

**PIONEER EDUCATORS HEALTH TRUST  
EMPLOYEE HEALTH BENEFIT  
PLAN DOCUMENT  
AND  
SUMMARY PLAN DESCRIPTION**

Originally Effective May 1, 2003, Amended and Restated Effective April 1, 2008



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**SUMMARY PLAN DESCRIPTION**

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The **plan** is an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA). For further information regarding ERISA, contact the **Plan Administrator**.

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**Plan Name**

Pioneer Educators Health Trust Employee Benefits Plan

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**Name, Address, and Phone Number Of Trust, Plan Administrator, And Fiduciary**

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

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**Plan Sponsor Identification Number**

35-2198318

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**Plan Number**

501

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**Group Number**

**Type Of Plan**

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

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**Plan Sponsor/Plan Administrator**

**Plan Sponsor** means, collectively, the participating institutions of the Oregon Independent Colleges Association (OICA). **Plan Administrator** is the person or persons acting on behalf of the **Trust** to aide in administration of benefits under the **plan**.

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**Type of Administration**

The processing of claims for benefits under the terms of the **plan** are provided through a company contracted by the **plan** which hereinafter is referred to as the **claims administrator**.

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**Trust Makes Decisions**

**Plan** is administered by **Trust** with claims administration by Regence BlueCross BlueShield of Oregon. **Trust** has full power and authority to determine all matters arising in the administration, interpretation, and application of the **plan**, not inconsistent with the provisions of applicable law, and its interpretation and decisions with respect thereto shall be final and conclusive.

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**Name, Address, And Phone Number Of Agent For Service Of Legal Process**

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

Legal process may also be served upon the **Plan Administrator** or the **plan** trustees at the **Plan Administrator's** address above.

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**Eligibility Requirements**

For detailed information regarding a person's eligibility to participate in the **plan**, including those who are not eligible and when coverage under the **plan** ends, refer to the SCHEDULE OF BENEFITS AND ELIGIBILITY sections of this **Plan Document**.

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## Source Of Plan Contributions

Contributions for plan expenses are obtained from the participating institutions of the **Plan Sponsor** and from **enrolled employees**. The **Plan Sponsor** evaluates the costs of the **plan** based on projected plan expenses and determines the amount to be contributed by the **Plan Sponsor** and the amount to be contributed by **enrolled employees**.

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## Funding Method

**Trust** will maintain a trust account for the receipt of money and property to fund the **plan**, for the management and investment of such funds, and for the payment of **plan** benefits and expenses from such funds.

The participating institutions of the **Plan Sponsor** shall deliver, from time to time to the **Trust**, amounts of money and property as shall be necessary to provide the **Trust** with sufficient funds to pay all **plan** benefits and reasonable expenses of administering the **plan** as the same shall be due and payable. The participating institutions of the **Plan Sponsor** may provide for all or any part of such funding by insurance issued by a company duly qualified to issue insurance for such purpose and may pay the premiums, therefore, directly or by funds deposited in the **Trust**.

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

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

**Enrollees** shall look only to the funds in the **Trust** for payment of **plan** benefits and expenses.

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## Ending Date Of Plan Year

December 31 of each year.

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## Renewal Date Of Benefits

April 1 of each year.

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## Plan Termination Provisions

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

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

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

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## Notice Of ERISA Rights

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

### Receive Information About Your Plan And Benefits

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

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

### Continue Group Health Plan Coverage

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

If **your plan** excludes or limits coverage of preexisting conditions, **you** are entitled to reduction or elimination of exclusionary periods of coverage

for any preexisting condition limitations under **your** group health plan if **you** have **creditable coverage** from another plan. **You** should be provided a certificate of **creditable coverage**, free of charge, from **your** group health plan when **you** lose coverage under the **plan**, when **you** become entitled to elect COBRA continuation coverage, when **your** COBRA continuation coverage ceases, if **you** request it before losing coverage, or if **you** request it up to 24 months after losing coverage. Without evidence of **creditable coverage**, **you** may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after **your** enrollment date in **your** coverage.

#### Prudent Actions By Plan Fiduciaries

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

#### Enforce Your Rights

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

#### Procedures For Filing Claims

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

For detailed information on how to submit a claim for benefits or how to file an appeal on a processed claim, refer to the Submission And Payment Of Claims and Grievance and Appeal Procedures provisions of this **plan booklet**.

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

#### Assistance With Your Questions

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

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## INTRODUCTION

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The following pages are the **Plan Document**, the written description of the **plan**. The **plan** means the employee welfare benefit plan that this **Plan Document** describes. This **Plan Document** and any amendments constitute the **Plan Document** and Summary Plan Description for this **Plan**. This **plan** is maintained for the exclusive benefit of the employees and each employee's rights under this **plan** are legally enforceable. The **Plan Sponsor** has the right to amend this **plan** at any time, and will make a "good faith" effort to communicate to **you**, on a timely basis, all such changes that affect benefit payment.

The requirements for being covered under this **plan**, the provisions concerning termination of coverage, a description of the **plan** benefits (including any limitations and exclusions), and the procedures to be followed in presenting claims for benefits and remedies available for redress of claims denied are outlined on the following pages of this **Plan Document**, and in the summaries of benefits and eligibility insert that is issued separate from (but are part of) this **Plan Document**.

**You** are entitled to this coverage if **you** are eligible in accordance with the provisions in this **Plan Document**. This **Plan Document** is void if **you** have ceased to be entitled to coverage. No clerical error will invalidate **your** coverage if otherwise validly in force.

This **Plan Document** replaces any plan document previously adopted by the **Plan Sponsor**.

Throughout this **Plan Document** the terms **you** and **your** mean the **enrolled employee**. The term **enrollee** means **you** or an **enrolled dependent**. The term **Trust** means Pioneer Educators Health Trust, the legal entity established for the benefit of the **Plan Sponsor** to receive contributions from the participating institutions of the **Plan Sponsor** and provide health benefit to employees and their dependents. The participating institutions of the Oregon Independent Colleges Association (OICA) are referred to collectively as the **Plan Sponsor**. The term **claims administrator** refers to Regence BlueCross BlueShield of Oregon, the claims processor for the **plan**. Please study the **plan** and become fully informed about its contents.

**IMPORTANT NOTE:** This document describes a preferred provider organization benefit plan. **Your** identification card and provider directory indicate which panel of providers applies to **your** benefits under this **plan**.

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## DEFINITIONS

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

**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 **enrolled employee** means an employee of the **Plan Sponsor** whose application is accepted by the **claims administrator** and who is enrolled under the **plan**.

An **enrolled dependent** means an eligible dependent of an **enrolled employee** whose application is accepted by the **claims administrator** and who is enrolled under the **plan**.

**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.

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 the **plan**. 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 the **claims administrator's** 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 the **claims administrator** 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 health care services or supplies that a physician or other health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an **illness, injury**, disease, or its symptoms, and that are:

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

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in **peer reviewed medical literature** generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of physicians and other health care providers practicing in relevant clinical areas and any other relevant factors.

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**.

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** includes, but is not limited to, 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 chiropractor, but only to treat a bone, muscle, or joint disorder;
- an acupuncturist;
- a naturopath;
- a psychologist;
- a licensed clinical social worker;
- a certified nurse practitioner;

- a registered physical, occupational, speech, or audiological therapist; or
- 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.

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

**Contracting durable medical equipment supplier** means a supplier of **durable medical equipment** who has contracted to provide services and supplies to **enrollees**.

A **contracting agency** means any of the following agencies that has 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 the **claims administrator** according to a proprietary database on medical/dental billings; or use of pharmacy or Medicare data, which is usual (not more than the provider's normal charge) and customary (falls within the range of average charges for a service or supply billed by most providers or vendors for the same or similar service or supply in the service area).

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## SUMMARY OF BENEFITS

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This is a summary of the benefits of the **plan**. It states at what percentages **covered expenses** are paid and describes any out-of-pocket maximum. It also states deductibles or benefit maximums applicable to the coverage. **You** may also be responsible for payment of part of the cost of coverage under the **plan**. Check with **your Plan Administrator** for information on any required contribution. The **Plan Document** spells out the benefits and the conditions, limitations, and exclusions of the **plan** in detail. Also, separately issued summaries of **your** benefits and an explanation of eligibility under the **plan** are also part of this **Plan Document**.

The **claims administrator** has 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 the **claims administrator's** website at [www.or.regence.com](http://www.or.regence.com) or through their Customer Service Department.

**IMPORTANT NOTE:** It is extremely important to use **preferred facilities** and **preferred professional providers** in order to receive the maximum benefits available under this **plan**. Services provided for an **emergency medical condition** (see DEFINITIONS) will be paid at the preferred level of benefits.

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### Maximum Lifetime Benefit

per **enrolled employee** or **enrolled dependent**: \$2,000,000

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### Calendar Year Deductible

	Preferred Providers	Nonpreferred Providers
Per <b>enrollee</b>	\$250  Includes the "Other Covered Expenses" listed later in this SUMMARY OF BENEFITS.	\$500
Aggregate deductible per <b>calendar year</b> (family maximum)	\$750	\$1,500

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## Out-Of-Pocket Maximum

	<u>Preferred Providers</u>	<u>Nonpreferred Providers</u>
Per <b>enrollee</b> per <b>calendar year</b> (does not include <b>copayments</b> , deductibles, or <b>covered expenses</b> paid at 100 percent)	\$2,000  Includes the "Other Covered Expenses" listed later in this SUMMARY OF BENEFITS.	\$6,000
Aggregate out-of-pocket maximum per <b>calendar year</b> (family maximum)	\$6,000	\$18,000

## Percentage Paid For Covered Expenses

After the deductible is satisfied, benefits under the **plan** are paid as explained in the following paragraphs for **covered expenses** incurred for the listed services and supplies.

### Preferred Providers And Other Covered Expenses

The **plan** pays **covered expenses** an **enrollee** incurs for **preferred facilities**, **preferred professional providers**, and Other Covered Expenses at the percentage listed until the **enrollee's** share of those **covered expenses** reaches the preferred provider out-of-pocket maximum. Once the preferred provider out-of-pocket maximum is reached, the **plan** pays 100% of those **covered expenses** (preferred and Other Covered Expenses) incurred during the rest of the **calendar year** for that **enrollee**, however any **copayments** will still apply.

### Nonpreferred Providers

The **plan** pays **covered expenses** an **enrollee** incurs for **nonpreferred facilities** and **nonpreferred professional providers** at the percentage listed for those services until those **covered expenses** reach the nonpreferred out-of-pocket maximum. Once the out-of-network out-of-pocket maximum is reached, the **plan** pays 100% of those nonpreferred **covered expenses** incurred during the rest of the **calendar year** for that **enrollee**, however any **copayments** will still apply.

### Cross Accumulation Of Deductibles And Out-Of-Pocket Maximums

Amounts applied toward satisfaction of the preferred provider deductible and out-of-pocket maximum may also be applied toward satisfaction of the nonpreferred provider deductible and out-of-pocket maximum and vice versa.

### Total Family Deductibles And Out-Of-Pocket Maximums

The **calendar year** deductibles and out-of-pocket maximums apply separately to **you** and each **enrolled dependent**, but no family will be required to satisfy more than the total family deductible and out-of-pocket

maximums shown above for any year, no matter how many **enrolled dependents** are in that family.

