100%, not subject to the deductible  80%/100%  100%, not subject to the deductible, see page 54  Covered expenses for medically necessary non-experimental transplantation procedures, see page 55  See page 68

\* See page 37 for an explanation of covered expenses.

\*\* Services and supplies for which there are no preferred providers will be paid at the preferred rate.

\*\*\* Your coverage pays covered expenses based on community standards for ground level transportation as determined by Regence BlueCross BlueShield of Oregon.

---

## HOW YOUR PLAN WORKS

---

### Preferred Provider

#### You Pay:

\$200 per year

20% of first \$10,000 after deductible

Nothing

#### This Plan Pays:

Nothing

80% of first \$10,000 after deductible

100% of eligible charges over \$10,000

### Nonpreferred Provider

#### You Pay:

\$200 per year

40% of first \$10,000 after deductible

Nothing

#### This Plan Pays:

Nothing

60% of first \$10,000 after deductible

100% of eligible charges over \$10,000

---

## PREAUTHORIZATION

---

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

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

### What Needs To Be Preauthorized

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

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

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

Preauthorization Process

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

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

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

Mail: Regence BCBSO Preauthorization Department  
PO Box 1271, E-9B, Portland, OR 97207-1271

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

To **preauthorize** care for **transplants**:

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

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

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

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

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

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

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

---

## **BENEFITS**

---

**We** pay a percentage of **covered expenses** up to the lifetime maximum shown in the SUMMARY OF BENEFITS for **you** and for each **enrolled dependent**. The explanation of how **we** pay and the description of **covered expenses** are given in the following sections.

Limitations and exclusions that apply to **covered expenses** are explained in the sections that follow the description of benefits.

There are other points that **we** want to explain about how the coverage works. One deals with when benefits are available to pay **covered expenses**. The second concerns any deductible amount **you** and each **enrolled dependent** are responsible for under this **contract**. The third point relates to the amount of **covered expenses we** pay after any required deductible is satisfied. The last few points relate to restoration

of benefits, **care management/alternative benefits**, and emergency care and how they are administered under the **contract**.

---

### When Benefits Are Available

**We** only pay benefits for **covered expenses** incurred when **you** and **your enrolled dependents'** coverage is in effect. Coverage is in effect when:

- **you** and **your enrolled dependents** are eligible to be covered according to the eligibility provisions of the **contract**;
- **you** and **your enrolled dependents** have applied for coverage and have been accepted by **us**; and
- **your** and **your enrolled dependents'** premium for the current month has been paid by CIS on a timely basis.

The expense of a service is incurred on the day the service is rendered and the expense of a supply is incurred on the day the supply is delivered to **you** or **your enrolled dependent**.

There is one exception to this rule. When **you** or **your enrolled dependent** is in the **hospital** on the day coverage ends, **we** will continue to provide benefits towards the **covered expenses** for that hospitalization until discharge from the **hospital** or until **you** or **your enrolled dependent's** benefits have been exhausted, whichever comes first. (This exception does not apply to **skilled nursing facilities** or other types of facilities.)

---

### Deductibles

This **contract** has a **calendar year** deductible. The amount of the individual deductible is shown in the SUMMARY OF BENEFITS. The deductible applies to medical expenses.

**We** will not begin to pay **your** or **your enrolled dependent's** expenses in any **calendar year** until the deductible amount is satisfied. The deductible applies separately to **you** and each **enrolled dependent**, but no family will be required to satisfy more than the total family deductible shown in the SUMMARY OF BENEFITS for any year, no matter how many **enrolled dependents** are in that family.

#### Deductible Carryover Privilege

In addition, there is a deductible carryover privilege. If **covered expenses** are incurred in the last three months of a **calendar year** and applied toward but do not satisfy the deductible for that year, they will be carried forward and applied toward the deductible for the following year.

**Example:**

**Your** deductible amount is \$200. **You** have \$10 in **covered expenses** in February and **you** have \$85 of such expenses in November. This doesn't satisfy the \$200 deductible, so **you** receive no benefits. However, the \$85 is applied toward the following year's deductible. This means **you** only have to have \$115 in **covered expenses** in the next year to satisfy that year's deductible and to begin receiving benefits.

**Once The Deductible Is Satisfied**

After the deductible is satisfied, **we** pay a percentage of the **covered expenses** incurred under the **contract** by **you** or **your enrolled dependents**. The percentage **we** pay and whether or not a stop-loss applies varies depending on the kind of service or supply and who rendered it. Refer to the DEFINITIONS Section for types of providers and the SUMMARY OF BENEFITS for a description of percentages paid and stop-loss amounts.

Note that if a stop-loss applies, it is accumulated separately for **you** and each of **your enrolled dependents** based upon **your** or **your enrolled dependent's covered expense**. However, if in any **calendar year**, two individual **enrollees** in a family have met the stop-loss amount shown in the SUMMARY OF BENEFITS, other family members need only meet any remaining family deductible to have **covered expenses** paid at 100% for the remainder of the **calendar year**, no matter how many **enrolled dependents** are in that family. And, **covered expenses** paid at 100 percent and/or any **copayment** amounts that **you** must pay do not accumulate toward the stop-loss amount.

**Example:**

Suppose you have \$20,000 in eligible major medical expenses this year and a deductible of \$200:

<b>You Pay</b>	<b>This Plan Pays</b>
\$ 200 (deductible)	Nothing
\$2,000 (20% of first \$10,000)	\$ 8,000 (80% of first \$10,000)
Nothing	<u>\$ 9,800 (100% over \$10,000)</u>
<u>\$2,200 TOTAL</u>	<u>\$17,800 TOTAL</u>

Most providers bill **us** directly. **We** will automatically accumulate charges eligible for coverage until the deductible amount is reached. Once **you** meet the deductible, **we** will automatically pay the specified percentage of **covered expenses**.

If a provider sends **you** a bill, there is an explanation of how to submit it to **us** in the "Submission and Payment of Claims" provision of the CONTRACT AND CLAIMS ADMINISTRATION Section.

---

## Restoration Of Benefits

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

---

## Deductible, Stop-Loss, And Out-Of-Pocket Maximum Renewal

Deductible, stop-loss, and out-of-pocket maximum provisions are calculated on a **calendar year** basis. This **contract** is renewed, with or without changes, each **contract year** (the 12-month period following either the original effective date of the **contract** or the date the **contract** renewed). A **contract year** may or may not coincide with a **calendar year**. When this **contract** is renewed mid-**calendar year**, any previously satisfied deductible, stop-loss, and/or out-of-pocket maximum amounts are credited toward similar provisions in the renewed contract. If the deductible, stop-loss, and/or out-of-pocket maximum amount increases mid-**calendar year**, **you** or **your enrolled dependent** must satisfy the new requirement less the amount already satisfied during the current **calendar year** under the previous contract.

---

## Care Management/Alternative Benefits

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

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

---

## Emergency Care

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

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

---

## COVERED EXPENSES

---

Subject to the terms of the **contract**, **covered expenses** means the following when incurred for the services and supplies (including medications) listed in the following sections and when **medically necessary** for diagnosis and/or treatment of an **illness** or **injury**:

- the contracted amount for listed services and supplies provided by a **participating facility**, **participating professional provider**, **preferred facility**, **preferred professional provider**, a **contracting agency**, or a **contracting durable medical equipment supplier**;
- the **reasonable amount** for listed services and supplies provided by a **nonparticipating facility**;
- the billed amount for listed services received from a **nonparticipating professional provider**, or the contracted amount for a **participating professional provider** for the same service, whichever is less;
- the billed amount for listed services and supplies provided by an agency other than a **contracting agency** for home health care, home infusion therapy, or **palliative hospice care** or the contracted amount for a **contracting agency** for the same service or supply, whichever is less;
- the billed amount for listed services and supplies provided by a **durable medical equipment supplier** that is not a **contracting durable medical equipment supplier** or the contracted amount for a **contracting durable medical equipment supplier** for the same service or supply, whichever is less;
- the **reasonable amount** for services and supplies provided by all other categories of providers that are neither participating nor nonparticipating (ambulance providers and non-DME suppliers for example).

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

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

**Preferred and participating providers** will not charge **you** or **your enrolled dependents** for any balances beyond the deductible and coinsurance amount for **covered expenses**. Facilities and **professional providers** that do not have a preferred or participating contract with **us**, however, may bill **you** for any balances over **our** payment level in addition to the deductible and coinsurance amount.

#### Example Of How Benefits Are Paid - Nonparticipating Professional Provider

The following is only an example. It assumes that there is a **calendar year** deductible and that **you** or **your enrolled dependent** has not met the stop-loss amount. Not all **covered expenses** are subject to a **calendar year** deductible or stop-loss. The actual benefits of the **plan** may vary. Read the SUMMARY OF BENEFITS thoroughly to determine how **your** benefits under the **plan** are paid.

<b>Nonparticipating professional provider's</b> charge for a service:	\$50.00
Amount allowed to a <b>participating professional provider</b> for the same service (the contracted amount):	\$45.00
Amount considered a <b>covered expense</b> for the <b>nonparticipating professional provider's</b> charge would be:	\$45.00
(nonparticipating professional provider's charge, not to exceed a <b>participating professional provider's</b> contracted amount for the same service)	

#### How That Covered Expense Would Be Paid

<b>Contract</b> coinsurance (supposing the deductible has been satisfied):	60%
(our responsibility is 60%, <b>your</b> responsibility is 40%)	
Amount <b>we</b> would pay to the <b>nonparticipating professional provider</b> :	\$27.00
Amount <b>you</b> would pay to the <b>nonparticipating professional provider</b> :	\$23.00
<b>Total</b>	<b>\$50.00</b>

Difference Between Participating And Nonparticipating Professional Provider Payment

If the \$50 charge had been for a visit to a **participating professional provider**, **our** payment to that provider would have been: \$36.00  
(80% of the contracted amount)

**Your** responsibility would have been: \$9.00

## **HOSPITAL CARE**

### **Hospital Inpatient Care**

The benefits for inpatient care provided by a **hospital** are explained in the following paragraphs.

A **hospital** is an institution that provides diagnostic and treatment facilities for inpatient surgical and medical care of persons who are **injured** or ill. It must be licensed under applicable laws as a general **hospital**. Its services must be under the supervision of a staff of physicians and must include 24-hour-a-day nursing service by registered nurses. Facilities that are primarily rest, retirement, or convalescent homes are not considered to be **hospitals**. Neither are facilities operated by agencies of the federal government.

