

2020 BOOKLET FOR:

CITY OF ALBANY

Regence ExpressionsSM

Group Number: 10007274

Regence BlueCross BlueShield of Oregon Dental Benefits



Regence

Regence BlueCross BlueShield of Oregon
is an Independent Licensee of the BlueCross and
BlueShield Association

NONDISCRIMINATION NOTICE

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

Regence:

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

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

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service

1-800-541-8981 (TTY: 711)

Customer Service for all other plans

1-888-344-6347 (TTY: 711)

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

Medicare Customer Service

Civil Rights Coordinator

MS: B32AG, PO Box 1827

Medford, OR 97501

1-866-749-0355, (TTY: 711)

Fax: 1-888-309-8784

medicareappeals@regence.com

Customer Service for all other plans

Civil Rights Coordinator

MS CS B32B, P.O. Box 1271

Portland, OR 97207-1271

1-888-344-6347, (TTY: 711)

CS@regence.com

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

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

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

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

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711) まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល្អ គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)::

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिक्टाइप: 711)

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄວນມີຜ້ອມໃຫ້ທ່ານ. ໂທ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر بہ زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذاكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)

Introduction

Regence BlueCross BlueShield of Oregon

Street Address:

100 SW Market Street
Portland, OR 97201

Claims Address:

P.O. Box 30805
Salt Lake City, UT 84130-0805

Customer Service/Correspondence Address:

P.O. Box 1827, MS CS B32B
Medford, OR 97501-9884

Appeals Address:

P.O. Box 1408
Lewiston, ID 83501

This Booklet provides the evidence and a description of the terms and benefits of coverage. The agreement between the Group and Regence BlueCross BlueShield of Oregon (called the "Contract") contains all the terms of coverage. Your plan administrator has a copy.

This Booklet describes benefits effective July 1, 2020, or the date after that on which Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Us and makes it void.

As You read this Booklet, please keep in mind that references to "You" and "Your" refer to both the Enrolled Employee and Enrolled Dependents (except that in the eligibility and continuation of coverage sections, the terms "You" and "Your" mean the Enrolled Employee only). The terms "We," "Us" and "Our" refer to Regence BlueCross BlueShield of Oregon and the term "Group" means the organization whose employees may participate under this coverage. Other terms are defined in the Definitions Section at the back of this Booklet or where they are first used and are designated by the first letter being capitalized.

Notice of Privacy Practices: Regence BlueCross BlueShield of Oregon has a Notice of Privacy Practices that is available by calling Customer Service or visiting the Web site listed below.

CONTACT INFORMATION

If You have questions, would like to learn more about Your coverage or would like to request written or electronic information regarding any other plan that We offer, talk with one of Our Customer Service representatives. Phone lines are open Monday-Friday 5 a.m. – 8 p.m. and Saturday 8 a.m. – 4:30 p.m. Pacific Time.

Customer Service: 1 (888) 367-2116
(TTY: 711)

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

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

Using Your Regence ExpressionsSM Booklet

YOUR PARTNER IN DENTAL CARE

Regence BlueCross BlueShield of Oregon is pleased that Your Group has chosen Us as Your partner in dental care. It's important to have continued protection against unexpected dental care costs. Thanks to the purchase of Regence Expressions, You have coverage that's comprehensive, affordable and provided by a partner You can trust in times when it matters most.

Regence Expressions provides You with great benefits that are quickly accessible and easy to understand, thanks to broad access to Dentists and innovative tools. With Regence Expressions dental coverage, You will discover more personal freedom to make informed dental care decisions, as well as the assistance You need to navigate the health/dental care system.

ACCESSING PROVIDERS

Regence Expressions gives You broad access to dental providers. Regence Expressions allows You to control Your out-of-pocket expenses, such as Coinsurance, for each Covered Service. Here's how it works - You control Your out-of-pocket expenses by choosing Your dental provider under two choices called: "Participating Dentist" and "Nonparticipating Dentist."

- **Participating Dentist.** You choose to see a Participating Dentist and save the most in Your out-of-pocket expenses. Choosing this dental provider option means You will not be billed for balances beyond the Allowed Amount for covered services.
- **Nonparticipating Dentist.** You choose to see a Nonparticipating Dentist and Your out-of-pocket expenses will generally be higher than a Participating Dentist. Also, choosing this dental provider option means You may be billed for balances beyond the Allowed Amount for covered services. This is sometimes referred to as balance billing.

For each benefit in this Booklet, We indicate the Dentist You may choose and Your payment amount for each dental provider option. Participating Dentist and Nonparticipating Dentist are also in the Definitions Section of this Booklet. You can go to **regence.com** for further dental provider network information.

ADDITIONAL ADVANTAGES OF MEMBERSHIP

When Your Group purchased Regence Expressions, You were provided with more than just great coverage. You also acquired Regence membership, which offers additional valuable services. The advantages of Regence membership include access to discounts on select items and services, personalized health/dental care planning information, health-related events and innovative health/dental-decision tools, as well as a team dedicated to Your personal dental care needs. You also have access to **regence.com**, an interactive environment that can help You navigate Your way through treatment decisions. **THESE ADDITIONAL VALUABLE SERVICES ARE A COMPLEMENT TO THE GROUP DENTAL PLAN, BUT ARE NOT INSURANCE.**

- **Go to regence.com.** It is a health/dental power source that can help You lead a healthy lifestyle, become a well-informed health/dental care shopper and increase

the value of Your health/dental care dollar. Have Your Member card handy to log on. Use the secure Member Web site to:

- view recent claims, benefits, and coverage;
- find a contracting provider;
- participate in online wellness programs and use tools to estimate upcoming healthcare costs; and
- discover discounts on select items and services*.

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

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Understanding Your Benefits

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

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

MAXIMUM BENEFITS

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

PERCENTAGE PAID UNDER THE CONTRACT (COINSURANCE)

Once You have satisfied any applicable Deductible, We pay a percentage of the Allowed Amount for Covered Services You receive, up to any Maximum Benefit. When Our payment is less than 100 percent, You pay the remaining percentage (this is Your Coinsurance). The percentage We pay varies, depending on the kind of service or supply You received and who rendered it.

We do not reimburse Dentists for charges above the Allowed Amount. A Participating Dentist will not charge You for any balances for Covered Services beyond Your Deductible and/or Coinsurance amount. Nonparticipating Dentists, however, may bill You for any balances over Our payment level in addition to any Deductible and/or Coinsurance amount. See the Definitions Section for descriptions of Participating and Nonparticipating Dentists.

DEDUCTIBLES

We will begin to pay benefits for Covered Services in any Calendar Year only after a Member satisfies the Calendar Year Deductible (if applicable). A Member satisfies the Deductible by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible.

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

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

HOW CALENDAR YEAR BENEFITS RENEW

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

Some benefits in this Booklet have a separate Lifetime Maximum Benefit and do not renew every Calendar Year. Those exceptions are specifically noted in the benefits sections of this Booklet.

Dental Benefits

In this section, You will learn about Your dental plan's benefits and how Your coverage pays for Covered Services. The explanation includes information about Maximum Benefits, Deductibles, Coinsurance, Covered Services and payment. For Your ease in finding the information regarding benefits most important to You, We have listed these benefits alphabetically, with the exception of the Preventive Dental Services.

MAXIMUM BENEFITS

Preventive, Basic and Major Dental Services:

Per Member: \$1,500 per Calendar Year

Orthodontic Dental Services, per Member: \$1,500 per Lifetime

After any applicable Deductible is met, We pay a portion of the Allowed Amount (or, for orthodontic dental services, a portion of the billed charges) for Covered Services, up to the Maximum Benefit amount for each Member each Calendar Year.

CALENDAR YEAR DEDUCTIBLES

Not applicable

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

Provider: Participating Dentist	Provider: Nonparticipating Dentist
Payment: We pay 100% of the Allowed Amount.	Payment: We pay 100% of the Allowed Amount and You pay balance of billed charges.