<b>Hospital Inpatient Care</b>		
	<u>Preferred Facility</u>	<u>Nonpreferred Facility</u>
Number of days	Unlimited	Unlimited
Semiprivate room	Paid at 80%	Paid at 60%
Intensive/coronary care unit	Paid at 80%	Paid at 60%
Additional <b>medically necessary hospital</b> services and supplies	Paid at 80%	Paid at 60%
Inpatient rehabilitation 30 days (60 days for head or spinal cord <b>injury</b> , or for treatment of stroke) per <b>calendar year</b>	Paid at 80%	Paid at 60%

  

<b>Hospital Outpatient Care</b>		
	<u>Preferred Facility</u>	<u>Nonpreferred Facility</u>
Outpatient surgery	Paid at 80%	Paid at 60%
Radium, radioisotope, and x-ray therapy	Paid at 80%	Paid at 60%
Chemotherapy	Paid at 80%	Paid at 60%
Preadmission testing	Paid at 80%	Paid at 60%
Diagnostic x-ray and laboratory tests	Paid at 100% (deductible waived)	Paid at 60%
Emergency room care ( <b>copayment</b> waived if admitted)	Paid at 80% after \$100 <b>copayment</b> (deductible waived)	Paid at 80% after \$100 <b>copayment</b> (deductible waived)

  

<b>Urgent Facility Care</b>		
	<u>Preferred Facility</u>	<u>Nonpreferred Facility</u>
	Paid at 100% after \$20 <b>copayment</b> (deductible waived)	Paid at 60%

  

<b>Skilled Nursing Facility Care</b>		
	<u>Preferred Facility</u>	<u>Nonpreferred Facility</u>
Number of days per <b>calendar year</b>	100	100

Semiprivate room plus <b>medically necessary</b> ancillary charges	Paid at 80%	Paid at 60%
<hr/>		
<b>Home Health Care</b>	<u>Preferred Provider</u>	<u>Nonpreferred Provider</u>
Home health care services and supplies are covered when provided by a <b>home health care agency</b> for a patient who is <b>homebound</b> (maximum 180 days per <b>calendar year</b> )	Paid at 80%	Paid at 60%
<hr/>		
<b>Hospice Care</b>	<u>Preferred Provider</u>	<u>Nonpreferred Provider</u>
<b>Hospice care</b> when provided by a Medicare or state certified <b>hospice care program</b>	Paid at 80%	Paid at 60%
<hr/>		
<b>Special Facility Care</b>	<u>Preferred Facility</u>	<u>Nonpreferred Facility</u>
Birthing center or ambulatory surgery facility	Paid at 80%	Paid at 60%
<hr/>		
<b>Professional Provider Services</b>	<u>Preferred Professional Provider</u>	<u>Nonpreferred Professional Provider</u>
Home or office visits (includes in-office surgery)	Paid at 100% after \$20 <b>copayment</b> (deductible waived)	Paid at 60%
Visits in <b>hospital</b> consultation in <b>hospital</b>	Paid at 80%	Paid at 60%
Surgery: surgeon, assistant surgeon anesthesiologist and supplies	Paid at 80%	Paid at 60%
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>	Paid at 80%	Paid at 60%
Contraceptive services	Paid at 80%	Paid at 60%

Radium, radioisotope, and x-ray therapy	Paid at 80%	Paid at 60%
Diagnostic x-ray and laboratory tests	Paid at 100% (deductible waived)	Paid at 60%
<b>Preventive Care</b>		
	<u>Preferred Professional Provider</u>	<u>Nonpreferred Professional Provider</u>
Annual women's examinations, including any Pap smears and mammograms	Paid at 100% after \$15 <b>copayment</b> (deductible waived)	Paid at 100% after \$15 <b>copayment</b> (deductible waived)
Well-baby care, including related services and supplies	Paid at 100% after \$20 <b>copayment</b> (deductible waived)	Paid at 60%
All other physical examinations, including related services and supplies	Paid at 100% after \$20 <b>copayment</b> (deductible waived)	Paid at 60%
Childhood immunizations for all <b>enrollees</b>	Paid at 100% (deductible waived)	Paid at 100% (deductible waived)
<b>Durable Medical Equipment</b>		
	<u>Preferred Provider</u>	<u>Nonpreferred Provider</u>
<b>Medically necessary durable medical equipment</b> and supplies are covered	Paid at 80%	Paid at 60%
<b>Transplants</b>		
	<u>Preferred Provider</u>	<u>Nonpreferred Provider</u>
Services and supplies for transplants, including donor procurement costs	Paid at 80%	Paid at 60%
<b>Infertility Diagnosis Services</b>		
	<u>Preferred Provider</u>	<u>Nonpreferred Provider</u>
Diagnosis only	Paid at 50%	Paid at 50%

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**Temporomandibular Joint Disorder Treatment**

	<u>Preferred Provider</u>	<u>Nonpreferred Provider</u>
<b>Medically necessary</b> expenses related to treatment of temporomandibular joint disorder	Paid at 50%	Paid at 50%

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**Mental Health And Chemical Dependency Services**

The **plan** covers **mental health and chemical dependency services** under the various sections of the **Plan Document** 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**.

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**Maternity Care**

**Covered expenses** for pregnancy care, childbirth, and related conditions are covered the same as any other condition for **you** or **your enrolled dependents**.

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**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.

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**Special Dental Care**

The **plan** covers treatment of accidental **injury** to natural teeth or a fractured jaw.

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**Alternative Care Plan**

Any deductible will be waived and the **plan** will pay 100 percent of the billed charges for services provided by the following alternative care providers up to a combined maximum of \$1,500 per **calendar year**:

- a chiropractor;
- an acupuncturist;
- a naturopath; and
- a massage therapist.

Copayments

**You or your enrolled dependent** is responsible for paying the first \$20 for each alternative care visit.

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**Other Covered Expenses**

**IMPORTANT NOTE:** The items listed in this category are paid as shown and not at the preferred/nonpreferred benefit levels.

Home infusion therapy (as specified)	Paid at 80%
Ambulance	Paid at 80%
Medications	Paid at 80%
Supplies and <b>durable medical equipment</b> provided by other than a <b>durable medical equipment</b> supplier	Paid at 80%
Outpatient diabetic instruction (as specified in the <b>Plan Document</b> )	Paid at 80%

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**Biofeedback Therapy**

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

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**Open Enrollment**

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**The 31-day period prior to April 1**

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## BENEFITS

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The **plan** pays a percentage of **covered expenses** up to the lifetime maximums shown in the SUMMARY OF BENEFITS for **you** and for each **enrolled dependent**. The explanation of how the **plan** pays 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 explain 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 **plan**. The third point relates to the amount of **covered expenses** the **plan** pays after any required deductible is satisfied. The last few points relate to restoration of benefits, case management/alternative benefits, and emergency care and how they are administered under the **plan**.

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### When Benefits Are Available

Benefits are paid only for **covered expenses** incurred when **your** 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 **plan**; and
- **you** and **your enrolled dependents** have applied for coverage and have been accepted by the **claims administrator**.

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. If **you** or **your enrolled dependent** is in the **hospital** on the day this **plan** terminates for one or more participating institutions and is immediately replaced by another group contract, benefits under the **plan** towards the **covered expenses** for that hospitalization will continue until discharge from the **hospital** or until **your** 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.)

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### Deductibles

The amount of the individual deductible is shown in the SUMMARY OF BENEFITS. The deductible applies to medical expenses.

This **plan** 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 aggregate family deductible shown in the SUMMARY OF BENEFITS for any year, no matter how many **enrolled dependents** are in that family.

#### Deductible Carryover

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.

#### Common Accident

If two or more members of a family are **injured** in the same accident, only one individual deductible amount will be deducted from all **covered expenses** related to the accident for all family members involved in the accident for the remainder of the **calendar year**.

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### **Once The Deductible Is Satisfied**

After the deductible is satisfied, this **plan** pays a percentage of the **covered expenses** incurred under the **plan** by **you** or **your enrolled dependents**. The percentage paid and whether the out-of-pocket maximum 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 the out-of-pocket maximum.

Note that the out-of-pocket maximum is accumulated separately for **you** and each of **your enrolled dependents** based upon **your** or **your enrolled dependent's covered expense**, however no family will be required to satisfy more than the aggregate family out-of-pocket maximum shown in the SUMMARY OF BENEFITS for any year, no matter how many **enrolled dependents** are in that family.

NOTE: **Covered expenses** paid at 100 percent do not accumulate toward the out-of-pocket maximum amount, nor do any **copayments** and/or deductibles.

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### **Restoration Of Benefits**

If **you** or one of **your enrolled dependents** receives medical benefits under this **plan**, 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.

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### **Deductible And Out-Of-Pocket Maximum Renewal**

Deductible and out-of-pocket maximum provisions are calculated on a **calendar year** basis. This **plan** is renewed, with or without changes, each **plan** year. A **plan** year may or may not coincide with a **calendar year**. When this **plan** is renewed mid-**calendar year**, any previously satisfied deductible and/or out-of-pocket maximum amounts are credited toward similar provisions in the renewed contract. If the deductible 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.

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## Case Management/Alternative Benefits

**Case management** is a program administered by the **claims administrator** which is designed to provide early detection and intervention in cases of serious **illness** or **injury** with the potential for major continuing claims expense. **Case management** will 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 **plan**, but which the **claims administrator** believes to be **medically necessary** and cost effective. The **plan** will not cover **alternative benefits** until the **claims administrator** has determined, at their 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 **alternative benefits** under the **plan** are paid for an **enrollee** shall not obligate the **claims administrator** to pay such benefits for other **enrollees**, nor shall it obligate them to pay continued or additional **alternative benefits** for the same **enrollee**. Benefits for **alternative benefits** are **covered expenses** for all purposes under this **plan**.

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## Emergency Care

**You** and **your enrolled dependents** are covered for **emergency medical screening exam expenses** (see DEFINITIONS Section) under the various sections of this **Plan Document** 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.

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## COVERED EXPENSES

Subject to the terms of the **Plan Document**, **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**;

- for a **nonparticipating facility** inside the **claims administrator's** service area, the contracted amount for **participating facilities** for the same service or supply;
- the billed amount for listed services received from a **nonparticipating professional provider** inside the **claims administrator's** service area, 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 inside the **claims administrator's** service area 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 inside the **claims administrator's** service area 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;
- for eligible providers outside the **claims administrator's** service area who are not contracted with a BlueCross and/or BlueShield plan, **covered expenses** will be based upon the allowed amount information of the Blue plan;
- 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).

When an **enrollee** visits an emergency room, the **plan** pays the same percentage of benefits that would have been paid for a similar service or supply at a **preferred facility**. However, in the case where the patient is admitted directly to a **nonpreferred facility** from the emergency room, the **claims administrator** 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 the **claims administrator** reasonably determines 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 any deductible and

coinsurance amount for **covered expenses**. Facilities and **professional providers** that do not have a preferred or participating contract with the **claims administrator**, however, may bill **you** for any balances over **plan** payment level in addition to any deductible and coinsurance amount.

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## 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. The **claims administrator** determines their definition of an intensive care unit by using the criteria of the Joint Commission on Accreditation of Hospitals, but the **claims administrator** reserves 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

The **plan** provides 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. The number of days in a **hospital** stay will be computed by counting the day of admission and the day of discharge as one day.

#### 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. The **plan** will cover neurodevelopmental therapy for children age seven years and under when such services are for maintenance of a child whose condition would otherwise deteriorate without the service.

#### Newborn Nursery Care

The **plan** will cover routine nursery care of a well-newborn infant under the newborn's own coverage. However, this benefit does not cover **professional provider** charges for well-baby care except as may be specifically provided elsewhere under the **plan**, 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 **Plan Document**.

#### If Benefits Under The Plan Change

If benefits under this **plan** 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.

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### **Hospital Outpatient Care**

The **plan** pays **hospital** charges for **medically necessary** outpatient care, including, but not limited to:

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

- diagnostic x-ray and laboratory tests related to an **illness** or **injury** and ordered by a physician.

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

#### 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 coinsurance provisions of the **plan** which also applies 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.

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### **Urgent Care Facility**

The **plan** pays for **medically necessary** services provided by an urgent care facility.

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### **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.

The **plan** covers up to 100 days per **calendar year** in a **skilled nursing facility**.

#### Skilled Nursing Facility Benefits

**Covered expenses** are limited to the daily service rate, up to the maximum amount that would have been paid if the patient were in a semiprivate **hospital** room. The patient's attending physician must give the **claims administrator** proof of medical necessity, that they 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

**You or your enrolled dependent** should contact the **claims administrator's** Preauthorization Department before receiving **skilled nursing facility** care. The Preauthorization provision in the CLAIMS ADMINISTRATION Section describes the **preauthorization** process.

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## 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**.

**Homebound** means 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.

The **plan** covers up to 180 **medically necessary** home health care visits per **calendar year**. A visit must be for intermittent care of not more than four 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, nor do the charges for the services of a licensed social worker paid according to this Home Health Care benefit count against the benefit maximums for treatment of **mental illness**. See the Palliative Hospice Care benefit and Chemical Dependency and Mental Illness limitation 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 the **claims administrator**, **you** are strongly urged to ask **your** provider to contact the **claims administrator's** Preauthorization Department before receiving such care to avoid a denial or reduction of benefits due to lack of **medical necessity**. See the Preauthorization provision in the CLAIMS

ADMINISTRATION Section for a description of the **preauthorization** process.

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## Hospice Care

The **plan** covers **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.

**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 **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 **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

**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 **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 **hospice care**.

### Preauthorization

**Preauthorization** is recommended for initial entry into a **hospice care** program and thereafter as the level of care within the program changes. If **hospice care** is provided by a provider that has not contracted with the **claims administrator**, **you** are strongly urged to ask **your** provider to contact the **claims administrator's** Preauthorization Department before receiving such care to avoid a denial or reduction of benefits due to lack of **medical necessity**. See the Preauthorization provision in the CLAIMS ADMINISTRATION 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 **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 **hospice care**, unless specifically approved by the **plan**.

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## Special Facility Care

Care provided in a **special facility**. A **special facility** is either an ambulatory surgical facility or a birthing center.