Hospitalization must be authorized by a physician and must be **medically necessary** for acute care and treatment of **illness** or **injury**.

Hospital Benefits

**Covered expenses** consist of the following:

- the charge for a semiprivate room or billed charges, whichever is less, up to the **hospital's** most common rate for a room with two beds;
- the charge for isolation care when **medically necessary** to protect other patients from contagion or to protect **you** or **your enrolled dependent** from contracting the **illnesses** of others;
- the charge for use of an intensive care or coronary care unit. **We** determine **our** definition of an intensive care unit by using the criteria of the Joint Commission on Accreditation of Hospitals, but **we** reserve the right to decide whether the unit in a particular **hospital** qualifies for coverage; and
- charges for other **hospital** services and supplies that are necessary for treatment and are ordinarily furnished by the **hospital**. These include, but are not limited to, operating and recovery rooms, traction equipment, and special diets.

---

## Number Of Inpatient Hospital Days Covered

**We** provide benefits for unlimited days of **hospital** inpatient care for most conditions. Inpatient treatment for some conditions, however, may be limited to a lesser number of days. They are described in the following paragraphs. **We** compute the number of days in a **hospital** stay by counting the day of admission and the day of discharge as one day.

---

## Skilled Nursing Facility Care

Services provided by a **skilled nursing facility** are explained in the following paragraphs.

A **skilled nursing facility** is a facility licensed under applicable laws to provide inpatient care under the supervision of a medical staff or a medical director. It must provide continuous 24-hour-a-day nursing service supervised by registered nurses.

### Skilled Nursing Facility Benefits

**We** cover skilled nursing care necessary for treatment of **illness** or **injury** up to a maximum of 100 **skilled nursing facility** days per stay. For benefits to renew after each stay, **you** or **your enrolled dependent** must be discharged from the facility and 90 consecutive days must pass before readmission to a **hospital** or a **skilled nursing facility**. **Covered expenses** are limited to the daily service rate, up to the maximum amount **we** would pay if the patient were in a semiprivate **hospital** room. The patient's attending physician must give **us** proof of medical necessity, that **we** find acceptable, showing that the patient would require hospitalization if care in a **skilled nursing facility** were not possible.

**Covered expenses** do not include an admission to a **skilled nursing facility** for a stay where care is provided principally for:

- senile deterioration; or
- mental deficiency or retardation;

nor do **covered expenses** include routine nursing care, self-help or training, personal hygiene, or custodial care.

### Preauthorization

If **skilled nursing facility** care is provided by a **nonparticipating facility**, **we** strongly urge **you** to contact **our** Preauthorization Department before receiving such care. See the PREAUTHORIZATION Section for a description of the **preauthorization** process.

---

## Inpatient Rehabilitative Hospital Care

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

---

## Newborn Nursery Care

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

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

---

## If Benefits Under This Contract Change

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

---

## Hospital Outpatient Care

**We** pay **hospital** charges for **medically necessary** outpatient care, including, but not limited to:

- surgery;
- radium, radioisotope, and x-ray therapy;
- chemotherapy;
- preadmission testing;

- diagnostic x-ray and laboratory tests related to an **illness** or **injury** and ordered by a physician; and
- emergency room care after \$100 **copayment**.

**Covered expenses** for a **professional provider's** fee billed by the **hospital** are paid under the other provisions of the **contract**.

#### Emergency Room Care

**You** or **your enrolled dependent** is responsible for paying the first \$100 for each emergency room visit. This separate \$100 **copayment** is in addition to the **calendar year** deductible and coinsurance provisions of this **contract** which also apply to the emergency room charges. The **copayment** charge will not be applied if the patient is admitted directly to the **hospital** from the emergency room. In addition, if emergency treatment is provided within 48 hours of an accidental **injury**, **covered expenses** begin with the first dollar of the emergency room charge and **you** or **your enrolled dependents** will not be required to pay the \$100 **copayment**.

---

#### **Outpatient Rehabilitative Care**

**We** cover up to 30 sessions each **calendar year** for rehabilitative services provided by a **professional provider** to a patient who is not confined to a **hospital**. If rehabilitative services are required following head, spinal cord **injury**, or a cerebral vascular accident (stroke), **we** may allow up to 60 sessions each **calendar year**. Rehabilitative services are physical, occupational, speech, or audiological therapy services necessary to restore or improve lost function caused by **illness** or **injury**. Rehabilitative services also include neurodevelopmental therapy for children age six and under when such services are for maintenance of a child whose condition would otherwise significantly deteriorate without the service. In order for **us** to cover any therapy, it must be part of a written plan of treatment prescribed by a physician.

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

---

#### **Special Facility Care**

Care provided in a **special facility**. A **special facility** is either an ambulatory surgical facility or a birthing center. **You** may apply **your** hospital inpatient benefit to these services.

**Covered expenses** consist of:

- procedure room charges, and
- charges for other services and supplies that are **medically necessary** for treatment.

---

## PROFESSIONAL PROVIDER SERVICES

---

The benefits for services provided by a **professional provider** are explained in the following paragraphs.

---

### Home Or Office Visits

A “visit” means the patient is actually examined by a **professional provider**. **Covered expenses** include physician consultations with written reports as well as second opinion surgery consultations.

---

### Cancer Screening

NOTE: The following Cancer Screening benefit is used with plans that do not have a Routine Physical Exam benefit. It is paid at contract benefits. If **your** plan includes a Routine Physical Exam benefit, the following benefit does not apply. Please see **your** Physical Exam benefit for cancer screening. **Your** Plan Administrator can confirm if **your** coverage includes the Routine Physical Exam benefit.

**We** pay for prostate and colorectal cancer screening examinations for **enrollees** age 50 or older or any individual at high risk. **We** pay for:

- a digital rectal examination and a prostate-specific antigen test every two years;
- one fecal occult blood test each **calendar year**;
- one flexible sigmoidoscopy every five years;
- one colonoscopy every ten years; or
- one double contrast barium enema every five years.

More frequent examinations will be covered if determined **medically necessary** by the treating physician.

---

### Annual Women's Examinations

Annual women's breast, pelvic, and Pap smear examinations are covered once every **calendar year**. However, more frequent examinations will be covered if **medically necessary** and recommended by the woman's health care provider. By breast examination, **we** mean a complete and thorough exam of the breast for women age 18 or older, including but not

limited to a clinical breast examination, performed by a health care provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer. Any **covered expenses** for laboratory, x-ray procedures, or mammography that accompany the examination will be covered according to the Diagnostic X-Rays And Laboratory Services provision, however routine mammographic breast screening will be covered according to the following schedule:

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

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

**You or your enrolled dependent** is responsible for paying the first \$15 for each annual women's examination visit. **Covered expenses** after this separate **copayment** are paid in full and are not subject to any **calendar year** deductible or coinsurance provisions of the **contract**.

### Physician's Visits In The Hospital

**We** pay for physician's visits to a patient during a **hospital** or **skilled nursing facility** stay. But visits relating to surgery performed during a **hospital** stay are not covered. (These visits are ordinarily included in the surgeon's fee.) **We** also pay for physician consultations with written reports during each **hospital** stay. Staff consultations required by **hospital** rules are not a **covered expense**. These benefits apply only if **you or your enrolled dependent** is eligible for **hospital** or **skilled nursing facility** benefits.

### Surgery

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

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

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

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

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

---

### Contraceptive Services

**Covered expenses** for certain **professional provider** contraceptive services are covered, including but not limited to vasectomy, tubal ligation, Depo-Provera, and insertion of IUD or Norplant (the actual prescription contraceptive may be covered elsewhere under the **contract**).

---

### Radium, Radioisotope, And X-Ray Therapy

**Covered expenses** include:

- treatment planning and simulation;
- professional services for administration and supervision; and
- treatments including the therapist, facility, and equipment charges.

---

### Diagnostic X-Rays And Laboratory Services

**Medically necessary** outpatient diagnostic x-rays and laboratory tests ordered by a **professional provider**. The x-rays or tests must be related to the treatment of an **illness** or **injury**, except that **we** will pay the laboratory charges for administration of the following when ordered:

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

\* **Covered expenses** for Pap smears and mammograms are not subject to any deductible and are paid at 100 percent.

The charge for the office visit in connection with any of the above is not covered under this benefit but may be covered elsewhere in the **contract**.

---

## Immunizations

**We** cover childhood immunizations for general use for **your enrolled dependent** children through age 18. **Covered expenses** do not include immunizations for the sole purpose of travel, occupation, or residence in a foreign country.

**Covered expenses** under this immunization benefit include the charge for the vaccine and its administration only. Charges for an office call or visit in connection with the immunization are not part of this immunization benefit, but may be paid under the other provisions of this **contract**.

**You** are responsible for paying the first \$5 each time a covered immunization is administered. If multiple immunizations are administered at the same time, only one **copayment** is required. **Covered expenses** after this separate **copayment** are paid in full and are not subject to any **calendar year** deductible and/or coinsurance provisions of the **contract**.

Immunizations for **enrollees** age 19 and over are subject to the deductible and are paid at the percentage shown in the SUMMARY OF BENEFITS.

---

## Therapeutic Injections

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

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

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

---

## Mental Health And Chemical Dependency Services

**We** will cover **mental health and chemical dependency services** under the various sections of the **contract** the same as **illness**. **Covered expenses** for **residential care** for treatment of **mental health**

**conditions**, however, is limited for **you** and for each of **your enrolled dependents** to 45 days per **calendar year**.

---

### **Maternity Care**

**We** cover pregnancy care, childbirth, and related conditions for **you** or **your enrolled dependents** under the various sections of this **contract** the same as **illness**.

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

---

### **Women's Health And Cancer Rights**

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

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

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

---

### **Special Dental Care**

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

---

## Chiropractic Care

**Your** coverage includes a benefit for up to 12 chiropractic office visits per calendar year. The **covered expenses** are paid as shown in the SUMMARY OF BENEFITS.

**Covered expenses** include care by a licensed chiropractic provider for treatment of musculoskeletal disorders only. **Covered expenses do not include** charges for supportive services, such as **durable medical equipment**, or x-ray and laboratory tests.

---

## Additional Accident Benefit

**We** will waive any required deductible for services and supplies **you** or **your enrolled dependent** receives as treatment for an accidental **injury**. Care must be received within 90 days of the **injury**.

---

## OTHER COVERED EXPENSES

The following other services and supplies are covered.

