CITY OF VANCOUVER

PREFERRED OPTION ONE PLAN

(Non-Uniformed & Independent Agencies)
Non-union, Coalition, Deputy Fire Marshals, OPEIU
Independent Agencies, AFSCME, COBRA and Part-time Employees

Effective January 1, 2009

BENEFITS BOOKLET

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Portland, OR 97207-1271

www.myRegence.com

To: All Eligible Employees

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

This **benefits booklet** describes benefits effective January 1, 2009, or the date after that on which **your** coverage became effective.

SPECIAL CONDITIONS:
Certain employees under the Law Enforcement and Firefighters Act are not covered under Workers' Compensation; Regence BlueCross BlueShield of Oregon covers those personnel on a 24-hour basis.

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INTRODUCTION

The following pages are the **benefits booklet**, a written description of the terms of the group health care benefit plan that this **benefits booklet** describes. For a copy of the **contract**, consult **your Plan Administrator**.

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

Throughout this **benefits booklet** the terms **you** and **your** mean the **enrolled employee**. The term **enrollee** means **you** or an **enrolled dependent**. The terms **we**, **us**, and **our** refer to Regence BlueCross BlueShield of Oregon. The term **group** means the organization whose employees are covered by this **contract**.

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 **contract**.

DEFINITIONS

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

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

Calendar year means the period from January 1 through December 31 each year.

Contract means the agreement between the **group** and **us** that contains all of the terms of the coverage.

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

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

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

Emergency medical condition means an emergent and acute onset of symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's health in serious jeopardy.

Emergency services means otherwise covered health care services **medically necessary** to evaluate and treat an **emergency medical condition**, provided in a hospital emergency department.

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

Enrolled employee means an employee of the **group** whose application is accepted by **us** and who is enrolled under this **contract**.

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.

Illness means a **physical illness** or **mental illness**. **Physical illness** is a disease or bodily disorder, including a chronic **illness** such as heart disease, diabetes, chronic obstructive pulmonary disease, and **chemical dependency**. **Mental illness** is a mental disorder listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association except the following which will not be considered **mental illness** for purposes of this **contract**:

- **chemical dependency** related disorders;
- life transition problems, currently referred to as V codes, and diagnostic codes 302 through 302.9 a found in the 4th edition;
- nursing home or **skilled nursing facility** services, home health care, and **custodial care**; and
- court ordered treatment unless **we** find such treatment to be **medically necessary**.

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. For purposes of this definition, an accidental **injury** includes a self-inflicted **injury** that results from a physical or mental condition, or from domestic violence.

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.

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.

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

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

Professional provider means any provider listed under RCW Title 18 including any of the following providers for **medically necessary** services covered under the **contract** and 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 described under the Special Dental Care benefit;
- a chiropractor;
- a psychologist;
- a licensed clinical social worker;
- a registered nurse licensed under Washington law;
- a registered physical, occupational, speech, or audiological therapist;
- an advanced registered nurse practitioner specializing in women's heath care and midwifery;
- a midwife licensed under RCW 18.50;
- a community mental health agency licensed under RCW 71.24;
- a Washington-licensed acupuncturist;*
- a Washington-licensed massage therapist when providing rehabilitative care;*
- a Washington-licensed naturopath;*
- a Washington-licensed nutritionist;
- a Washington-registered counselor;
- a Washington-registered hypnotherapist;
- a Washington-certified marriage and family therapist;
- a sex offender treatment provider, including an "affiliated" provider;
- a chemical dependency counselor;

- a chiropractic x-ray technician;
- a dietician;
- a health care assistant;
- a licensed practical nurse;
- a registered nursing assistant;
- a certified nursing assistant;
- an occupational therapy assistant;
- a radiological technologist;
- an x-ray technician;
- a Washington-certified mental health counselor;
- a Washington-certified social worker; or
- a Washington-licensed chiropractor.*

  * Benefits under this **contract** for these provider categories are limited only to expenses incurred from providers **we** have designated as Washington Supplemental Providers. No benefits are payable for providers who **we** have not designated as Washington Supplemental Providers. The exception is for chiropractors, in which case **we** will pay for the services of a nonparticipating **professional provider** up to the amounts stated in the Chiropractic Care provision. See **your** Washington Supplemental Provider listing for a description of covered providers. This listing of Washington Supplemental Providers is available to **you**, at no cost, upon enrollment or at any other time from **your Plan Administrator** or from **us** on **our** website at www.myRegence.com or through **our** Customer Service Department.

Usual and customary or reasonable charge means:

- **usual** -- not more than the provider's or vendor's normal charge for a given service or supply; and
- **customary** -- an amount which falls within the range of **usual charges** for the service or supply billed by most providers or vendors for the same or similar service or supply in **our** service area; or

- **reasonable** -- an amount which is **usual** and **customary** or which because of unusual circumstances, inadequacy of data, or other reasons is established by **us** on an individual basis.

With respect to benefits for the treatment of **chemical dependency** as described in the Chemical Dependency limitation of the **contract**, **usual and customary or reasonable charges** will be taken into account only on specific components of such treatment for which a **usual and customary or reasonable charge** has been established based on **our** statistically reliable measures as determined by the criteria set forth in this definition.

SUMMARY OF BENEFITS

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

We have contracted with **professional providers** and facilities to provide services and supplies to **enrollees** under this **plan**. **Your** provider directory lists which panel of providers applies to **your** benefits under the **plan**. This listing of participating providers is available to **you**, at no cost, upon enrollment or at any other time from **your Plan Administrator** or from **us** on **our** website at www.myRegence.com or through **our** 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 **contract.** Services provided for an **emergency medical condition** (see DEFINITIONS) will be paid at the preferred level of benefits.

Maximum Lifetime Benefit

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

Calendar Year Deductible

	Preferred Provider	Nonpreferred Provider
per **enrollee**:	$100	$200
total family:	$300	$600

Percentage We Pay For Covered Expenses

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

Preferred Facilities, Preferred Professional Providers, and Other Services and Supplies
We pay **covered expenses** an **enrollee** incurs for **preferred facilities**, **preferred professional providers**, and Other Services And Supplies at the first percentage listed until those **covered expenses*** total $10,000 in a **calendar year** (the stop-loss amount). Once these **covered expenses** exceed the stop-loss amount, **we** then pay 100 percent of **covered expenses** incurred during the rest of the **calendar year** for that **enrollee.**

* All **covered expenses** accumulate to the same stop-loss amount. **Covered expenses** shown with a single percentage (no first percentage) or that are paid at the 100 percent level, or any **copayment** amounts the **enrollee** pays do not accumulate toward the stop-loss amount.

Nonpreferred Facilities and Nonpreferred Professional Providers
We pay **covered expenses** an **enrollee** incurs for **nonpreferred facilities** and **nonpreferred professional providers** at the first percentage listed for those services until those **covered expenses*** total $10,000 in a **calendar year** (the stop-loss amount). Once **covered expenses** for **nonpreferred facilities** and **nonpreferred professional providers** exceed the stop-loss amount, **we** then cover 100 percent of **covered expenses** incurred during the rest of the **calendar year** for that **enrollee**.

* All **covered expenses** accumulate to the same stop-loss amount. **Covered expenses** shown with a single percentage (no first percentage) or that are paid at the 100 percent level, or any **copayment** amounts the **enrollee** pays do not accumulate toward the stop-loss amount.

Hospital Inpatient Care

	Preferred Facility	Nonpreferred Facility
Number of days	Unlimited	Unlimited
Semiprivate room	Paid at 90%/100%	Paid at 70%/100%
Intensive/coronary care unit	Paid at 90%/100%	Paid at 70%/100%
Additional **medically necessary hospital** services and supplies	Paid at 90%/100%	Paid at 70%/100%
Inpatient rehabilitation:		
for neurodevelopmental therapy is limited to 30 days per **calendar year**	Paid at 90%/100%	Paid at 70%/100%
for all other rehabilitation therapy, 30 days (60 days for head or spinal cord **injury**, or for treatment of stroke) per **calendar year**	Paid at 90%/100%	Paid at 70%/100%

	Preferred Facility	Nonpreferred Facility
Hospital Outpatient Care		
Outpatient surgery	Paid at 90%/100%	Paid at 70%/100%
Radium, radioisotope, and x-ray therapy	Paid at 90%/100%	Paid at 70%/100%
Chemotherapy	Paid at 90%/100%	Paid at 70%/100%
Preadmission testing	Paid at 90%/100%	Paid at 70%/100%
Diagnostic x-ray and laboratory	Paid at 90%/100%	Paid at 70%/100%
Emergency room care:		
medical emergency	Paid at 90%/100% after $100 **copayment**	Paid at 90%/100% after $100 **copayment**
nonemergency care	Paid at 90%/100% after $100 **copayment**	Paid at 70%/100% after $100 **copayment**
Skilled Care In A Nursing Home Or Skilled Nursing Facility		
Number of days per stay	100	100
Semiprivate room plus **medically necessary** ancillary charges	Paid at 90%/100%	Paid at 70%/100%
Special Facility Care		
Birthing center or ambulatory surgery facility	Paid at 90%/100%	Paid at 70%/100%

Professional Provider Services	Preferred Professional Provider	Nonpreferred Professional Provider
Home or office visits, including office surgery	Paid at 100% after $15 **copayment** (not subject to the deductible)	Paid at 70%/100%
Annual women's examinations	Paid at 100% after $10 **copayment** (not subject to the deductible)	Paid at 70%/100%
Visits in **hospital**	Paid at 90%/100%	Paid at 70%/100%
consultation in **hospital**	Paid at 90%/100%	Paid at 70%/100%

	Preferred Professional Provider	Nonpreferred Professional Provider
Surgery:		
surgeon, assistant surgeon,	Paid at 90%/100%	Paid at 70%/100%
anesthesiologist, and supplies	Paid at 90%/100%	Paid at 70%/100%
Contraceptive services	Paid at 90%/100%	Paid at 70%/100%
Radium, radioisotope, and x-ray therapy	Paid at 90%/100%	Paid at 70%/100%
Diagnostic x-ray and laboratory tests	Paid at 90%/100%	Paid at 70%/100%
Preventive Care		
Well-baby care and physical examinations	Paid at 100% after $15 **copayment** (not subject to the deductible)	Paid at 70%/100% (subject to the deductible)
Immunizations		
Childhood immunizations for all **enrollees** (not subject to deductible)	Paid at 100% after $5 **copayment**	Paid at 100% after $5 **copayment**
Therapeutic Injections		
Therapeutic injections, such as allergy shots, when given in the **professional provider's** office	Paid at 90%/100%	Paid at 70%/100%
Temporomandibular Joint Disorder Treatment (TMJD)		
TMJD is covered under the various parts of the **contract** the same as for other **injuries** or musculoskeletal disorders	Paid at 90%/100%	Paid at 70%/100%
Home Health Care		
We cover certain services and supplies (see the COVERED EXPENSES Section for exact qualifications and limitations)	Paid at 90%/100%	Paid at 70%/100%

	Preferred Professional Provider	Nonpreferred Professional Provider
Home Infusion Therapy		
We cover certain services and supplies (see the COVERED EXPENSES Section for exact qualifications and limitations)	Paid at 90%/100%	Paid at 70%/100%
Palliative Hospice Care		
We cover certain services and supplies (see the COVERED EXPENSES Section for exact qualifications and limitations)	Paid at 90%/100%	Paid at 70%/100%
PKU Formulas		
If the presence of phenylketonuria (PKU) is detected, **we** provide coverage for **medically necessary** formulas. This benefit is not subject to any waiting period of the **contract**	Paid at 90%/100%	Paid at 70%/100%
Outpatient Diabetic Instruction		
We pay for outpatient diabetic instruction when provided by health care professionals as allowed under Washington law (Title 18) for the treatment of diabetes	Paid at 90%/100%	Paid at 70%/100%
Durable Medical Equipment		
We cover **medically necessary durable medical equipment** and supplies which relate directly to the treatment of an **illness** or **injury**	Paid at 90%/100%	Paid at 70%/100%

Maternity Care

Covered expenses for maternity care are covered the same as any other condition for **you** or **your enrolled dependents.**

Prostate Cancer Screening

We cover prostate cancer screening services under the various sections of this **contract** if recommended by a physician, a physician's assistant, or an advanced registered nurse practitioner.

Colorectal Cancer Screening

We cover colonoscopies, sigmoidoscopies, fecal occult tests, and barium enemas under the various sections of this **contract** subject to any deductible and/or coinsurance, however, any maximums for physical examinations will not apply.

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.

Special Dental Care

We cover treatment of accidental **injury** to natural teeth or a fractured jaw.

Additional Accident Care

We will waive the deductible and pay **covered expenses** incurred within 90 days of an accidental **injury**. Benefits will be paid at the percentage shown previously.