**Covered expenses** consist of:

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

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## 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 in-office surgery, physician consultations with written reports as well as second opinion surgery consultations.

### Physician's Visits In The Hospital

The **plan** pays 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.) The **plan** also pays 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, the **plan** will pay as follows:

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

#### Outpatient Rehabilitative Care

The **plan** covers 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), the **plan** 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 seven and under when such services are for maintenance of a child whose conditions 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.

#### Contraceptive Services

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

#### 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**. 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 **Plan Document**.

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## **Preventive Care**

Preventive care benefits are provided under four categories: annual women's examinations, well-baby care, physical examinations, and immunizations. (A description of each follows.)

### 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. Breast examination means 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. 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.

### Well-Baby Care

The **plan** covers charges of the **professional provider** for nine physical examinations of **your enrolled dependent** child under two years of age, including related laboratory tests and x-ray examinations. Those nine visits include:

- the standard in-hospital examination at birth; and
- eight additional office examinations of a well infant during the first two years of the infant's life.

### Physical Examinations

For **you** and **your enrolled dependent** over two years of age, The **plan** covers physical examinations and related laboratory tests and x-ray examinations as long as a third party is not liable for these charges. The **plan** covers only as often and up to the following amounts:

### Frequency --

- Children: Age 2 - 6, one examination every **calendar year**.  
Age 7 - 18, one examination every two **calendar years**.
- Adults: Age 19 - 34, one examination every four **calendar years**.  
Age 35 and above, one examination every two **calendar years**.
- NOTE: Physical examinations are calculated according to age from the previous date of service.

Included in the above examinations are prostate cancer screening examinations including a digital rectal examination and a prostate-specific antigen test for men age 35 or older, or as determined by the treating physician for men of any age who are at high risk for prostate cancer.

The following services for colorectal cancer screening for **enrollees** age 35 or older (or any individual at high risk) are paid as an **illness** under the **plan** and therefore not subject to any maximums for physical examinations:

- 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.

#### Immunizations

The **plan** covers childhood immunizations for general use for both adults and children. For **enrollees** over age 18, the **plan** covers only those immunizations recommended by the American Academy of Family Physicians. Immunizations for hepatitis B are covered only for **your enrolled dependent** children under age 19. **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 **Plan Document**.

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#### **Nutritional Counseling Services**

The **plan** will pay for one four-hour nutritional counseling session in the lifetime of an **enrollee** while he or she is receiving home health care or **hospice care**.

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## Therapeutic Injections

The **plan** covers 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. When the injection is part of an office visit, expenses for the injection will be paid under the Home Or Office Visits benefit.

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

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

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## Durable Medical Equipment And Supplies

The **plan** covers the following **medically necessary durable medical equipment** and supplies when required by standard treatment practices:

- artificial limbs, prosthetics, orthotics (inserts are covered with diabetic diagnosis only), including custom molded orthotics, eyes and maxillofacial prosthetic devices (maxillofacial prosthetic devices must be **medically necessary** for the restoration and management of head and facial structures that cannot be replaced by living tissue, are defective due to disease, trauma, or developmental deformity to control or eliminate infection and pain and restore facial configuration and function). Replacement of such devices will be covered only after five years from the date of the original placement, unless a physiological change in **your** or **your enrolled dependent's** condition necessitates earlier replacement;
- casts, trusses, limb or back braces, and crutches;
- support stockings and wigs required following chemotherapy, surgery, or burns, however the **plan** limits payment for wigs to one wig per **calendar year** up to a maximum of \$200;
- 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 the **claims administrator**; 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 **plan** and are not covered. However, if medical necessity is established and **preauthorization** is granted, the **plan** will cover motor-driven wheelchairs and seat-lift mechanisms.

#### Preauthorization

Before the **plan** pays for **durable medical equipment**, it should be **preauthorized**. See the Preauthorization provision in the CLAIMS ADMINISTRATION Section for a description of the **preauthorization** process.

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## Transplants

The **plan** covers services and supplies for transplants, including donor procurement costs (see following paragraph for a description). For a list of covered transplants, please contact the **claims administrator's** Customer Service Department.

#### Donor Organ Benefits

Transplant benefits include donor organ procurement costs. Procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ, and other such procurement costs that the **plan** determines.

#### Limit For Donor Expenses

If services are received either from providers that are nonpreferred or at other than a contracting transplant facility (a Center of Excellence facility which has contracted or arranged to provide transplant services for the **enrollees** under this **plan**), donor costs are limited to \$10,000 per covered transplant.

#### 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 **plan** 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, **you** or **your enrolled dependent's** physician must contact the **claims administrator's** 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 provision in the CLAIMS ADMINISTRATION Section for a description of the **preauthorization** process.

Only written approval from the **claims administrator** 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 **plan** except as follows:

- the 24-month exclusion period will not apply to **enrolled employees** whose hire date with the **Plan Sponsor** is before May 1, 2008. This will include the **enrolled employee's enrolled dependents**;
- the 24-month exclusion period will not apply if the **recipient** or **self-donor** has been continuously covered under this **plan** since birth; or
- the duration of the 24-month exclusion period will be reduced by the amount of **you** or **your enrolled dependent's** combined periods of prior **creditable coverage** if the most recent period of **creditable coverage** ended within 63 days of **you** 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 **plan** 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, the **plan** 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 the **plan**;
- donation-related services or supplies provided to an enrolled **donor** if the **recipient** is not covered under the **plan** 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.

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#### **Infertility Diagnosis Services**

The **plan** will cover infertility testing for **enrolled employees** and enrolled spouses. Benefits are limited to the actual testing for diagnosis of infertility. Any outside intervention procedures (artificial insemination for example) is not covered.

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## Temporomandibular Joint Disorder Treatment

The **plan** will cover **medically necessary** surgical and nonsurgical treatment of temporomandibular joint dysfunction (TMJ) or myofascial pain syndrome. Devices associated with this type of surgery, including but not limited to orthodontic and prosthetic devices, are not part of this benefit but may be covered elsewhere under the **plan**.

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## Mental Health And Chemical Dependency Services

The **plan** will cover **mental health and chemical dependency services** under the various sections of the **Plan Document** 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**.

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## Maternity Care

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

To the extent this **plan** provides coverage for maternity care, benefits for the mother and her newborn's length of inpatient stay (beginning with the time of admission) will not be limited 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**.

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## 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, the **plan** 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).

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## Special Dental Care

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

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## Alternative Care Plan

Alternative care plan benefits are provided for four categories of service: chiropractic care, acupuncture care, naturopathic care, and massage therapy. (A description of each follows.) Any deductible will be waived and billed charges will be paid at 100 percent of for the alternative care services described below when provided to treat an **illness or injury** that is covered under the **plan**. The services must also be within the scope of the provider's license or registry.

### Copayments

**You or your enrolled dependent** is responsible for paying the first \$20 for each alternative care visit.

### Chiropractic Care

The **plan** covers charges of a chiropractor for treatment of bone, muscle, and joint disorders, including related laboratory tests and x-ray examinations.

### Acupuncture

The **plan** covers charges for office visits, including the initial evaluation, and treatments provided by an acupuncturist.

### Naturopathic Care

The **plan** covers charges for office visits, including the initial evaluation, to a naturopath.

### Massage Therapy

The **plan** covers charges for massage therapy performed by a physical therapist or chiropractor.

### Limitations And Exclusions

Payment under this Alternative Care Plan provision is limited to \$1,500 per **calendar year** for **you** and each of **your enrolled dependents**. Also, in addition to the exclusions listed in the GENERAL EXCLUSIONS Section, the following services and supplies are not covered under this Alternative Care Plan provision:

- minor surgery, obstetric-gynecological care, and proctology services; and
- **durable medical equipment** and supplies.

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## **OTHER COVERED EXPENSES**

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**IMPORTANT NOTE:** The services and supplies listed in this section are not paid at preferred/nonpreferred provider benefit levels. Please refer to the SUMMARY OF BENEFITS for an explanation of how the benefits under this section are paid.

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### **Home Infusion Therapy**

The **plan** covers 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 the **claims administrator**, **you** are strongly urged to ask **your** provider to contact the **claims administrator's** Preauthorization Department before receiving such care to avoid a denial or reduction of benefits due to lack of **medical necessity**. See the Preauthorization provision in the CLAIMS ADMINISTRATION Section for a description of the **preauthorization** process.

**Ambulance Transportation**

The **plan** covers transportation by state-certified ambulance for transportation 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**. The **claims administrator** will send their payment for **covered expenses** directly to the ambulance service provider, unless **you** have already paid them, in which case **you** will be paid directly.

**Medications**

The **plan** covers the following **medically necessary** medications when required by standard treatment practices for the treatment of an **illness** or **injury**:

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

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

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

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### Supplies And Durable Medical Equipment

The **plan** covers **medically necessary** supplies and **durable medical equipment** when required by standard treatment practices under this OTHER COVERED EXPENSES Section when provided by other than a **durable medical equipment supplier**. Supplies and **durable medical equipment** provided by a **durable medical equipment** supplier are paid under the Durable Medical Equipment And Supplies benefit under the COVERED EXPENSES Section.

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### Outpatient Diabetic Instruction

The **plan** pays 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. The **plan** 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 **plan**.

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## GENERAL LIMITATIONS

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

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### Biofeedback Therapy

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

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### Medicare

In certain situations, this **plan** is primary to Medicare. This means that when **you** or **your enrolled dependent** is enrolled in Medicare and this **plan** at the same time, the **plan** 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, the **plan** 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 the **plan** is paying secondary to Medicare, the **plan** will not pay any part of expenses a Medicare-eligible **enrollee** incurs from providers who have opted out of Medicare participation.

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## GENERAL EXCLUSIONS

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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 the **plan** 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 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 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. 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 CLAIMS ADMINISTRATION Section.

#### Experimental Or Investigational Services

Treatments, procedures, equipment, medications, devices, and supplies (hereafter called **services**) which are, in the **claims administrator's** 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 U.S. 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 the **claims administrator** 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 if **you** or **your enrolled dependent** is in the **hospital** on the day this **plan** terminates for one or more participating institutions and is immediately replaced by another group contract, benefits under the **plan** towards the **covered expenses** for that hospitalization will continue until discharge from the **hospital** or until **your** 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.)

#### 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 the **claims administrator's** medical policy criteria are met. See the Preauthorization provision in the CLAIMS ADMINISTRATION 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

#### Acupuncture

Acupuncture services and supplies except as provided in the Alternative Care Plan provision.

#### Orthopedic Shoes

#### Family Planning

Services and supplies for family planning (except sterilization), artificial insemination, in vitro fertilization, or surgery to correct voluntary sterilization. Infertility testing for **enrolled employees** and enrolled spouses is covered according to the Infertility Diagnosis Services benefit of the **Plan Document**.

#### Cosmetic/Reconstructive Services And Supplies

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

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

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

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

#### Orthognathic Services

Repair, surgical 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.

### Impotence Medications

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

### The Following Services And Supplies

The **plan** does not cover the following services and supplies:

- eye examinations, including eye exercises, except as may be specifically covered in the **plan**;
- 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 **plan**. This exclusion does not apply to cochlear implants;
- the fitting, provision, or replacement of eyeglasses except as specifically covered in the **plan**;
- telephone consultations, missed appointments, completion of claim forms, or completion of reports requested by the **claims administrator** 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** (not including prosthetics or orthotics) or how to care for a family member;
- instruction programs, including, but not limited to, those to learn to self-administer medications or nutrition, except as specifically covered in the **plan** 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.

#### Dental Examinations And Treatments

Except as specifically described as covered in any dental care benefit in this **Plan Document**. 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.

#### 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

Treatment of paraphilias will not be covered under the **plan** no matter the age of the **enrollee**. Additionally, any "V code" diagnoses will not be covered under the **plan** except the following when **medically necessary**: parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger, and bereavement for children five years of age or younger. "V code" means diagnosis codes as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR) that describe Relational Problems, Problems Related To Abuse Or Neglect or other issues that may be the focus of assessment or treatment. This would

include, but is not limited to, such issues as occupational or academic problems.

Custodial Care

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

Developmental/Learning Disabilities

Developmental and learning disabilities for **enrollees** age eight 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 DUIL may be covered but are subject to certain exclusions and regular **copayments** or coinsurance.

Personality Disorders

Services and supplies for the treatment of a well established pattern of behavior causing significant impairment in social or occupational functioning.

Behavior Modification

Psychological enrichment or self-help programs for mentally healthy individuals, including assertiveness training, image therapy, sensory movement groups, marathon group therapy, and sensitivity training.

Counseling Or Treatment In The Absence Of Illness

Includes individual or family counseling or treatment for marital, social, behavioral, family, occupational, or religious problems; or treatment of normal transitional response to stress.

Charges Over Amount Allowed

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

Benefits Not Stated

Services and supplies not specifically described as benefits in the **plan**.