---

### Home Health Care

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

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

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

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

Maximum Visits

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

Preauthorization

If home health care is provided by a provider that has not contracted with **us, we** strongly urge **you** to ask **your** provider to contact **our** Preauthorization Department before receiving such care to avoid a denial or reduction of benefits due to lack of medical necessity. See the PREAUTHORIZATION Section for a description of the **preauthorization** process.

---

## Home Infusion Therapy

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

Limited Services

Home infusion therapy is limited to the following:

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

Additionally, **covered expenses** include only the following **medically necessary** services and supplies:

- solutions, medications, and pharmaceutical additives;

- pharmacy compounding and dispensing services;
- durable medical equipment;
- ancillary medical supplies;
- nursing services associated with:
  - patient and/or alternative care giver training;
  - visits necessary to monitor intravenous therapy regimen;
  - emergency services;
  - administration of therapy; and
- collection, analysis, and reporting of the results of laboratory testing services required to monitor response to therapy.

#### Preauthorization

If home infusion therapy is provided by a provider that has not contracted with **us**, **we** strongly urge **you** to ask **your** provider to contact **our** Preauthorization Department before receiving such care to avoid a denial or reduction of benefits due to lack of medical necessity. See the PREAUTHORIZATION Section for a description of the **preauthorization** process.

---

### **Palliative Hospice Care**

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

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

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

### Levels Of Care

**Palliative hospice care** benefits are limited to the following treatment settings:

- routine home care;
- continuous home care;
- inpatient respite care; and
- inpatient hospice care.

Additionally, **covered expenses** for **palliative hospice care** include the following when provided under one of the previously listed levels of care:

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

### Preauthorization

**Preauthorization** is recommended for initial entry into a **palliative hospice care** program and thereafter as the level of care within the program changes. If **palliative hospice care** is provided by a provider that has not contracted with **us**, **we** strongly urge **you** to ask **your** provider to contact **our** Preauthorization Department before receiving such care to avoid a denial or reduction of benefits due to lack of medical necessity. See the PREAUTHORIZATION Section for a description of the **preauthorization** process.

### Exclusions

In addition to the exclusions listed in the GENERAL EXCLUSIONS Section, the following exclusions apply for **palliative hospice care**:

- care that is not palliative;
- services provided to other than the terminally ill patient, including separate charges for bereavement counseling for **you** or **your enrolled dependents** except when provided and billed by the **hospice care program**;
- pastoral and spiritual counseling;
- services performed by family members or volunteer workers;

- homemaker or housekeeping services, except by home health aides as ordered in the hospice treatment plan;
- supportive environmental materials, including, but not limited to, hand rails, ramps, air conditioners, and telephones;
- normal necessities of living, including, but not limited to, food, clothing, and household supplies;
- food services, such as Meals on Wheels;
- separate charges for reports, records, or transportation;
- legal and financial counseling services;
- services and supplies not included in the hospice treatment program or not specifically set forth as a hospice benefit; and
- services and supplies in excess of the stated limitations or services and supplies provided more than six months after the initial date of covered **palliative hospice care**, unless specifically approved by **us**.

---

### Ambulance Transportation

**We** cover ambulance transportation up to 500 miles per **calendar year**. Your coverage pays eligible charges based on community standards as determined by Regence BlueCross BlueShield of Oregon for transportation by state-certified ambulance at the percentage of covered expenses shown in the SUMMARY OF BENEFITS to the nearest **hospital** that has the facilities to give the necessary treatment. Certified air ambulance transportation will be covered if it is **medically necessary**, based on **usual and customary** or **reasonable** charges. **We** will send **our** payment for **covered expenses** directly to the ambulance service provider, unless **you** have already paid them, in which case **we** will pay **you** directly.

---

### Supplies, Appliances, Medications, And Durable Medical Equipment

**We** cover the following **medically necessary** supplies, appliances, medications, and **durable medical equipment** when required by standard treatment practices for the treatment of an **illness** or **injury**:

- nonprescription elemental enteral formula for home use when ordered by the patient's physician as long as:
  - the formula is **medically necessary** for the treatment of severe intestinal malabsorption; and

- the formula comprises the sole or an essential source of the patient's nutrition;
- **medical foods**, such as PKU formula, for treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which there exists medically standard methods of diagnosis, treatment, and monitoring. **Medical foods** means foods that are:
  - formulated to be consumed or administered enterally under the supervision of a physician;
  - specifically processed or formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts;
  - for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients, or have other specific nutrient requirements as established by medical evaluation; and
  - essential to optimize growth, health, and metabolic homeostasis.

Charges for diagnosis, treatment, and monitoring of the disorder requiring **medical foods** are covered elsewhere in the **contract**;

- the following **medically necessary durable medical equipment** and supplies when required by standard treatment practices for the treatment of an **illness** or **injury**:
  - artificial limbs and eyes and maxillofacial prosthetic devices (maxillofacial prosthetic devices must be **medically necessary** for the restoration and management of head and facial structures that cannot be replaced by living tissue, are defective due to disease, trauma, or developmental deformity to control or eliminate infection and pain and restore facial configuration and function);
  - casts, trusses, limb or back braces, and crutches;
  - rental (not to exceed the reasonable purchase price if the item can be purchased) of a wheelchair, hospital-type bed, oxygen, or other **durable medical equipment** unique to medical care or treatment as determined by **us**; and
  - other supplies, including nonself-administered injectable medications, up to a maximum 90-day supply at any one time.

The term **durable medical equipment** means an item that can withstand repeated use, is primarily used to serve a medical

purpose, is generally not useful to a person in the absence of **illness or injury**, and is appropriate for use in the **enrollee's** home. Examples include oxygen equipment and wheelchairs. **Durable medical equipment** may not serve solely as a comfort or convenience item.

Deluxe equipment with mechanical or electrical features such as motor-driven wheelchairs and chair lifts, environmental modifications such as wheelchair ramps or elevators for the home, and devices and equipment used for environmental control or to enhance the environmental setting such as air conditioners, humidifiers, air filters, and portable whirlpool pumps, are not considered **durable medical equipment** under this **contract** and are not covered. However, if medical necessity is established and **preauthorization** is granted, **we** will cover motor-driven wheelchairs and seat-lift mechanisms.

#### Preauthorization

Before **we** pay for **durable medical equipment**, it should be **preauthorized**. See the PREAUTHORIZATION Section for a description of the **preauthorization** process.

---

### Outpatient Diabetic Instruction

(This benefit is not subject to any deductible.)

**We** pay 100 percent of the billed charges for services and supplies used in outpatient diabetes self-management programs as described here when they are provided by a **health care professional** or by a credentialed or accredited diabetic education program for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes. For the purposes of this benefit, a **health care professional** means a physician, registered nurse, nurse practitioner, certified diabetes educator, or licensed dietitian with demonstrated expertise in diabetes. **We** will pay for one outpatient diabetes self-management program of assessment and training after diagnosis, including up to three hours per year of assessment and training when there is a material change of condition. Diabetic medications, supplies, and equipment not included in the charge for the outpatient diabetes self-management program are covered elsewhere under the **contract**.

The benefits paid for diabetic instruction under this **contract** do not accumulate to the stop-loss amount to increase the percentage paid toward other **covered expenses**.

---

## GENERAL LIMITATIONS

---

There are limitations on the benefits available under this **contract** for the treatment of certain conditions and the use of certain procedures. These limitations are described in this section.

---

### Biofeedback Therapy

**Covered expenses** for biofeedback therapy services are limited to treatment of tension headaches or migraine headaches.

---

### Transplants

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

#### Definitions

In addition to the definitions in the DEFINITIONS Section, the following definitions apply to this **transplant** limitation:

A **contracting transplant facility** is a Center of Excellence facility with which **we** have contracted or arranged to provide **facility transplant services** for the **enrollees** under this **contract**. **We preauthorize transplants**, in part, based on where the **transplant** will be performed and **we** reserve the right to contract with specific facilities to perform **facility transplant services** and to base payment on such third party contracts.

The **contracted amount** is the amount the **contracting transplant facility** has agreed to accept as payment in full for **facility transplant services** for a specific type of **transplant**.

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

- heart;
- heart/lung or lung;
- liver;
- kidney;
- pancreas;

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

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

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

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

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

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

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

**Facility transplant services** means all **medically necessary** services and supplies provided by a health care facility in connection with a **covered transplant** except **donor costs** and antirejection medications.

**Medically necessary** for purposes of this **transplant** limitation means the **recipient** or **self-donor** meets the medical necessity criteria for a **transplant** as documented in The Regence Group medical policy.

**Professional provider transplant services** means all **medically necessary** services and supplies provided by a **professional provider** in connection with a **covered transplant** except **donor costs** and antirejection medications.

#### Benefits

Benefits for a **covered transplant** are payable as follows:

Facility Benefits -- **We** will waive any otherwise applicable deductible and coinsurance of the **contract** and pay 100 percent of the **contracted amount** for **facility transplant services** for a **covered transplant** performed at a **contracting transplant facility**. Payments of the **contracted amount** at 100 percent do not accumulate toward the stop-loss amount (the point at which coinsurance is no longer payable) under the **contract**.

**We** pay 60 percent of reasonable charges towards the cost of **facility transplant services** for a **covered transplant** performed at other than a **contracting transplant facility**. Any deductible amount under the **contract** shall apply but the percentage of payment (60 percent) will remain the same throughout the **calendar year**. These payments do not accumulate toward the stop-loss amount under the **contract**.

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

Professional Provider Benefits -- **We** pay for **professional provider transplant services** according to the benefits for **professional providers** under the **contract**.

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

Limited Waiver Of Contract Maximum Benefit

If the expenses of a **transplant** at a **contracting transplant facility** would cause **you** or **your enrolled dependent** to exceed the lifetime maximum benefit under the **contract**, **we** will waive the lifetime limit to the extent such expenses for **facility** and **professional provider transplant services** and **donor costs** exceed the limit. This waiver will not apply to the cost of antirejection medications, a **transplant** at a noncontracting facility, or to any future **transplants**.

Benefits For Antirejection Medications -- Antirejection medications following the **covered transplant**, will be covered according to the benefits for prescription medications, if any, under the **contract**.