Nutritional Counseling

We pay for the initial visit, plus two follow-up visits, per condition for nutritional counseling, subject to all conditions, limitations and exclusions under the **contract**.

Other Services And Supplies

IMPORTANT NOTE: The items listed in this category are paid as shown, after a $100 deductible per **enrollee** or $300 family deductible, and not at the preferred/nonpreferred benefit levels.

Neurodevelopmental therapy is limited to 30 sessions per **calendar year**	Paid at 80%/100%
All other rehabilitative care, maximum 30 sessions (60 sessions for head or spinal cord **injury** or for treatment of stroke) per **calendar year**	Paid at 80%/100%

Ambulance transportation (up to 500 miles per **calendar year** for nonemergencies)	Paid at 80%/100%
Blood or blood plasma	Paid at 80%/100%

Chemical Dependency

We pay **covered expenses** to a specified maximum. (See Chemical Dependency under the GENERAL LIMITATIONS Section for exact qualifications and limitations.)

Mental Illness

We pay **covered expenses** to specified maximums. (See Mental Illness under the GENERAL LIMITATIONS Section for exact qualifications and limitations.)

Biofeedback Therapy

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

Chiropractic Care

After a $15 **copayment, covered expenses** for the services of a chiropractor are limited to manipulation of the spine and related supporting services (including x-rays, lab, etc.) to treat a bone, muscle, or joint disorder. **Covered expenses** are paid at 100 percent of billed charges up to a $400 maximum for each **enrollee** per **calendar year**.

Note: Once the above maximum is reached, **we** will pay **contract** benefits for chiropractic care but only when such care is provided by a Washington Supplemental Provider.

Alternative Care Providers

Each visit to a Washington-licensed chiropractor, acupuncturist, massage therapist, naturopath, nutritionist, a Washington-registered counselor, registered hypnotherapist, certified marriage and family therapist, and a certified mental health counselor is paid at 100 percent after a $15 **copayment**. (See the definition of **professional provider** and **preferred professional provider** in the **DEFINITIONS** Section for exact qualifications.)

Transplants

We pay **covered expenses** for certain **transplant** procedures. (See Transplants under the GENERAL LIMITATIONS Section for exact qualifications and limitations.)

Open Enrollment

The month of November for a January 1 effective date

BENEFITS

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

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

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

When Benefits Are Available

We only pay benefits for **covered expenses** incurred when **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 **contract**;
- **you** and **your enrolled dependents** have applied for coverage and have been accepted by **us**; and
- **your** and **your enrolled dependents'** premium for the current month has been paid by the **group** on a timely basis.

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

Deductibles

If this **contract** has a **calendar year** deductible, the amount of the individual deductible is shown in the SUMMARY OF BENEFITS. If the SUMMARY OF BENEFITS indicates that there is no **calendar year** deductible (“none”), then this Deductibles provision does not apply. The deductible applies to medical expenses.

We will not begin to pay **your** or **your enrolled dependent’s** expenses in any **calendar year** until the deductible amount is satisfied. The deductible applies separately to **you** and each **enrolled dependent**, but

no family will be required to satisfy more than the total family deductible shown in the SUMMARY OF BENEFITS for any year, no matter how many **enrolled dependents** are in that family.

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

Once The Deductible Is Satisfied

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

Note that if a stop-loss applies, it is accumulated separately for **you** and each of **your enrolled dependents** based upon **your** or **your enrolled dependent's covered expense**. And, **covered expenses** paid at 100 percent and/or any **copayment** amounts that **you** must pay do not accumulate toward the stop-loss amount.

Restoration Of Benefits

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

Care Management/Alternative Care Benefits

Care Management

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

Individual Benefits

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

us to pay continued or additional **individual benefits** for the same **enrollee**. **Our** payments for **individual benefits** are **covered expenses** for all purposes under this **contract.**

Alternative Care Benefits

As an alternative to hospitalization or other inpatient care, the benefits of this **contract** will be provided for substitution of home health care when provided in lieu of hospitalization or other inpatient care, when furnished by a licensed home care agency or by a **home health care agency** or hospice agency that is covered under this **contract**, if such care can be provided at equal or lesser cost. Substitution of less expensive or less intensive services shall be made only with the consent of the patient and upon the recommendation of the patient's attending physician or licensed health care provider that such services will adequately meet the patient's needs. The decision to substitute less expensive or less intensive services shall be determined based on the medical needs of the individual patient. **We** may require a written treatment plan that has been approved by the patient's attending physician or licensed health care provider. Coverage will be limited to the maximum benefit payable for **hospital** or other inpatient expenses under this **contract** and will be subject to any applicable deductible, coinsurance, and **contract** limits. Benefits under this provision will only be provided when the patient's condition is serious enough to require inpatient care and the patient could qualify for the inpatient benefits of this **contract.** No benefits will be provided for **custodial care**.

Emergency Care

You and **your enrolled dependents** are covered for emergency medical screening expenses and stabilization of **emergency services** under the various sections of this **contract.**

COVERED EXPENSES

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

- the contracted amount for listed services and supplies provided by a **participating facility**, a **participating professional provider**, a **preferred facility**, a **preferred professional provider**, or a **contracting agency**;
- the **reasonable charge** for listed services and supplies provided by a **nonparticipating facility**, except that, for **emergency services**, any amount **you** must pay (the difference between what **we** pay a **nonparticipating facility** and what **we** would have paid a **participating facility** for the same services) will never be greater than $50;

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

- the billed amount, paid at the preferred percentage level, for listed services and supplies received from an eligible category of facilities or **professional providers** with whom **we** have not contracted to provide preferred services and supplies to **enrollees** under this **contract**;

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

- the **usual and customary or reasonable charge** for all other listed services and supplies.

Hold Harmless
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 **us**, however, may bill **you** for any balances over **our** payment level in addition to any deductible and coinsurance amount.

Payment When Treatment Is For An Emergency Medical Condition
For an **emergency medical condition** only, **we** pay a **nonpreferred professional provider** the same percentage of benefits as **we** would have paid a **preferred professional provider** for a similar service.

In addition, if **your** or **your enrolled dependent's** medical condition necessitates **emergency services** at a **nonpreferred facility**, **we** pay the same percentage of benefits **we** would have paid for a similar service or supply at a **preferred facility**. However, after receiving covered **emergency services** at a **nonpreferred facility**, **we** can require an **enrollee** to transfer to a **preferred facility** as soon as his or her medical condition safely permits. Payment for **covered expenses** for a **nonpreferred facility** for care beyond the date **we** reasonably determine an **enrollee** can be safely transferred will revert back to the percentage payable for a **nonpreferred facility**. If, while **you** or **your enrolled dependent** is hospitalized in a **nonparticipting facility** and **your** or **your enrolled dependent's** condition has stabilized, **we** cannot reach an agreement with the **nonpreferred facility** as to care beyond stabilization, **we** will immediately arrange for an alternative plan of treatment.

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 (for **hospitals** that have not contracted with **us**, **we** will apply **contract** benefits on the **hospital's** billed charges if there are no in-network facilities within a reasonable proximity of the individual requiring care);

- the charge for isolation care when **medically necessary** to protect other patients from contagion or to protect **you** or **your enrolled dependent** from contracting the **illnesses** of others;

- the charge for use of an intensive care or coronary care unit. **We** determine **our** definition of an intensive care unit by using the criteria of the Joint Commission on Accreditation of Hospitals, but **we** reserve the right to decide whether the unit in a particular **hospital** qualifies for coverage; and

- charges for other **hospital** services and supplies that are necessary for treatment and are ordinarily furnished by the **hospital**. These include, but are not limited to, operating and recovery rooms, traction equipment, and special diets.

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

Inpatient Rehabilitative Hospital Care
Covered expenses are limited to 30 days of rehabilitative care each **calendar year** for an inpatient stay in a **hospital** that has a specialized department for providing such care. However, for treatment required following head or spinal cord **injury**, or for treatment of a cerebral vascular accident (stroke), the limit may be increased to 60 days per **calendar year**. These benefits will continue only as long as **you** or **your enrolled dependent** requires the full rehabilitative team approach and services can only be provided on an inpatient basis. In order to be a **covered expense**, rehabilitative services must be part of a physician's formal written program to improve and restore lost function following **illness** or **injury**. The services must be consistent with the condition that is being treated.

We will pay for an additional 30 days of inpatient rehabilitative care, including occupational, speech, and physical therapy, each **calendar year** for neurodevelopmental therapy.

Newborn Nursery Care
(Not subject to the deductible.)

We cover routine nursery care of a well-newborn infant under the newborn's own coverage while the mother is confined in the **hospital** and receiving maternity benefits under the **contract**. However, this benefit does not cover **professional provider** charges for well-baby care or pediatric standby charges for vaginal delivery except as provided under the Preventive Care benefit.

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

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

Hospital Outpatient Care

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

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

Emergency Room Care
You or **your enrolled dependent** is responsible for paying the first $100 for each emergency room visit. This separate $100 **copayment** is in addition to the **calendar year** deductible and coinsurance provisions of this **contract** which also apply to the emergency room charges. The **copayment** charge will not apply when the patient is admitted directly from the emergency room to a **hospital** or other facility on an inpatient basis.

Skilled Care In A Nursing Home Or Skilled Nursing Facility

Skilled care provided by a **nursing home** or **skilled nursing facility**. The benefits are explained in the following paragraphs.

A **nursing home** is a facility as defined in RCW 18.51.10. A **skilled nursing facility** is a facility eligible according to applicable laws to provide inpatient care under the supervision of a medical staff or a medical director. Both must provide continuous 24-hour-a-day nursing service supervised by registered nurses.

We cover up to 100 **nursing home** or **skilled nursing facility** days per stay. For benefits to renew after each stay, **you** or **your enrolled dependent** must be discharged from the facility and 90 consecutive days must pass before readmission to a **hospital**, a **nursing home**, or a **skilled nursing facility.**

Facility Benefits
Covered expenses are limited to the daily service rate, up to the maximum amount **we** would pay if the patient were in a semiprivate **hospital** room. The patient's attending physician must give **us** proof of medical necessity, that **we** find acceptable, showing that the patient would require hospitalization if care in a **nursing home** or **skilled nursing facility** were not possible.

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

- senile deterioration;
- mental deficiency or retardation; or
- **mental illness**;

nor do **covered expenses** include routine nursing care (where **medical necessity** has not been established), self-help or training, personal hygiene, or custodial care.

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

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.

Professional Provider Services

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

Home Or Office Visits
A "visit" means the patient is actually examined by a **professional provider**. **Covered expenses** include physician consultations with written reports as well as second opinion consultations from a **professional provider** of **your** or **your enrolled dependent's** choice.

When home or office visits (including office surgery) are provided by a **preferred professional provider**, **you** or **your enrolled dependent** is responsible for paying the first $15 for each visit. **Covered expenses** after this separate **copayment** are paid in full and not subject to the deductible or coinsurance provisions of the **contract**. Home or office visits provided by a **nonpreferred professional provider** are paid at regular **contract** benefits.

Annual Women's Examinations
(These benefits are not subject to the deductible, when services are provided by **preferred professional providers**.)

Annual women's breast, pelvic, and Pap smear examinations are covered once every **calendar year**, unless the patient is designated high risk. Any **covered expenses** for laboratory, x-ray procedures, or

mammography that accompany the examination will be covered under the provisions for these types of services outlined in this **contract.**

You or **your enrolled dependent** is responsible for paying the first $10 for each annual women's examination visit by **preferred professional providers**. **Covered expenses** after this separate **copayment** are paid in full and are not subject to any **calendar year** deductible or coinsurance provisions of the **contract.** Annual women's examination visits provided by a **nonpreferred professional provider** are paid at regular **contract** benefits.

Physician's Visits In The Hospital

We pay for physician's visits to a patient during a **hospital** or **skilled nursing facility** stay. But visits relating to surgery performed during a **hospital** stay are not covered. (These visits are ordinarily included in the surgeon's fee.) **We** also pay for physician consultations with written reports during each **hospital** stay.

Surgery

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

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

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

For bilateral procedures or procedures performed through different incisions in a single operative session, **we** will pay the first procedure at normal **contract** benefits and **covered expenses** for any subsequent procedures at a percentage no more than 50 percent of normal **contract** benefits.

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 **contract**).

Radium, Radioisotope, And X-Ray Therapy

Covered expenses include:

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

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

- Pap smears;
- mammograms;
- hemocult; and
- PKU testing (PKU formulas are paid according to the PKU Formula benefit).

Mammograms are covered under the recommendation of a physician, an advanced Washington-registered nurse practitioner, or Washington-licensed physician's assistant. The charge for the office visit in connection with any of the above is not covered under this benefit but is covered elsewhere in the **contract**.