We cover the following preventive and diagnostic dental services:

- Bitewing x-ray series, limited to two per Member per Calendar Year.
- Complete intra-oral mouth x-rays, limited to one in a three-year period.
- Preventive oral examinations, limited to two per Member per Calendar Year.
- Problem focused oral examinations.
- Panoramic mouth x-rays, limited to one in a three-year period.
- Cleanings, limited to two per Member per Calendar Year. (However, in no Calendar Year will any Member be entitled to more than two exams whether cleaning or periodontal maintenance.)
- Sealants, limited to permanent bicuspids and molars of Members under 18 years of age.
- Space maintainers for Members under 12 years of age.
- Topical fluoride application for Members under 18 years of age, limited to two treatments per Member per Calendar Year.

BASIC DENTAL SERVICES

Provider: Participating Dentist	Provider: Nonparticipating Dentist
Payment: We pay 100% of the Allowed Amount.	Payment: We pay 100% of the Allowed Amount and You pay balance of billed charges.

We cover the following basic dental services:

- Complex oral surgery procedures including surgical extractions of teeth, impactions, alveoloplasty, vestibuloplasty and residual root removal.
- Emergency treatment for pain relief.
- Endodontic services consisting of:
 - apicoectomy;
 - debridement;
 - direct pulp capping;
 - pulpal therapy;
 - pulpotomy; and
 - root canal treatment.
- Endodontic benefits will **not** be provided for:
 - indirect pulp capping; and
 - pulp vitality tests.
- Fillings consisting of composite and amalgam restorations.
- General dental anesthesia or intravenous sedation administered in connection with the extractions of partially or completely bony impacted teeth and to safeguard the Member's health (for example, a child under seven years of age).
- Periodontal services consisting of:
 - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery) limited to once per Member per quadrant in a five-year period;
 - debridement limited to once per Member in a three-year period;
 - gingivectomy and gingivoplasty limited to once per Member per quadrant in a three-year period;
 - periodontal maintenance limited to two per Member per Calendar Year. (However, in no Calendar Year will any Member be entitled to more than two exams whether periodontal maintenance or cleaning); and
 - scaling and root planing limited to once per Member per quadrant in a two-year period.
- Uncomplicated oral surgery procedures including removal of teeth, incision and drainage.

MAJOR DENTAL SERVICES

Provider: Participating Dentist	Provider: Nonparticipating Dentist
Payment: We pay 100% of the Allowed Amount.	Payment: We pay 100% of the Allowed Amount and You pay balance of billed charges.

We cover the following major dental services:

- Adjustment and repair of dentures and bridges, except that benefits will not be provided for adjustments or repairs done within one year of insertion.
- Bridges (fixed partial dentures), except that benefits will not be provided for replacement made fewer than seven years after placement.
- Crowns, crown build-ups, inlays and onlays, except that benefits will not be provided for any of the following:
 - any crown, inlay or onlay replacement made fewer than seven years after placement (or subsequent replacement) whether or not originally covered in this Booklet; and
 - additional procedures to construct a new crown under an existing partial denture framework.
- Dental implant crown and abutment related procedures, limited to one per Member per tooth in a seven-year period.
- Dentures, full and partial, including:
 - denture rebase, limited to one per Member per arch in a three-year period; and
 - denture relines, limited to one per Member per arch in a three-year period.
- Denture benefits will **not** be provided for:
 - any denture replacement made fewer than seven years after denture placement (or subsequent replacement) whether or not originally covered in this Booklet;
 - interim partial or complete dentures; or
 - pediatric dentures.
- Endosteal implants, limited to four per Member Lifetime.
- Recement crown, inlay or onlay.
- Repair of crowns is limited to one per tooth per Member Lifetime.
- Repair of implant supported prosthesis or abutment, limited to one per tooth per Member Lifetime.

ORTHODONTIC DENTAL SERVICES

Provider: All Dentists
Payment: We pay 50% of billed charges and You pay balance of billed charges.
Limit: \$1,500 per Member Lifetime

After You have been covered by this dental plan for at least 12 months, We cover the following orthodontic dental services:

- The initial and subsequent installations of orthodontic appliances and all non-surgical orthodontic treatments concerned with the reduction or elimination of an existing malocclusion, subject to the submission of a treatment plan (submitted by the attending provider). The treatment plan should include all of the following information:
 - a diagnosis indicating an abnormal occlusion that can be corrected by orthodontic treatment;
 - the estimated length of required treatment;
 - the initial banding fee; and
 - the total orthodontic treatment charge.
- If treatment stops before the end of the prescribed treatment period, benefits will end on the last day of the month during which the treatment was discontinued.
- If You had dental coverage immediately before coverage under this Contract, We will waive the orthodontia waiting period stated previously.

General Exclusions

The following are the general exclusions from coverage in this Booklet. Other exclusions may apply and, if so, will be described elsewhere in this Booklet. We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, **including any direct complications or consequences that arise from them**. However, these exclusions will not apply with regard to an otherwise Covered Service for an Injury, if the Injury results from an act of domestic violence regardless of whether such condition was diagnosed before the Injury, as required by law.

Aesthetic Dental Procedures

Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.

Antimicrobial Agents

Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.

Collection of Cultures and Specimens

Sample collections, such as, but not limited to, saliva or tissue of the oral cavity.

Conditions Caused By Active Participation In a War or Insurrection

The treatment of any condition caused by or arising out of a Member's active participation in a war in the service of a non-United States nation-state or similar entity or in an insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services

The treatment of any Member's condition that the Secretary of Veterans Affairs determines to be a service-connected disability, that is a disability incurred in performance of service in the uniformed services of the United States or to be aggravated in such service.

Connector Bar or Stress Breaker

A device attached to a prosthesis or coping which serves to stabilize and anchor prosthesis.

Cosmetic/Reconstructive Services and Supplies

Except for Dentally Appropriate services and supplies to treat a congenital anomaly and to restore a physical bodily function lost as a result of Illness or Injury, We do not cover cosmetic and/or reconstructive services and supplies.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance (for example, bleaching of teeth).

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

Desensitizing

Application of desensitizing medicaments or desensitizing resin for cervical and/or root surface.

Diagnostic Casts or Study Models

Services and supplies provided in connection with diagnostic casts or study models including taking the impression and pouring the study models.

Duplicate X-Rays

Additional copy of original x-rays.

Expenses Before Coverage Begins or After Coverage Ends

Services and supplies incurred before Your Effective Date under the Contract or after Your termination under the Contract.

Facility Charges

Services and supplies provided in connection with facility services, including hospitalization for dentistry and extended-care facility visits.

Fees, Taxes, Interest

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

Fractures of the Mandible (Jaw)

Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

Gold-Foil Restorations

The restoration of a defect/decay in a tooth using pure gold leaf material.

Government Programs

Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or government program, except for facilities that contract with Us and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. We do not cover government facilities outside the service area (except as required by law for emergency services).

Home Visits

House call by provider to patient's home.

Implants

Services and supplies provided in connection with implants, whether or not the implant itself is covered, including, but not limited to:

- interim endosseous implants;
- eposteal and transosteal implants;
- sinus augmentations or lift;
- implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis;

- radiographic/surgical implant index; and
- unspecified implant procedures.

Investigational Services

Investigational treatments or procedures (Health Interventions), services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). We also exclude any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section in this Booklet.

Medications and Supplies

Charges in connection with medication, including take home drugs, pre-medications, therapeutic drug injections and supplies.

Motor Vehicle Coverage and Other Available Insurance

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

Nitrous Oxide

Administration and supply of nitrous oxide.

Non-Direct Patient Care

Services that are not direct patient care, including charges for:

- appointments scheduled and not kept ("missed appointments");
- preparing or duplicating medical reports and chart notes;
- preparing itemized bills or claim forms (even at Our request); and
- visits or consultations that are not in person (including telephone consultations and e-mail exchanges).

Non-Duplication of Medicare

When, by law, this coverage would not be primary to Medicare Part B had You properly enrolled in Medicare Part B when first eligible, benefits will be reduced to the extent that those benefits are or would have been provided by any part of Medicare Part B regardless of whether or not You choose to accept those benefits.