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## **CLAIMS ADMINISTRATION**

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

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## Right Of Reimbursement And Subrogation

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

Any medical (or dental, if applicable) or prescription medication expenses **you** incur for treatment of an **injury** or **illness** will be excluded under the **plan** 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. The **claims administrator** may choose 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, benefits may be advanced pending the resolution of the claim upon the following conditions:

- By accepting or claiming benefits, **you** agree that the **plan** is entitled to reimbursement of the full amount of benefits that have been 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 benefits under the **plan** have been provided.

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. The **plan's** right to reimbursement, however, will not exceed the amount of recovery.

- The **claims administrator** may require **you** to sign and deliver all legal papers and take any other actions to secure the **plan's** rights (including an assignment of rights to pursue **your** claim if **you** fail to pursue **your** claim). If **you** are asked to sign a trust agreement or other document to reimburse the **plan** from the proceeds of any recovery, **you** will be required to do so as a condition to advancement of any benefits. If benefits were paid before the agreement is signed, **you** agree to reimburse the **plan** 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 the **plan's** rights and will cooperate fully with the **claims administrator**, including signing any documents within the required time and providing prompt notice of any settlement. **You** must notify the **claims administrator** of any facts that may impact the right to reimbursement or subrogation, including but not necessarily limited to the following:

- the filing of a lawsuit,
- the making of a claim against any third party;
- scheduling of settlement negotiations (including but not necessarily limited to a minimum of 21 days advance notice of the date, time, location, and participants to be involved in any settlement conferences or mediations); 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 the **plan's** right of reimbursement or subrogation (notification of a minimum of 5 business days prior to the settlement is required).

**You** must acknowledge that the **claims administrator** is 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.

The **plan** is entitled to reimbursement from the first dollars received from any recovery and the **plan** will not reduce its lien due to **you** not being made whole. The **plan** shall not be liable for any expenses or fees **you** incur in connection with obtaining a recovery. **You**, however, may request to be paid under the **plan** 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 the **plan** paid. The **claims administrator** has 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 the **plan's** 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, any benefits advanced for any **illness** or **injury** resulting from the action or omission of a third party through legal action may be recovered under the **plan**.

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

Please contact the **claims administrator's** 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 the **claims administrator** 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, benefits for **covered expenses** under the **plan** may be advanced if **you** or **your enrolled dependent** agrees to hold any recovery obtained in trust for the **plan**.

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## Coordination Of Benefits

This provision applies when **you** have health care coverage under more than one plan. This means that if **you** are covered under any other individual or group medical contract or plan (referred to as **other plan** and defined below), the benefits under this **plan** and those of the **other plan** will be coordinated in accordance with the provisions of this provision. Please note that in the following section the terms **you** and **your** also include **your enrolled dependents**.

### Benefits Subject To This Provision

All of the benefits provided under this **plan** are subject to this Coordination Of Benefits provision.

### Definitions

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

**Allowable expense** means, with regard to services that are covered in full or part by this **plan** or any **other plan(s)** covering **you**, the amount on which that plan would base its benefit payment for a service, including coinsurance or **copayments** and without reduction for any applicable deductible, except that the following are examples of expenses that are not an **allowable expense**:

- An expense or portion of an expense not covered by any of **your** involved plans.
- The difference between the cost of a private **hospital** room and the cost of a semiprivate **hospital** room, unless one of **your** involved plans provides coverage for private **hospital** rooms.

- When this **plan** restricts coordination of benefits to certain types of coverage or benefits, any expenses for other types of coverage or benefits. See the Benefits Subject To This Provision paragraph, above, for restrictions on the types of coverage or benefits to which coordination applies.
- Any amount by which a **primary plan's** benefits were reduced because **you** did not comply with that plan's provisions regarding second surgical opinion or precertification of services or failed to use a contracting provider (except, if the **primary plan** is a closed panel plan and does not pay because a nonpanel provider is used, the **secondary plan** (if it is not a closed panel plan) shall pay as if it were the **primary plan**).
- A **primary plan's** deductible, if the **primary plan** is a high-deductible health plan as defined in the Internal Revenue Code and the **claims administrator** is notified both that all plans covering a person are high-deductible health plans and that the person intends to contribute to a health savings account in accordance with the Internal Revenue Code.
- An expense that a provider is prohibited by law or contract from charging **you**.

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

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

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

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

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

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

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

**Other plan** does not include:

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

**Primary plan** means the plan that must determine its benefits for **your** health care before the benefits of another plan and without taking the existence of that other plan into consideration. (This is also referred to as that plan being “primary” to that other plan.) There may be more than one

**primary plan.** A plan is a **primary plan** with regard to another plan in any of the following circumstances:

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

**Secondary plan** means a plan that is not a **primary plan**. **You** may have more than one **secondary plan**. If **you** are covered under more than one **secondary plan**, the order of benefit determination provision decides the order in which **your secondary plans'** benefits are determined in relation to each other.

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

#### Order of Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### Primary Health Plan Benefits

When, in accordance with the order of benefit determination, this coverage is the **primary plan**, benefits of this **plan** will be paid as if no **other plan** exists.

#### Secondary Health Plan Benefits

If, in accordance with the order of benefit determination, one or more **other plans** are primary to this **plan**, the benefits of this **plan** will be calculated as follows:

The **claims administrator** will calculate the benefits that would have been paid for a service if this **plan** were the **primary plan**. The **claims administrator** will compare the **allowable expense** under this **plan** for that service to the **allowable expense** for it under the **other plan(s)** by which **you** are covered. The lesser of the following will be paid under this **plan**:

- the unpaid charges for the service, up to the higher (highest) **allowable expenses** among the involved plans, and
- the benefits that the **claims administrator** would have paid for the service if this **plan** were the **primary plan**.

Deductibles, coinsurance and **copayments** under this **plan** will be used in the calculation of the benefits that would have been paid if this were the **primary plan**, but they will not be applied to the unpaid charges **you** owe after the **primary plan's** payment. Payment under this **plan** therefore will be reduced so that it, when combined with the **primary plan's** payment, does not exceed the higher (highest) **allowable expense** among the

involved plans and any deductible under this **plan** will be credited toward any amount that would have been credited to the deductible if this **plan** had been the only plan.

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

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

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

#### Right to Receive and Release Needed Information

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

#### Facility of Payment

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

### Right of Recovery

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

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

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### **Disclosure Of Health Information**

By accepting benefits under this **plan**, **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 the **claims administrator** or their designee.

The privacy of **your** personal information is of utmost importance to the **claims administrator**. They will request and disclose only that information which is necessary to determine liability for any benefits provided under the **plan** or as required by law. Failure to receive this necessary information may result in denial of a claim. For further information on the manner in which the **claims administrator** may request, use and disclose **your** or **your enrolled dependent's** medical information, please review their Consumer Privacy Notice. This notice is available on their website at [www.or.regence.com](http://www.or.regence.com) or by calling the number on the back of **your** identification card. Please note that the **claims administrator** may revise their Consumer Privacy Notice at any time.

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### **Benefits Are Not Transferable**

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

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### **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 **plan** 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.

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### **You Must Submit Health Information**

The **claims administrator** 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. The **claims administrator** can also require **you** and any of **your enrolled dependents** to authorize any health care provider to give the **claims administrator** information about a condition for which **you** and any of **your enrolled dependents** claim benefits.

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### **Plan Is 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. Neither the **plan** nor the **claims administrator** is responsible for the quality of health care **you** or **your enrolled dependent** receives, since all those who provide care do so as independent contractors. Neither the **plan** nor **claims administrator** can be held liable for any claim or damages connected with **injuries you** or **your enrolled dependent** suffers while receiving health services or supplies.

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### **Submission And Payment Of Claims**

The **claims administrator** processes claims as **they** receive them. The date the **claims administrator** receives 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 benefits to be paid under the **plan**. Claims submitted beyond that date are not eligible for benefits. If circumstances beyond **your** control prevent **you** from submitting a claim within one year, the period will be extended to 30 days beyond the time **you** could have reasonably submitted the claim.

The **claims administrator** has 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 **plan** has died, is a minor, or is incompetent, the **claims administrator** may pay the benefits (up to \$1,000) to a relative by blood or marriage of that person who they 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 the **claims administrator** receives an inquiry regarding a properly submitted claim and it is believed that **you** expect a response to that inquiry, the **claims administrator** will respond to the inquiry within 30 days of when it was first received.

### Claim Determinations

Within 30 days of receipt of a claim, the **claims administrator** will notify **you** of the action they 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 the **claims administrator** cannot take action on the claim due to circumstances beyond their control, they 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 action on the claim is expected.
- When the **claims administrator** cannot take action on the claim due to lack of information, they 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 the **claims administrator** with the requested information within 45 days of receiving the request for additional information. If they do not receive the requested information to process the claim within the 45 days that is allowed, the claim will be denied.

### 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 the **claims administrator** directly for the entire cost of the **hospital** stay. The **claims administrator** will pay the **hospital** and send **you** copies of their 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**. **You** will, of course, be reimbursed if any of the charges **you** pay are covered under the **plan**.

If **you** or **your enrolled dependent** receives treatment in a **hospital** which will not bill the **claims administrator**, or in a **hospital** outside the **plan** service area, **you** will receive a bill. In order to claim **your** benefits for these charges, send a copy of the bill to the **claims administrator**, 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** or **your enrolled dependent** receives outside the United States.

#### Professional Provider Claims

A **professional provider** may bill charges directly to the **claims administrator**. If not, **you** may send **professional provider** bills to the **claims administrator 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 the **claims administrator** the **professional provider's** bill.

#### Other Health Care Claims

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

#### Ambulance Claims

Bills forwarded to the **claims administrator** 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. The **claims administrator** will send the payment for **covered expenses** directly to the ambulance service provider, unless **you** have already paid them, in which case **you** will be paid directly.

#### Claims Processing Report

The **claims administrator** will report to **you** on the action they take on a claim on a form called a Claims Processing Report. The **claims administrator** may pay claims, deny them, or accumulate them toward satisfying any deductible.

If all or part of a claim is denied, the reason for such 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 the **claims administrator** has taken on **your** or **your enrolled dependent's** claim.

#### External Review

In the event **your** claim is denied based on:

- **medical necessity**; or
- experimental or investigational status;

**you** are entitled to review by an independent external review organization.

#### Filing A Lawsuit

Any legal action arising out of this **plan** and filed against the **claims administrator** 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 **plan** and may only be filed after exhaustion of the administrative remedies.

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## **Preauthorization**

**Preauthorization** is a tool used to find the most appropriate and cost-effective level of medical care for **plan** 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 the **claims administrator** to determine the treatment that best meets **your** or **your enrolled dependent's** medical needs. This teamwork helps save thousands of dollars each year, which translates into savings for **you**.

**Preauthorization** refers to the process by which a proposed service or supply (including medications) is deemed to be **medically necessary** under the **plan** before it is rendered.

#### What Needs To Be Preauthorized

Some services and supplies (as may be described in this **Plan Document**) must be **preauthorized** before they will be considered for payment under the **plan**. These services and supplies are listed on a Focused Notification List which is provided to contracting providers twice a year. Note that services or supplies which are not included on the Focused Notification List are not preauthorized.

Preauthorization By Contracting Providers -- Providers that have contracted with the **claims administrator** to provide benefits to the **enrollees** under the **plan** know how the **preauthorization** process works

and will normally request **preauthorization**, if necessary, for **you** or **your enrolled dependent's** proposed service or supply.

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

#### Preauthorization Process

When a **preauthorization** request for benefits under the **plan** is received from **you** or **your enrolled dependent**, or **you** or **your enrolled dependent's** provider, **you** or the provider will be notified of the **claims administrator's** decision within 15 days of receipt of the **preauthorization** request. However, this 15-day period may be extended an additional 15 days in the following situations:

- When a decision cannot be reached due to circumstances beyond the **claims administrator's** control, **you** or the provider will be notified within the initial 15-day period that the extension is necessary, including an explanation of why the extension is necessary and when the **claims administrator** expects to reach a decision.
- When a decision cannot be reached due to lack of information, **you** or the provider will be notified 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 the **claims administrator** with the requested information within 45 days of receiving the request for additional information. Once the needed information has been received, **you** will be notified of the **claims administrator's** decision within 48 hours after **you** supplied it or at the end of the period **you** were allowed to supply the needed information to the **claims administrator**.

The 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

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### Replacing Earlier Contract

If this **plan** replaces an earlier Regence BlueCross BlueShield of Oregon contract, benefits that were paid under the earlier contract will be applied against the maximum benefits available under this **plan**.