Preventive Care

Preventive care benefits are provided under two categories: well-baby care and physical examinations. (A description of each follows.)

Well-Baby Care
We cover charges of the **professional provider** for physical examinations of **your enrolled dependent** child under two years of age. This benefit is not subject to the deductible. **We** cover:

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

Physical Examinations
This benefit is not subject to the deductible.

For **you** and **your enrolled dependent** over two years of age, **we** cover physical examinations and related laboratory tests and x-ray examinations as long as a third party is not liable for these charges. **We**

only cover one examination every **calendar year** for **you** and **your enrolled dependent** age 2 and above.

Amounts Payable -- For each physical examination, including related laboratory tests and x-ray examinations, **we** pay up to $200 for **you** and **your enrolled dependents**.

Annual women's breast, pelvic, and Pap smear examinations, including mammograms, are covered according to the Professional Provider Services benefit of this **contract** and not this Preventive Care benefit.

Immunizations

This benefit is not subject to the deductible.

We cover immunizations for general use for both adults and children. Immunizations for hepatitis B are covered only for **your enrolled dependent** children under age 19 unless **medically necessary**. **Covered expenses** do not include immunizations for the sole purpose of travel, occupation, or residence in a foreign country.

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

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

Therapeutic Injections

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

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

Temporomandibular Joint Disorder Treatment

Temporomandibular joint disorders (**TMJD**) are covered under the medical coverage provisions of the **contract** the same as for other **injuries** or musculoskeletal disorders.

For purposes of medical coverage under this **contract**, **temporomandibular joint disorders** (**TMJD**) means those disorders which have one or more of the following characteristics:

- pain in the musculature associated with the temporomandibular joint;
- internal derangements of the temporomandibular joint;
- arthritic problems with the temporomandibular joint; or
- an abnormal range of motion or limitation of motion of the temporomandibular joint.

Benefits under medical coverage will be paid for **covered expenses** which are:

- reasonable and appropriate for the treatment of a disorder of the temporomandibular joint under all the factual circumstances of the case;
- effective for the control or elimination of one or more of the following caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food;
- recognized as effective, according to the professional standards of good medical practice; and
- not experimental or investigational or primarily for cosmetic purposes.

Home Health Care

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

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

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

Note that this home health care benefit does not include home care services provided as part of a hospice treatment plan or ongoing hourly shift care in the home, 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 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 **us**, **we** strongly urge **you** to ask **your** provider to contact **our** Preauthorization Department before receiving such care to avoid a denial or reduction of benefits due to lack of medical necessity. See the Preauthorization provision in the CONTRACT AND CLAIMS ADMINISTRATION Section for a description of the **preauthorization** process.

Home Infusion Therapy

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

Limited Services
Home infusion therapy is limited to the following:

- aerosolized pentamidine;
- intravenous medication therapy;
- total parenteral nutrition;
- enteral nutrition (under certain circumstances);
- hydration therapy;
- intravenous/subcutaneous pain management;

- terbutaline infusion therapy;
- SynchroMed pump management;
- IM/SC bolus/push medications; and
- blood product administration.

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

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

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

Palliative Hospice Care

We cover **palliative hospice care** as described here when provided by a Medicare or state certified **hospice care program**. A **hospice care program** is a coordinated program of home and inpatient care, available 24 hours a day, that uses an interdisciplinary team of personnel to provide palliative and supportive services to a **patient-family unit** experiencing a life threatening disease with a limited prognosis. A **patient-family unit** is the patient and any family members who are caring

for the patient. These services include acute, respite, and home care to meet the physical, psychosocial, and special needs of a **patient-family unit** during the final stages of **illness** and dying.

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

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

<u>Levels Of Care</u>
Palliative hospice care benefits are limited to the following treatment settings:

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

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

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

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

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

PKU Formulas

If the presence of phenylketonuria (PKU) is detected, **we** provide coverage for the formulas determined to be **medically necessary** for the treatment of PKU. When the formula is billed as part of an office visit, it will be paid under the home or office visits benefit. Any waiting period limitation of this **contract** does not apply to this PKU benefit.

Outpatient Diabetic Instruction

Services and supplies used in outpatient diabetes self-management training programs are covered under this **contract** when they are

provided by a health care professional for the treatment of diabetes. For the purposes of this diabetic instruction benefit, health care professionals means a health care provider as allowed under Washington law (Title 18). When diabetic instruction is billed as an office visit, the services will be paid under the home or office visit benefit.

Supplies, **Appliances**, **And Durable Medical Equipment**

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

- the following **medically necessary durable medical equipment** and supplies when required by standard treatment practices for the treatment of an **illness** or **injury**:

  – artificial limbs and eyes;

  – casts, trusses, limb or back braces, and crutches; and

  – rental (not to exceed the reasonable purchase price if the item can be purchased) of a wheelchair, hospital-type bed, oxygen, or other **durable medical equipment** unique to medical care or treatment as determined by **us**;

  - the following diabetic supplies are always covered under this Supplies, Appliances, And Durable Medical Equipment benefit: insulin pumps and accessories to the pumps; insulin infusion devices; and foot care appliances (orthotics) for prevention of complications associated with diabetes;

  - the following diabetic supplies are covered under this Supplies, Appliances, And Durable Medical Equipment benefit only when they are not covered under any prescription medications benefit of the **contract**: disposable insulin needles and syringes; blood glucose monitors; disposable blood/urine glucose/acetone testing agents (chemstrips); and glucose elevating agents;

  – other supplies, including nonself-administered injectable medications, up to a maximum 90-day supply at any one time.

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

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

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

Maternity Care

We cover pregnancy care, childbirth, and related conditions for **you** or **your enrolled dependents** under the various sections of this **contract** the same as **illness.** This includes **medically necessary** prenatal testing for congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy, as determined to be **medically necessary** in accordance with standards set in rule by the board of health.

We will not limit benefits for the mother and her newborn's length of inpatient stay (from the time of delivery) to less than 48 hours for a normal delivery and 96 hours for a caesarean section. However, the attending physician in consultation with the mother may decide on an early discharge. In all cases, length of inpatient stay and the type and location of the follow-up care including in-person care, will be determined by the **enrollee's** attending provider, in consultation with the patient, based on accepted medical practice. Such hospitalization does not need to be **preauthorized**. By attending provider, **we** mean a **professional provider**, as defined in the **contract**, but limited to:

- a physician;
- a physician's assistant when providing women's health care services;
- an advanced nurse practitioner specializing in women's health care and midwifery; and
- a midwife licensed under RCW 18.50.

Coverage for the newly born child will be no less than the coverage of the child's mother for the first three weeks following birth, even if there are

separate **hospital** admissions, so long as the mother is enrolled under the **contract**.

Prostate Cancer Screening

We cover prostate cancer screening services under the various sections of this **contract** if recommended by a physician, a physician's assistant, or an advanced registered nurse practitioner.

Colorectal Cancer Screening

We cover colonoscopies, sigmoidoscopies, fecal occult tests, and barium enemas under the various sections of this **contract** subject to any deductible and/or coinsurance, however, any maximums for physical examinations will not apply.

Women's Health And Cancer Rights

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

- reconstruction of the breast on which the mastectomy was performed;

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

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

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

Special Dental Care

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

In addition, **we** will cover **medically necessary** general anesthesia services (**professional provider**, **hospital**, and ambulatory surgical facility) for dental conditions that cannot be safely and effectively treated in the dentist's office for **enrollees** who are physically or developmentally disabled or who are under age seven.

Additional Accident Benefit

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

Nutritional Counseling

We pay for the initial visit, plus two follow-up visits, per condition for nutritional counseling, subject to all conditions, limitations and exclusions under the **contract**.

OTHER SERVICES AND SUPPLIES

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.

Neurodevelopmental Therapy

We cover up to 30 sessions each **calendar year** for neurodevelopmental therapy, including occupational, speech, and physical therapy. **Covered expenses** do not include neurodevelopmental therapy that is covered under the Home Health Care provision.

Other Outpatient Rehabilitative Care

In addition to the benefit for neurodevelopmental therapy, **we** cover up to 30 sessions each **calendar year** for rehabilitative services provided by a **professional provider** to a patient who is not confined to a **hospital.** If rehabilitative services are required following head, spinal cord **injury**, or a cerebral vascular accident (stroke), **we** may allow up to 60 sessions each **calendar year**. Rehabilitative services are physical, occupational, speech, or audiological therapy services necessary to restore or improve lost function caused by **illness** or **injury**. 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.

Ambulance Transportation

We cover **medically necessary** transportation by state-certified ambulance. This is for transportation to the nearest **hospital** that has the facilities to give the necessary treatment. Ground ambulance transportation when transportation is not due to an **emergency medical condition** is limited to 500 miles per **calendar year**. Certified air ambulance transportation will be covered if it is **medically necessary**.

Blood Or Blood Plasma

Blood or blood plasma is covered when **medically necessary** for the treatment of an **illness** or **injury**.

GENERAL LIMITATIONS

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

Chemical Dependency

Coverage will be provided only for valid diagnoses of **chemical dependency** as defined in the current Diagnostic Statistical Manual (DSM).

Definitions
In addition to the definitions in the DEFINITIONS Section, the following definitions apply to this **chemical dependency** limitation.

Approved treatment program means a treatment facility approved under RCW 70.96A.020.

Chemical dependency means an **illness** characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under chapter RCW 69.50 and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance of physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

Emergency admission is when **your** or **your enrolled dependent's** condition requires admission to a facility because of an **emergency medical condition**.

Residential/partial hospitalization means care in a residential facility, **hospital**, or other facility which provides an organized full-day or part-day program of treatment and is licensed for the particular level of care for which reimbursement is being sought.

Treatment for **chemical dependency** means **medically necessary** treatment and supporting services provided to **you** or **your enrolled dependent** by an **approved treatment program** on either an inpatient, **residential/partial hospitalization**, or outpatient basis. Treatment may include medical evaluations, psychiatric evaluations, room and board (inpatient or residential only), psychotherapy, counseling, behavior therapy, recreation therapy, family therapy, and prescription medications and supplies prescribed by an **approved treatment program.** Treatment also includes **medically necessary** detoxification.

Preauthorization

The following **preauthorization** procedure should be followed before **you** or **your enrolled dependent** receives treatment for **chemical dependency** in order to decrease the possibility that benefits will be reduced or denied for inappropriate treatment setting or length of stay.

Prior to receiving treatment in a **hospital**, **residential/partial hospitalization** facility, or **approved treatment program** (except for **medically necessary** detoxification), the patient's attending physician should contact **our** Preauthorization Department. See the Preauthorization provision in the CONTRACT AND CLAIMS ADMINISTRATION Section for a description of the **preauthorization** process.

The Preauthorization Department will then recommend the expected length of stay and the appropriate treatment setting. Notification of **our** decision will be communicated by letter to the facility, the physician, and/or **you** or **your enrolled dependent.** The determination will be valid for 90 days from the date of the letter.

If an **emergency admission** must take place when **our** office is closed, please contact **us** immediately at the earliest opportunity during regular business hours. Only **emergency services** or **medically necessary** detoxification will be reimbursed when **preauthorization** has not been obtained. **We** may require transfer to a facility/program which is medically appropriate based on the criteria given previously.

Benefits

Benefits for the treatment of **chemical dependency** are subject to all conditions, limitations, and exclusions of this **contract.** See the GENERAL EXCLUSIONS Section for specific conditions/services excluded from coverage. In addition, **our** payment under the **contract** for the treatment of **chemical dependency** is limited for each **enrollee** to $14,500 for **covered expenses** received during any 24-consecutive-month period. (Note that **medically necessary** detoxification services do

not count toward this $14,500 maximum if the patient is not yet enrolled in other **chemical dependency** treatment). This $14,500 maximum will be adjusted annually for changes in the medical care component of the Consumer Price Index.

Exclusions
In addition to the exclusions listed in the GENERAL EXCLUSIONS Section, the following exclusions apply for treatment of **chemical dependency**:

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

Mental Illness

Coverage will be provided only for valid diagnoses of **mental illness** as defined in the current Diagnostic Statistical Manual (DSM).

Definitions
In addition to the definitions in the DEFINITIONS Section, the following definitions apply to this **mental illness** limitation.

Approved treatment program means a treatment facility approved under RCW 70.96A.020.

Community mental health agency means a community mental health agency licensed by the Washington Department of Social and Health Services to provide outpatient treatment for **mental illness** under RCW 71.24. The agency must have in effect a plan for quality assurance and peer review, and treatment must be supervised by a physician or a psychologist.

Emergency admission is when **your** or **your enrolled dependent's** condition requires admission to a facility because of an **emergency medical condition**.

Outpatient visit means a clinical treatment session with an eligible provider under the **plan**.