Preauthorization

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

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

Preauthorization Procedures

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

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

24-Month Exclusion Period

No benefits for **covered transplants** will be payable during the first 24 months an individual is covered under this **contract** except as follows:

- the 24-month exclusion period will not apply if the **recipient** or **self-donor** has been continuously covered under this **contract** since birth; or
- **we** will reduce the duration of the 24-month exclusion period by the amount of **your** or **your enrolled dependent's** combined periods of prior **creditable coverage** if the most recent period of **creditable coverage** ended within 63 days of **your** or **your**

**enrolled dependent's enrollment date. Creditable coverage** means any of the following coverages:

- group coverage (including FEHBP and Peace Corps);
- individual coverage (including student health plans);
- Medicaid;
- Medicare;
- CHAMPUS/Tricare;
- Indian Health Service or tribal organization coverage;
- plans of a state, the US, a foreign country, or a political subdivision of one of these;
- state high risk pool coverage; and
- public health plans.

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

#### Exclusions

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

- any **transplant** procedure that has not been **preauthorized**;
- any **transplant** performed outside of the United States;
- purchase of any organ or tissue;
- donor or organ procurement services and costs incurred outside the United States, unless specifically approved by **us**;
- donation-related services or supplies provided to an enrolled **donor** if the **recipient** is not covered under this **contract** and eligible for **transplant** benefits. This exclusion does not apply to complications or unforeseen effects resulting from the donation of tissue;

- services or supplies for any **transplant** not specifically named as covered including the **transplant** of animal organs or artificial organs; and
- chemotherapy with autologous, allogeneic, or syngeneic hematopoietic stem cells **transplant** for treatment of any type of cancer not specifically named as covered.

---

## Medicare

In certain situations, this **contract** is primary to Medicare. This means that when **you** or **your enrolled dependent** is enrolled in Medicare and this **contract** at the same time, **we** pay benefits for **covered expenses** first and Medicare pays second. Those situations are:

- when **you** or **your** enrolled spouse is age 65 or over and by law Medicare is secondary to the employer group health plan;
- when **you** or **your enrolled dependent** incurs **covered expenses** for kidney **transplant** or kidney dialysis and by law Medicare is secondary to the employer group health plan; and
- when **you** or **your enrolled dependent** is entitled to benefits under Medicare disability and by law Medicare is secondary to the employer group health plan.

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

---

## **GENERAL EXCLUSIONS**

---

The following services and supplies are not covered.

### Services Otherwise Available

This exclusion includes:

- services and supplies for which payment could be obtained in whole or in part if **you** or **your enrolled dependent** had applied for payment under any city, county, state, or federal law except for Medicaid coverage;
- services and supplies **you** or **your enrolled dependent** could have received in a **hospital** or program operated by a government agency or authority; unless reimbursement under this **contract** is otherwise required by law;
- charges for services and supplies for which **you** or **your enrolled dependent** cannot be held liable because of an agreement between the provider rendering the service and another third party payor which has already paid for such service or supply; and
- services and supplies for which no charge is made, or for which no charge is normally made in the absence of insurance.

### Service-Related Conditions

The treatment of any condition caused by or arising out of service in the armed forces of any country or from an insurrection.

### Third Party Liability

Services and supplies for treatment of **illness** or **injury** for which a third party is or may be responsible to the extent of any recovery received from or on behalf of the third party. See the Right Of Reimbursement And Subrogation provision in the CONTRACT AND CLAIMS ADMINISTRATION Section.

### Motor Vehicle Coverage And Other Insurance Liability

Benefits that are payable under any automobile medical, personal injury protection (PIP), automobile no-fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to or makes benefits available to **you** or **your enrolled dependent**, whether or not application is duly made therefor. See the Right Of Reimbursement And Subrogation provision in the CONTRACT AND CLAIMS ADMINISTRATION Section.

### Work-Related Conditions

Expenses for services incurred as a result of any work-related **injury** or **illness**, including any claims that are resolved pursuant to a disputed

claim settlement for which **you** or **your enrolled dependent** has or had a right to compensation. The only exception would be if **you** or **your enrolled dependent** is exempt from state or federal workers' compensation law. See the Right Of Reimbursement And Subrogation provision in the CONTRACT AND CLAIMS ADMINISTRATION Section.

Experimental Or Investigational Services

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

- have not yet received final US Food and Drug Administration (FDA) approval for other than experimental, investigational, or clinical testing. However, if a medication is prescribed for other than its FDA approved use and the medication is recognized as effective for the use for a particular diagnosed condition, benefits for the medication when so used will not be excluded under this exclusion. To be considered effective for other than its FDA approved use, the Oregon Health Resources Commission must have determined that the medication is effective for the treatment of that condition; or
- are determined by **us** to be in an experimental and/or investigational status. The following will be considered in making the determination whether the **service** is in an experimental and/or investigational status:
  - whether there is sufficient **scientific evidence** to permit conclusions concerning the effect of the **services** on health outcomes. "**Scientific evidence**" consists of:
    - well-designed and well-conducted clinical trials documenting improved health outcomes published in **peer reviewed medical (or dental) literature**. **Peer reviewed medical (or dental) literature** means a US scientific publication which requires that manuscripts be submitted to acknowledged experts inside or outside the editorial office for their considered opinions or recommendations regarding publication of the manuscript. Additionally, in order to qualify as **peer reviewed medical (or dental) literature**, the manuscript must actually have been reviewed by acknowledged experts before publication; and

- evaluations by national professional medical (or dental) organizations, national consensus panels or other national technology evaluation bodies which have published a technology assessment or practice guideline based on **peer reviewed medical (or dental) literature**;
- whether the **scientific evidence** demonstrates that the **services** improve health outcomes as much or more than established alternatives;
- whether the **scientific evidence** demonstrates that the **services'** beneficial effects outweigh any harmful effects;
- whether any improved health outcome from the **service** is attainable outside investigational settings; and
- the advice of participating professional providers medical (or dental).

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

#### Care Of Inmates

Services and supplies **you** or **your enrolled dependent** receives while in the custody of any state or federal law enforcement authorities or while in jail or prison.

#### Expenses Incurred Before Coverage Begins Or After Coverage Ends

Services and supplies incurred before enrollment under the **plan** or after enrollment under the **plan**. The only exception is that when **you** or **your enrolled dependent** is in the **hospital** on the day the coverage ends, **we** will continue to provide benefits for that hospitalization until **your** or **your enrolled dependent's** discharge from the **hospital** or **your** or **your enrolled dependent's** benefits have been exhausted, whichever comes first.

#### Services Provided By A Member Of Your Immediate Family

#### Treatment Not Medically Necessary

Services and supplies that are not **medically necessary** for the treatment of an **illness** or **injury** (except as may be specifically provided).

#### Growth Hormones

Growth hormone conditions other than growth hormone deficiency in children, failure in children secondary to chronic renal insufficiency prior to **transplant**, or for the promotion of wound healing in patients with severe, active burns while hospitalized. Growth hormone for the

treatment of these listed conditions is covered when **our** medical policy criteria are met. See the PREAUTHORIZATION Section for a description of the **preauthorization** process.

#### Surgery To Alter Refractive Character Of The Eye

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

#### Orthodontic Treatment

#### Massage Or Massage Therapy

#### Cosmetic/Reconstructive Services And Supplies

Services and supplies (including medications) rendered for **cosmetic** or **reconstructive** purposes, including complications resulting from **cosmetic** or **reconstructive** surgery except as follows:

- if the surgery is performed to correct a functional disorder or as the result of an accidental **injury**;
- if the surgery is performed for correction of congenital anomalies in children under age 18; or
- the surgery is related to breast **reconstruction** following a mastectomy necessary because of **illness** or **injury** in accordance with the Women's Health And Cancer Rights benefit.

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

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

#### Counseling Or Treatment In The Absence Of Illness

For example, educational, social, image, behavioral or recreational therapy; sensory movement groups; marathon group therapy; sensitivity training; EAP services; wilderness programs; premarital or marital counseling; family counseling (however family counseling will be covered when the identified patient is a child or an adolescent with a covered diagnosis and the family counseling is part of the treatment).

Sexual Dysfunction

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

Sexual Reassignment Treatment and Surgery

Treatment, surgery or counseling services for sexual reassignment.

Mental Health Treatment For Certain Conditions

**We** will not cover treatment of paraphilias no matter the age of the **enrollee**. Additionally, **we** will not cover all V code diagnoses except the following when **medically necessary**: parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger, and bereavement for children five years of age or younger.

Benefits Not Stated

Services and supplies not specifically described as benefits in this **contract**.

Impotence Medications

Any medication therapy for the treatment of impotence regardless of cause.

The Following Services And Supplies

**We** do not cover the following services and supplies:

- routine physical examinations, except as may be specifically covered in the **contract** and except for routine annual Pap smear and breast mammographies according to the guidelines of the American Cancer Society;
- eye examinations, including eye exercises;
- the fitting, provision, or replacement of eyeglasses except as specifically covered in the **contract**;
- well-child care, except as specifically covered in the **contract**;
- well-baby and well-child care, including **professional provider** charges for routine newborn care, except as specifically covered in the **contract**;
- routine tests and screening procedures, except as specifically covered in the **contract**;
- treatment for corns and calluses, removal of nails (except complete removal), and other routine foot care;

- the fitting, provision, or replacement of hearing aids, including implantable hearing aids and the surgical procedure to implant them except as specifically covered in the **contract**;
- telephone consultations, missed appointments, completion of claim forms, or completion of reports requested by **us** in order to process claims;
- self-help or training programs, including, but not limited to, those to stop smoking, control weight, or provide general fitness;
- programs that teach a person how to use **durable medical equipment** or how to care for a family member;
- instruction programs, including, but not limited to, those to learn to self-administer medications or nutrition, except as specifically covered in the **contract** under the Outpatient Diabetic Instruction benefit;
- appliances, or equipment primarily for comfort, convenience, cosmetics, environmental control, or education, such as air conditioners, humidifiers, air filters, whirlpools, heat lamps, or tanning lights; and
- private duty nursing, including ongoing hourly shift care in the home, or personal items such as telephones, televisions, and guest meals in a **hospital** or **skilled nursing facility**.

#### Treatment For Obesity Or Weight Control

Surgery or treatment (including any later complications), even if **you** or **your enrolled dependent** has other medical conditions related to or caused by obesity. Specifically excluded are: gastric stapling or bypass procedures, weight loss programs, counseling, hypnosis, biofeedback, neurolinguistic programming, guided imagery, and other forms of relaxation training as well as subliminal suggestion used to modify eating behavior.

#### Acupuncture

#### Orthopedic Shoes

#### Orthognathic Services

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

Family Planning

Services and supplies for family planning (except sterilization), artificial insemination, in vitro fertilization, diagnosis and treatment of infertility, or surgery to correct voluntary sterilization.