Occlusal Treatment

Services and supplies provided in connection with dental occlusion, including the following:

- occlusal analysis and adjustments; and
- occlusal guards.

Oral Hygiene Instructions

Instruction and education materials for home care, including tooth brushing technique, flossing and use of special oral hygiene aids.

Oral Surgery

Oral surgery treating any fractured jaw and orthognathic surgery. By "orthognathic surgery," We mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.

Personal Items

Items that are primarily for comfort, convenience, cosmetics, contentment, hygiene, aesthetics or other nontherapeutic purposes.

Photographic Images

Photographic images obtained by intraoral and extraoral cameras.

Pin Retention in Addition to Restoration

Small metal rod used to aid in support of a restoration.

Precision Attachments

Device to stabilize or retain a prosthesis when seated in mouth.

Prosthesis

Services and supplies provided in connection with dental prosthesis, including the following:

- maxillofacial prosthetic procedures; and
- modification of removable prosthesis following implant surgery.

Provisional Splinting

Interim or temporary stabilization of loose/mobile teeth.

Replacements

Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken.

Riot, Rebellion and Illegal Acts

Services and supplies for treatment of an illness, injury or condition caused by a Member's **voluntary participation** in a riot, armed invasion or aggression, insurrection or rebellion or sustained by a Member arising directly from an act deemed illegal by an officer or a court of law.

Self-Help, Self-Care, Training or Instructional Programs

Self-help, non-dental self-care and training programs. This exclusion does not apply to services for training or educating a Member when provided without separate charge in connection with Covered Services.

Separate Charges

Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure), including the following:

- any supplies;
- local anesthesia; and
- sterilization.

Services and Supplies Provided by a Member of Your Family

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

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

Services Performed in a Laboratory

Services rendered in/by a laboratory.

Surgical Procedures

Services and supplies provided in connection with the following surgical procedures:

- exfoliative cytology sample collection or brush biopsy;
- incision and drainage of abscess extraoral soft tissue, complicated or non-complicated;
- radical resection of maxilla or mandible;
- removal of nonodontogenic cyst, tumor or lesion;
- surgical stent; or
- surgical procedures for isolation of a tooth with rubber dam.

Temporomandibular Joint (TMJ) Disorder Treatment

Services and supplies provided in connection with TMJ disorder other than surgical correction of the TMJ required as the result of an Injury.

Third-Party Liability

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

Tooth Transplantation

Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization.

Travel and Transportation Expenses

Travel and transportation expenses.

Veneers

Thin laminated restoration that covers the facial surface and/or the incisal edge of a tooth, and/or may extend between the adjoining surfaces of adjacent teeth.

Work-Related Conditions

Except when a Member is exempt from state or federal workers' compensation law, expenses for services or supplies incurred as a result of any work-related Illness or Injury (even if the service or supply is not covered by workers' compensation benefits) are not covered. This includes any claims resolved as a result of a disputed claim settlement.

If an Illness or Injury could be considered work-related, a Member will be required to file a claim for workers' compensation benefits before We will consider providing any coverage.

Contract and Claims Administration

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

PREAUTHORIZATION

Preauthorization refers to the process by which We determine that a proposed service or supply is Dentally Appropriate and provide approval for it before it is rendered.

Preauthorization is performed to ensure that the dental services You receive are aligned with evidence-based criteria and to determine whether the requested service meets Our Dentally Appropriate criteria. Preauthorization also ensures that services or supplies You receive are safe, effective and appropriate.

Contracted Providers

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

Non-Contracted Providers

We do not require prior authorization of non-contracted providers' services under the Contract. That is, neither You nor Your non-contracted provider is required to obtain prior authorization of any service or supply in order to be eligible for coverage of that service or supply and a claim for a non-contracted provider's service or supply that is otherwise covered under the Contract will not be denied solely for lack of prior authorization. However, benefits will be paid for services and supplies covered under the Contract only if all terms and conditions of the Contract are met, including (unless specified to the contrary) it being Dentally Appropriate. You may request that a non-contracted provider preauthorize services on Your behalf to determine whether it's Dentally Appropriate prior to the services being rendered.

Services Requiring Preauthorization

A comprehensive list of services and supplies that must be preauthorized may be obtained by visiting Our Web site or contacting Customer Service. Preauthorization requests should be submitted by Your provider following the instructions on Our Web site.

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

Time Frame for Response

You will be notified in writing within two business days after We receive the preauthorization request to let You know whether the request has been approved, denied, or if more information is needed to make a determination. When more information is needed to make a determination, We will notify You in writing of the determination within two business days after We receive the additional information or

within 15 calendar days of the original two business days if no additional information is received unless a longer time period to respond is allowed under federal law.

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

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

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

MEMBER CARD

When You, the Enrolled Employee, enroll with Us, You will receive a Member card. It will include important information such as Your identification number, Your Group number and Your name.

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

If You lose Your card, or if it gets destroyed, You can get a new one by contacting Customer Service. You can also view or print an image of Your Member card by visiting Our Web site on Your PC or mobile device. If coverage under the Contract terminates, Your Member card will no longer be valid.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims reimbursement is due, We decide whether to pay You, the provider or You and the provider jointly. We may make benefit payments for a child covered by a legal qualified medical child support order (QMCSO) directly to the custodial parent or legal guardian of such child. If a person entitled to receive payment under the Contract has died, is a minor or is incompetent, We may pay the benefits up to \$1,000 to a relative by blood or marriage of that person when We believe that person is equitably entitled to the payment. A payment made in good faith under this provision will fully discharge Us to the extent of the payment.

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

If We receive an inquiry regarding a properly submitted claim and We believe that You expect a response to that inquiry, We will respond to the inquiry within 30 days of the date We first received it.

Calendar Year and Contract Year

The Deductible and Maximum Benefit provisions are calculated on a Calendar Year basis. This Contract is renewed, with or without changes, each Contract Year. A Contract Year is the 12-month period following either the Contract's original Effective Date or subsequent renewal date. A Contract Year may or may not be the same as a Calendar Year. When Your Contract renews on other than January 1 of any year, any Deductible You satisfied or amount accumulated toward a Maximum Benefit before the date the Contract renews will be carried over into the next Contract Year. If the Deductible amount increases during the Calendar Year, You will need to meet the new requirement minus any amount You already satisfied under the previous Contract during that same Calendar Year.

Timely Filing of Claims

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

Participating Dentist Claims

You must present Your identification card when obtaining Covered Services from a Participating Dentist. You must also furnish any additional information requested. The Participating Dentist will furnish Us with the forms and information We need to process Your claim.

Participating Dentist Reimbursement

We will pay a Participating Dentist directly for Covered Services. Participating Dentists have agreed to accept the Allowed Amount as full compensation for Covered Services. Your share of the Allowed Amount is any amount You must pay due to Deductible and/or Coinsurance. A Participating Dentist may require You to pay Your share at the time You receive care or treatment.

Nonparticipating Dentist Claims

In order for Us to pay for Covered Services, You or the Dentist must first send Us a claim. Be sure the claim is complete and includes the following information:

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

Nonparticipating Dentist Reimbursement

In most cases, We will pay the Nonparticipating Dentist directly for Covered Services provided by a Nonparticipating Dentist.

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

Reimbursement Examples

Here is an example of how Your selection of a Participating Dentist or Nonparticipating Dentist affects Our payment and Your cost sharing amount. For purposes of this example, let's assume that Participating Dentist services are subject to a 20 percent Coinsurance and Nonparticipating Dentist services are also subject to a 20 percent Coinsurance. The benefit table from the Dental Benefits Section would appear as follows:

Provider: Participating Dentist	Provider: Nonparticipating Dentist
Payment: After Deductible, We pay 80% and You pay 20% of the Allowed Amount.	Payment: After Deductible, We pay 80% of the Allowed Amount and You pay balance of billed charges.