Residential/partial hospitalization means care in a residential facility, **hospital**, or other facility which provides an organized full-day or part-day program of treatment and is licensed for the particular level of care for which reimbursement is being sought.

State hospital means any **hospital** operated and maintained by the state of Washington for the care of the mentally ill as defined in RCW

72.23.010.

<u>Preauthorization</u>
The following **preauthorization** procedure should be followed before **you** or **your enrolled dependent** receives treatment for **mental illness** in order to decrease the possibility that benefits will be reduced or denied for inappropriate treatment setting or length of stay.

Prior to receiving treatment in a **hospital**, **residential/partial hospitalization** facility, or **approved treatment program**, the patient's attending physician should contact **our** Preauthorization Department. See the Preauthorization provision in the CONTRACT AND CLAIMS ADMINISTRATION Section for a description of the **preauthorization** process. **Preauthorization** is not required for involuntary commitment to a **state hospital**.

The Preauthorization Department will then recommend the expected length of stay and the appropriate treatment setting. Notification of **our** decision will be communicated by letter to the facility, the physician, and/or **you** or **your enrolled dependent**. The determination will be valid for 90 days from the date of the letter.

If an **emergency admission** must take place when **our** office is closed, please contact **us** immediately at the earliest opportunity during regular business hours. Only **emergency services** will be reimbursed when **preauthorization** has not been obtained. **We** may require transfer to a facility/program which is medically appropriate based on the criteria given previously.

In order to appropriately administer **your** or **your enrolled dependent's** benefits, **we** will need to evaluate certain information related to **your** or **your enrolled dependent's** care, such as diagnostic details; treatment codes; treatment plan; progress notes from the mental health provider; and, for inpatient care, admitting history and physical and discharge summary.

<u>Benefits</u>
Benefits for treatment of **mental illness** are subject to all the conditions, limitations and exclusions of this **benefits booklet**. See the GENERAL EXCLUSIONS Section for specific services/conditions excluded from coverage. **We** will cover the treatment of **mental illness** up to the following maximums for **you** and each of **your enrolled dependents**:

- for inpatient or **residential/partial hospitalization** care, 30 days each **calendar year** of care, including the services of a physician; and

- 20 **outpatient visits** per **calendar year** for mental health care.

On average, **enrollees** under this **plan** who use outpatient mental health services use seven outpatient visits per **calendar year**. This allows **enrollees** to regain stability and manage their symptoms, **our** most common goal for treatment. However, treatment goals will depend on the diagnosis of the disorder.

All services must be obtained from eligible providers under this **contract**, including, but not limited to, physicians licensed under RCW 18.83, a **community mental health agency** or a Washington **state hospital**.

Exclusions
In addition to the exclusions listed in the GENERAL EXCLUSIONS Section, **we** will not pay for family education or support groups.

Mental Health Services And Your And Your Enrolled Dependent's Rights
Regence BlueCross BlueShield of Oregon and state law have established standards to assure the competence and professional conduct of mental health service providers, to guarantee **your** and **your enrolled dependents'** right to informed consent to treatment, to assure the privacy of **your** and **your enrolled dependents'** medical information, to enable **you** and **your enrolled dependents** to know which services are covered under this **contract**, and to know the limitations on the coverage. If **you** or **your enrolled dependent** would like a more detailed description than is provided here of covered benefits for mental health services under this **contract**, or if **you** or **your enrolled dependent** has a question or concern about any aspect of mental health benefits, **you** or **your enrolled dependent** may contact **our** Customer Service Department (phone numbers are listed on the back of **your** identification card).

If **you** or **your enrolled dependent** would like to know more about **your** or his or her rights under the law, or **you** or **your enrolled dependent** thinks anything **you** or he or she received under this **plan** may not conform to the terms of the **contract** or rights under the law, **you** or **your enrolled dependent** may contact the Office of the Insurance Commissioner at 1-(800)-562-6900. If **you** or **your enrolled dependent** has a concern about the qualifications or professional conduct of the mental health service provider, **you** or **your enrolled dependent** may call the State Health Department at 1-(800)-525-0127.

Questions And Answers Regarding Mental Health Services

- What are the steps that must be taken to have outpatient mental health services paid for by my **plan**? (Outpatient visits for treatment of **mental illness** do not require any kind of referral or **preauthorization** to be covered.)

Yes	No	Description Of Services
√		Direct self-referral to a participating provider with no **preauthorization** or approval.
	√	Primary care provider referral required; primary care provider may determine the number of visits.
	√	**Preauthorization**, predetermination of medical necessity, preverification of benefits, and eligibility or referral required.

- What information about my mental condition will anyone other than my mental health provider see?

  In order to appropriately administer **your** or **your enrolled dependent's** benefits, **we** will need to evaluate certain information related to **your** or **your enrolled dependent's** care, such as diagnostic details; treatment codes; treatment plan; progress notes from the mental health provider; and, for inpatient care, admitting history and physical and discharge summary.

  We won't disclose **your** personal information unless **we** are allowed or required by law to make the disclosure, or if **you** (or **your** authorized representative) give **us** permission. Please see **our** Notice of Privacy Practices disclosure on **our** website www.myRegence.com.

- Do I have to pay a higher **copayment**, deductible, or other charges than I pay for my other covered medical services to get mental health services under this **plan**?

Same	Less	More	Type Of Copayment, Deductible, Etc.
√			Deductibles
√			**Copayments**
√			Coinsurance
		√*	Other Cost Sharing

* Benefits for the treatment of **mental illness** are limited. See Mental Illness under this Mental Illness limitation for specified maximums.

- What is the maximum number of **medically necessary** inpatient days and outpatient visits I can get each year under this **plan**?

  See Mental Illness under this Mental Illness limitation for specified maximums.

- What is the average number of outpatient visits this **plan** pays for people who have been provided mental health services:

On average, **enrollees** under this **plan** who use outpatient mental health services use seven outpatient visits per **calendar year**.

- In which of the following circumstances where I might need mental health services would I find them excluded or subject to restrictions or limitations other than **medical necessity**?

Restricted	Unrestricted	Excluded	Service
	√		Diagnostic testing to determine if mental disorder exists.
	√*		A mental disorder that has a congenital or physical basis, such as Tourette's Syndrome, or may be partially covered under the medical services portion of the health plan.
√*			A court orders treatment.
	√*		Treatment surrounding self-inflicted harm, such as a suicide attempt.
	√*		There is a diagnosed eating disorder.
√*			There is a diagnosed mental disorder related to sexual functioning, or a sex change.
√*			Couples for marriage therapy.
		√	**Custodial care**.

* Benefits for the treatment of **mental illness** are subject to limitations and exclusions of the **contract**.

- What is the plan's most common goal in financing treatment in adults? Children?

  Our most common goal for treatment for adults and children is to allow **enrollees** to regain stability and manage their symptoms. However, treatment goals will depend on the diagnosis of the disorder.

Biofeedback Therapy

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

Chiropractic Care

After a $15 **copayment, covered expenses** for the services of a chiropractor are limited to manipulation of the spine and related supporting services (including x-rays, lab, etc.) to treat a bone, muscle, or joint disorder. **Covered expenses** are paid at 100 percent of billed charges up to a $400 maximum for each **enrollee** per **calendar year**.

Note: Once the above maximum is reached, **we** will pay **contract** benefits for chiropractic care but only when such care is provided by a Washington Supplemental Provider. This listing of Washington Supplemental Providers is available to **you**, at no cost, upon enrollment or at any other time from **your Plan Administrator** or from **us** on **our** website at www.myRegence.com or through **our** Customer Service Department.

Alternative Care Providers

Each visit to a Washington-licensed chiropractor, acupuncturist, massage therapist, naturopath, nutritionist, a Washington-registered counselor, registered hypnotherapist, certified marriage and family therapist, and a certified mental health counselor is paid at 100 percent after a $15 **copayment**. (See the definition of **professional provider** and **preferred professional provider** in the **DEFINITIONS** Section for exact qualifications for Washington Supplemental Providers. This listing of Washington Supplemental Providers is available to **you**, at no cost, upon enrollment or at any other time from **your Plan Administrator** or from **us** on **our** website at www.myRegence.com or through **our** Customer Service Department.

Transplants

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

Definitions

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

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

facility transplant services and to base payment on such third party contracts.

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

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

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

Transplant means a procedure or a series of procedures by which an organ or tissue is either:

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

For purposes of this limitation, the term **transplant** includes a ventricular assist device (VAD) when used as a bridge to a heart **transplant** for a patient who is suffering from severe congestive heart failure, is in

imminent risk of dying before a heart is available, and has been approved as a heart **transplant** candidate. In addition, in treatment of cancer, the term **transplant** includes any chemotherapy and related course of treatment which the **transplant** supports.

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

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

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

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

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

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

<u>Benefits</u>
Benefits for a **covered transplant** are payable as follows:

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

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

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

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

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

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

Limited Waiver Of Contract Maximum Benefit

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

Preauthorization

All **transplant** procedures must be **preauthorized** for type of **transplant** and be **medically necessary** according to the common **preauthorization** process used consistently by all of **our** affiliate plans.

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

Preauthorization Procedures

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

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

12-Month Waiting Period

No benefits for **covered transplants** will be payable during the first 12 months an individual is covered under this **contract** except as follows:

- the 12-month waiting period will not apply if the **recipient** or **self-donor** has been continuously covered under this **contract** since birth; or

- **we** will reduce the duration of the 12-month waiting period by the amount of **your** or **your enrolled dependent's** combined periods of prior **creditable coverage** if the most recent period of **creditable coverage** ended within 63 days of **your** or **your enrolled dependent's enrollment date**. **Creditable coverage** means any of the following coverages:

  – group coverage (including FEHBP and Peace Corps);

  – individual coverage (including student health plans);

  – Medicaid;

  – Medicare;

  – CHAMPUS/Tricare;

  – Indian Health Service or tribal organization coverage;

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

  – state high risk pool coverage; and

  – public health plans (including S-CHIP health plans).

  Prior **creditable coverage** is determined separately for each **enrollee**. However, if benefits for the **transplant** would not have been payable under the previous coverage for any reason, no credits for such prior **creditable coverage** will be given under this **contract** toward the 12-month waiting period. The **enrollee** is responsible for furnishing evidence of the terms of **transplant** coverage under the previous coverage.

Exclusions

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

- any **transplant** performed outside of the United States;
- purchase of any organ or tissue;
- donor or organ procurement services and costs incurred outside the United States, unless specifically approved by **us**;
- any **transplant** procedure that has not been **preauthorized**;
- donation-related services or supplies provided to an enrolled **donor** if the **recipient** is not covered under this **contract** and eligible for **transplant** benefits. This exclusion does not apply to complications or unforeseen effects resulting from the donation of tissue;
- services or supplies for any **transplant** not specifically named as covered including the **transplant** of animal organs or artificial organs; and
- chemotherapy with autologous, allogeneic, or syngeneic hematopoietic stem cells **transplant** for treatment of any type of cancer not specifically named as covered.

Medicare

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

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

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

GENERAL EXCLUSIONS

The following services and supplies are not covered:

Services Otherwise Available
This exclusion includes:

- services and supplies for which payment could be obtained in whole or in part if **you** or **your enrolled dependent** had applied for reimbursement under any program funded in whole or in part under any city, county, state, or federal government except for Medicaid coverage;

- services and supplies **you** or **your enrolled dependent** could have received in a **hospital** or program operated by a government agency or authority, unless reimbursement under this **contract** is otherwise required by law;

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

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

Conditions Incurred In Or Aggravated During Performance In The Uniformed Services
The treatment of any **enrollee's** condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Conditions Caused By Active Participation In A War Or Insurrection
The treatment of any condition caused by or arising out of an **enrollee's** active participation in a war or insurrection.

Third Party Liability
Services and supplies for treatment of **illness** or **injury** for which a third party is responsible to the extent of any recovery received from or on behalf of the third party. See the Third Party Liability provision in the CONTRACT AND CLAIMS ADMINISTRATION Section.

Motor Vehicle Coverage
Services and supplies for treatment of **illness** or **injury** to the extent **you** or **your enrolled dependent** recovers or is entitled to recover from motor vehicle insurance including, but not limited to, primary medical payments coverage, uninsured motorists, or underinsured motorist coverage. See the Motor Vehicle Coverage provision in the CONTRACT AND CLAIMS ADMINISTRATION Section.

Work-Related Conditions
Services and supplies for treatment of **illness** or **injury** arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense for the service or supply is paid under workers' compensation. The only exception would be if **you** or **your enrolled dependent** is exempt from state or federal workers' compensation law. See the Workers' Compensation provision in the CONTRACT AND CLAIMS ADMINISTRATION Section.