Dental Examinations And Treatments

Except as specifically described as covered in any dental care benefit in this **benefits booklet**. For the purposes of this exclusion, the term **dental examinations and treatments** means services and supplies provided to prevent, diagnose, or treat diseases or conditions of the teeth and supporting tissues or structures, including, but not limited to, services and supplies rendered:

- to repair defects which have developed because of tooth loss;
- to restore the ability to chew; or
- to control bruxism.

Physical Exercise Programs

Even though they may be prescribed for a specific condition.

Custodial Care

Includes routine nursing care and rest cures, and hospitalization for environmental change.

Developmental Disabilities/Learning Disabilities/Autism

Developmental disabilities/learning disabilities and autism for **enrollees** age seven years or older.

Services Required By State Law As A Condition Of Maintaining A Valid Driver's License

Diversion Education programs, however diversion treatment or other court mandates for DUII may be covered but are subject to certain exclusions and regular **copayments** or coinsurance.

Charges Over Amount Allowed

Any charge for services and supplies over the amount allowed according to the terms of the **contract**.

---

## PRESCRIPTION MEDICATION BENEFITS

---

This section describes the benefits for **prescription medications** available under this **contract**.

**We** contract with an outside **prescription medication** vendor to administer this **prescription medication** benefit. **Your** identification card identifies **your** health program, and enables **you** to participate in this **prescription medication** program.

**We** contract with **pharmacies** to provide a nationwide network. **Pharmacies** that participate in this network submit claims electronically on-line, which are then processed according to **your** plan benefits.

**You** must use **your** identification card at any **participating pharmacy**, including those listed in **our** Pharmacy Provider Directory. If **you** would like a directory, **you** may obtain one from the **group** or from **us**.

**IMPORTANT NOTE: Prescription medications** must be purchased from a **participating pharmacy** (except for emergencies), must be **medically necessary** for diagnosis and/or treatment of an **illness** or **injury**, and must be the subject of a **prescription order**.

---

### Prescription Medication Benefits Replace Contract Benefits

The **prescription medication** benefits described in this Section replace any **prescription medication** benefits under this **contract**. And any balances over the maximum amount available under this **prescription medication** benefit are not eligible for payment under any other provision of the **contract**.

---

### Definitions

In addition to the definitions in the DEFINITIONS Section, the following definitions apply to this **prescription medication** benefit:

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

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

**Copayment**, for purposes of this **prescription medication** benefit, means any amount **you** or **your enrolled dependent** must pay for a

covered **prescription medication** or for insulin under this **prescription medication** coverage. **Copayment** amounts are assessed on each covered **prescription medication** claim.

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

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

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

as the **brand name medication**.

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

**Mail order supplier** means a mail order pharmacy that has contracted with **us** to provide mail order services to **enrollees**.

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

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

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

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

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

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

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

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

---

## How To Use The Prescription Medication Benefit

Benefits, except as described for emergencies, are provided only for **prescription medications** obtained from **participating pharmacies**. **You or your enrolled dependent** is required to present **your** identification card at the **pharmacy** in order to have the **prescription medication** claim submitted by the **pharmacy** electronically on-line. **You or your enrolled dependent** must pay any required deductible or **copayment** at the time of purchase.

If **you or your enrolled dependent** uses a nonparticipating **pharmacy** in an emergency situation, or **you or your enrolled dependent** uses a **participating pharmacy** but the claim is not submitted by the **pharmacy** electronically on-line, **you or your enrolled dependent** must pay for the **prescription medication** in full at the time of purchase. For reimbursement, **you** must complete a Prescription Medication Claim Form and then mail the form and receipt to **us**. How **you** will be reimbursed is described later.

---

## Amount Payable

The amount **we** cover and any **copayment** or other amount **you or your enrolled dependent** must pay depends on whether or not a

**participating pharmacy** is used and whether or not the **prescription medication** claim is submitted electronically on-line. In addition, the amount **we** cover and any **copayment** or other amount **you** or **your enrolled dependent** must pay depends on whether the **prescription medication** is a **generic medication** or a **brand name medication** and whether it is on the **preferred medication list**.

Participating Pharmacy (When Claim Is Submitted Electronically On-Line)

Each **generic medication** dispensed by a **participating pharmacy** is subject to a **copayment** of \$10. Each **brand name medication** on the **preferred medication list** dispensed by a **participating pharmacy** is subject to a **copayment** of \$20 or 20 percent of the **covered prescription medication expense**, whichever is greater. Each **brand name medication** not on the **preferred medication list** dispensed by a **participating pharmacy** is subject to a **copayment** of \$40 or 20 percent of the **covered prescription medication expense**, whichever is greater.

**You** or **your enrolled dependent** need only present **your** identification card to the **participating pharmacy** and pay any **copayment** at the time of purchase.

Participating Pharmacy (When Claim Is Not Submitted Electronically On-Line)

**Participating pharmacies** are required to submit claims electronically on-line on **your** behalf. However, there may be instances when they are unable to do so. For example, if **you** or **your enrolled dependent** does not present an identification card, in which case **you** or **your enrolled dependent** must pay for the **prescription medication** in full at the time of purchase. For reimbursement, **you** or **your enrolled dependent** must complete a Prescription Medication Claim Form and then mail the form and receipt to **us**. **You** will be reimbursed based on the amount claimed (the full price of the medication), less any applicable **copayment** that would have been required had the **prescription medication** been dispensed and submitted electronically on-line by a **participating pharmacy** when any out-of-pocket maximum has not been met, and less an additional \$10 penalty. Payment will be sent directly to **you**.

Nonparticipating Pharmacy – Emergencies Only

There are no benefits for nonparticipating **pharmacies**. However, should **you** or **your enrolled dependent** experience an **emergency medical condition** and have a **prescription order** that results from the emergency filled at a nonparticipating **pharmacy**, **we** will cover a five-day supply of **prescription medications** obtained from the nonparticipating **pharmacy**. In this case, **you** or **your enrolled dependent** must pay for the **prescription medication** in full at the time of purchase. For reimbursement, **you** or **your enrolled dependent** must complete a Prescription Medication Claim Form and then mail the form and receipt to **us**. **You** will be reimbursed based on the amount claimed (the full price of the medication), less any applicable **copayment** that would have been

required had the **prescription medication** been dispensed and submitted electronically on-line by a **participating pharmacy** when any out-of-pocket maximum has not been met, and less an additional \$10 penalty. Payment will be sent directly to **you**.

---

### Maximum Out Of Pocket Expense

The **copayment** for **prescription medication** obtained from a **participating pharmacy** will be waived during the remainder of a **calendar year** in which **your** or **your enrolled dependent's** out-of-pocket expenses (**copayments**) reach \$2,500. The out-of-pocket maximum applies separately to each **enrollee**.

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

Expenses incurred at both **participating pharmacies** and nonparticipating **pharmacies** and expenses incurred for mail order **prescription medications** accumulate toward the out-of-pocket maximum, but the \$10 penalty charged when claims are not submitted electronically on-line does not.

---

### Grace Period

The 60 days following the date this **prescription medication** benefit is in effect for **you** will be used as a grace period. During this grace period, if **you** or **your enrolled dependent** use a nonparticipating **pharmacy** or if the **participating pharmacy** does not submit the claim electronically on-line, the **pharmacy** will require **you** or **your enrolled dependent** to pay for the prescription in full. **You** or **your enrolled dependent** may then submit a Prescription Medication Claim Form (available from the **group**) to **us**. **You** will be reimbursed as shown under Participating Pharmacy (When Claim Is Submitted Electronically On-Line) in the Amount Payable provision.

---

### Mail Order Benefit

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

Under this benefit, **you** or **your enrolled dependent** pays a **copayment** of \$20 each time a **generic medication** is dispensed or refilled by the **mail order supplier**. **You** or **your enrolled dependent** pays a

**copayment** of \$40 or 20 percent of the **covered prescription medication expense**, whichever is greater, each time a **brand name medication** from the **preferred medication list** is dispensed or refilled by the **mail order supplier**. **You** or **your enrolled dependent** pays a **copayment** of \$80 or 20 percent of the **covered prescription medication expense**, whichever is greater, each time a **brand name medication** not on the **preferred medication list** is dispensed or refilled by the **mail order supplier**. These **copayments** are not eligible for payment under any other portion of the **contract**.

#### How To Obtain Mail Order Prescription Medications

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

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

#### Refills

If a **prescription order** includes refills, they may also be obtained from the **mail order supplier**. The mail order form includes instructions on how to obtain refills.

---

## Limitations

The following limitations apply to this **prescription medication** benefit.

#### Maximum Supply

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

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

The largest allowable quantity at one time per **prescription medication** purchased from the **mail order supplier** is a 90-day supply. The maximum quantity for **self-injectable medications** purchased from the

**mail order supplier** is a 30-day supply. The provider, however, may choose to prescribe some **prescription medications** in smaller quantities or **you** or **your enrolled dependent** may choose to purchase some **prescription medications** in smaller quantities. The amount payable and **copayment** is always based on each dispensing. Some examples of how the maximum 90-day supply works:

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

#### Maximum Quantities

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

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

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

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

#### Refills

Refills obtained from a **pharmacy** are allowed after 75 percent of the supply from the previous **prescription order** is used. Refills obtained from the **mail order supplier** are allowed after all but 20 days of the previous **prescription order** is used. **You** or **your enrolled dependent** is responsible for the full cost of any **prescription medications** that are denied at the **participating pharmacy** for 'refill too soon' due to this quantity limitation.

---

## Exclusions

In addition to the exclusions listed in the GENERAL EXCLUSIONS Section, the following exclusions apply to this **prescription medication** benefit.

### Nonprescription Medications

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

Prescription Medications Obtained From A Nonparticipating Pharmacy  
Except for emergency situations.

### Contraceptives

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

### Devices Or Appliances

Devices or appliances of any type, even if they may require a **prescription order**. Examples of excluded devices are therapeutic devices, artificial appliances, hypodermic needles, syringes, or similar devices (except needles, syringes, and testing supplies including lancets used for treatment of diabetes). Some devices and appliances may be covered under other provisions of the **contract**.

Prescription Medications With No Proven Therapeutic Indication

Prescription Medications That Are Not Medically Necessary

Administration Or Injection Of Prescription Or Nonprescription Medications

Immunization Agents, Biological Sera, Blood Or Blood Plasma

### Vitamins And Fluoride

Except those that by law require a **prescription order**.