Now, let's assume that the Dentist's charge for a service is \$500 and the Allowed Amount for that Dentist's charge is \$400. Finally, We will assume that You have met the Deductible. Here's how that Covered Service would be paid:

- Participating Dentist: We would pay 80 percent of the Allowed Amount and You would pay 20 percent of the Allowed Amount, as follows:
 - Amount Participating Dentist must "write-off" (that is, cannot charge You for): \$100
 - Amount We pay (80% of the \$400 Allowed Amount): \$320
 - **Amount You pay** (20% of the \$400 Allowed Amount): **\$80**
 - Total: \$500
- Nonparticipating Dentist: We would pay 80 percent of the Allowed Amount. (For purposes of this example, We assume \$400 also is the Reasonable Charge upon which the Nonparticipating Dentist's Allowed Amount is based. The Reasonable Charge can be lower than the Allowed Amount for Participating Dentists.) Because the Nonparticipating Dentist does not accept the Allowed Amount, You would pay 20 percent of the Allowed Amount, plus the difference between the Nonparticipating Dentist's billed charges and the Allowed Amount, as follows:
 - Amount We pay (80% of the \$400 Allowed Amount): \$320
 - **Amount You pay** (20% of the \$400 Allowed Amount and the \$100 difference between the billed charges and the Allowed Amount): **\$180**
 - Total: \$500

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

Freedom of Choice of Dentist

Nothing contained in this Booklet is designed to restrict You in selecting the Dentist of Your choice for dental care or treatment.

Claims Determinations

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

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

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

Claims Processing Report

We will tell You how We have acted on a claim. We use a form called a claims processing report. We may pay claims, deny them or accumulate them toward satisfying any Deductible. If We deny all or part of a claim, the reason for Our action will be stated on the claims processing report. The claims processing report will also include instructions for filing an Appeal or Grievance if You disagree with the action.

NONASSIGNMENT

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

CLAIMS RECOVERY

If We pay a benefit to which You or Your Enrolled Dependent was not entitled, or if We pay a person who is not eligible for benefits at all, We reserve the right to recover the payment from the person We paid or anyone else who benefited from it, including a provider of services. Our right to recovery includes the right to deduct the mistakenly paid amount from future benefits We would provide the Enrolled Employee or any of his

or her Enrolled Dependents, even if the mistaken payment was not made on that person's behalf.

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

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND DENTAL RECORDS

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

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

- an insurance carrier or group health plan;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies;
- a clinic, hospital, long-term care or other medical facility; or
- a physician, Dentist, pharmacist or other physical or behavioral health care practitioner.

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

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

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

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

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

LIMITATIONS ON LIABILITY

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

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

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

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

As used herein, the term "third-party," means any party that is, or may be, or is claimed to be responsible for Illness or Injuries to You. Such Illness or Injuries are referred to as "third-party Injuries." Third-party includes any party responsible for payment of expenses associated with the care or treatment of third-party Injuries.

If We pay benefits under this Booklet to You for expenses incurred due to third-party Injuries, then We retain the right to repayment of the full cost, to the extent permitted by applicable law, of all benefits provided by Us on Your behalf that are associated with the third-party Injuries. To the extent that such third-party Injuries are the result of a motor vehicle accident, and to the extent that Our right to repayment is governed by Oregon law, We retain the right to repayment of the cost of benefits provided from any settlement, judgement, or other payment received by You to the extent that such settlement, judgement, or other payment exceeds the amount that fully compensates You for Your Injuries. Our rights of recovery apply to any recoveries made by or on Your behalf from the following sources, including, but not limited to:

- payments made by a third-party or any insurance company on behalf of the third-party;
- any payments or awards under an uninsured or underinsured motorist coverage policy;
- any workers' compensation or disability award or settlement;
- medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and

- any other payments from a source intended to compensate You for Injuries resulting from an accident or alleged negligence.

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

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

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

Advancement of Benefits

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

- By accepting or claiming benefits, You agree that We are entitled to reimbursement of the full amount of benefits that We have paid, to the extent permitted by applicable law, out of any settlement or recovery from any source. This includes any judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Illness or Injury for which We have provided benefits.
- You or Your representative agree to give Us a first-priority lien on any recovery, settlement, judgment or other source of compensation which may be had from any party to the extent permitted by applicable law of the full cost of all benefits associated with third-party Injuries provided by Us (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- Further, You agree to pay, as the first priority, from any recovery, settlement, judgment or other source of compensation, any and all amounts due to Us as reimbursement for the full cost, to the extent permitted by applicable law, of all benefits associated with third-party Injuries paid by Us (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement).
- Our rights apply without regard to the source of payment for medical expenses, whether from the proceeds of any settlement, arbitration award or judgment or other

characterization of the recovery by the Member and/or any third-party or the recovery source. We are entitled to reimbursement from the first dollars received from any recovery to the extent permitted by applicable law. This applies regardless of whether:

- the third-party or third-party's insurer admits liability;
 - the health care expenses are itemized or expressly excluded in the recovery; or
 - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered in this Booklet.
- We will not reduce Our reimbursement or subrogation due to Your not being made whole unless such a reduction is required by applicable law. Our right to reimbursement or subrogation, however, will not exceed the amount of recovery.
 - By accepting benefits under this Booklet, You or Your representative agree to notify Us promptly (within 30 days) and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to third-party Injuries sustained by You.
 - You and Your representative must cooperate with Us and do whatever is necessary to secure Our rights of subrogation and reimbursement under this Booklet. We may require You to sign and deliver all legal papers and take any other actions requested to secure Our rights (including an assignment of rights to pursue Your claim if You fail to pursue Your claim of recovery from the third-party or other source). Unless prohibited by applicable law, if We ask You to sign a trust agreement or other document to reimburse Us from the proceeds of any recovery, You will be required to do so as a condition to advancement of any benefits.
 - You must agree that nothing will be done to prejudice Our rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by Us. You will also cooperate fully with Us, including signing any documents within the required time and providing prompt notice of any settlement or other recovery. You must notify Us of any facts that may impact Our right to reimbursement or subrogation, including, but not necessarily limited to, the following:
 - the filing of a lawsuit;
 - the making of a claim against any third-party;
 - scheduling of settlement negotiations (including, but not necessarily limited to, a minimum of 21 days advance notice of the date, time, location and participants to be involved in any settlement conferences or mediations); or
 - intent of a third-party to make payment of any kind to Your benefit or on Your behalf and that in any manner relates to the Illness or Injury that gives rise to Our right of reimbursement or subrogation (notification is required a minimum of five business days before the settlement).
 - You and/or Your agent or attorney must agree to serve as constructive trustee and keep any recovery or payment of any kind related to Your Illness or Injury which gave rise to Our right of subrogation or reimbursement segregated in its own account, until Our right is satisfied or released.

- In the event You and/or Your agent or attorney fails to comply with any of these conditions, We may recover any such benefits advanced for any Illness or Injury through legal action.
- Any benefits We have provided or advanced are provided solely to assist You. By paying such benefits, We are not acting as a volunteer and are not waiving any right to reimbursement or subrogation.

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

Motor Vehicle Coverage

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

Workers' Compensation

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

- You must notify Us in writing within five days of any of the following:
 - filing a claim;
 - having the claim accepted or rejected;
 - appealing any decision;
 - settling or otherwise resolving the claim; or
 - any other change in status of Your claim.
- If the entity providing workers' compensation coverage denies Your claim and You have filed an appeal, We may advance benefits for Covered Services if You agree to hold any recovery obtained in a segregated account for Us.

Fees and Expenses

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

Future Related Expenses

Unless prohibited by applicable law, benefits for otherwise Covered Services may be excluded when You have received a recovery from another source relating to an Illness or Injury for which We would normally provide benefits. However, the amount of any

Covered Services excluded under this provision will not exceed the amount of Your recovery.

COORDINATION OF BENEFITS

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

Benefits Subject to this Provision

All of the benefits provided in this Booklet are subject to this Coordination of Benefits provision.

Definitions

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

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

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

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

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

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

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

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

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

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

Other Plan does not include:

- Independent noncoordinated hospital indemnity coverage or other fixed indemnity coverage.
- School accident-type coverage that covers students for accidents only, including athletic injuries, either on a 24-hour basis or a "to and from school basis."
- Group long-term care insurance for non-medical services (such as personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care, and custodial care) or that pay a fixed daily benefit without regard to actual expenses incurred or services received.
- Accident only coverage.
- Specified disease or specified accident coverage.
- Medicare supplement coverage.
- A state plan under Medicaid, or a governmental plan that, by law, provides benefits that are excess to those of private insurance or other nongovernmental coverage.