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

- have not yet received final 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 which it is being prescribed, 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, a medication must be so recognized:

  - in one of the standard reference compendia;

  - in a majority of relevant **peer-reviewed medical** (**or dental**) **literature** if not recognized in one of the standard reference compendia; or

  - by the U.S. Secretary of Health and Human Services;

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

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

    well-designed and well-conducted clinical trials documenting improved health outcomes published in **peer reviewed medical** (**or dental**) **literature. Peer reviewed medical** (**or dental**) **literature** means a US scientific

publication which requires that manuscripts be submitted to acknowledged experts inside or outside the editorial office for their considered opinions or recommendations regarding publication of the manuscript. Additionally, in order to qualify as **peer reviewed medical** (**or dental**) **literature**, the manuscript must actually have been reviewed by acknowledged experts before publication; and

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

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

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

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

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

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

APPEAL PROCEDURE: If **we** deny a request for **preauthorization** of benefits or a claim on the basis of this exclusion, **enrollees** may appeal the denial by submitting an appeal request according to the Member Appeals Process provision of this **contract**.

However, once **we** have received a fully documented request, a review of the request will be made and **you** will receive a response from **our** grievance coordinator within 14 days for **preauthorization** requests, and within 20 days for claim requests.

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**.

Services Provided By A Member Of Your Immediate Family

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

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

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

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

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

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

Orthodontic Treatment

Gender Identity Disorders
Services and supplies to diagnose, rule out, or treat gender identity disorders (including sex change procedures) as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders. However, treatment of children under age 19 for such diagnoses may be covered and should be **preauthorized**. See the Preauthorization provision in the CONTRACT AND CLAIMS ADMINISTRATION Section for a description of the **preauthorization** process.

Treatment Of Mental Illness For Which There Is No Effective Cure

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

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

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

- routine physical examinations, except as may be specifically covered in the **contract** and except for routine annual Pap smear and breast mammographies according to the guidelines of the American Cancer Society;

- eye examinations, including eye exercises;

- the fitting, provision, or replacement of eyeglasses except as specifically covered in the **contract**;

- routine tests and screening procedures, except as specifically covered in the **contract**;

- treatment for corns and calluses, removal of nails (except complete removal), and other routine foot care;

- the fitting, provision, or replacement of hearing aids, including implantable hearing aids and the surgical procedure to implant them except as specifically covered in the **contract**;

- telephone consultations, completion of claim forms, or completion of reports requested by **us** in order to process claims;

- self-help or training programs, including, but not limited to, those to stop smoking, control weight, or provide general fitness;

- programs that teach a person how to use **durable medical equipment** or how to care for a family member;

- instruction programs, including, but not limited to, those to learn to self-administer medications or nutrition, except as specifically covered in the **contract**;

- 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**, **nursing home**, 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.

Off-The-Shelf Orthotics
We do not cover off-the-shelf orthotics or orthotics that are not **medically necessary**.

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

Dental Examinations And Treatments
Except as specifically described as covered in this **benefits booklet**. For the purposes of this exclusion, the term **dental examinations and treatments** means services and supplies provided to prevent, diagnose,

or treat diseases or conditions of the teeth and supporting tissues or structures, including, but not limited to, services and supplies rendered:

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

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

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

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.

Services Rendered By Nonparticipating Providers
Notwithstanding the BlueCard Program provision of the **contract**, and unless the **contract** states otherwise, services and supplies rendered by an acupuncturist, massage therapist, naturopath, or chiropractor not directly contracted with Regence BlueCross BlueShield of Oregon.

CONTRACT AND CLAIMS ADMINISTRATION

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

Third-Party Liability

This provision applies when **you** incur health care expenses in connection with an **illness** or **injury** for which one or more third parties may be responsible. In that situation, benefits for otherwise **covered expenses** are excluded under this **contract** to the extent **you** receive a recovery from or on behalf of the responsible third party in excess of full compensation for the loss. **We** refer to the legally liable party as the "third party" in this provision. If **you** do not pursue a recovery of the benefits **we**

have advanced, we may choose, in **our** discretion, to pursue recovery on **your** behalf (this is called subrogation).

Here are some rules which apply in these third-party liability situations:

- If a claim for health care expense is filed with **us** and **you** have not yet received recovery from the responsible third party, **we** will advance benefits for **covered expenses** if **you** agree to hold, or direct **your** attorney or other representative to hold, the recovery against the other party in trust for **us** to the extent it exceeds full compensation to **you** for the loss, up to the amount of benefits **we** paid in connection with the **illness** or **injury**.

- **You** and/or **your** agent or attorney must agree to keep segregated in its own account the amount of the benefits **we** have paid for the condition from any recovery or payment of any kind for **your** benefit or on **your** behalf that is in any manner related to the **illness** or **injury** giving rise to **our** right to reimbursement, until **our** right is satisfied or released.

- In the event **you** and/or **your** agent or attorney fails to comply with any of the above conditions, **we** may recover any benefits **we** have advanced for any **injury** or **illness** through legal action against **you** and/or **your** agent or attorney.

- If **we** pay benefits for the treatment of an **illness** or **injury**, **we** will be entitled to have the amount of the benefits **we** have paid for the condition separated from the proceeds of any recovery **you** receive out of any settlement or recovery from any source, including any arbitration award, judgment, settlement, disputed claim settlement, uninsured motorist payment, or any other recovery related to the **injury** or **illness** for which **we** have provided benefits, to the extent it exceeds full compensation to **you** for the loss. This is true regardless of whether:

  - the third party or the third party's insurer admits liability;

  - the health care expenses are itemized or expressly excluded in the third-party recovery; or

  - the recovery includes any amount (in whole or in part) for services, supplies, or accommodations covered under the **contract**. The amount to be held in trust shall be calculated based upon claims that are incurred on or before the date of settlement or judgment, unless agreed to otherwise by the parties.

- Any benefits **we** advance are solely to assist **you**. By advancing such benefits, **we** are not acting as a volunteer and are not waiving any right to reimbursement or subrogation.

Motor Vehicle Coverage

Most motor vehicle insurance policies provide medical expense coverage and uninsured and/or underinsured motorists insurance. When **we** use the term **motor vehicle insurance** below, it includes medical expense coverage, personal injury protection coverage, uninsured motorists coverage, underinsured motorists coverage, or any coverage similar to any of these coverages. Benefits for health care expenses are excluded under this **contract** to the extent that **you** receive payments from medical expense coverage, personal injury protection coverage, uninsured motorists coverage, or underinsured motorists coverage. Benefits for health care expenses are excluded under this **contract** if **you** receive payments from medical expense coverage, personal injury protection coverage, uninsured motorists coverage, or underinsured motorists coverage for such expenses to the extent those payments exceed the amount necessary to fully compensate **you**, along with all other payments **you** receive to compensate **you** for **your injuries**, losses, or damages, for those **injuries**, losses, or damages.

Here are some rules which apply with regard to motor vehicle insurance coverage:

- If a claim for health care expenses arising out of a motor vehicle accident is filed with **us** and motor vehicle insurance has not yet paid, **we** may advance benefits for **covered expenses** as long as **you** agree in writing:
  - to give **us** information about any motor vehicle insurance coverage which may be available to **you**; and
  - to otherwise secure **our** rights and **your** rights.
- If **we** have paid benefits before motor vehicle insurance has paid, **we** are entitled to have the amount of the benefits **we** have paid separated from any subsequent motor vehicle insurance recovery or payment made to or on behalf of **you** held in trust for **us**. The amount of benefits **we** are entitled to will never exceed the amount **you** receive from all insurance sources that fully compensates **you** for **your** loss and we will only seek to recover amounts **you** have received from other insurance sources to the extent those amounts exceed full compensation to **you** for **you**r other **injuries**, losses, or damages.
- **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, both this provision and the Third-Party Liability provision apply. However, **we** will not seek double reimbursement.

Workers' Compensation

This provision applies if **you** have filed or are entitled to file a claim for workers' compensation. Benefits for treatment of an **illness** or **injury** arising out of or in the course of employment or self-employment for wages or profit are excluded under this **contract**. The only exception would be if **you** are exempt from state or federal workers' compensation law.

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

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

- If the entity providing workers' compensation coverage denies **your** claims and **you** have filed an appeal, **we** may advance benefits for **covered expenses** if **you** agree to hold any recovery obtained in trust for **us** according to the Third-Party Liability provision.

Coordination Of Benefits

This Coordination Of Benefits (COB) provision applies when an **enrollee** has health care coverage under more than one **Plan**. **Plan** is defined below.

The order of benefit determination rules govern the order which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary Plan**. The **Primary Plan** must pay benefits according to its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary Plan** is the **Secondary Plan**. The **Secondary Plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100 percent of the total **Allowable Expense**.

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

- A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

- **Plan** includes: group, individual, or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), **Closed Panel Plans** or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

- **Plan** does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under the two preceding paragraphs is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

- **This Plan** means, in a COB provision, the part of the **contract** providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the **contract** providing health care benefits is separate from **This Plan**. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

- The order of benefit determination rules determine whether **This Plan** is a "**Primary Plan**" or "**Secondary Plan**" when the **enrollee** has health care coverage under more than one **Plan**.

- When **This Plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan**'s benefits. When **This Plan** is secondary, it determines its benefits after those of another **Plan** and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total **Allowable Expense** for that claim. This means that when **This Plan** is secondary, it must pay the amount which, when combined with what the **Primary Plan** paid, totals 100 percent of the highest **Allowable Expense**. In addition, if **This Plan** is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the **Primary Plan**) and record these savings as a

benefit reserve for the **enrollee.** This reserve must be used to pay any expenses during that **calendar year**, whether or not they are an **Allowable Expense** under **This Plan**. If **This Plan** is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

- **Allowable Expense** is a health care expense, including deductibles, coinsurance and **copayments**, that is covered at least in part by any **Plan** covering the **enrollee.** When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable Expense** and a benefit paid. An expense that is not covered by any **Plan** covering the **enrollee** is not an **Allowable Expense**.

  The following are examples of expenses that are not **Allowable Expenses**:

  - The difference between the cost of a semiprivate hospital room and a private hospital room is not an **Allowable Expense**, unless one of the **Plans** provides coverage for private hospital room expenses.

  - If an **enrollee** is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable Expense.**

  - If an **enrollee** is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable Expense**.

- **Closed Panel Plan** is a **Plan** that provides health care benefits to **enrollee**s in the form of services through a panel of providers who are primarily employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

- **Custodial Parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the **calendar year** excluding any temporary visitation.

Order Of Benefit Determination Rules

When an **enrollee** is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

- The **Primary Plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan.**

- A **Plan** that does not contain a coordination of benefits provision that is consistent with chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both **Plans** state that the complying plan is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the **Plan** provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed Panel Plan** to provide out-of-network benefits.

- A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan.**

- Each **Plan** determines its order of benefits using the first of the following rules that apply:

  - Non-Dependent Or Dependent -- The **Plan** that covers the **enrollee** other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree is the **Primary Plan** and the **Plan** that covers the **enrollee** as a dependent is the **Secondary Plan**. However, if the **enrollee** is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the **enrollee** as a dependent, and primary to the **Plan** covering the **enrollee** as other than a dependent (e.g., a retired employee), then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the **enrollee** as an employee, member, policyholder, subscriber, or retiree is the **Secondary Plan** and the other **Plan** is the **Primary Plan.**

  - Dependent Child Covered Under More Than One Plan -- Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

    (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      (i) the **Plan** of the parent whose birthday falls earlier in the **calendar year** is the **Primary Plan**; or

(ii) if both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary Plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) if a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to claim determination periods commencing after the **Plan** is given notice of the court decree;

(ii) if a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

(iii) if a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of rule (a) above determine the order of benefits;

(iv) if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of rule (a) above determine the order of benefits; or

(v) if there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

1. the **Plan** covering the **Custodial Parent**, first;

2. the **Plan** covering the spouse of the **Custodial Parent**, second;

3. the **Plan** covering the noncustodial parent, third; and then

4. the **Plan** covering the spouse of the noncustodial parent, last.

(c) For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the

provisions of rules (a) or (b) above determine the order of benefits as if those individuals were the parents of the child.

- Active Employee Or Retired Or Laid-Off Employee -- The **Plan** that covers an **enrollee** as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary Plan**. The **Plan** covering that same **enrollee** as a retired or laid-off employee is the **Secondary Plan**. The same would hold true if an **enrollee** is a dependent of an active employee and that same **enrollee** is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under Non-Dependent Or Dependent can determine the order of benefits.

- COBRA Or State Continuation Coverage -- If an **enrollee** whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the **enrollee** as an employee, member, subscriber, or retiree or covering the **enrollee** as a dependent of an employee, member, subscriber, or retiree is the **Primary Plan** and the COBRA or state or other federal continuation coverage is the **Secondary Plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under Non-Dependent Or Dependent can determine the order of benefits.