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

All Blue Cross and Blue Shield licensees ("Plans") participate in the BlueCard<sup>®</sup> Program. This Program benefits **enrollees** who incur **covered expenses** outside the **plan** service area. Not all claims incurred outside of the **plan** 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, the **claims administrator** will remain responsible for meeting their obligations under the **plan**. 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 the **plan's** 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 the **claims administrator**.

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, withholdings, 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, the **claims administrator** 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.

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## **GRIEVANCE AND APPEAL PROCEDURES**

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This Section describes the procedures for filing a grievance or appeal when **you** receive an adverse claim decision.

### Level One Appeal

The “**named fiduciary**” for purposes of a level one appeal of a denied claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the **claims administrator**.

**You**, or **your** authorized representative, may request a review of a denied claim by making written request to the **named fiduciary** within 180 days from receipt of notification of the denial and stating the reasons **you** feel the claim should not have been denied.

The following describes the review process **your** and rights:

- **You** have the right to submit documents, information and comments.
- **You** have the right to access, free of charge, relevant information to the claim for benefits.
- The review takes into account all information **you** submitted, even if it was not considered in the initial benefit determination.
- The review by the **named fiduciary** will not afford deference to the original denial.
- The **named fiduciary** will not be:
  - the individual who originally denied the claim, nor
  - subordinate to the individual who originally denied the claim.
- If original denial was, in whole or in part, based on medical judgment:
  - the **named fiduciary** will consult with a **professional provider** who has appropriate training and experience in the field involving the medical judgment; and
  - the **professional provider** utilized by the **named fiduciary** will be neither an individual who was consulted in connection with the original denial of the claim, nor a subordinate of any other **professional provider** who was consulted in connection with the original denial.
- If requested, the **named fiduciary** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

Notice Of Benefit Determination On Appeal

The **named fiduciary** will provide **you** (or **your** authorized representative) with a written notice of the appeal decision within 30 days of receipt of a written request for the appeal.

If the appeal is denied, the notice will contain an explanation of the decision, including:

- The specific reasons for the denial.
- Reference to specific **Plan** provisions on which the denial is based.
- A statement that **you** have the right to access, free of charge, relevant information to the claim for benefits.

- A statement that **you** have the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974 if **your** appeal is denied.
- If an internal rule, guideline, protocol or other similar criterion was relied upon, the notice will contain either:
  - a copy of that criterion, or
  - a statement that such criterion was relied upon and will be supplied free of charge, upon request.
- If the denial was based on **medical necessity, experimental/ investigational** treatment or similar exclusion or limit, the **Plan** will supply either:
  - an explanation of the scientific or clinical judgment, applying the terms of the **Plan** to an explanation of the scientific or clinical judgment, applying the terms of the **Plan** to **your** or **your enrolled dependent's** medical circumstances, or
  - a statement that such explanation will be supplied free of charge, upon request.

Level Two Voluntary Appeal (May Include External Review)

The “**named fiduciary**” for purposes of a level two appeal of a denied claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the **Plan Administrator**.

**You** or **your** authorized representative, may request a review of a denied claim by making written or verbal request to the **named fiduciary** within 180 days from receipt of notification of the level one denial and stating the reasons **you** feel the claim should not have been denied. Written requests may be sent to the following address:

Pioneer Educators Health Trust  
 c/o Rico Bocala  
 USI Northwest  
 700 NE Multnomah Street, Suite 1300  
 Portland, OR 97232

If **you** decide to proceed with the voluntary second level appeal, the internal review appeal will be determined by an appeal panel comprised of reviewers not previously involved in the case. **You** and **your** representative, if any, have the opportunity to appear before the review board. Within 7 days of receipt of an appeal, **You** or **your** representative will receive an acknowledgement letter from the **named fiduciary**. The **named fiduciary's** appeal coordinator will notify **you** or

**your** representative, in writing, of the decision within 30 days of receiving the appeal.

This final internal appeal, which is voluntary on **your** part, may qualify for a further voluntary appeal, external review. External review is available only for certain types of appeals described below 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 the **named fiduciary** for level two appeals have mutually agreed to waive that requirement.

#### External Review

If an external review is requested, the request for external review will be forwarded to the Department of Consumer and Business Services (DCBS).

The IRO will review the external review request based upon:

- an adverse determination based on medically necessity (i.e. cosmetic or nonparticipating provider services);
- an adverse determination for treatment determined as experimental or investigational; or
- For purposes of continuity of care (no interruption of an active course or treatment).

In order to have the appeal decided by an IRO, **you** or **your** representative must:

- sign a waiver granting the independent review organization access to medical records; and
- have exhausted all other appeal opportunities under this **Plan** unless **you** and the **named fiduciary** for level two have mutually agreed to waive that requirement.

The IRO is assigned by the DCBS and is not connected with the **Plan** in any way. **You** are not responsible for the costs of the independent review.

A written response to an appeal will be sent to the **enrollee** or their representative within twenty (20) days of the IRO receiving the appeal. **The Plan is not bound by the decision made by the IRO. However, the Plan may nevertheless follow the decision of the IRO. If the Plan does not follow the decision of the IRO, a suit may be filed against the Plan.** Please refer to the Claims Procedures within this document for further information regarding appeals.

For more information regarding external review, please contact CoreSource, Inc. at 1-866-280-4120.

Assistance From The Department Of Consumer And Business Services  
You also have the right to file a complaint and seek assistance from the director of the DCBS at:

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

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

#### Foreign Claims

In the event **you** or **your enrolled dependent** incurs a **covered expense** in a foreign country, **you** will be responsible for providing the claim information to the **claims administrator**.

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## **DISCLOSURE STATEMENT**

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The following Disclosure Statement includes questions and answers to fully inform **you** and **your enrolled dependents** about some of the benefits and policies of the **plan**.

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### **What Are My Rights And Responsibilities As A Member Under The Plan?**

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 the **claims administrator's** 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 **Plan Document** to make sure services are covered by the **plan**;
- make sure services are **preauthorized** when required by this **plan** before receiving medical care;
- contact the **claims administrator's** 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.

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### 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.

---

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

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

provider would be denied (or paid at a level below the benefit for an out-of-area provider) if the provider's preferred contract with the **plan** is terminated or the provider is no longer participating in the **plan's** preferred provider network, the **plan** 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 the **plan**;
- the care is **medically necessary** and otherwise covered under the **plan**;
- **you** or **your enrolled dependent** remains eligible for benefits and enrolled under the **plan**; and
- the **plan** has not terminated.

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

- retires;
- dies;
- no longer holds an active license;
- has relocated outside of the **plan** 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, the **plan** 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, the **plan** 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 the **plan** or, if applicable, the provider group notifies **you** of **your** or **your enrolled dependent** of the right to continuity of care, or the date the **plan** receives or approves the request for continuity of care.

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### **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?**

See Enforce Your Rights under the Notice Of ERISA Rights provision for a description of how **you** may voice concerns under the **plan**.

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

**Your** or **your enrolled dependent's** feedback is very important to Regence BlueCross BlueShield of Oregon. If **you** or **your enrolled dependent** has suggestions for improvements about the **plan** or the **claims administrator's** services, the **claims administrator** would like to hear from **you** or **your enrolled dependent**.

The **claims administrator** has 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 1071  
 Portland, OR 97207-1071

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

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

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## What Are The Claims Administrator's Prior Authorization And Utilization Review Criteria?

Prior authorization, also known as **preauthorization**, is the process the **claims administrator** uses to determine the **medical necessity** of a service before it is rendered. Contact the **claims administrator's** 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 Regence BlueCross BlueShield of Oregon 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 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 the **claims administrator** examines 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 **Plan Document**.

Let Regence BlueCross BlueShield of Oregon know if **you** or **your enrolled dependent** would like a written summary of information that the **claims administrator** may consider in its utilization review of a particular condition or disease. Simply call the Customer Service phone number on the back of **your** identification card.

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

The **claims administrator** has 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, the **claims administrator** will 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.

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

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

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**What Additional Information Can I Get Upon Request?**

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

- Rules related to the **claims administrator's** 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 the **claims administrator's** annual report on complaints and appeals.
- A description of the **claims administrator's** risk-sharing arrangements with physicians and other providers consistent with risk-sharing information required by the Health Care Financing Administration.
- A description of the **claims administrator's** 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 the **claims administrator's** prior authorization and utilization review procedures.

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## WHO IS ELIGIBLE

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Refer to the ELIGIBILITY insert for a description of employee and dependent eligibility. The following sections describe how to enroll, when coverage begins and ends and possible continuation of coverage under the **plan**.

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## HOW TO ENROLL

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The following section explains how to enroll **yourself** and **your** eligible dependents.

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### When You First Become Eligible

**You** must file an application (written or electronic, if applicable) for **yourself** and any dependents **you** want enrolled within 31 days of the **normal effective date** (see WHEN GROUP COVERAGE BEGINS). **You** have the responsibility of timely forwarding to the **Plan Sponsor** all applications for enrollment under the **plan**.

---

### Enrolling New Dependents

#### New Spouse (Including Stepchildren)

If **you** marry while **you** are enrolled under the **plan**, **your** spouse and his or her children become eligible to apply for coverage under this **plan** on the date of the marriage. **Your** new stepchildren must meet the eligibility requirements for all children in order to be enrolled.

#### 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 **plan** on the date domestic partnership is established.

#### Newborn And Adopted Children

If **you** acquire a new dependent child by birth or adoption, **your** child becomes eligible to apply for coverage under this **plan** on the date of birth or adoption (or **placement** 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. The newborn must be eligible under the terms of the **plan**.

#### How To Enroll Your New Dependents

To obtain coverage for newly acquired or newly eligible dependents, **you** will need to submit a completed application (written or electronic, if applicable) within 31 days of the **normal effective date** (see WHEN GROUP COVERAGE BEGINS). **You** have the responsibility of timely forwarding to the **Plan Sponsor** all applications for enrollment under the **plan** for any newly eligible dependents.

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## WHEN GROUP COVERAGE BEGINS

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### Employees

If **you** application, including payment, is submitted within the allowed time (see HOW TO ENROLL), the date coverage under the **plan** begins (the **normal effective date**) for **you** and **your** eligible dependents will be the first of the month following the date **you** became eligible to apply for coverage. For example, if **you** were hired by the **Plan Sponsor** on October 15, **your** coverage (and coverage for any of your eligible dependents) will begin on November 1.

### Newly Acquired Dependents

If application, including payment, for your newly acquired dependents is submitted within the allowed time (see HOW TO ENROLL), the date coverage under the **plan** begins (the **normal effective date**) for **your** eligible dependents will be the date the dependent is acquired (for adopted children, this is the date of **placement**).

### When You Enroll Per Special Enrollment

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, **your** and **your enrolled dependents' normal effective date** will be the date of birth, adoption, or **placement** as long as the **claims administrator** receives **your** application and payment within the allowed time.

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## 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 or individual **health benefit plan** due to:
  - the exhaustion of federal COBRA or Oregon state continuation;
  - the loss of eligibility due to legal separation, divorce, death, termination of employment or reduction in hours; or the employer contributions were terminated; or
  - involuntary loss of coverage under Medicaid, Medicare, CHAMPUS/Tricare, Indian Health Service, or a publicly sponsored or subsidized health plan, like the Oregon Health Plan.

In all of the above situations, **you** and/or **your** eligible dependents become eligible for coverage under this **plan** on the date the other

coverage ends. Note that loss of eligibility does not include a voluntary termination of coverage, a loss because premiums were not paid 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 **plan** 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 **plan** 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 **plan** 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 **plan**, if any. If the **plan** 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 **plan**, if any. If the **plan** does have an open enrollment period, it will be shown in the SUMMARY OF BENEFITS.

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## Open Enrollment

Open enrollment is the period of time designated by the **Plan Sponsor** (see the SUMMARY OF BENEFITS insert for the date) during which **you** may change benefit plans or enroll in this **plan** if **you** did not do so when **you** were first eligible, and **you** do not qualify for Special Enrollment. An open enrollment will be permitted once in each **calendar year**. If **you** fail to make written application as provided by the **Plan Sponsor** during the open enrollment period, **you** will automatically retain **your** present coverage.

Except in the following situations, the open enrollment period is the only time **you** may change benefit options or modify enrollment:

- A change in family status, including only the following:
  - a change in **your** legal marital status;

- a change in the number of dependents;
  - termination or commencement of employment by **you**, **your** spouse, or **your** dependent child;
  - a change in **your** work schedule;
  - **your** dependent satisfies (or ceases to satisfy) the dependent eligibility requirements of the **plan**; or
  - a change residence or worksite that affects access to coverage under the **plan**.
- A change in the cost of coverage under **your** group medical plan.
  - Cessation of required contributions.
  - Taking or returning from a leave of absence under the Family Medical Leave Act of 1993.
  - Significant change in **your** health coverage obtained through **your** spouse's employment.
  - A special enrollment period as mandated by the Health Insurance Portability and Accountability Act of 1996.
  - A court order, judgment, or decree.
  - Entitlement to Medicare or Medicaid.
  - A COBRA qualifying event.