### Smoking Deterrent Medications

Prescription Medications For Smoking Cessation

### Prescription Medications Dispensed In A Facility

**Prescription medications** dispensed in a facility to **you** or **your enrolled dependent** while a patient in a **hospital, skilled nursing facility**, nursing home or other health care institution.

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

Prescription Medications For Treatment Of Infertility

Medications Prescribed For Cosmetic Purposes

Tretinoin (i.e. Retin-A) For Enrollees Age 26 Or Over

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

Medications Prescribed For Treatment Of Nail Fungus (Onychomycosis)  
Including but not limited to, Sporanox and Lamisil, except when **our** medical policy criteria are met and when the treatment has been **prior authorized**. See the PREAUTHORIZATION Section for a description of the **prior authorization** process.

Penlac

Renova

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

Any Medication Therapy For The Treatment Of Impotence Regardless Of Cause

Growth Hormones

Growth hormones for conditions other than growth hormone deficiency in children, failure in children secondary to chronic renal insufficiency prior to **transplant**, or for the promotion of wound healing in patients with severe, active burns while hospitalized. Growth hormone for the treatment of these listed conditions is covered when **our** medical policy criteria are met.

Injectable Prescription Medications

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

Newly Approved Prescription Medications

**Prescription medications** newly approved by the Federal Food and Drug Administration (FDA) may be excluded for up to 18 months after the approval date. The list of newly approved **prescription medications** currently excluded is provided to **participating pharmacies** and is available to **enrollees** on **our** website (www.or.regence.com) and in paper form from **us**.

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

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

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

## Prior Authorization

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

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

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

## General Provisions

The following paragraphs describe important provisions related to this **prescription medication** benefit.

Right To Examine Records

**We** can require **you** or any of **your enrolled dependents** to authorize any **participating pharmacy** furnishing **prescription medications** under this benefit to make available to **us** information relating to a **prescription order** or any other records **we** need in order to approve a claim payment.

Group Coverage Benefits Only

These **prescription medication** benefits are provided only under group coverage and are not available under any nongroup plan provided by **us**.

We Are Not Responsible For Damages

**We** cannot be held liable for any claim or damages connected with **illness** or **injuries** suffered by **you** or any of **your enrolled dependents** arising out of the use of any **prescription medication** or supply.

We Have The Right To Deny Benefits

**We** reserve the right to deny benefits for any services or supply prescribed or dispensed in a manner **we** determine is contrary to generally accepted medical practices. In addition, a **pharmacy** need not dispense a **prescription order** which, in the **pharmacist's** professional judgment, should not be filled.

Utilization Review Program

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

Recovery Of Benefits Paid By Mistake

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

---

**Contract Terms Apply**

All terms and conditions of the **contract** apply to this **prescription medication** benefit except when provisions under this **prescription medication** benefit specifically contradict the **contract**, then the provisions of this **prescription medication** benefit apply. Benefits will not be paid under both this **prescription medication** plan and the

regular benefits of the **contract** if an item is covered under both. **Copayment** and any deductible amounts and noncovered expenses **you** or **your enrolled dependent** is responsible for under this **prescription medication** plan do not apply to any of the maximum benefits under the regular benefits of the **contract**, including any maximum-out-of-pocket limit.

---

**CONTRACT AND CLAIMS ADMINISTRATION**

---

This section explains how **we** treat various matters having to do with administering **your** and **your enrolled dependent's** benefits and/or claims, including situations that may arise in which **your** or **your enrolled dependent's** health care expenses are the responsibility of a source other than **us**.

---

**Right Of Reimbursement And Subrogation**

---

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

**We** will exclude any medical (or dental, if applicable) or prescription medication expenses **you** incur for treatment of an **injury** or **illness** if the costs associated with the **injury** or **illness** may be recoverable from a third party or through workers' compensation or from any other source. This includes first party payer payments for any automobile personal injury protection or medical payments and uninsured or underinsured motorist coverages. **We** may choose, at **our** discretion, reimbursement or subrogation as a means to recovery.

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

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

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

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

- **You** must agree that **you** will do nothing to prejudice **our** rights and will cooperate fully with **us**, including signing any documents within the required time and providing prompt notice of any settlement. **You** must notify **us** of any facts that may impact **our** right to reimbursement or subrogation, including but not necessarily limited to the following:
  - the filing of a lawsuit,
  - the making of a claim against any third party;
  - scheduling of settlement negotiations (including but not necessarily limited to a minimum of 21 days advance notice of the date, time, location, and participants to be involved in any settlement conferences or mediations); and
  - intent of a third party to make payment of any kind to **your** benefit or on **your** behalf which is in any manner related to the **injury** or **illness** which gives rise to **our** right of reimbursement or subrogation (notification of a minimum of 5 business days prior to the settlement is required).

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

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

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

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

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

#### Motor Vehicle Coverage

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

#### Workers' Compensation

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

- **You** must notify **us** in writing within five days of filing a workers' compensation claim.
- If the entity providing workers' compensation coverage denies **your** or **your enrolled dependent's** claims and **you** have filed an appeal, **we** may advance benefits for **covered expenses** if **you** or **your enrolled dependent** agrees to hold any recovery obtained in trust for **us**.

### **Coordination Of Benefits**

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

#### Definitions

In addition to the definitions in the DEFINITIONS Section, the following are definitions that apply to this provision:

- For purposes of this provision, the term **plan** means any of the following which provide benefits or services for or because of hospital-medical-surgical, dental, vision, or medication care:
  - group, blanket, or franchise health insurance policies issued by insurers including health care service contractors;
  - other prepaid coverage under service plan contracts or under group or individual practice;
  - labor-management trusteed plans, labor organization plans, employer organization plans, or employee benefit organization plans;
  - hospital-medical-surgical, dental, vision, or medication coverage in government programs (as permitted by law);

- other group-type coverage which 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.

Each contract or other arrangement for coverage described previously is a separate **plan**. Also, if an arrangement has two or more parts and this provision applies only to one of the two, each of the parts is a separate **plan**.

- The term **plan** does not include the following:
  - individual or family benefits provided through insurance contracts, subscriber contracts, coverage through health maintenance organizations, or other prepayment, service, group practice, or individual practice **plans**;
  - group or group-type hospital indemnity benefits of \$100 per day or less paid on other than an expense incurred basis. However, the term **plan** does include the amount of such benefits which exceed \$100 per day. It does not include reimbursement-type benefits even if the **enrollee** has the right to elect indemnity-type benefits in lieu of reimbursement benefits at the time of the claim; and
  - school accident-type coverages covering grammar school, middle school, high school, and college students for accidents only, including athletic **injuries**, either on a 24-hour basis or on a to-and-from school basis.
- **This plan** means the part of this **contract** that provides benefits for health care expenses. If this **contract** contains more than one of the following:
  - hospital-medical-surgical benefits,
  - dental benefits,
  - vision benefits, or
  - outpatient prescription medication plan benefits (separate **copayments**, deductible, or coinsurance),

then each of the preceding shall be considered a separate **plan**.

- **Allowable expense** means any necessary, reasonable, and customary item of expense for health care when the item is covered at least in part by one or more **plans** covering the person for whom the claim is made. However, if this **contract** contains

more than one **plan**, an expense covered by one of the **plans** and not by the others will be an **allowable expense** for the **plan** that covers it and not for the others.

The difference between the cost of a private **hospital** room and the cost of a semiprivate **hospital** room is not considered an **allowable expense** under the previous definition unless the patient's stay in a private **hospital** room is **medically necessary**.

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

- **Claim determination period** means a **calendar year**. However, a **claim determination period** does not include any time before or after the period when the person was enrolled under this **contract**.

#### Order Of Benefit Determination Rules

If this provision applies, the order of benefit determination rules should be looked at first. These rules determine whether the benefits of **this plan** are determined before or after those of another **plan**. The benefits of **this plan** shall not be reduced when, under the order of benefit determination rules, **this plan** determines its benefits before or after those of another **plan**. The benefits of **this plan** may be reduced when, under the order of benefit determination rules, another **plan** determines its benefits first.

In general, when there is a basis for a claim under **this plan** and another **plan**, **this plan** is a secondary **plan** which has its benefits determined after those of the other **plan** unless:

- the other **plan** has rules coordinating its benefits with those of **this plan**; and
- both those rules and **this plan's** rules as set forth in the following paragraphs require that **this plan's** benefits be determined before those of the other **plan**.

**This plan** determines its order of benefits using the first of the following rules which applies:

- Non-Dependent/Dependent -- The benefits of the **plan** which covers the person as an **enrolled employee** (that is, other than a dependent) are determined before those of the **plan** which covers the person as a dependent.

- Dependent Child/Parents Not Separated Or Divorced -- Except as stated in the next rule, when **this plan** and another **plan** cover the same child as the dependent of different persons called **parents**:
  - the benefits of the **plan** of the **parent** whose birthday falls earlier in the year are determined before those of the **plan** of the **parent** whose birthday falls later in that year; but
  - if both **parents** have the same birthday, the benefits of the **plan** which covers the **parent** longer are determined before those of the **plan** which covers the other **parent** for a shorter period. However, if the other **plan** does not have the rule described in the immediately preceding paragraph, but instead has a rule based on the gender of the **parent**, and if, as a result, the **plans** do not agree on the order of benefits, the rule in the other **plan** will determine the order of the benefits.
- Dependent Child/Separated Or Divorced Parents -- If two or more **plans** cover a person as a dependent child of divorced or separated **parents**, benefits for the child are determined in this order:
  - first the **plan** of the **parent** with custody of the child; then
  - the **plan** of the spouse of the **parent** with the custody of the child; and finally
  - the **plan** of the **parent** not having custody of the child.

However, if the specific terms of a court decree state that one of the **parents** is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the **plan** of that **parent** has actual knowledge of those terms, the benefits of that **plan** are determined first. This paragraph does not apply with respect to any **claim determination period** or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- Active/Inactive Employee -- The benefits of a **plan** which covers a person as an active employee (or as that employee's dependent) are determined before those of a **plan** which covers that person as an inactive employee (or as that employee's dependent). 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 is ignored.
- Longer/Shorter Length Of Coverage -- If none of the previous rules determine the order of benefits, the benefits of the **plan** which covered the employee or dependents longer are

determined before those of the **plan** which covered that person for the shorter time.