- Longer Or Shorter Length Of Coverage -- The **Plan** that covered the **enrollee** as an employee, member, policyholder, subscriber, or retiree longer is the **Primary Plan** and the **Plan** that covered the **enrollee** the shorter period of time is the **Secondary Plan**.

If the preceding rules do not determine the order of benefits, the **Allowable Expenses** must be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This Plan** will not pay more than it would have paid had it been the **Primary Plan**.

Effect On The Benefits Of This Plan
When **This Plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a claim determination period are not more than the total **Allowable Expenses**. In determining the amount to be paid for any claim, the **Secondary Plan** must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total **Allowable Expense** for that claim. Total **Allowable Expense** is the highest **Allowable Expense** of the **Primary Plan** or the **Secondary Plan**. In addition, the **Secondary**

Plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

Right To Receive And Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under **This Plan** and other **Plans**. **We** may get the facts **we** need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this **Plan** and other **Plans** covering an **enrollee** claiming benefits. **We** need not tell, or get the consent of, any person to do this. Each **enrollee** claiming benefits under **This Plan** must give **us** any facts **we** need to apply those rules and determine benefits payable.

Facility Of Payment
If payments that should have been made under **This Plan** are made by another **Plan**, **we** have the right, at **our** discretion, to remit to the other **Plan** the amount **we** determine appropriate to satisfy the intent of this provision. The amounts paid to the other **Plan** are considered benefits paid under **This Plan**. To the extent of such payments, **we** are fully discharged from liability under **This Plan**.

Right Of Recovery
We have the right to recover excess payment whenever **we** have paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. **We** may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

If an **enrollee** is covered by more than one health benefit plan, the **enrollee** or his or her provider should file all claims with each **Plan** at the same time. If Medicare is the **Primary Plan**, Medicare may submit claims to the **enrollee's** secondary carrier on their behalf.

If the **group** or **enrollee** has questions about this Coordination Of Benefits provision, please contact the Washington State Insurance Department.

Benefits Are Not Transferable

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

Submission And Payment Of Claims

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

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

We have the sole right to decide whether to pay benefits to **you**, to the provider of services, or to **you** and the provider jointly.

Hospital Claims

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

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

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

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

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

Professional Provider Claims

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

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

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

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

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

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

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

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

review process, in which case legal action must be filed within three years of completion of that process.

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

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

Member Appeals Process

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

First Step, Filing The Initial Appeal
There are three steps to **our** appeal process. The first level of review is filing a **grievance**. **You** may file **your grievance** within 180 days of **our** decision by writing **us** a letter, filling out a **grievance** form, or by contacting **our** Customer Service Department to provide **your** information over the phone. The Customer Service contact information is provided below. **We** will send **you** an acknowledgement letter outlining **your** issues, as well as advising **you** of **your** rights. **You** or **your** representative will receive a written decision from **our** grievance coordinator within 14 days of **our** receipt of **your** grievance. **We** may request an extension to 30 days if additional time is needed. For postservice claims involving an investigational procedure, **you** will receive a response within 20 working days.

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

- for appeal of preservice claims, within 14 calendar days of **our** receiving **your** appeal;

- for appeals of postservice claims denied as investigational, within 30 calendar or 20 working days of **our** receiving **your** appeal; or

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

If We Fail To Respond Within The Time Periods
If **we** fail to respond within the time periods provided, **you** may proceed as if **your** complaint has been rejected, including submitting such complaint to an independent review organization.

Third Step, External Independent Review
The third and final level of appeal may be filed verbally or in writing within 180 days of **our** decision. **You** have the right to an independent review of decision made by **us.** The appeal will be conducted by an independent review organization (IRO). An IRO is not connected in any way with Regence BlueCross BlueShield of Oregon and **you** are not responsible for the costs of the independent review. A written response to **your** appeal will be sent to **you**.

If **you** are not sure whether **your** appeal is eligible for an independent external review or **you** want more information, please contact **our** Customer Service Department. The Customer Service contact information is provided below.

Continued Payment Of Services
If **you** request review of **our** denial of services due to **our** modifying, refusing, or terminating services previously covered, **we** will continue to pay for those services until **we** reach a determination or the determination by the IRO is completed. If **our** determination or the determination by the IRO agrees with **our** denial, **you** will be responsible for the cost of the continued health service that was paid for under this provision.

Expedited Procedure
If **you** or **your** representative believes that a decision denying **preauthorization** or referral for a service will jeopardize **your** life, health, or ability to regain maximum function, **you** or **your** representative may request an expedited appeal. **You** can do this by contacting the Customer Service Department and requesting an expedited review of **your** case. A decision will be made within 72 hours or less. However, if the appeal does not meet the expedited criteria, the appeal will be handled through the standard process.

Contact Us
For information about **our Grievance** and Appeals process, **you** may contact **our** Customer Service Department at (Portland area) (503) 225-

5336, or toll-free at (800) 452-7390, or **you** can write to **our** Customer Service Department at the following address:

Regence BlueCross BlueShield of Oregon
Customer Service Department
Grievance or Appeal Coordinator, C-7A
PO Box 1271
Portland, OR 97207-9861

Contacting The Insurance Commissioner
You also have the right to file a complaint and seek assistance from the office of the Insurance Commissioner. **You** can write to the Insurance Commissioner at:

Office of the Insurance Commissioner
ATTN: Consumer Advocacy
PO Box 40256
Olympia, WA 98504-0256

Or call: (800) 562-6900 (toll-free in WA only)
(360) 586-0241 (TDD)

Or visit their website at www.insurance.wa.gov

Preauthorization

There are certain medical services and supplies (including medications) which must be **preauthorized** before they will be considered for payment under the **contract**. **Preauthorization** and **preauthorize** mean the procedure whereby **we** determine that the proposed service or supply is **medically necessary** based upon the information provided to **us.**

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

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

Preauthorization By Noncontracting Providers -- If **you** or **your enrolled dependent** receives care from a provider with whom **we** have not contracted, **you** or **your enrolled dependent** may be liable for charges **we** deny because the service or supply is not **medically necessary**.

Avoid that risk by asking **your** or **your enrolled dependent's** provider to contact **our** Preauthorization Department.

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

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

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

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

Mail:	PO Box 1271, E-9B Portland, OR 97207-1271	
Telephone:	Portland area: Toll-free:	(503) 525-4795 1-(800)-824-8563

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

Mail:	PO Box 1271, E-9B Portland, OR 97207-1271	
Telephone:	Portland: Toll-free:	(503) 226-8783 1-(800)-560-0749
Fax:		(503) 226-8754

<u>Honoring Preauthorization</u>
We will honor **your** or **your enrolled dependent's preauthorization** for the 30 calendar days following **preauthorization**, unless coverage under this **plan** terminates and **we** are aware of and notify **you** or **your enrolled dependent** of such termination before the end of those 30 days. In that

case, **we** will cover only the **preauthorized** service or supply if incurred prior to termination.

Medication Rebate

Regence BlueCross BlueShield of Oregon participates in arrangements with medication manufacturers which allow **us** to receive rebates based, among other things, on the volume of certain prescription medications purchased on behalf of **enrollees**. Any rebates **we** receive from medication manufacturers are credited directly or indirectly to the **group** to reduce prescription medication claims expense and thereby help reduce future premium rate increases. **We** will withhold a percentage of the total rebate to cover **our** costs of collecting and administering the rebate program. What this means is that even if **you** do not have prescription medication coverage, the retail price **you** pay toward prescription medications will be discounted when **you** present **your** Regence BlueCross BlueShield of Oregon identification card to the pharmacy at the time of purchase.

Out-Of-Area Claims Service - BlueCard® Program

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

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

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

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

Often, this "negotiated price" will consist of a simple discount. But, sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, or other nonclaims transactions with **your** health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average

expected savings with **your** provider or a group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount **you** pay is considered a final price and **you** will not be responsible for any balances beyond any deductible and coinsurance amount.

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

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

Replacing Earlier Contract

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

You Must Submit Health Information

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

Health Care Responsibility

All health care services are provided by facilities and professionals who are neither employees nor agents of Regence BlueCross BlueShield of Oregon. The fact that a provider is listed in **our** provider directory does

not mean the provider is **our** employee or agent. **Your** providers are responsible for the quality of care they render. **We** are responsible for the quality of health care **you** receive only as provided under RCW 48.43.545.

Claims Recoveries

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

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

WHO IS ELIGIBLE

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

Employees

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

Dependents

If **you** are married, **your** legal spouse is eligible to apply for coverage. So are **your** qualified domestic partner and **your** or **your** qualified domestic partner's unmarried children under age 25.

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

- both domestic partners are in an intimate, committed and exclusive relationship;
- share a common residence;
- are each 18 years of age or older;
- not married to another party and are each other's sole domestic partner;
- are capable of consenting to this domestic partnership; and
- both of the following are true;
  - neither domestic partner are not nearer of kin to each other than second cousins, whether of whole or half blood computing by the rules of civil law; and
  - neither domestic partner is a sibling, child, grandchild, aunt, uncle, niece, nephew to the other person.

The following are considered children:

- **your** or **your** qualified domestic partner's natural child;

- **your** or **your** qualified domestic partner's adoptive child, a stepchild living in **your** home, or a nonresident stepchild if there is a qualified medical child support order that requires the spouse or **your** domestic partner to provide health insurance coverage; and

- children related to **you** or **your** qualified domestic partner by blood or marriage for whom **you** are the legal guardian (**you** will need to provide a court order showing legal guardianship).

If **you** have a child who is incapable of self-support because of a physical handicap or developmental disability, that child may be eligible to remain enrolled even though he or she is over the maximum age allowed for dependent children under the **contract**. To be eligible the handicap must have occurred before the child reaches the maximum age allowed under the **contract**. **You** must certify to **us** that these conditions have been met within 31 days before or 31 days after the child reaches the maximum age. **We** will not require additional proof of incapacity more frequently than annually after the two-year period following the child's attainment of the limiting age.

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

Newly Acquired Dependents

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

New Spouse (Including Stepchildren)
If **you** marry while **you** are enrolled under the **contract**, **your** spouse and his or her children become eligible to apply for coverage under this **contract** 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 **contract** on the date the Declaration of Domestic Partnership is executed. When application for coverage is submitted to **us**, it must include a completed Declaration of Domestic Partnership.

Newborn Children
Your or **your enrolled dependent**'s newborn child will be covered for 31 days after it is born, including but not limited to coverage for congenital anomalies. **We** must have notice of the birth. To continue the newborn's coverage beyond this 31-day period, the child must be eligible under the terms of the **contract**. It is important to note that, except in the case of a

newborn of a female **enrollee** receiving maternity benefits under this **contract**, **we** may terminate coverage retroactive to date of birth when a newborn child does not meet the eligibility requirements of this **contract.**

Adoptive Children
A child will be enrolled as **your** or **your** qualified domestic partner's dependent child on the date of assumption by **you** of a legal obligation for full or partial support of the child in anticipation of adoption.

HOW TO ENROLL

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

When You First Become Eligible

You must file an application for **yourself** and any dependents **you** want enrolled within 31 days before or after the **normal effective date** (see WHEN GROUP COVERAGE BEGINS). **You** file the application with **your** employer's payroll or personnel office.

Enrolling New Dependents

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

If **you** do not already have family coverage and **you** want to continue coverage for **your** natural newborn child beyond the first 31 days or to enroll an adoptive child, **you** must submit a new application, including any additional premium to the **group**, listing the newborn or adoptive child as a dependent within 60 days after the child is born or the date of assumption.

Late Enrollment

If **you** and/or **your** eligible dependents wish to enroll under the **contract** but did not enroll when first eligible (late enrollee), **you** may apply for coverage as follows:

- During **your group's** annual Open Enrollment period. Check with the group administrator regarding the Open Enrollment period. **You** must file an application before the Open Enrollment period in order to obtain coverage.
- If **you** and/or **your** eligible dependents lose coverage under another group **health benefit plan** or health insurance due to:

- the exhaustion of federal COBRA or Washington state (if applicable) continuation;

- loss of eligibility (including legal separation, divorce, death, termination of employment or reduction in hours, or exhaustion of lifetime maximum on total benefits); or

- the employer contributions were terminated;

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

- If **you** declined coverage when **you** were first eligible and **you** subsequently marry, **you** become eligible for coverage under this **contract** on behalf of **yourself**, **your** spouse, and any eligible dependent children on the date of marriage.

- If **you** declined coverage when **you** were first eligible and **you** subsequently acquire a new dependent child by birth, adoption, or placement for adoption, **you** become eligible for coverage under this **contract** along with **your** eligible spouse and eligible dependent children including the newly acquired child on the date of the birth, adoption, or placement.