Primary Plan means the plan that must determine its benefits for Your health care before the benefits of an Other Plan and without taking the existence of that Other Plan into consideration. (This is also referred to as that plan being "primary" to that Other

Plan.) There may be more than one Primary Plan. A plan is a Primary Plan with regard to another plan in any of the following circumstances:

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

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

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

Order of Benefit Determination

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

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

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

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

If a court decree awards joint custody of You without specifying that one of Your parents is responsible for Your health care expenses or health care coverage, a plan that covers You as the dependent of Your parent whose Birthday occurs earlier in the Year will be primary over a plan that covers You as the dependent of Your parent whose Birthday occurs later in the Year. If both parents have the same Birthday, the plan of the parent who has been covered by his or her plan longer shall be primary to the plan of the other

parent. If the Other Plan does not contain this dependent rule, the Other Plan's dependent rule will govern.

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

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

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

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

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

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

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

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

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

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

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

Primary Health Plan Benefits

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

Secondary Health Plan Benefits

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

We will calculate the benefits that We would have paid for a service if this coverage were the Primary Plan. We will compare the Allowable Expense in this Booklet for that service to the Allowable Expense for it under the Other Plan(s) by which You are covered. We will pay the lesser of:

- the unpaid charges for the service, up to the higher (highest) Allowable Expenses among the involved plans, or
- the benefits that We would have paid for the service if this coverage were the Primary Plan.

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

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

Nothing contained in this Coordination of Benefits provision requires Us to pay for all or part of any service that is not covered under this coverage. Further, in no event will this

Coordination of Benefits provision operate to increase Our payment over what We would have paid in the absence of this Coordination of Benefits provision.

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

Resolving Your Concerns

If You believe a policy, action or decision of Ours is incorrect, please contact Our Customer Service department. If We cannot resolve Your concern to Your satisfaction, You or Your Representative (any Representative authorized by You) may Appeal -- that is, ask for Us to review Your case again.

If You have concerns regarding a decision, action or statement by Your provider, We encourage You to discuss these concerns with the provider. If You remain dissatisfied after discussing Your concern with Your provider, You may file a Grievance with Our Customer Service department. However, if You would prefer to discuss Your concern with Us rather than Your provider, please contact Our Customer Service department.

Grievances and Appeals can be initiated through either written or verbal request. A written request can be made by sending it to Us at: Appeals Coordinator, Regence BlueCross BlueShield of Oregon, P.O. Box 1408, Lewiston, ID 83501 or facsimile 1 (888) 496-1542. Verbal requests can be made by calling Us at 1 (888) 367-2116.

Each Grievance or Appeal, including Expedited Appeals, must be pursued within 180 days of Your receipt of Our determination (or, in the case of a Grievance, within 180 days of Your receipt of Our original adverse decision that You are Appealing). If You don't act within this time period, You will not be able to continue to pursue the Grievance and Appeal process and may jeopardize Your ability to pursue the matter in any forum.

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

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

Filing A Grievance

The first step in the process to resolving Your concern is filing a Grievance. Within five business days of receiving Your Grievance, We will send a written acknowledgement and information describing the entire Grievance and Appeal process and Your rights.

Filing Appeals

If You don't agree with Our decision after filing a Grievance, You may file an Appeal. Appeals are reviewed by an employee or employees who were not involved in, or subordinate to anyone involved in, the prior decision. In Appeals that involve issues requiring medical judgment, the decision is made by Our staff of health care professionals. You or Your Representative may submit written materials supporting Your Appeal, including written testimony on Your behalf. For Post-Service Appeals, a written notice of the decision will be sent within 30 days of receipt of the Appeal. For Appeals involving a Pre-Service preauthorization of a procedure, We will send a written notice of the decision within 30 days of receipt of the Appeal.

VOLUNTARY EXTERNAL APPEAL - IRO

A voluntary Appeal to an Independent Review Organization (IRO) is available only after You have exhausted the internal Grievance and Appeal process. Also, the issue being Appealed must address one of the following:

- Dentally Appropriate;
- determination that the treatment is Investigational; or
- the treatment denied is part of an active course of treatment for purposes of continuity of care.

We coordinate voluntary external Appeals, but the decision is made by an Independent Review Organization (IRO) at no cost to You. In order to have the Appeal decided by an IRO, You must sign a waiver granting the IRO access to medical or dental records. We will provide the IRO with the Appeal documentation. A written notice of the IRO's decision will be sent to You within 30 days of receipt of Your request. We are bound by the decision made by the IRO, even if it conflicts with Our definition of Dentally Appropriate. If You want more information regarding IRO review, please contact Customer Service.

The voluntary external Appeal by an IRO is optional and You should know that other forums may be utilized as the final level of Appeal to resolve a dispute You have with Us. This includes, but is not limited to, civil action under Section 502(a) of ERISA, where applicable, or, if Your plan is not an ERISA plan, under appropriate state statutes or rules.

EXPEDITED APPEALS

An Expedited Appeal is available as described here:

Expedited Appeal

The Expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for Us to make the Grievance or Appeal decision. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the Expedited Appeals time frame) to provide written materials. A verbal notice of Our decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of receipt of the Expedited Appeal. A written notice is also provided.

Voluntary Expedited Appeal - IRO

If You disagree with the Expedited Appeal decision made by Us and You or Your Representative reasonably believes that preauthorization remains clinically urgent (Pre-Service), You may request a voluntary Expedited Appeal to an IRO. The issues eligible for a voluntary Expedited Appeal to an IRO are the same as described above for non-urgent IRO review.

We coordinate voluntary Expedited Appeals, but the decision is made by an IRO at no cost to You. In order to have the Expedited Appeal decided by an IRO, You must sign a waiver granting the IRO access to medical or dental records. We will provide the IRO with the Expedited Appeal documentation. Verbal notice of the IRO's decision will be provided to You and Your Representative as soon as possible after the decision, but no

later than within 72 hours of Your request. We are bound by the decision made by the IRO, even if it conflicts with Our definition of Dentally Appropriate. If You want more information regarding IRO review, please contact Customer Service.

The voluntary Expedited Appeal by an IRO is optional and You should know that other forums may be used as the final level of Expedited Appeal to resolve a dispute You have with Us, including, but not limited to, civil action under Section 502(a) of ERISA, where applicable or, if Your plan is not an ERISA plan, under appropriate state statutes or rules.

INFORMATION

If You have any questions about the Grievance and Appeal process outlined here, You may contact Customer Service or You can write to Customer Service department at the following address: Regence BlueCross BlueShield of Oregon, P.O. Box 1827, MS CS B32B, Medford, OR 97501-9884.

You also have the right to file a complaint and seek assistance from the Oregon Division of Financial Regulation. Assistance is available by calling: (503) 947-7984 or the toll-free message line at 1 (888) 877-4894; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit; P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: <http://dfr.oregon.gov/gethelp/Pages/file-a-complaint.aspx>; or by Email at: DFR.InsuranceHelp@oregon.gov.

DEFINITIONS SPECIFIC TO THE GRIEVANCE AND APPEAL PROCESS

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

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

Expedited Appeal means a Grievance or Appeal where the application of regular Grievance or Appeal time frames:

- could, on a Pre-Service or concurrent care claim, jeopardize Your life, health or ability to regain maximum function, or
- would, according to a physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without the disputed care or treatment.

Grievance means the initial complaint, verbal or written, submitted by or on behalf of a Member regarding the availability, delivery or quality of the health care (including preauthorization determinations), claims payments or matter related to the relationship between the Member and Us.

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

voluntary external Expedited Appeals, through an independent contractor relationship with Us and/or through assignment to Us via state regulatory requirements. The IRO is unbiased and is not controlled by Us.