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## WHEN GROUP COVERAGE ENDS

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

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### Plan Termination

If this **plan** is terminated, and the **Plan Sponsor** offers no other group health plan, coverage ends for **you** and **your enrolled dependents** on the date the **plan** terminates.

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### 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 **plan** according to the CONTINUATION OF COVERAGE Section of this **Plan Document**.

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### **When You Lose Retiree Eligibility**

If **you** are retired, coverage for **you** and **your enrolled dependents** will end on the last day of the monthly period that **your** retiree eligibility ends, including on the first day of the monthly period that **you** become eligible for Medicare.

Additional coverage may be available to **your** dependents according to the CONTINUATION OF COVERAGE Section of this **Plan Document**.

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### **When Your Spouse Loses 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, or on the first day of the monthly period that he or she becomes eligible for Medicare, whichever happens first.

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### **If You Or Your Enrolled Dependent Joins The Armed Forces**

If **you** or **your enrolled dependent** becomes a full-time, active member of the armed forces of any country, coverage under this **plan** will end on the last day of the month in which active membership began.

---

### **If Your Dependents Lose Eligibility**

#### Spouse Termination

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.

#### Domestic Partner Termination

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 of the ELIGIBILITY insert are no longer being met. **You** are required to give notice to the **Trust Plan Administrator** a change within 31 days of such a change.

#### Dependent Child Termination

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 **plan**. When **your enrolled dependent** child reaches the maximum age for eligibility under the **plan**, coverage ordinarily ends on the last day of the month in which the child reaches the limiting age.

#### Termination For All Dependents

Coverage under the **plan** ordinarily ends for **your enrolled dependents** on the last day of the monthly period in which any of the following occur:

- **you** fail to make the any required contributions on **your** dependents' behalf;
- the **plan** discontinues dependent coverage for any and all dependents; and
- an **enrolled dependent** becomes an eligible employee under the **plan**.

It may be possible for **your** ineligible dependents to continue coverage under this **plan** according to the CONTINUATION OF COVERAGE Section of this **Plan Document**.

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#### **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 **plan** according to the CONTINUATION OF COVERAGE Section of this **Plan Document**.

#### Termination Of Employment

If **your** employment terminates, as defined by the **Plan Sponsor's** personnel policies, **your** coverage will ordinarily end for **you** and all **enrolled dependents** on the last day of the **Plan Sponsor's** payment period during which employment ends.

#### Loss Of Eligibility

If **you** no longer meet the eligibility requirements under the **plan**, **your** coverage will ordinarily end for **you** and all **enrolled dependents** on the last day of the **Plan Sponsor's** payment period during which eligibility ends.

#### Lack Of Contributions

If **you** fail to make the any required contributions, coverage under the **plan** ends for **you** and **your enrolled dependents** on the last day of the monthly period in which required contributions were made.

#### Leave Of Absence

If **you** are granted a non-FMLA leave of absence by the **Plan Sponsor**, **you** can continue coverage for up to three months. Payments must be made through the **Plan Sponsor** in order to maintain coverage during a leave of absence.

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

#### Family And Medical Leave

If the **Plan Sponsor** grants **you** an unpaid leave of absence under the Family and Medical Leave Act of 1993, as amended, (FMLA), the following rules will apply:

- During the FMLA leave, the **Plan Sponsor** will continue to pay the same portion of **your** contribution for **plan** benefits. **You** will be responsible to continue payment for any contribution remaining for **yourself**, as well as any required contribution for **your enrolled dependent's**. If **you** fail to make the required contribution during a FMLA leave within 30 days after the date the contribution was due, coverage under the **plan** will end effective on the date the contribution was due.
- If coverage under the **plan** was terminated during an approved FMLA leave, and **you** return to active work immediately upon completion of that leave, coverage under the **plan** will be reinstated on the date **you** return to active work as if coverage had not terminated, provided **you** make any necessary contributions and **you** enroll for coverage within 31 days of **your** return to active work.
- If **you** fail to return from a leave under FMLA, the **Plan Sponsor** may require **you** to repay any contributions paid on **your** behalf during the unpaid leave. This repayment will be required only if **you** fail to return from a leave that is not related to a "serious health condition," as defined in FMLA, or when events leading to **your** not returning were beyond **your** control.
- If **you** are on leave for an FMLA-qualifying reason, **you** remain eligible under the **plan** only for a period equivalent to FMLA leave and may not also continue coverage under a non-FMLA leave.

#### Workers' Compensation

If **you** incur an **injury** or **illness** for which a workers' compensation claim is filed, coverage under the **plan** will continue for **you** and any of **your enrolled dependent's** for six months as long as timely payment of any required contribution by **you** and/or by the **Plan Sponsor** is made. Such coverage will end if **you** obtain full-time employment with another employer.

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## Rescinding Coverage

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

If coverage is rescinded as described above, payments made will be retained as liquidated damages and the **claims administrator** reserves the right to recover from **you** or **your enrolled dependent** the benefits paid under the **plan** as a result of such wrongful activity that are in excess of the payments. In addition, future enrollment under any Regence BlueCross BlueShield of Oregon contract, the contract of any of its subsidiaries, or this **plan** or any other plan for which Regence BlueCross BlueShield of Oregon or any of its subsidiaries provides claims administration services may be denied for a period of up to five years.

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## MILITARY MOBILIZATION

If **you** are called for active duty by the United States Armed Services (including the Coast Guard, the National Guard, or Public Health Service), **you** and **your enrolled dependents** may continue **your** health coverage, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than 31 days, **you** and **your enrolled dependents** may not be required to pay more than the **Plan Sponsor's** share, if any, applicable to that coverage. If the leave is 31 days or longer, then the **Plan Administrator** (or its designee) may require **you** and **your enrolled dependents** to pay no more than 102 percent of the full contribution.

The maximum length of the continuation of coverage required under USERRA is the lesser of:

- 24 months beginning on the day that the leave begins; or
- a period beginning on the day that the leave began and ending on the day after you fail to return to employment within the time allowed.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA continuation. Upon return from active duty, **you** and **your** eligible dependents will be reinstated without any preexisting conditions exclusions or waiting periods, regardless of **your** election of COBRA continuation coverage.

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## CERTIFICATES OF CREDITABLE COVERAGE

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The **Plan Administrator** will provide each terminating **enrollee** with a Certificate of Creditable Coverage, certifying the period of time the individual was covered under this **plan**. For employees with dependent coverage, the certificate provided may include information on all **enrolled dependents**. This **plan** intends to, at all times, comply with the provisions of the Health Insurance Portability and Accountability Act of 1996.

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## CONTINUATION OPTIONS UNDER OREGON MEDICAL INSURANCE POOL

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If an individual's coverage under the **plan** terminates and that coverage was continuously in effect for a period of at least 180 days, the individual is eligible for coverage under the Oregon Medical Insurance Pool (OMIP) as long as an application for coverage is made not later than the 63rd day after the date of first eligibility and the individual is an Oregon resident at the time of such application. Please see the Oregon Medical Insurance Pool rules for more information at [www.omip.state.or.us](http://www.omip.state.or.us).

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## CONTINUATION OF COVERAGE (COBRA)

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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.

NOTE: This COBRA continuation provision describes continuation for domestic partners. However, **your** domestic partner and/or **your** domestic partner's children may not be eligible for COBRA continuation of coverage. See the ELIGIBILITY insert for details. If the insert indicates that COBRA continuation is not available for domestic partners and their children, references to continuation for domestic partners in this COBRA continuation provision do not apply.

**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).

**Your** spouse or **your** qualified 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;
- termination of **your** domestic partnership;
- dissolution of marriage (divorce) or legal separation from **you**; 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** domestic partner terminate **your** domestic partnership;
- **you** and **your** spouse dissolve your marriage (divorce) or legally separate;
- **you** become entitled to Medicare; or
- the child loses eligibility as a dependent under the **plan**.

If **you** are retired, **you** and **your enrolled dependents**, or **your** surviving spouse or domestic partner has the right to elect continuation of coverage when coverage would otherwise be lost or substantially eliminated because the **Plan Sponsor** and/or **Trust** filed a Chapter 11 (reorganization) bankruptcy.

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

#### Notification Responsibilities

This **plan document** is considered the **plan's** reasonable procedures as required under COBRA. As part of these reasonable procedures, **You** or **your enrolled dependent** has the responsibility to inform the **Plan Administrator** in writing of a divorce, legal separation, or a child losing dependent status within 60 days of the date of the event. However, in the event of the termination of a domestic partnership, **you** have the responsibility to file a Statement of Termination of Domestic Partnership with the **Plan Administrator** within 31 days of noncompliance with any of the qualifying conditions of the partnership. The **Plan Sponsor** has the responsibility to notify the **Plan Administrator** of the employee's death,

termination of employment, reduction in hours, Medicare eligibility, or the **Plan Sponsor** and/or **Trust's** filing Chapter 11 bankruptcy.

#### Once Notification Is Given

When the **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 **plan**.

#### 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. Please note that for qualified beneficiaries whose coverage is extended beyond 18 months due to disability, the **plan** will charge 148 percent of the regular monthly payment in addition to the 2 percent administration fee the **Plan Sponsor** may charge. Payment for continuation of coverage must be made to the **Plan Sponsor** on a timely basis within 30 days of the date the **Plan Sponsor** normally makes their monthly payment to the **claims administrator**. The only exception is the payment for the period preceding the election which may be made up to 45 days from the date of election. Payment for those on continuation must be submitted to the **claims administrator** each month with the **Plan Sponsor's** regular monthly 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 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 30 days. The extended continuation will end the month that begins more than 30 days from the final determination that the qualified beneficiary is no longer disabled.

- For Chapter 11 bankruptcy, continuation may last for the lifetime of the enrolled retiree or the surviving spouse or domestic partner of a retiree. On the death of the retiree, any of his or her **enrolled dependents** may continue coverage for an additional 36 months.
- For death, dissolution of marriage, termination of domestic partnership, or **your** legal separation, continuation may last for up to 36 months.

However, there is a special Oregon statute (applicable to insurance policies issued in Oregon to employers of 20 or more employees) that allows a spouse who is age 55 or over at the time coverage would otherwise end due to the death, dissolution of marriage, 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 **plan**.

- For a dependent child ceasing to be eligible as a dependent under the plan, continuation may last for up to 36 months.
- If **you** or **your** domestic partner becomes 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 **plan** will end for a person on the last day of the month in which any of the following occurs, whichever happens first:

- payment for a person on continuation is not made to the **Plan Sponsor** or to the **claims administrator** 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 (except when the individual is on continuation due to a Chapter 11 bankruptcy); or
- the applicable period of continuation ends.

In addition, continuation will end on the day this **plan** terminates. However, continuing coverage may still be available under the succeeding plan unless the **Plan Sponsor** no longer provides a group health plan for any of its employees.

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## **PLAN CONTACT INFORMATION**

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Questions concerning this **plan**, including any available continuation coverage, can be directed to the **Plan Administrator**.

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## **ADDRESS CHANGES**

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In order to help ensure the appropriate protection of rights and benefits under this **plan**, **you** and/or **your enrolled dependents** should keep the **Plan Administrator** (or its designee) informed of any changes to **your** current address.

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## GENERAL PROVISIONS

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This section explains various provisions concerning the relationship between the **Trust** and the **claims administrator**.

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### No Waiver

The failure or refusal of either party to demand strict performance of this **plan** or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision.

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### Plan Sponsor And Trust Are The Agent

The **Plan Sponsor** and **Trust** are **your** and **your enrolled dependent's** agent for all purposes under this **plan** and not the agent of Regence BlueCross BlueShield of Oregon.

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### Governing Law

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

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### Choice Of Forum

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

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### Representations Are Not Warranties

In the absence of fraud, all statements made in an application 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**.

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## PRESCRIPTION MEDICATION BENEFITS

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

The **claims administrator** contracts 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.

The **claims administrator** contracts 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 the **claims administrator's** Pharmacy Provider Directory. If **you** would like a directory, **you** may obtain one from the **Plan Sponsor** or from the **claims administrator**.

**IMPORTANT NOTE: Prescription medications** must be **medically necessary** for diagnosis and/or treatment of an **illness** or **injury** and must be the subject of a **prescription order**.

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### Prescription Medication Benefits Replace Benefits

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

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### 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**. **Copayment** amounts are assessed on each covered **prescription medication** claim.

**Covered prescription medication expense** means, for **participating pharmacies**, the amount the **plan** has 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 the **plan** 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 the **plan** has 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 the **claims administrator** to provide mail order services to **enrollees**.