#### Effect On The Benefits Of This Plan

This provision applies when in accordance with the order of benefit determination rules stated previously, **this plan** is a secondary **plan** to one or more other **plans**. In that event, the benefits of **this plan** may be reduced under this provision. Such other **plan** or **plans** are referred to as **the other plans** immediately following this paragraph.

The benefits of **this plan** will be reduced when the sum of:

- the benefits that would be payable for **allowable expenses** under **this plan** in the absence of this provision; and
- the benefits that would be payable for **allowable expenses** under **the other plans**, in the absence of provisions with a purpose like that of this provision whether or not a claim is made;

exceeds those **allowable expenses** in a **claim determination period**. In that case, the benefits of **this plan** will be reduced so that they and the benefits payable under **the other plans** do not total more than those **allowable expenses**. When the benefits of **this plan** are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of **this plan**.

Any amount by which a secondary **plan's** benefits have been reduced in accordance with this provision shall be used by the secondary **plan** to pay **allowable expenses** not otherwise paid which were incurred during the **claim determination period** by the person for whom the claim is made. As each claim is submitted, the secondary **plan** determines its obligation to pay for **allowable expenses** based on all claims which were submitted up to that point during the **claim determination period**.

#### Right To Receive And Release Necessary 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. **We** need not tell or get the consent of any person to do this. Each person claiming benefits under **this plan** must give **us** any facts **we** need to pay the claim.

#### Facility Of Payment

Any **payment made** under another **plan** may include an amount which should have been paid under **this plan**. If so, **we** may pay that amount to the organization which made the payment. That amount will then be treated as though it were a benefit paid under **this plan**. **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 the amount of **payments made** by **us** is more than **we** should have paid under this provision, **we** may recover the excess from one or more of:

- the persons **we** have paid or for whom **we** have paid;
- insurance companies; or
- other organizations.

The amount paid includes the reasonable cash value of any benefits provided in the form of services.

A secondary **plan** which provides benefits in the form of services may recover the reasonable cash value of providing 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 the primary **plan**.

Nothing in this provision shall be interpreted to require a **plan** to reimburse a covered person in cash for the value of services provided by the **plan** which provides benefits in the form of services.

### **Disclosure Of Health Information**

By accepting benefits under this **contract**, **you** and **your enrolled dependents** shall be deemed to have consented to the examination of **your** or **your enrolled dependents'** health record information for purposes of utilization review, health care provider credentialing, quality assurance, and peer review by **us** or **our** designee.

### **Benefits Are Not Transferable**

Only **you** and **your enrolled dependents** are entitled to benefits under this **contract**. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on **us**.

### **Hold Harmless In The Event Of Nonpayment**

Under state law, providers contracting with a health care service contractor like Regence BlueCross BlueShield of Oregon to provide services to its **enrollees** agree to look only to the health care service contractor for payment of the part of an expense which is covered by the **contract** and may not bill an **enrollee** in the event the health care service

contractor fails to pay the provider for whatever reason. The provider may bill the **enrollee** for applicable coinsurance, **copayments**, and deductibles and for noncovered expenses except as may be restricted in the provider contract.

---

### You Must Submit Health Information

**We** can require **you** and any of **your enrolled dependents** to submit information concerning benefits to which **you** or **your enrolled dependents** are entitled when necessary to process claims. **We** can also require **you** and any of **your enrolled dependents** to authorize any health care provider to give **us** information about a condition for which **you** and any of **your enrolled dependents** claim benefits.

---

### We Are Not Responsible For The Quality Of Health Care

In all cases, **you** and **your enrolled dependents** have the exclusive right to choose a health care provider. **We** are not responsible for the quality of health care **you** or **your enrolled dependent** receives, since all those who provide care do so as independent contractors. **We** cannot be held liable for any claim or damages connected with **injuries you** or **your enrolled dependent** suffers while receiving health services or supplies.

---

### Claims Recoveries

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

**We** regularly engage in activities to identify and recover claims payments which should not have been paid (for example, claims which are the responsibility of another, duplicates, errors, fraudulent claims, etc.). **We** will credit to **your group's** experience or the experience of the pool under which **your group** is rated all amounts that **we** recover, less **our** reasonable expenses in obtaining the recoveries.

---

### Submission And Payment Of Claims

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

**You** must submit claims within one year of the time **you** or **your enrolled dependent** receives services or supplies for **us** to pay benefits. Claims submitted beyond that date are not eligible for benefits. If circumstances

beyond **you** control prevent **you** from submitting a claim within one year, the period will be extended to 30 days beyond the time **you** could have reasonably submitted the claim.

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

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

#### Hospital Claims

If **you** or an **enrolled dependent** is hospitalized, in most cases, all **you** need to do is present **your** Regence BlueCross BlueShield of Oregon identification card to the admitting office. Most **hospitals** will bill **us** directly for the entire cost of the **hospital** stay. **We** will pay the **hospital** and send **you** copies of **our** payment record. The **hospital** will then bill **you** for any of the charges that were not covered by **your** Regence BlueCross BlueShield of Oregon benefits.

Sometimes, however, the **hospital** will ask **you**, at the time of discharge, to pay amounts that might not be covered by **your** benefits. If this happens, **you** are responsible for these amounts **yourself**. **We** will, of course, reimburse **you** if any of the charges **you** pay are covered by this **contract**.

If **you** or **your enrolled dependent** receives treatment in a **hospital** which will not bill **us**, or in a **hospital** outside **our** service area, **you** will receive a bill. In order to claim **your** benefits for these charges, send a copy of the bill to **us**, and be sure it includes all of the following information:

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

The same procedure should be followed with bills for **hospital** or **professional provider** care **you** receive outside the United States.

#### Professional Provider Claims

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

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

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

#### Other Health Care Claims

As explained previously in this **benefits booklet**, this **contract** provides benefits for certain other **covered expenses** such as medical supplies. Bills should be forwarded to **us** as **you** receive them. Or **you** may send them to **us** at regular intervals -- for example, once a month.

#### Ambulance Claims

Bills forwarded to **us** for ambulance service must show where a patient was picked up and where he or she was taken. They should also show the date of service, the patient's name, and the patient's group and identification numbers.

#### Claim Determinations

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

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

needed. **You** must provide **us** with the requested information within 45 days of receiving the request for additional information. If **we** do not receive the requested information to process the claim within the 45 days **we** have allowed, **we** will deny the claim.

#### Filing A Lawsuit

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

#### Claims Processing Report

**We** will report to **you** on the action **we** take on a claim on 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 to file an appeal or **grievance** if **you** disagree with the action **we** have taken on **your** or **your enrolled dependent's** claim.

---

### **Member Appeals And Grievance Process**

This procedure is designed to keep lines of communication open and to provide an opportunity for mutual understanding among **our enrollees**, providers, and **us**. **Grievances** and appeals are promptly directed to appropriate individuals within Regence BlueCross BlueShield of Oregon so action can be taken quickly, and on an informal basis if possible.

**Final decisions may be decided by an independent review organization (IRO), as explained below under the third step in the grievance and appeals process.**

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

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

### First Step – Filing A Grievance

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

### Second Step – Filing Second Appeal

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

- for appeals of preservice (**preauthorization**) claims, within 14 calendar days of **our** receiving **your** appeal; or
- for appeals of postservice claims, within 30 calendar days of **our** receiving **your** appeal.

### Third Step –Voluntary Appeal - External Independent Review

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

- an adverse determination based on medical necessity (cosmetic or nonparticipating provider services, for example);

- an adverse determination for treatment determined as experimental or investigational; or
- for purposes of continuity of care (no interruption of an active course of treatment).

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

- sign a waiver granting the independent review organization access to medical records; and
- have exhausted all other appeals and **grievance** opportunities under this **contract** unless, with **your** consent, **we** waive this requirement.

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

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

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

#### Expedited Procedure

In the event **you or your** physician reasonably believes a decision denying a **preauthorization** of a service is clinically urgent and that application of the regular appeal timeframes could jeopardize **your** life, health, or ability to regain maximum function, **you or your** representative may request an Expedited Appeal. Expedited Appeal also is available if a physician with knowledge of **your** medical condition concludes that application of the regular appeal timeframes to the review of **our** denial of **preauthorization** of a service would subject **you** to severe pain that cannot be adequately managed without the disputed service. The appeal request must be made verbally or in writing within 180 days after **you** receive notice of the initial written **preauthorization** denial, should state the need for a decision on an expedited basis, and must include documentation necessary for the appeal decision. The appeal request, including any additional information or comments, must be made to the appeal coordinator. However, if the appeal issue doesn't meet the expedited criteria, the appeal will be handled through the standard appeal process. If the appeal meets the expedited criteria, a verbal notice of the

decision will be provided to **you** or **your** representative no later than one working day or seventy-two hours of receipt of the request. A written notice will be provided within one working day of the verbal notification. If **you** are not satisfied with that decision, **you** may ask for an expedited, second level appeal similar to the Second Step appeal process described above.

#### How To Contact Us

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

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

#### Assistance From The Department Of Consumer And Business Services

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

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

or call: (503) 947-7984

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

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

---

### **Replacing Earlier Contract**

If this **contract** replaces an earlier Regence BlueCross BlueShield of Oregon contract or the contract of one of **our** subsidiary or affiliate companies, **we** will apply benefits that were paid under the earlier contract against the maximum benefits available under this **contract**.

---

### **Medication Rebate**

Regence BlueCross BlueShield of Oregon participates in arrangements with medication manufacturers which allow **us** to receive rebates based, among other things, on the volume of certain prescription medications purchased on behalf of **enrollees**. Any rebates **we** receive from medication manufacturers are credited directly or indirectly to CIS to reduce prescription medication claims expense and thereby help reduce

future premium rate increases. **We** will withhold a percentage of the total rebate to cover **our** costs of collecting and administering the rebate program.

---

### Out-Of-Area Claims Service - BlueCard® Program

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

Under BlueCard, when **enrollees** incur **covered expenses** within the geographic area served by another Blue Cross and/or Blue Shield Plan ("Host Plan") and the claim is processed through BlueCard, **we** will remain responsible for meeting **our** obligations under the **contract**. The Host Plan will only be responsible for providing such services as contracting with its participating providers and handling the interaction with those providers according to BlueCard policies.

When **you** or an **enrolled dependent** receives covered health care services outside **our** service area from a provider who has a participating contract with the Host Plan and the claim is processed through BlueCard, the amount **you** pay for **covered expenses** is usually calculated on the lower of:

- the actual billed charges; or
- the negotiated price that the Host Plan passes on to **us**.