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

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

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

Who Is Eligible, How to Enroll and When Coverage Begins

This section contains the terms of eligibility under the Contract for an employee and his or her dependents. It explains how to enroll Yourself and/or Your eligible dependents when first eligible or during an annual enrollment period. It also describes when coverage under the Contract begins for You and/or Your eligible dependents. Of course, payment of any corresponding monthly premiums is required for coverage to begin on the indicated dates.

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

INITIALLY ELIGIBLE, WHEN COVERAGE BEGINS

You will be entitled to enroll in coverage for Yourself and Your eligible dependents within 30 days of Your first becoming eligible for coverage under the eligibility requirements in effect with the Group and as stated in the following paragraphs. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

If You and/or Your eligible dependents do not enroll for coverage under the Plan when first eligible or You do not enroll in a timely manner, You and/or Your eligible dependents must wait until the next annual enrollment period to enroll.

Employees

You become eligible to enroll in coverage on the date You have worked for the Group long enough to satisfy any required probationary period.

Dependents

Your Enrolled Dependents are eligible for coverage when You have listed them on the enrollment form or on subsequent change forms and when We have enrolled them in coverage under the Contract. Your newly Eligible Domestic Partner who is not an Oregon-Registered Domestic Partner is eligible for coverage when a domestic partnership is established and an enrollment form or a subsequent change form is submitted to Us along with an affidavit of qualifying domestic partnership. By "established," We mean the date on which the conditions described below are met. Dependents are limited to the following:

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

- You and Your domestic partner share a close, personal relationship and are responsible for each other's common welfare;
 - neither You nor Your domestic partner is legally married to anyone else or has had another domestic partner within the 30 days immediately before enrollment of Your domestic partner;
 - You and Your domestic partner share the same regular and permanent residence and intend to continue doing so indefinitely;
 - You and Your domestic partner share joint financial responsibility for Your basic living expenses, including food, shelter and medical expenses; and
 - You and Your domestic partner are not more closely related by blood than would bar marriage in Your state of residence.
- Your (or Your spouse's or Your Eligible Domestic Partner's) child who is under age 26 and who meets any of the following criteria:
 - Your (or Your spouse's or Your Eligible Domestic Partner's) natural child, step child, adopted child or child legally placed with You (or Your spouse or Your Eligible Domestic Partner) for adoption;
 - a child for whom You (or Your spouse or Your Eligible Domestic Partner) have court-appointed legal guardianship; and
 - a child for whom You (or Your spouse or Your Eligible Domestic Partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).
 - Your (or Your spouse's or Your Eligible Domestic Partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of developmental disability or physical handicap that began before his or her 26th birthday, if You complete and submit Our affidavit of dependent eligibility form, with written evidence of the child's incapacity, within 31 days of the later of the child's 26th birthday or Your Effective Date and either:
 - he or she is an enrolled child immediately before his or her 26th birthday; or
 - his or her 26th birthday preceded Your Effective Date and he or she has been continuously covered as Your dependent on group coverage since that birthday.

Our affidavit of dependent eligibility form is available by visiting Our Web site or by calling Customer Service.

NEWLY ELIGIBLE DEPENDENTS

You may enroll a dependent who becomes eligible for coverage after Your Effective Date by completing and submitting an enrollment request (and, for an Eligible Domestic Partner who is not an Oregon-Registered Domestic Partner, an affidavit of qualifying domestic partnership form) to Us. Request for enrollment of a new child by birth, adoption or placement for adoption must be made within 60 days of the date of birth, adoption or placement for adoption. Request for enrollment of all other newly eligible dependents must be made within 30 days of the dependent's attaining eligibility. Coverage for such dependents will begin on their Effective Dates (which, for a new child by birth, adoption or placement for adoption, is the date of birth, adoption or placement for adoption, if enrolled within the specified 60 days).

ANNUAL ENROLLMENT PERIOD

The annual enrollment period is the period of time before the Group's Renewal Date and is the only time, other than initial eligibility, during which You and/or Your eligible dependents may enroll. You must submit an enrollment form (and, for an Eligible Domestic Partner who is not an Oregon-Registered Domestic Partner, an affidavit of qualifying domestic partnership form) on behalf of all individuals You want enrolled. Coverage for You and Your enrolling eligible dependents will begin on the Effective Date.

DOCUMENTATION OF ELIGIBILITY

You must promptly furnish or cause to be furnished to Us any information necessary and appropriate to determine the eligibility of a dependent. We must receive such information before enrolling a person as a dependent under the Contract.

When Group Coverage Ends

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

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

CONTRACT TERMINATION

If the Contract is terminated or not renewed by the Group or Us, coverage ends for You and Your Enrolled Dependents on the date the Contract is terminated or not renewed.

If the Contract is terminated and coverage is not replaced by the Group, We will mail the Group a notice of termination. It is then the duty of the Group to send each Enrolled Employee a notice of the termination, explaining rights to continuation of coverage under federal and/or state law.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, Your and Your Enrolled Dependents' coverage ends on the 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 the Contract according to the continuation of coverage provisions of this Booklet.

TERMINATION OF YOUR EMPLOYMENT OR YOU ARE OTHERWISE NO LONGER ELIGIBLE

If You are no longer eligible due to termination of employment or You are otherwise no longer eligible according to the terms of the Contract, Your coverage will end for You and all Enrolled Dependents on the last day of the monthly period in which eligibility ends.

NONPAYMENT OF PREMIUM

If You fail to make required timely contributions to premium, Your coverage will end for You and all Enrolled Dependents.

FAMILY AND MEDICAL LEAVE

If Your Group grants You a leave of absence under the Family and Medical Leave Act of 1993 (Public Law 103-3, "FMLA") the following rules will apply. The Act is generally applicable to private employers of 50 or more employees and public employers of any size. You will be entitled to continued coverage under this provision only to the extent You are eligible for leave under the terms of the FMLA:

- You and Your Enrolled Dependents will remain eligible to be enrolled under the Contract during the FMLA leave for a period of up to 12 weeks during a 12-month period for one of the following:
 - in order to care for Your newly born child;
 - in order to care for Your spouse, child or parent, if such spouse, child or parent has a serious health condition;
 - the placement of a child with You for adoption or foster care; or
 - You suffer a serious physical or mental health condition.

During the FMLA leave, You must continue to pay the monthly premium through the Group on time. The provisions described here will not be available if the Contract terminates.

If You and/or Your Enrolled Dependents elect not to remain enrolled during the FMLA 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 enrollment form just as if You were a newly eligible employee. In this situation, if You reenroll within the required time, all of the terms and conditions of the Contract will resume at the time of reenrollment as if there had been no lapse in coverage. You (and/or Your Enrolled Dependents) will receive credit for any waiting period served before the FMLA leave and You will not have to re-serve any probationary period under the Contract, although You and/or Your Enrolled Dependents will receive no waiting period credits for the period of noncoverage.

Persons entitled to coverage under this provision will not be entitled to any other extension of benefits described in this section for the same situation that entitles them to coverage under this provision. Entitlement to FMLA leave does not constitute a qualifying event for the purpose of COBRA continuation. However, a person who does not return to active employment following FMLA leave may be entitled to COBRA continuation coverage. The duration of that COBRA continuation will be calculated from the date the person fails to return from the FMLA leave.

The provisions and administration described here are based on the requirements of the Family and Medical Leave Act of 1993, as amended, and will be governed by the FMLA law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and FMLA, the minimum requirements of FMLA will govern. This leave provision is available only to groups that are required by law to comply. The Group must keep Us advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by FMLA.

LEAVE OF ABSENCE

If You are granted a non-FMLA temporary leave of absence by Your Group, You can continue coverage for up to three months. Premiums must be paid through the Group in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by Your employer at Your request during which You are still considered to be employed and are carried on the

employment records of the Group. A leave can be granted for any reason acceptable to the Group. If You are on leave for an FMLA-qualifying reason, You remain eligible under the Contract only for a period equivalent to FMLA leave and may not also continue coverage under a non-FMLA leave.

If You and/or Your Enrolled Dependents elect not to remain enrolled during the leave of absence, You (and/or Your Enrolled Dependents) may reenroll under the Contract only during the next annual enrollment period.