**Maintenance medication** means a **prescription medication** that the **plan** has 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 **claims administrator** 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 **claims administrator**.

**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 the **plan** as being covered. 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 the **plan** for self-injection.

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## How To Use The Prescription Medication Benefit

At a **participating pharmacy**, **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** 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 the **claims administrator**. How **you** will be reimbursed is described later.

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## Amount Payable

The amount the **plan** covers 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 the **plan** covers 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 \$15. Each **brand name medication** on the **preferred medication list** dispensed by a **participating pharmacy** is subject to a **copayment** of \$35. Each **brand name medication** not on the **preferred medication list** dispensed by a **participating pharmacy** is subject to a **copayment** of \$55.

**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 the **claims administrator**. **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. Payment will be sent directly to **you**.

Nonparticipating Pharmacy

**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 **claims administrator**. **You** will be reimbursed 50 percent of the amount claimed (the full price of the medication). Payment will be sent directly to **you**.

Generic Medications

In the situation where a generic **equivalent medication** is available to a **brand name medication** and the prescribing provider specifies that a generic **equivalent medication** can be dispensed, if **you** or **your enrolled dependent** chooses to have the **pharmacist** fill the **prescription order** with the **brand name medication**, **you** or **your enrolled dependent** will be responsible for paying the difference between the price of the generic **equivalent medication** and the price of

the **brand name medication** at the time of purchase, in addition to the applicable **brand name medication copayment**.

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### 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 **Plan Sponsor**) to **claims administrator**. **You** will be reimbursed as shown under Participating Pharmacy (When Claim Is Submitted Electronically On-Line) in the Amount Payable provision.

After the 60-day grace period is over, if **you** or **your enrolled dependent** does not present an identification card at the time of purchase, the **pharmacy** will require **you** or **your enrolled dependent** to pay for the prescription in full. The same procedure outlined previously will be followed, except that **you** will be reimbursed 50 percent of the covered expense, whether dispensed by a participating or nonparticipating **pharmacy** (no additional **copayment** will be subtracted).

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### 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 \$30 each time a **generic medication** is dispensed or refilled by the **mail order supplier**. **You** or **your enrolled dependent** pays a **copayment** of \$70 each time a **brand name medication** from the **preferred medication list** is dispensed or refilled by the **mail order supplier**. **Brand name medications** not on the **preferred medication list** are subject to a **copayment** of \$110. 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 the **Plan Sponsor'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.

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## 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, the **plan** has 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. Information from the US Food and Drug Administration (FDA) and from scientific publications will be used to establish these maximum quantities.

Any amount over the established maximum quantity is not covered, except if the **plan** determines 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 the **claims administrator's** 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.

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## 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**.

#### Contraceptives

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

Devices Or Appliances

Devices or appliances of any type, even if they may require a **prescription order**. Some devices and appliances may be covered under the other provisions of the **Plan Document**.

Diabetic Supplies

Except for disposable insulin needles/syringes.

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**.

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 the **claims administrator's** medical policy criteria are met and when the treatment has been **preauthorized**. See the Preauthorization provision in the CLAIMS ADMINISTRATION Section for a description of the **preauthorization** process.

Penlac

Renova

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

Prescription Medications 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 **claims administrator's** 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**.

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

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**Preauthorization**

There are certain **prescription medications** which must be **preauthorized** before they will be considered for payment under this **prescription medication** benefit. **Preauthorize** and **preauthorization** mean the process by which a **prescription medication** is determined to be **medically necessary**, based on the information provided to the **plan**, before it is dispensed. Coverage for medications that have been **preauthorized** begins on the date the **plan** determines that the medication is **medically necessary**. Any medication that requires **preauthorization** that is purchased without such **preauthorization** or is purchased before the date that the medication was determined to be **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 **preauthorization**. The medical information necessary to determine **medical necessity** for medications that require **preauthorization** 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 **preauthorization** is necessary for the **prescription medication**. To find out in advance whether a **prescription medication** requires **preauthorization**, contact Customer Service (number on the back of **your** identification card) or check the **claims administrator's** website at [www.or.regence.com](http://www.or.regence.com). For more information on **preauthorization**, please see Preauthorization under the CLAIMS ADMINISTRATION Section.

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## General Provisions

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

### Right To Examine Records

**You** or any of **your enrolled dependents** may be required to authorize any **participating pharmacy** furnishing **prescription medications** under this benefit to make available to the **plan** information relating to a **prescription order** or any other records needed 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 the **claims administrator**.

### The Claims Administrator Not Responsible For Damages

The **claims administrator** 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.

### Right To Deny Benefits

The **claims administrator** reserves the right to deny benefits for any services or supply prescribed or dispensed in a manner they 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 a payment is mistakenly made for **you** or **your enrolled dependent**, or on **your** or **your enrolled dependent's** behalf, the **plan** has 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 provided to the **enrollee**, even if the mistaken payment was not made on that person's behalf.

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**Plan Booklet Terms Apply**

All terms and conditions of the **Plan Document** apply to this **prescription medication** benefit except when provisions under this **prescription medication** benefit specifically contradict the **Plan Document**, 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 **plan** 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 **plan**, including the maximum-out-of-pocket limit.

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## VISION CARE BENEFITS

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This section describes the vision care benefits available to **you** and **your enrolled dependents**.

IMPORTANT NOTE: Benefits for the services and supplies provided under this section will be provided separately from the preferred provider provisions of the medical portion of the **Plan Document**.

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### Definitions

In addition to the definitions in the DEFINITIONS Section, the following definitions apply to this vision care benefit:

An **ophthalmologist** means a doctor of medicine or osteopathy who limits his or her practice to ophthalmology.

An **optician** means an individual **optician** or outlet of an optical company or dispensary.

An **optometrist** means a doctor of optometry.

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### Covered Expenses

**Covered expenses** are limited to the scheduled allowances shown for the services and supplies listed in the paragraphs that follow. The **plan** will cover these amounts as indicated.

#### Examinations

There is a \$10 **copayment** for **you** or **your enrolled dependents** for each vision examination under this vision care benefit. This **copayment** is the amount **you** or **your enrolled dependent** is required to pay to a provider for each examination. An examination includes a complete medical eye examination or visual analysis. The **plan** covers one vision examination every 12 months for **you** and **your enrolled dependents**.

#### Lenses

The **plan** will pay up to the allowances listed below for one pair of lenses every 24 months for **you** and **your enrolled dependents**:

<u>Type of Lens</u>	<u>Allowance Per Pair</u>
Single Vision	\$ 62
Bifocal	\$ 95
Trifocal	\$ 122

#### Frames

The **plan** will pay up to \$75 for frames every 24 months when necessary to accommodate newly prescribed lenses.

Contact Lenses

If contact lenses are selected by **you** or **your enrolled dependent** in place of the lenses and frame benefit, **covered expenses** are limited \$137 every 24 months.

Contact lenses necessary after cataract surgery or if they are the only means to correct vision to 20/70 or better are paid at regular **plan** benefits.

**Exclusions**

In addition to exclusions listed in the GENERAL EXCLUSIONS Section, the following exclusions apply to this vision care benefit:

- treatment of eyes or special procedures such as orthoptics or vision training;
- charges for fashion eyewear features such as flintglass, blended, coated, tinted (except tints #1 and #2), or oversize lenses;
- additional charges for partially covered frames;
- charges for prisms, prism segs, slab-off, and other special purpose vision aids; and
- replacement of lenses and frames, unless **you** or **your enrolled dependent** is otherwise eligible for benefits.

**General Provisions**

The following paragraphs describe important provisions related to this vision care benefit.

Right To Examine Records

**You** or **your enrolled dependents** may be required to authorize any provider furnishing benefits under this vision care benefit to make available to the **plan** information relating to any records needed in order to approve a claim payment.

Group Coverage Benefits Only

This vision care benefit is only provided under group coverage and is not available under any nongroup plan provided by the **claims administrator**.

We Are Not Responsible For Damages

The **plan** 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 services or supplies rendered by any **professional provider** or any vision care appliance.

Right To Deny Benefits

The **claims administrator** reserves the right to deny benefits for any services or supply prescribed or dispensed in a manner they determine is contrary to generally accepted medical practices.

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**Plan Document Terms Apply**

All terms and conditions of the **Plan Document** apply to this vision care benefit except when provisions under this vision care benefit specifically contradict the **Plan Document**, then the provisions of this vision care benefit apply.

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## DENTAL CARE BENEFITS

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**IMPORTANT NOTE:** Benefits for the services and supplies provided under this **plan** will be provided separately from the preferred provider provisions of the medical portion of the **benefits booklet**.

This **plan** covers a wide range of services including fillings, simple extractions, cleaning, x-rays, artificial teeth, crowns, and dentures.

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### Definitions

In addition to the definitions in the DEFINITIONS Section, the following definitions apply to this **plan**.

The term **plan** means the dental benefits described in this DENTAL CARE BENEFITS Section.

**Dental services** means services and supplies provided to diagnose, prevent, or treat diseases or conditions of the teeth and supporting tissues, including conditions arising from the loss of teeth or those services provided solely by dentists.

**Necessary dental care** means those **dental services** which are essential and necessary according to accepted dental practice to assure a satisfactory outcome in the treatment of any **illness, injury**, or condition and which could not have been omitted without adversely affecting the patient's condition, and which in the **claims administrator's** judgment, meet the following criteria:

- 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 **you or your enrolled dependent's** condition;
- appropriate with regard to widely accepted standards of good dental 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 may mean a provider's office or ambulatory surgical facility instead of a hospital, or using amalgam instead of gold fillings).

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 NECESSARY DENTAL CARE. WE WILL DETERMINE

WHETHER THE SERVICES ARE ELIGIBLE FOR PAYMENT UNDER THE CONTRACT. 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.

**Orthodontics** and **orthodontia**, for plans that include orthodontic coverage, is the branch of dentistry for the care of dental and dentofacial irregularities through the use of corrective appliances to bring teeth, lips, and jaws into proper alignment and to achieve facial balance.

A **professional provider** means any of the following for **necessary dental care** within the scope of the provider's state license or registry:

- a dentist (doctor of medical dentistry or doctor of dental surgery);
- a denturist (person licensed to provide limited prosthetic services);
- an orthodontist (dentist who limits his or her practice to the dental specialty and practice of correcting abnormally aligned or positioned teeth); or
- a physician (doctor of medicine or osteopathy).

**Usual, customary, and reasonable (UCR)** means a charge which is not higher than the usual charge made by the provider, and does not exceed the usual charge made by most providers of like services in the same area.

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## Summary Of Dental Benefits

This is a summary of the benefits of this Fee-For-Service Plans I and II. The text that follows this summary spells out the actual benefits, conditions, limitations, and exclusions. Plan II dental benefits include orthodontic benefits, Plan I does not.

Calendar Year Maximum: \$1,500 per **enrollee**.

Under this **plan**, benefits are provided for preventive, basic, complicated, and major **dental services**.

Calendar Year Deductible:     \$ 50 per **enrollee**  
   \$ 3 per family

The **calendar year** deductible applies separately to each **enrollee** before benefits for restorative, complicated, and major **dental services** are paid, and orthodontia services when **your plan** covers orthodontia. However, no family will be required to satisfy more than three individual deductibles

in any **calendar year**. In addition, if two or more members of a family are **injured** in the same accident, only one individual deductible amount will be deducted from all **dental services** related to the accident for all family members involved in the accident for the remainder of the **calendar year**.

Percentage Paid For Preventive Dental Services And The Percentage Paid After The Deductible For Basic, Complicated, And Major Dental Services:

Preventive <b>dental services</b> :	100%
Restorative <b>dental services</b> :	80%
Complicated <b>dental services</b> :	80%
Major <b>dental services</b> :	50%
Orthodontic services:	50%

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## Covered Expenses

This is a description of the dental benefits available under this **plan**. Benefits will be provided only for **necessary dental care** rendered by a **professional provider**.

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

### Treatment Plan

When charges for future **dental services** are expected to be more than \$500 **you** or **your enrolled dependent** are urged to have the **professional provider** submit a **treatment plan** before providing the service. A **treatment plan** is a report written by the **professional provider** listing the proposed **dental services** and charges. Once a treatment plan is submitted, the **professional provider** will be notified of the benefits available for the **dental services** and **you** or **your enrolled dependent** will know in advance the coverage available under this **plan**. Benefits will be payable only if **you** or **your** dependent is enrolled under the **plan** at the time **dental services** are provided.

### Covered Expenses

Subject to the terms and conditions of this **Plan Document**, the **plan** pays up to the **calendar year** maximum shown in the SUMMARY OF DENTAL BENEFITS for **covered expenses** each **calendar year** for **you** and each of **your enrolled dependents**.

**Covered expenses** under this **plan** means the **usual, customary, and reasonable** charge for covered **dental services** when incurred for **necessary dental care**. Services and supplies not listed in this **plan** are not covered.