- If **you** and/or **your** dependents declined coverage when initially eligible because **you** and/or **your** dependents were enrolled under a Department of Social and Health Services (DSHS) plan, **you** and/or **your** eligible dependents are eligible to enroll under this **contract** within the 60 days following the Washington State Department of Social and Health Services' (DSHS') determination that it is cost-effective for the eligible employee and/or dependent to have coverage under the **contract**.

- If the **group** has an **alternative health benefit plan** (see the DEFINITIONS Section) and **you** and **your** dependents (if any) were covered under that plan, **you** and **your** eligible dependents will be considered eligible to enroll under this **contract** on the date **you** move to an area not serviced by the **alternative health benefit plan** or the date the **alternative health benefit plan** ceases operation.

WHEN GROUP COVERAGE BEGINS

If **we** receive **your** and/or **your enrolled dependents'** application, including premium, within the allowed time (see HOW TO ENROLL), the date coverage under the **contract** begins (the **normal effective date**) for **you** and/or **your** eligible dependents (other than newborn or adoptive

children, see below) will be the first of the month following the date **you** or **your enrolled dependent** became eligible to apply for coverage.

The exception to the above is if **you** are enrolling **yourself** along with **your** eligible dependents according to the Late Enrollment provision when **you** declined coverage when **you** were first eligible and **you** subsequently acquire a new dependent child by birth, adoption, or placement for adoption. In this case, **your** and **your enrolled dependents' normal effective date** will be the date of birth, adoption, or placement as long as **we** receive **your** application and premium within the allowed time.

Newborn And Adoptive Children

Coverage for **your** newborn child begins as of the date of birth. However if **you** do not already have family coverage, **you** must apply and pay the applicable premium within 60 days of the birth to continue coverage beyond the first 31 days.

If **you** already have family coverage, coverage for an adoptive child will begin as of the date **you** assume a legal obligation for full or partial support of the child in anticipation of adoption. If **you** do not have family coverage, **you** must apply and pay the applicable premium within 60 days of the date of assumption for the child to be added as of the date of assumption.

Failure to apply as required for a newborn or adoptive child means **you** must wait until the next Open Enrollment period to add the child.

WHEN GROUP COVERAGE ENDS

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

Contract Termination

If the **contract** is terminated, coverage ends for **you** and **your enrolled dependents** on the date the **contract** terminates.

If the **contract** terminates and the **group** replaces this **contract** with other group coverage within 31 days, the right to convert to an individual conversion plan is not available.

Termination By Enrolled Employee

You may end **your** coverage, or coverage for any **enrolled dependent**, by giving **us** written notice through the **group**. Coverage will end on the last day of the monthly period through which premiums are paid. If **you** end **your** own coverage, coverage for **your** dependents also ends.

If You Die

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

If Your Dependents Lose Eligibility

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

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

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

It may be possible for **your** ineligible dependents to continue coverage under this **contract** according to the CONTINUATION OF COVERAGE Section of this **benefits booklet**. These dependents have the right to convert to individual coverage when their group coverage ends as explained in the CONVERSION TO INDIVIDUAL COVERAGE Section of this **benefits booklet**.

If You Lose Eligibility

If **you** are no longer eligible as explained in the following paragraphs, **your** and **your enrolled dependents**' coverage ordinarily ends on the last day of the monthly period in which **your** eligibility ends. However, it may be possible for **you** and/or **your enrolled dependents** to continue coverage under this **contract** according to the CONTINUATION OF COVERAGE Section of this **benefits booklet**. **You** also have the right to convert to individual coverage according to the CONVERSION TO INDIVIDUAL COVERAGE Section.

Leaves Of Absence
This provision describes what happens with **your** coverage when **your group** grants **you** a leave of absence. In all cases, premium for **you** and any of **your enrolled dependent's** must be paid to **us** during an approved leave of absence.

A leave of absence is a period off work preapproved and granted by **your** employer during which **you** are considered by the **group** to be in active status. A leave can be granted for any reason acceptable to the **group**. It's important to note that if **you** qualify under more than one leave of absence at any one time, all leaves of absence will run concurrently.

Family And Medical Leave - If the leave of absence is an authorized Family and Medical Leave Act of 1993 (FMLA), **you** and **your enrolled dependents** will remain eligible to be enrolled under the **contract** during the approved leave. In all events, **your** and **your enrolled dependents**' rights under the FMLA will be at least those of the Family and Medical Leave Act of 1993 and its regulations.

If **you** and/or **your enrolled dependents** elect not to remain enrolled during the leave, **you** (and/or **your enrolled dependents**) will be eligible to be reenrolled under the **contract** on the date **you** return from the FMLA leave. In order to reenroll after **you** return from a FMLA leave, **you** must sign a new application within 90 days of **your** return to work. In this situation, all of the terms and conditions of the **contract** will resume at the time of reenrollment as if there had been no lapse in coverage. **You** (and/or **your enrolled dependents**) will receive credit for any waiting period served prior to the FMLA leave and **you** will not have to re-serve any group eligibility waiting period under this **contract**, although **you** and/or **your enrolled dependents** will receive no waiting period credits for the period of noncoverage.

On-The-Job Injury Or Illness Leave - If the leave of absence is necessary due to **your** suffering a workers' compensation on-the-job **injury** or **illness** and the medical prognosis is for **your** return to work in an active status within one year, **you** can continue coverage according to the CONTINUATION OF COVERAGE Section of this **benefits booklet**. Or, if **you** choose, **you** may continue coverage for **yourself** and **your enrolled dependents** as if **you** were an active employee for up to 12 months. If **you** remain covered in this "active employee" status and **you** are unable to return to active work after 12 months, **you** can continue coverage under the CONTINUATION OF COVERAGE provision of this **benefits booklet**, however the last six months of leave of absence coverage under the **contract** will be counted toward the period of time allowed under COBRA continuation.

Other Leaves Of Absence - If **you** are granted a non-FMLA or non-workers' compensation leave of absence for **your** own illness or injury by **your group** and the intention is for **you** to return to work in an active status, **you** can continue coverage for up to six months. If **you** are

unable to return to active work after six months, **you** can continue coverage under the CONTINUATION OF COVERAGE provision of this **benefits booklet**.

Strike Or Lockout
If **you** are involved in a work stoppage because of a strike or lockout or other labor dispute, **your** coverage can be continued for up to six months. **You** are responsible for the full premium as it comes due and may make payment directly to the **group**. In all cases, **we** must receive the premiums by the Premium Due Date.

This six months of continued coverage is in lieu of and not in addition to any continuation of coverage provisions of the **contract.**

Termination Of Employment
If **your** employment terminates, **your** coverage will ordinarily end for **you** and all **enrolled dependents** on the last day of the **group**'**s** premium payment period during which employment ends.

Reenrolling After Arbitrator's Reinstatement
If **you** are rehired and return to active work within 24 months of an arbitrator's reinstatement, **you** and any previously **enrolled dependents** may reenroll under the **contract** on the date **you** are rehired, regardless of any lapse in coverage.

Your group must notify **us** that **you** are being rehired following an arbitrator's reinstatement and the necessary premiums for **your** coverage must be paid. **You** must complete and sign a new application listing all eligible dependents to be reenrolled.

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

Furthermore, if **you** are rehired within the same **calendar year**, **you** will receive credit for any deductible applied during **your** previous enrollment for that **calendar year**. **Your enrolled dependents**, who were enrolled under the **contract** at the time **you** were discharged prior to arbitration overturning the discharge, may also reenroll and any previously satisfied deductible amounts will be credited if reenrollment occurs in the same **calendar year**.

Rescinding Coverage

We may rescind the **contract** from the beginning as never effective for established fraud by the **group** and **we** may rescind **your** and/or **your enrolled dependent's** coverage for established fraud.

If **we** rescind, **we** will reimburse premium less any claims paid; and will pursue reimbursement for claims paid exceeding any premium. If **we** rescind for established fraud, **we** reserve the right to deny future coverage for groups and individuals whose coverage has been rescinded for established fraud committed by them, subject to state guaranteed eligibility laws.

CONTINUATION OF COVERAGE (COBRA)

This section applies only when the group health plan of the **group** is subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA. This section will automatically cease to be effective when federal law requiring continuation of eligibility for coverage no longer applies to the group health plan. Check with **your** plan administrator to see if it applies.

Under certain circumstances, **you** and/or **your enrolled dependents** may have the right to continue coverage beyond the time coverage would ordinarily have ended. The following rights and obligations regarding continuation of coverage are governed by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. In the event of any conflict between this Continuation of Coverage provision and COBRA, COBRA shall govern.

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

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

Your spouse or **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 **contract**.

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 **contract** during the continuation period shall be considered a qualified beneficiary.

Notification Responsibilities
You or **your enrolled dependent** has the responsibility to inform the **group's** 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 **group's** plan administrator within 31 days of noncompliance with any of the qualifying conditions of the partnership. The **group** has the responsibility to notify the **group's** plan administrator of the employee's death, termination of employment, reduction in hours, or Medicare eligibility.

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

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

Making Monthly Payments
You or **your enrolled dependent** is responsible for the full cost of continuation. Please note that for qualified beneficiaries whose coverage is extended beyond 18 months due to disability, **we** will charge 148 percent of the regular monthly premium in addition to the 2 percent administration fee the **group** may charge. Premium for continuation of coverage must be paid to the **group** on a timely basis within 30 days of the **group's** Premium Due Date. The only exception is the premium payment for the period preceding the election which may be made up to 45 days from the date of election. Premium for those on continuation must be submitted to **us** each month with the **group's** regular monthly premium payment in order to maintain continuation of coverage.

How Long Continued Coverage Lasts
Coverage may be continued as follows:

- For termination of employment or reduction of hours, continuation may last for up to 18 months. However, there is one exception. It applies when a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time prior to or during the first 60 days of continuation coverage. In that situation, each qualified beneficiary may have up to a total of 29 months of continuation, but only if the Social Security Administration makes the determination within the first 18 months of that continuation period and the qualified beneficiary notifies the plan administrator both within that 18-month period and within 60 days of the determination. Thereafter, if there is a final determination of nondisability, the qualified beneficiary must so notify the plan administrator within 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 death, dissolution of marriage, termination of domestic partnership, or **your** legal separation, continuation may last for up to 36 months.

- 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 **contract** will end for a person on the last day of the monthly premium payment period in which any of the following occurs, whichever happens first:

- premium for a person on continuation is not paid to the **group** or to **us** on a timely basis;

- after electing continuation a person becomes covered under any other group plan. However, coverage under another plan will not cause continuation to end so long as the other plan excludes or limits coverage for a preexisting condition of a qualified beneficiary in accordance with federal law;

- after electing continuation a person becomes entitled to Medicare; or

- the applicable period of continuation ends.

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

State Mandated Continuation of Coverage
An individual may have a right to continuation of group coverage under both federal and, if the **group** has elected it, state coverage law. (If applicable, state mandated continuation benefits will be described under a separate section.) In almost all cases, the federal law offers greater benefits with fewer restrictions than state law. However, continuation will be administered according to whichever law offers the greatest benefit to the **enrollee** and for which a given individual is eligible. The maximum number of months an **enrollee** may continue coverage, however, will

never be more than the amount available under the federal continuation provision.

CONVERSION TO INDIVIDUAL COVERAGE

If **you** or **your enrolled dependents** lose eligibility for coverage under this **contract**, **you** and/or **your enrolled dependents** may be entitled to convert to **our** individual conversion plan or the Medicare supplement plan **we** are offering at that time. The benefits of the conversion plan will be different from the benefits under this **contract**. Furthermore, if **you** and/or **your enrolled dependents** lose eligibility and are eligible for but do not choose to continue coverage under COBRA continuation, selection of one of **our** conversion plans will forfeit **your** and/or **your enrolled dependents**' right to Health Insurance Portability Accountability Act of 1996 (HIPAA) individual market protections.

The following individuals have the right to convert to the conversion plan without submitting a health application:

- **you** or **your** enrolled eligible dependents who are terminating from the **group**, including dependents who lose coverage due to the employee's termination of employment (and loss of coverage) due to gross misconduct;
- **your** enrolled surviving spouse or divorced spouse and his or her eligible dependents; and
- **your** enrolled children who have lost their eligibility as dependents under the **contract**.

Individuals who wish to convert must meet eligibility requirements and other conditions explained in the following paragraphs. The conversion right is generally not available if the **group** cancels the **contract** and replaces it with a similar group contract within 31 days. But it is available even in that situation to those who transferred directly to this **contract** from previous Regence BlueCross BlueShield of Oregon coverage.