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs (unless specified to the contrary below), his or her coverage will end on the last day of the monthly period in which his or her eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Contract according to the continuation of coverage provisions of this Booklet.

Divorce or Annulment

Eligibility ends for Your enrolled spouse and the spouse's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the monthly period following the date a divorce or annulment is final.

If You Die

If You die, coverage for Your Enrolled Dependents ends on the last day of the monthly period in which Your death occurs.

Dissolution or Annulment of Oregon-Registered Domestic Partnership

If the contract with Your Oregon-Registered Domestic Partner ends, eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the monthly period following the date the dissolution or annulment was final.

Termination of Domestic Partnership

If Your domestic partnership other than an Oregon-Registered Domestic Partnership terminates after the Effective Date (including any change in status such that You and Your domestic partner no longer meet any of the requirements outlined in the definition of a dependent), eligibility ends for the domestic partner and the domestic partner's children (unless such children remain eligible by virtue of their continuing relationship to You) on the last day of the monthly period following the date of termination of the domestic partnership. You are required to provide notice of the termination of a domestic partnership within 30 days of its occurrence. You may not file another affidavit of qualifying domestic partnership within 90 days after a request for termination of a domestic partnership has been received.

Loss of Dependent Status

- For an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the last day of the monthly period in which the child exceeds the dependent age limit.

- For an enrolled child who is no longer eligible due to disruption of placement before legal adoption and who is removed from placement, eligibility ends on the date the child is removed from placement.
- For an enrolled child who is no longer an eligible dependent for any other cause (not described above), eligibility ends on the last day of the monthly period in which the child is no longer a dependent.

OTHER CAUSES OF TERMINATION

Members may be terminated for either of the following reasons. However, it may be possible for them to continue coverage under the Contract according to the continuation of coverage provisions of this Booklet.

Fraudulent Use of Benefits

If You or Your Enrolled Dependent engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of material fact in connection with coverage, coverage under the Contract will terminate for that Member.

Fraud or Misrepresentation in Application

We have issued this Booklet in reliance upon all information furnished to Us by You or on behalf of You and Your Enrolled Dependents. In the event of any intentional misrepresentation of material fact or fraud regarding a Member (including, but not limited to, a person who is listed as a dependent, but does not meet the eligibility requirements in effect with the Group), We may take any action allowed by law or Contract, including denial of benefits or termination of coverage and may subject the person making the misrepresentation or fraud to prosecution for insurance fraud and associated penalties.

COBRA Continuation of Coverage

COBRA is a continuation of this coverage for a limited time after certain events cause a loss of eligibility. COBRA continuation does not apply to all groups.

If Your Group is subject to COBRA, COBRA continuation is available to Your Enrolled Dependents if they lose eligibility because:

- Your employment is terminated (unless the termination is for gross misconduct);
- Your hours of work are reduced;
- You die;
- You and Your spouse divorce or the marriage is annulled;
- You and Your domestic partner terminate the domestic partnership;
- You become entitled to Medicare benefits; or
- Your enrolled child loses eligibility as a child under this coverage.

COBRA also is available to You if You lose eligibility because Your employment terminates (other than for gross misconduct) or Your hours of work are reduced. (A special COBRA continuation also applies to You and Your Enrolled Dependents under certain conditions if You are retired and Your Group files for bankruptcy.)

There are some circumstances involving disability or the occurrence of a second one of these events that can result in extension of the limited period of continuation following a termination of employment or reduction in working hours. COBRA also can terminate earlier than the maximum periods.

General Rules

Generally, You or Your Enrolled Dependents are responsible for payment of the full premium for COBRA continuation, plus an administration fee, even if the Group contributes toward the premiums of those not on COBRA continuation. The administration fee is 2 percent or, during any period of extension for disability, 50 percent.

In order to preserve Your and Your Enrolled Dependent's rights under COBRA, You or Your Enrolled Dependents must inform the Group in writing within 60 days of:

- Your divorce or annulment, termination of domestic partnership or a loss of eligibility of a child;
- Your initial loss of eligibility due to Your termination of employment or reduction in working hours and You experience another one of the events listed above; or
- a Social Security disability determination that You or Your Enrolled Dependent were disabled for Social Security purposes at the time of a termination of employment or reduction in working hours or within the first 60 days of COBRA continuation following that event. (If a final determination is later made that You or Your Enrolled Dependent is no longer disabled for Social Security purposes, You or Your Enrolled Dependent must provide the Group notice of that determination within 30 days of the date it is made.)

The Group also must meet certain notification, election and payment deadline requirements. It is therefore very important that You keep the Group informed of the current address of all Members who are or may become qualified beneficiaries.

If You or Your Enrolled Dependents do not elect COBRA continuation coverage, coverage under the Contract will end according to the terms of the Contract and We will not pay claims for services provided on and after the date coverage ends. Further, this may jeopardize Your or Your Enrolled Dependents' future eligibility for an individual plan.

Notice

The Contract includes additional details on the COBRA Continuation provisions outlined here and complete details are available from Your Group.

Non-COBRA Continuation of Coverage

A Group that is not required to offer COBRA Continuation of Coverage must offer a continuation of Group coverage benefits to You and Your Enrolled Dependents upon loss of eligibility for coverage.

We will notify You and Your Enrolled Dependents of this continuation right. If You and/or Your Enrolled Dependents do not receive notice, You may contact Us directly within 60 days following termination of coverage and elect continuation of coverage.

If You and/or Your Enrolled Dependents choose to continue coverage under this right, You must enroll in writing and pay the premium for such coverage within 60 days of coverage termination. You will be required to make timely premium payments to the Group. The Group may charge You and Your Enrolled Dependents a premium no higher than the current rate paid for coverage of a comparable Member (or Members) who lost coverage and the Group is not required to make any contribution toward premiums for continuation coverage. Where an enrollment form and premium are received within the 60-day period, the accepting Member's coverage continues, without interruption, from the date the Member's coverage was terminated.

This continuation of coverage will terminate when the first of the following occurs:

- You and/or Your Enrolled Dependents fail to make payment of premiums for the coverage to the Group within its established time frame;
- nine months elapse; or
- the Group's coverage is terminated.

If the Group replaces coverage with a similar plan, those who have continued coverage may obtain coverage under the replacement policy for the balance of the period that they would have been allowed to extend benefits under the replaced coverage.

Other Continuation Options

This section describes situations when coverage may also be extended for You and/or Your Enrolled Dependents beyond the date of termination.

Reenrolling After Layoff

This provision always applies when the Group plan is not subject to the continuation of coverage provisions of COBRA, or if a Group subject to the continuation of coverage provisions of COBRA chooses to administer it. If Your plan includes COBRA continuation, check with Your plan administrator to see if this Reenrolling After Layoff provision applies.

If You are rehired and return to active work within nine months of being laid off, You and any previously Enrolled Dependents may reenroll under the Contract on the date You are rehired, regardless of any lapse in coverage. Your Group must notify Us that You are being rehired following a layoff and the necessary premiums for Your coverage must be paid. All Contract provisions will resume at the time You reenroll whether or not there was a lapse in Your coverage. Any exclusion period not completed at the time the employee was laid off must be satisfied. However, the period of Your layoff will be counted toward the exclusion period. At the time You are rehired, You do not have to re-satisfy any Group eligibility waiting period required by the Contract.

General Provisions

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

CHOICE OF FORUM

Any legal action arising out of the Contract must be filed in a court in the state of Oregon.

ERISA (IF APPLICABLE)

This provision applies if the Contract is part of an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA).

The Group intends that the Contract be maintained for the exclusive benefit of the employees.

The Group intends to continue this coverage indefinitely, but it also reserves the right to discontinue or change this coverage at any time. If the Group terminates the Contract for any reason and does not replace the coverage with comparable benefits, employees will receive ample notice. Employees will also receive instructions for converting their coverage to an individual plan.