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## Deductible

The **plan** will not pay toward the initial amount of those **covered expenses** incurred in each **calendar year** until the deductible has been met. How the deductible applies to **you** and to each of **your enrolled dependents** is explained in the SUMMARY OF DENTAL BENEFITS.

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## Percentage Paid

After the applicable deductible, the **plan** pays the percentage of **covered expenses** as described in the SUMMARY OF DENTAL BENEFITS for **you** and **your enrolled dependents**.

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## Preventive Dental Services

The **plan** covers the following preventive **dental services**:

Oral Examinations

Examinations of the mouth and teeth twice in any **calendar year**.

Prophylaxis

The cleaning, scaling, and polishing of teeth twice in any **calendar year**.

Topical Fluoride Application

Topical fluoride application to the exposed tooth surface for **enrollees** age 17 or under, twice in any **calendar year**.

Sealants

Once in any 48 month period for **enrollees** age 17 or under. Coverage is limited to permanent teeth.

X-Rays

Full-mouth x-rays are covered once in every 60-month period. Bitewing x-rays are covered once each **calendar year** based on the last date of service.

**Basic Dental Services**

The **plan** covers the following basic **dental services**:

Simple Oral Surgery

The simple removal of teeth, biopsies, incisions, and drainage. The allowance for an oral surgery includes routine x-rays, a **treatment plan**, local anesthesia, and post-surgical care.

Fillings

Fillings of silver amalgam, silicate, or plastic restorative material. If **you** or **your enrolled dependent** elects to have another more costly restorative material, such as gold, coverage is limited to the cost of a silver amalgam filling. Multiple restorations on one surface and anterior restorations involving adjoining surfaces will be treated as a single filling.

Space Maintainers

Space Maintainers required to preserve the space between teeth because of premature loss of a primary tooth for **enrollees** age 17 and under. The primary teeth are the first set of teeth, sometimes known as baby teeth. The **plan** covers space maintainers used in **orthodontics** to create a space between the teeth only when orthodontic services are covered. The allowance for space maintainers includes all adjustments made within six months of its installation.

Basic Periodontic Services

Nonsurgical services of the connective tissues around and supporting the teeth. Periodontal exams are covered, however, a separate charge for periodontal charting is not a **covered expense**. Periodontal scaling and root planing, per quadrant, is limited to once in any 24-month period,

based on the last date of service. Following periodontal surgery, periodontal maintenance will be covered as a basic **dental service**, in replacement of the prophylaxis benefit provided as a preventive **dental service** twice in any **calendar year**. Periodontic maintenance can begin three months after periodontic surgery.

Palliative Emergency Treatment

Emergency treatment that is primarily for relief, not cure.

Endodontics

The prevention, diagnosis, and treatment of disease and **injuries** of the tooth pulp, root, and surrounding tissue. This includes pulpotomy; direct pulp capping when pulp is exposed, as documented by x-ray (indirect pulp capping is not covered); and root canal treatment. A separate charge for cultures or postoperative care following root canal treatment is not a **covered expense**. Apicoectomy and surgical follow-up for an apical infection when performed within three months of the procedure, is included within the allowance for root canal treatment.

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**Complicated Dental Services**

The **plan** covers the following complicated **dental services**:

Complex Oral Surgery

Specific surgeries pertaining to the gums, teeth, or tooth structure for dental purposes and the treatment of traumatic alveolar fractures and dislocated teeth. These include: surgical extractions, impaction, alveoloplasty, vestibuloplasty, sinusotomy, and residual root removal. The allowance for an oral surgery includes routine x-rays, a **treatment plan**, local anesthesia, and postsurgical care. A separate charge for alveoloplasty will not be covered when performed in conjunction with the removal of teeth.

Complex Periodontal Services

Surgical procedures, including: gingival curettage, gingivectomy, osseous surgery, flap entry and closure, and mucogingivoplastic surgery. Periodontal surgery includes the **treatment plan**, local anesthesia, and preoperative and postoperative care that occur within six months following a periodontal surgery. Complex periodontal services are covered once, per quadrant, in a 36-month period.

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**Major Dental Services**

The **plan** covers the following major **dental services**:

Onlays

Veneers

Crowns

Crowns consisting of a cast restoration are covered. Crowns placed for the purpose of periodontal splinting, or on teeth that can be restored with a filling or some other means, are not **covered expenses**. Buildups, including pin retention, are covered only on posterior teeth that have root canal fillings.

Fixed Bridges

Fixed bridges are permanent, nonremovable replacements for missing teeth lost while covered under this **plan**. No benefit will be provided for fixed bridges made for **enrollees** under the age of 16.

Full Or Partial Dentures

**Covered expenses** include denture relines, limited to once within 12 months of insertion of an immediate denture. Otherwise, relines are covered once in each 24-month period. No payment will be made for cast restorations for partial denture abutment teeth unless the crown is required to restore the tooth, nor will any benefit be provided for removable cast partials made for **enrollees** under the age of 16.

Repair Or Adjustment Of Dentures And Bridges

Repair or adjustment of artificial teeth. No payment will be made for denture or bridge repair or adjustment within one year of insertion.

**Covered expenses** for onlays, crowns, bridges, and dentures do not include replacement of an existing denture (full or partial), onlay, bridge, or crown, for any reason, less than seven years after the date of the most recent replacement.

For replacement of missing teeth with full or partial dentures, **covered expenses** are limited to the charge for the standard procedure. Personalized restoration, precision attachments, implant attachments, and special techniques are not covered.

When a prosthetic device is provided by a dentist, a statement certifying oral health must be obtained from a dentist, a physician, or a qualified dentist before the service is performed (except when services are to repair a denture or to replace a denture fit within the 12 months before placement of the prosthetic device).

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## Orthodontia Services

Only when **your plan** includes orthodontia services (check with **your Plan Administrator**), this Orthodontia Services benefit applies.

The **plan** covers 50 percent of **usual, customary, and reasonable** charge for necessary **orthodontic** treatment up to a lifetime maximum of \$1,500 for **enrollees** covered under this **orthodontia** plan.

Covered **orthodontia** services include diagnosis, including x-rays, study models, and photographs, prevention, and treatment, however, diagnosis will be covered only once during any five-consecutive-year period.

Before benefits are payable, a **treatment plan** must be approved.

#### Treatment Plan

For the purposes of this **orthodontia** benefit, a **treatment plan** is a report written by **you** or **your enrolled dependent's** orthodontist listing proposed services. This report must include the total **orthodontic** charge, the initial banding fee, and the estimated length of required treatment. It must show a diagnosis indicating an abnormal occlusion which can be corrected by **orthodontic** care.

In order for covered services to be covered, especially in cases where treatment is underway when coverage begins or ends, all **orthodontic** treatment must be performed while **you** or **your enrolled dependent** is enrolled under this **orthodontia** plan and it cannot exceed the length of time prescribed in the **treatment plan**.

#### Stopping Treatment Early

If **orthodontic** treatment stops before the end of the prescribed treatment period, benefits will be covered through the end of the month that treatment was discontinued.

#### Second Treatment Plan

A second **treatment plan** will be covered if five years have passed since the end of the last treatment period and the lifetime maximum benefit has not been reached.

#### Right To Review Records

The **claims administrator** has the right to review **you** or **your enrolled dependent's** dental records, including x-rays, photographs and models, to determine whether **orthodontic** treatment is covered.

#### How Orthodontia Is Paid

For **enrollees** enrolled under this **orthodontia** plan, the **plan** covers 50 percent of **usual, customary, and reasonable** charge or the lifetime maximum of \$1,500, whichever is less.

At the initial visit, the orthodontist charges a banding fee or a down payment. The **plan** covers 50 percent of that initial charge. Any eligible balances remaining of the lifetime maximum will be prorated over the prescribed treatment period and will be paid quarterly.

#### Previous Orthodontia Coverage

If this **orthodontia** plan replaces a previous Regence BlueCross BlueShield of Oregon **orthodontic** plan, benefits that were paid under the previous plan will be applied against the \$1,500 lifetime maximum payment available under this **orthodontia** benefit.

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## Limitations

The following limitations apply to this **plan**.

### Orthodontic Treatment Before Coverage

If **you** or **your enrolled dependent** received **orthodontic** services before being covered by the **orthodontia** plan, the number of months **you** or **your enrolled dependent** was treated previously will be subtracted from the total number of months during which benefits will be provided.

### Treatment Options

When there is more than one method of treatment for a dental condition, payment may be limited to the treatment method with the lesser charge.

### Care By More Than One Professional Provider

When **you** or **your enrolled dependent** transfers care from one **professional provider** to another while receiving treatment, or if more than one **professional provider** gives care for one dental procedure, the **plan** pays benefits for only the amount that would have been considered **covered expenses** if one **professional provider** had performed the service.

### Right To Examine Dental Services

The **claims administrator** has the right to review x-rays and to have a **professional provider** of their choice physically examine the **dental services** for which **you** or **your enrolled dependent** requests coverage under this **plan**. The cost of this examination is covered under the **plan**.

### Replacing Earlier Plan

If this **plan** replaces a previous Regence BlueCross BlueShield of Oregon dental plan, benefits that were paid under the previous plan will be applied against the maximum benefit available under this **plan**.

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## Exclusions

In addition to the exclusions listed in the GENERAL EXCLUSIONS Section, the following exclusions apply to the benefits of this **plan**:

### Appliances Or Restorations

Appliances or restorations used for periodontal splinting, to increase vertical dimensions, restore the occlusion (bite), or correct habits such as tongue thrusting, except when a documented case of bruxism requires a splint which will be covered as a major **dental service**.

### Indirect Pulp Capping

### Missing Teeth

**Dental services** to replace teeth missing on the date coverage began under this **plan** are excluded under the following conditions:

- if there was no coverage in place on the date the tooth was lost;
- if there was a lapse of coverage of more than 31 days since the tooth was lost and coverage began under this **plan**; or
- there was coverage under another plan when the tooth was lost but no treatment was begun before coverage began under this **plan**.

Temporomandibular Joint (TMJD) Or Jaw Joint And Related Problems  
Services or supplies for the treatment of jaw joint problems including, but not limited to, temporomandibular joint syndrome, disorder or dysfunction, craniomandibular disorder, or other disorders of the joint linking the jawbone and skull and the complex of muscles, nerves, or other tissues related to that joint.

Temporary Dentures

Any full or partial denture that is intended for placement in the mouth for less than 12 months.

Inlays

Dental Implants

Dental implants, including attachment devices.

Congenital Or Developmental Malformations

Services to correct congenital or developmental malformations including hypoplasia, fluorosis, discoloration of teeth, or deformed teeth, are not covered when such services are for cosmetic purposes.

Premedications, Take Home Prescription Medications, Supplies

There is no benefit for premedications, prescription medications to be taken or used outside the dental office, hypnosis, analgesics (i.e., nitrous oxide), or any other euphoric medication, fluoride rinse, or mouthwash.

Hospital Treatment

No benefit will be paid toward hospital service or supply charges, or additional fees charged by a dentist, for the hospital treatment of **you** or **your enrolled dependent**.

Missed Appointments

Charges made for a missed appointment are not a **covered expense**.

Local Anesthesia

Separate charges for local anesthesia, when used during restorative procedures, are not **covered expenses**.

Services That Are Not Necessary Dental Care

Orthodontic Services

**Orthodontic** services, except extractions for **orthodontic** purposes. This exclusion does not apply when **your plan** includes orthodontia services.

Replacement And/Or Repair Of Orthodontic Appliances

When **your plan** includes orthodontia services, those services do not include replacement and/or repair of **orthodontic** appliances prescribed under the **treatment plan**.

Cosmetic Services And Supplies

**Dental services** (including medications) rendered for or in support of cosmetic purposes, including complications resulting from cosmetic surgery except if the surgery is performed to treat a disease, correct a functional disorder, or as the result of an accidental **injury**.

Gnathologic Recordings

Recording of jaw movements and positions.

A Fee For Writing A Prescription For Medications Or For Filling Out Claim FormsStudy Models

Models of teeth and surrounding tissue for purposes of study and treatment planning, unless **orthodontia** services are a benefit of this **plan**.

Educational Programs

**Dental services** for plaque control or to teach nutritional and oral hygiene techniques.

General Anesthesia

Except when, in **our** judgment, it is necessary for complex oral surgery or due to the existence of a concurrent medical condition.

Services Paid Under Medical Contract

Services and supplies paid under a separate Regence BlueCross BlueShield of Oregon medical contract due to an accidental **injury**.

**Plan Booklet Terms Apply**

All terms and conditions of the **Plan Document** apply to this dental care benefit except when provisions under this dental care benefit specifically contradict the **Plan Document**, then the provisions of this dental care benefit apply.