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

Statutes in a small number of states may require the Host Plan to use a basis for calculating **enrollee** liability for **covered expenses** that does not reflect the entire savings realized, or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate **enrollee** liability calculation methods that differ from the usual BlueCard Program method noted above or require a surcharge, **we** would then calculate **enrollee** liability for any covered health care

services using the methods outlined by the applicable state statute in effect at the time the **enrollee** received care.

Under BlueCard, recoveries from a Host Plan or from participating providers of a Host Plan for overpayments on paid claims can arise in several ways, including, but not limited to, anti-fraud and abuse credits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Plan will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard policies, which generally require correction on a claim-by-claim or prospective basis.

---

## **DISCLOSURE STATEMENT - PATIENT PROTECTION ACT**

---

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

---

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

No one can deny **you** or **your enrolled dependent** the right to make **your** own choices. As a member, **you** and **your enrolled dependents** have the right to:

- be treated with dignity and respect;
- impartial access to treatment and services without regard to race, religion, gender, national origin, or disability;
- know the name of the physicians, nurses, or other health care professionals who are treating **you** or **your enrolled dependent**;
- the medical care necessary to correctly diagnose and treat any covered **illness** or **injury**;
- have providers tell **you** or **your enrolled dependent** about the diagnosis, the treatment ordered, the prognosis of the condition, and instructions required for follow-up care;
- know why various tests, procedures, or treatments are done, who the persons are who give them, and any risks **you** or **your enrolled dependent** needs to be aware of;
- refuse to sign a consent form if **you** or **your enrolled dependent** does not clearly understand its purpose, cross out any part of the

form **you** or **your enrolled dependent** doesn't want applied to care, or have a change of mind about treatment **you** or **your enrolled dependent** previously approved;

- refuse treatment and be told what medical consequences might result from **your** or **your enrolled dependent's** refusal;
- be informed of policies regarding "living wills" as required by state and federal laws (these kinds of documents explain **your** or **your enrolled dependent's** rights to make health care decisions, in advance, if **you** or **your enrolled dependent** becomes unable to make them);
- expect privacy about care and confidentiality in all communications and in **your** or **your enrolled dependent's** medical records;
- expect clear explanations about benefits and exclusions;
- contact **our** Customer Service Department and ask questions or present complaints; and
- be informed of the right to appeal an action or denial and the related process.

**You** and **your enrolled dependents** have a responsibility to:

- tell the provider **you** or **your enrolled dependent** is covered by Regence BlueCross BlueShield of Oregon and show an identification card when requesting health care services;
- be on time for appointments and to call immediately if there is a need to cancel an appointment or if **you** or **your enrolled dependent** will be late. **You** or **your enrolled dependent** is responsible for any charges the provider makes for "no shows" or late cancellations;
- provide complete health information to the provider to help accurately diagnose and treat **your** or **your enrolled dependent's** condition;
- follow instructions given by those providing health care to **you** or **your enrolled dependent**;
- review this health care **benefits booklet** to make sure services are covered by the **plan**;
- make sure services are **preauthorized** when required by this **plan** before receiving medical care;

- contact **our** Customer Service Department if **you** or **your enrolled dependent** believes adequate care is not being received;
- read and understand all materials about **your** health benefits and make sure family members that are covered under this **plan** also understand them;
- give an identification card to **your** 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** or **your enrolled dependent** experiences an emergency situation, **you** or **your enrolled dependent** should obtain care from the nearest appropriate facility, or dial 911 for help.

If there is any doubt about whether **your** or **your enrolled dependent's** condition requires emergency treatment, **you** or **your enrolled dependent** can always call the provider for advice. The provider is able to assist **you** or **your enrolled dependent** in coordinating medical care and is an excellent resource to direct **you** or **your enrolled dependent** to the appropriate care since he or she is familiar with **your** or **your enrolled dependent's** medical history.

---

### How Will I Know If My Benefits Change Or Are Terminated?

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

---

### What Happens If I Am Receiving Care And My Doctor Is No Longer A Contracting Provider?

When a **professional provider's** contract with **us** ends for any reason, **we** will give notice to those **enrollees** that **we** know, or should reasonably know, are under the care of the provider of their rights to receive continued care (called "continuity of care"). **We** will send this notice no later than 10 days after the provider's termination date or 10 days after the date **we** learn the identity of an affected **enrollee**, whichever is later. The exception to **our** sending the notice is when the **professional provider** is part of a group of providers and **we** have agreed to allow the provider group to provide continuity of care notification to **enrollees**.

### When Continuity Of Care Applies

If **you** or **your enrolled dependent** is 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-area provider) if the provider's preferred contract with **us** is terminated or the provider is no longer participating in **our** preferred provider network, **we** will continue to pay **plan** benefits for services and supplies provided by the **professional provider** as long as:

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

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

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

### How Long Continuity Of Care Lasts

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

- the day following the date on which the active course of treatment entitling **you** or **your enrolled dependent** to continuity of care is completed; or
- the 120<sup>th</sup> day after notification of continuity of care.

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

- the 45<sup>th</sup> day after the birth;
- the day following the date on which the active course of treatment entitling **you** or **your enrolled dependent** to continuity of care is completed; or
- the 120<sup>th</sup> day after notification of continuity of care.

The notification of continuity of care will be the earlier of the date **we** or, if applicable, the provider group notifies **you** of **your** or **your enrolled dependent** of the right to continuity of care, or the date **we** receive or approve the request for continuity of care.

---

### **Complaint And Appeals: If I Am Not Satisfied With My Health Plan Or Provider What Can I Do To File A Complaint Or Get Outside Assistance?**

To voice a complaint with **us**, simply follow the process outlined under Member Appeals And Grievance Process in the CONTRACT AND CLAIMS ADMINISTRATION Section of this **benefits booklet**, including, if applicable, information about filing an appeal through an independent review organization without charge to **you**.

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

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

or call: (503) 947-7984

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

---

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

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

**We** have formed several advisory committees -- the Member Advisory Committee for **enrollees**, the Marketing Advisory Panel for employers, and the Provider Advisory Committee for health care professionals -- to allow participation in the development of corporate policies and to provide feedback. If **you** or **your enrolled dependent** would like to become a member of the Member Advisory Committee, send **your** or **your enrolled dependent's** name, identification number, address, and phone number to the vice president of Customer Service at the following address. The advisory committees generally meet two times per year.

Regence BlueCross BlueShield of Oregon  
ATTN: Vice President, Customer Service, C-7A  
P.O. Box 1271  
Portland, OR 97207-1271

Or send **your** comments to **us** over the internet at:  
[www.or.regence.com](http://www.or.regence.com)

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

---

### What Are Your Prior Authorization And Utilization Review Criteria?

Prior authorization, also known as **preauthorization**, is the process **we** use to determine the **medical necessity** of a service before it is rendered. Contact **our** Customer Service Department at the phone number on the back of **your** identification card, or ask **your** or **your enrolled dependent's** provider for a list of services that need to be **preauthorized**. Many types of treatment may be available for certain conditions; the **preauthorization** process helps the provider work together with **you** or **your enrolled dependent**, other providers, and **us** to determine the treatment that best meets **your** or **your enrolled dependent's** medical needs and to avoid duplication of services.

This teamwork helps save thousands of dollars in premiums each year, which then translates into savings for **you**. And, **preauthorization** is **your** and **your enrolled dependents'** assurance that medical services won't be denied because they are not **medically necessary**.

Utilization review is a process in which **we** examine services an **enrollee** receives to ensure that they are **medically necessary**—appropriate with regard to widely accepted standards of good medical practice. For further explanation, look at the definition of **medically necessary** in the DEFINITIONS Section of this **benefits booklet**.

Let **us** know if **you** or **your enrolled dependent** would like a written summary of information that **we** may consider in **our** utilization review of a particular condition or disease. Simply call the Customer Service phone number on the back of **your** identification card.

---

### How Are Important Documents (Such As My Medical Records) Kept Confidential?

**We** have a written policy to protect the confidentiality of health information. Only employees who need to know in order to do their jobs may access **enrollee** personal information. Disclosure outside the company is permitted only when necessary to perform functions related to providing **your** or **your enrolled dependent's** coverage and/or when otherwise allowed by law. Note that with certain limited exceptions, Oregon law requires insurers to obtain a written authorization from the **enrollee** 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 identification card. One of **our** representatives will coordinate the services of an interpreter over the phone. **We** can help with sign language as well as spoken languages.

---

### What Additional Information Can I Get From You Upon Request?

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

- Rules related to **our** medication formulary, including information on whether a particular medication is included or excluded from the formulary.
- Provisions for referrals for specialty care, behavioral health services, and **hospital** services, and how **enrollees** may obtain the care or services.
- A copy of **our** annual report on complaints and appeals.
- A description of **our** risk-sharing arrangements with physicians and other providers consistent with risk-sharing information required by the Health Care Financing Administration.
- A description of **our** efforts to monitor and improve the quality of health services.
- Information about procedures for credentialing network providers and how to obtain the names, qualifications, and titles of the providers responsible for an **enrollee's** care.

- Information about **our** prior authorization and utilization review procedures.

---

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

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

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

To obtain the mentioned information, write to:

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

or call: (503) 947-7984

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

---

### GENERAL PROVISIONS

---

This section explains various provisions concerning the relationship between CIS and **us**.

---

#### No Waiver

The failure or refusal of either party to demand strict performance of this **contract** 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.

---

**Enrollee's Agent**

CIS and the **groups** are the agent of their employees for all purposes under this **contract** and not the agent of Regence BlueCross BlueShield of Oregon.

---

**Governing Law**

To the extent this **contract** is governed by state law, the interpretation and validity of the **contract** will be governed by the laws of the state of Oregon without regard to its conflict of law rules.

---

**Choice Of Forum**

Any legal action arising out of this **contract** must be filed in either state or federal court in the state of Oregon.

---

**Representations Are Not Warranties**

In the absence of fraud, all statements made in an application or in **your** enrollment by **you** or **your enrolled dependent** will be deemed 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** or **your enrolled dependent**, a copy of which has been furnished to **you** or **your enrolled dependent**.

---

**Relationship To Blue Cross And Blue Shield Association**

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

## HEALTH PROMOTION PROGRAM

The description of the following health promotion program is provided in this member handbook as a convenience. This program is not insurance. It is a complement to, but does not form a part of, the group health plan.

### SPECIAL BEGINNINGS®

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

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

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

Other benefits of the program include:

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