Eligibility For A Conversion Plan

To enroll in the conversion plan, **you** or **your** enrolled surviving or divorced spouse or the surviving or ineligible child applying for conversion for themselves and any eligible dependents must:

- be under 65 years old and/or not eligible for Medicare. Individuals who are eligible for Medicare are eligible to convert to one of **our** products for Medicare-age individuals; and
- not be enrolled in a group health plan. The limited exception to this requirement is if **you** and/or **your** dependents enroll in a group plan under which **you** and/or **your** dependents are subject

to exclusions for preexisting conditions or waiting periods greater than the group plan from which **you** and/or **your** dependents just came. In this case, **you** and/or **your** dependents may apply for or continue enrollment under the conversion plan until the preexisting conditions, exclusions, and/or waiting periods of the group plan no longer apply.

How To Enroll For A Conversion Plan

In order to exercise the right to conversion, the person must file a written application with **us** and pay the applicable premium within 31 days after the group coverage ends.

Please note that once the change to the conversion plan has been made, it is not possible to reenroll under this **contract** unless **you** are rehired.

Conversion For Those Who Reach 65

When **you** or **your** spouse reaches the age of 65, **you** or **your** spouse may convert to one of **our** products for Medicare-age individuals. If **you** convert to such coverage, **your enrolled dependents** are no longer eligible for group coverage under this **contract**, but they are eligible for the conversion plan.

GENERAL PROVISIONS

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

We Are Not The Agent

Regence BlueCross BlueShield of Oregon is not **your** or **your enrolled dependent's** agent for any purposes under this **contract**.

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**.

Relationship To Blue Cross And Blue Shield Association

The **group** on behalf of itself and its **enrollees** hereby expressly acknowledges its understanding that this **contract** constitutes a contract solely between the **group** and Regence BlueCross BlueShield of Oregon, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent

Blue Cross and Blue Shield Plans (the **Association**), permitting Regence BlueCross BlueShield of Oregon to use the Blue Cross and Blue Shield Service Marks in the state of Oregon and a portion of the state of Washington, and that Regence BlueCross BlueShield of Oregon is not contracting as the agent of the **Association.** The **group** on behalf of itself and its **enrollees** further acknowledges and agrees that it has not entered into this **contract** based upon representations by any person or entity other than Regence BlueCross BlueShield of Oregon and that no person or entity other than Regence BlueCross BlueShield of Oregon shall be held accountable or liable to the **group** or the **enrollees** for any of **our** obligations to the **group** or the **enrollees** created under this **contract**. This paragraph shall not create any additional obligations whatsoever on the part of Regence BlueCross BlueShield of Oregon other than those obligations created under other provisions of this **contract**.

INFORMATION REGARDING ERISA

If the **plan** this **benefits booklet** describes is an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA), the following information applies. For further information regarding ERISA, contact the **Plan Administrator**.

Plan Name

CITY OF VANCOUVER Employee Health Care Benefits Plan.

Type Of Plan

Group Health Care Benefits Plan.

Plan Sponsor

Plan Sponsor is **your** employer unless otherwise designated by **your** employer. Contact **your** employer for more information.

Plan Administrator

Plan Administrator is **your** employer unless otherwise designated by **your** employer. Contact **your** employer for more information.

Funding

As the underwriter of the **plan**, **we** are responsible for funding the benefits described in the **benefits booklet**. **We** administer claims and provide other administrative services for the **plan**. **Our** name and address are: Regence BlueCross BlueShield of Oregon, 100 SW Market Street, Portland, OR 97201-5766.

Plan Termination Provisions

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

The employer'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 employer 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, other than the payment of benefits for **covered expenses** incurred before the **plan** was terminated, except as may be described otherwise in the **benefits booklet**. The amount and form of any final benefit will depend on any contract provisions affecting the **plan**, and the employer's decisions.

Notice Of 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:

<u>Receive Information About Your Plan And Benefits</u>
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 and collective bargaining agreements.

<u>Continue Group Health Plan Coverage</u>
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 **benefits booklet** 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, 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 or health insurance issuer 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

If **your** claim for a welfare benefit is denied or ignored in whole or in part, **you** have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps **you** can take to enforce the above rights. For instance, if **you** request a copy of plan documents or the latest annual report from the **plan** and do not receive them within 30 days, **you** may file suit in a Federal court. In such a case, the court may require the **Plan Administrator** to provide the materials 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**.

If **you** have a claim for benefits which is denied or ignored, in whole or in part, **you** may file suit in a state or Federal court. 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.

PRESCRIPTION MEDICATION BENEFITS

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

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

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

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

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

Prescription Medication Benefits Replace Contract Benefits

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

Definitions

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

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

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

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

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

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

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

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

as the **brand name medication.**

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

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

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

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

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

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

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

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

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

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

How To Use The Prescription Medication Benefit

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

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

Amount Payable

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

enrolled dependent must pay depends on whether the **prescription medication** is a **generic medication** or a **brand name medication** and whether it is on the **preferred medication list.**

Participating Pharmacy (When Claim Is Submitted Electronically On-Line)
Each **generic medication** dispensed by a **participating pharmacy** is subject to a **copayment** of $10. Each **brand name medication** on the **preferred medication list** dispensed by a **participating pharmacy** is subject to a **copayment** of $20. Each **brand name medication** not on the **preferred medication list** dispensed by a **participating pharmacy** is subject to a **copayment** of $40.

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

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

Nonparticipating Pharmacy – Emergencies Only
There are no benefits for nonparticipating **pharmacies**. However, should **you** or **your enrolled dependent** experience an **emergency medical condition** and have a **prescription order** that results from the emergency filled at a nonparticipating **pharmacy**, **we** will cover a five-day supply of **prescription medications** obtained from the nonparticipating **pharmacy**. In this case, **you** or **your enrolled dependent** must pay for the **prescription medication** in full at the time of purchase. For reimbursement, **you** or **your enrolled dependent** must complete a Prescription Medication Claim Form and then mail the form and receipt to **us**. **You** will be reimbursed based on the amount claimed (the full price of the medication), less any applicable **copayment** that would have been required had the **prescription medication** been dispensed and submitted electronically on-line by a **participating pharmacy** when the out-of-pocket maximum has not been met. Payment will be sent directly to **you**.

Maximum Out Of Pocket Expense

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

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

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

Grace Period

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

Mail Order Benefit

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

Under this benefit, **you** or **your enrolled dependent** pays a **copayment** of $20 each time a **generic medication** is dispensed or refilled by the **mail order supplier. You** or **your enrolled dependent** pays a **copayment** of $40 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 $80. These **copayments** are not eligible for payment under any other portion of the **contract.**

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

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

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

Limitations

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

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

- if one tablet per day is prescribed, up to 34 tablets for a 34-day supply will be covered; or
- if one tablet per week is prescribed, up to four tablets for a 28-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 84-day supply will be covered.

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

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

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

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

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

Exclusions

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

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

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

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

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 **contract**.

Diabetic Supplies
Except for disposable insulin needles/syringes.

Prescription Medications With No Proven Therapeutic Indication

Prescription Medications That Are Not Medically Necessary

Immunization Agents, Biological Sera, Blood, Or Blood Plasma

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

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

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

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

Penlac

Renova

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

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 **our** medical policy criteria are met.

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

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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Prior Authorization

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

Participating providers, including **participating pharmacies**, are notified which **prescription medications** require **prior authorization.** The

medical information necessary to determine **medical necessity** for medications that require **prior authorization** must be provided by the health care provider who is prescribing the medication.

If **you** or **your enrolled dependent** takes a **prescription order** to a **participating pharmacy** and show **your** identification card, the **pharmacy** will let **you** or **your enrolled dependent** know if **prior authorization** is necessary for the **prescription medication**. To find out in advance whether a **prescription medication** requires **prior authorization**, contact Customer Service (number on the back of **your** identification card) or check **our** website at www.myRegence.com. For more information on **prior authorization**, please see Preauthorization under the CONTRACT AND CLAIMS ADMINISTRATION Section.

General Provisions

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

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

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

Health Care Responsibility
We cannot be held liable for any claim or damages connected with **illness** or **injuries** suffered by **you** or any of **your enrolled dependents** arising out of the use of any **prescription medication** or supply. **We** are responsible for the quality of health care **you** receive only as provided under RCW 48.43.545.

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

Utilization Review Program
Included as part of this **prescription medication** benefit is a medication utilization review program. Utilizing a database of information on every **enrollee's prescription medication** claims, the program alerts a dispensing **pharmacist** of potential conflicts in medication therapy, duplicate **prescription medications**, and overuse before the **enrollee** obtains the **prescription medication**. **Prescription medication** claims

submitted electronically on-line by a **participating pharmacy** are analyzed with the **enrollee's** active medication profile for potential medication problems. Claims determined to be excessive utilization and therefore not **medically necessary** will be denied.

Enrollee's Right To Safe And Effective Pharmacy Services
State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee **your** right to know what drugs are covered and what coverage limitations are under the **plan** described in this **contract**. If **you** would like more information about the drug coverage policies under this **plan**, or if **you** have a question or a concern about pharmacy benefits, please contact **us** at (800) 452-7390.

If **you** would like to know more about **your** or **your enrolled dependent**'s rights under the law, or if **you** think anything **you** or **your enrolled dependent** received from this **plan** may not conform to the terms of this **contract**, **you** may contact the Washington State Office of Insurance Commissioner at (800) 562-6900. If **you** have a concern about the **pharmacists** or **pharmacies** serving **you** or **your enrolled dependent,** please call the State Department of Health at (360) 236-4825.

Contract Terms Apply

All terms and conditions of the **contract** apply to this **prescription medication** benefit except when provisions under this **prescription medication** benefit specifically contradict the **contract**, then the provisions of this **prescription medication** benefit apply. Benefits will not be paid under both this **prescription medication** plan and the regular benefits of the **contract** if an item is covered under both. **Copayment** and any deductible amounts and noncovered expenses **you** or **your enrolled dependent** is responsible for under this **prescription medication** plan do not apply to any of the maximum benefits under the regular benefits of the **contract**, including the maximum-out-of-pocket limit.

VISION CARE BENEFITS

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 any preferred provider provisions of the medical portion of the **contract**.

Definitions

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

Contracting vision care provider is an **ophthalmologist**, **optician**, or **optometrist** or a group of **ophthalmologists**, **opticians**, or **optometrists** that **we** have contracted with (either directly or through an organization representing such providers) to provide vision care benefits to the **enrollees** under the **contract**.

Ophthalmologist means a doctor of medicine or osteopathy who limits his or her practice to ophthalmology.

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

Optometrist means a doctor of optometry.

Covered Expenses

The following are **covered expenses** for the services and supplies described in this vision care benefit.

- The contracted amount for listed services and supplies provided by a **contracting vision care provider**. The **contracting vision care provider** has agreed to accept this amount as payment in full.

- Either 70 percent of the billed amount for listed services and supplies provided by an **ophthalmologist**, **optician**, or **optometrist** who has not contracted with **us** to provide vision care benefits to the **enrollees** under the **contract**, or 70 percent of what **we** would have paid to a **contracting vision care provider** for the same service or supply, whichever is less.

<u>Examinations</u>
One vision examination every 12 months for **you** and **your enrolled dependents**.

Copayment
There is a $15 **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.

Lenses And Frames
We will pay up to the contracted amount for one pair of standard size and quality white glass or white plastic lenses every 12 months for **you** and **your enrolled dependents**. For frames **we** will pay up to the contracted amount for one standard frame every 24 months when necessary to accommodate newly prescribed lenses.

One $25 **copayment** will apply if frames and lenses are purchased at the same time during the **calendar year**. If frames and/or lenses are purchased in separate **calendar years**, each will be subject to a $25 **copayment**.

Contact Lenses
One pair of contact lenses every 12 months for **you** and **your enrolled dependents**, if they are necessary after cataract surgery or if they are the only means to correct vision to 20/70 or better.

If contact lenses are selected as an alternative to lenses and a frame, **covered expenses** are limited to the amount **we** would have paid for regular lenses and a frame. **We** will base **our** payment on the type of contact lenses purchased (single, bifocal, or trifocal). **You** or **your enrolled dependent** is responsible for the difference between the provider's retail charge and **our** benefit payment.

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
We can require **you** or **your enrolled dependents** to authorize any provider furnishing benefits under this vision care benefit to make available to **us** information relating to any records **we** need 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 **us.**

Health Care Responsibility
We cannot be held liable for any claim or damages connected with **illness** or **injuries** suffered by **you** or any of **your enrolled dependents** arising out of the use of any services or supplies rendered by any **professional provider** or any vision care appliance. **We** are responsible for the quality of health care **you** receive only as provided under RCW 48.43.545.

We Have The Right To Deny Benefits
We reserve the right to deny benefits for any service or supply prescribed or dispensed in a manner **we** determine is contrary to generally accepted medical practices.

Contract Terms Apply

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