Rights and Protection

Employees are entitled to certain rights and protection under ERISA. ERISA provides that all employees shall be entitled to:

- Examine without charge, at the plan administrator's office, all policy documents, including insurance policies and copies of certain documents filed by the plan administrator with the U.S. Department of Labor, such as detailed annual reports and policy descriptions.
- Obtain copies of documents governing the operation of the plan upon written request to the plan administrator. The plan administrator may make a reasonable charge for the copies.
- Continue, generally at their own expense, health care coverage of themselves, their spouses and children if coverage ends due to certain qualifying events. Review the summary plan description and governing documents of the coverage for rules and other details about such COBRA continuation rights.

Duties

In addition to creating rights for employees, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries," have a duty to do so prudently and in the interest of employees and their dependents. No one, including the employer, or any other person, may fire an employee or otherwise discriminate against one in any way to prevent an employee from obtaining a welfare benefit or exercising his or her rights under ERISA.

If an employee's claim for a welfare benefit is denied (or ignored) in whole or in part, he or she must receive a written explanation of the reason for the denial. Employees have the rights to obtain copies of related documents without charge and to Appeal any

denial within certain time frames. Under ERISA, there are steps they can take to enforce the above rights. For instance, if an employee requests certain materials from the plan administrator in writing and does not receive them within 30 days, the employee may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay an employee up to \$110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the plan administrator.

Denied Claims

If an employee has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or federal court. An employee may also do so if he or she disagrees with a decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order. If fiduciaries misuse money, or if an employee is discriminated against for asserting his or her rights, employees may seek assistance from the U.S. Department of Labor or file suit in a federal court. The court will decide who should pay court costs and legal fees. If an employee is successful, the court may order the person an employee has sued to pay these costs and fees. If an employee loses, the court may order the employee who sued to pay these costs and fees, for example, if it finds the claim frivolous. If an employee has any questions about the plan, he or she should contact the plan administrator.

If You Need More ERISA Information

If an employee has any questions about this statement or his or her rights under ERISA, or if he or she needs assistance obtaining documents from the plan administrator, the employee should contact the nearest Field Office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in the telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Employees can also obtain publications about their ERISA rights and responsibilities by calling the publications hotline of the Employee Benefits Security Administration.

GOVERNING LAW

The Contract will be governed by and construed in accordance with the laws of the United States of America and by the laws of the state of Oregon without regard to its conflict of law rules.

GROUP IS AGENT

The Group is Your agent for all purposes under the Contract and not the agent of Regence BlueCross BlueShield of Oregon. You are entitled to health care benefits pursuant to an agreement between Us and the Group. In the Contract, the Group agrees to act as agent for You in acknowledging Your agreement to the terms, provisions, limitations and exclusions contained in this Booklet. You, through the enrollment form signed by the Enrolled Employee, and as beneficiaries of the Contract, acknowledge and agree to the terms, provisions, limitations and exclusions in this Booklet.

MODIFICATION OF CONTRACT

We shall have the right to modify or amend the Contract from time to time. However, no modification or amendment will be effective until 30 days (or longer, as required by law) after written notice has been given to Members or to the Group, and modification must be uniform within the product line and at the time of renewal. Exceptions to this modification provision for circumstances beyond Our control are further addressed in the Contract.

NO WAIVER

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

NOTICES

Any notice to Members or to the Group required in the Contract will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Enrolled Employee or to the Group will be addressed to the Enrolled Employee or to the Group at the last known address appearing in Our records. If We receive a United States Postal Service change of address form (COA) for an Enrolled Employee, We will update Our records accordingly. Additionally, We may forward notice for an Enrolled Employee to the Group administrator if We become aware that We don't have a valid mailing address for the Enrolled Employee. Any notice to Us required in the Contract may be given by mail addressed to: Regence BlueCross BlueShield of Oregon, P.O. Box 30805, Salt Lake City, UT 84130-0805; provided, however that any notice to Us will not be considered to have been given to and received by Us until physically received by Us.

PREMIUMS

Premiums are to be paid to Us by the Group, in advance, and on or before the premium due date. Failure by the Group to make timely payment of premiums may result in Our terminating the Group's or Member's coverage on the last day of the monthly period through which premiums are paid or such later date as is provided by applicable law.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Group on behalf of itself and its Members expressly acknowledges its understanding that the Contract constitutes an agreement 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 Us to use the Blue Cross and Blue Shield Service Marks in the state of Oregon and in Clark County in the state of Washington and that We are not contracting as the agent of the Association. The Group on behalf of itself and its Members further acknowledges and agrees that it has not entered into the 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 will be held accountable or liable to the Group or the Members for any of Our

obligations to the Group or the Members created under the Contract. This paragraph will not create any additional obligations whatsoever on the part of Regence BlueCross BlueShield of Oregon other than those obligations created under other provisions of the Contract.

REPRESENTATIONS ARE NOT WARRANTIES

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

TAX TREATMENT

We do not provide tax advice. Consult Your financial or tax advisor for information about the appropriate tax treatment of benefit payments and reimbursements.

WHEN BENEFITS ARE AVAILABLE

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

- the person is eligible to be covered according to the eligibility provisions of the Contract;
- the person has enrolled in coverage and has been enrolled by Us; and
- premium for the person 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 provided and the expense of a supply is incurred on the day the supply is delivered to You.

Definitions

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

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

Allowed Amount means:

- With respect to Participating Dentists, the amount Participating Dentists have agreed to accept as full payment for Covered Services as determined by Us.
- With respect to Nonparticipating Dentists, Reasonable Charges for Covered Services as determined by Us.

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

Booklet is the description of the benefits for this coverage. The Booklet is part of the Contract between the employer Group and Us.

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

Covered Service means those services or supplies that are required to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues (including treatment that restores the function of teeth) and are Dentally Appropriate. These services must be performed by a Dentist or other provider practicing within the scope of his or her license.

Dentally Appropriate means a dental service recommended by the treating Dentist or other provider, who has personally evaluated the patient, and determined by Us (or Our designee) to be all of the following:

- appropriate, based upon the symptoms, for determining the diagnosis and management of the condition;
- appropriate for the diagnosed condition, disease or Injury in accordance with recognized national standards of care;
- not able to be omitted without adversely affecting the Member's condition; and
- not primarily for the convenience of the Member, Member's family or provider.

A DENTAL SERVICE MAY BE DENTALLY APPROPRIATE YET NOT BE A COVERED SERVICE IN THIS BOOKLET.

Dentist means an individual who is licensed to practice dentistry (including a doctor of medical dentistry, doctor of dental surgery, or a denturist). A Dentist also means a dental hygienist who is permitted by his or her respective state licensing board, to independently bill third parties.

Effective Date means the date specified by Us, following Our receipt of the enrollment form, as the date coverage begins for You and/or Your dependents.

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

Enrolled Dependent means an Enrolled Employee's eligible dependent who is listed on the Enrolled Employee's completed enrollment form and who is enrolled under the Contract.

Enrolled Employee means an employee of the Group who is eligible under the terms of the Contract, has completed an enrollment form and is enrolled under this coverage.

Family means an Enrolled Employee and his or her Enrolled Dependents.

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

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

Illness means a congenital malformation that causes functional impairment; a condition, disease, ailment or bodily disorder, other than an injury; and pregnancy.

Injury means physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical or that is the direct result of an accident, independent of illness or any other cause.

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

- The Scientific Evidence must permit conclusions concerning the effect of the Health Intervention on Health Outcomes, which include the disease process, illness or injury, length of life, ability to function and quality of life.
- The Health Intervention must improve net Health Outcome.
- The Scientific Evidence must show that the Health Intervention is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research setting.

In applying the above criteria, We will review Scientific Evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating physician or practitioner regarding the Health Intervention.

Lifetime means the entire length of time a Member is covered under the Contract (which may include more than one coverage) through the Group with Us.

Member means an Enrolled Employee or an Enrolled Dependent.

Nonparticipating Dentist means a Dentist who is not a Participating Dentist.

Participating Dentist means a Dentist who has an effective participating contract with Us to provide services and supplies to Members in accordance with the provisions of this coverage.

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

- 125% of the fee paid by Medicare for the same services or supplies;
- The average amount that Participating Dentists have agreed to accept as full payment for the same or similar services or supplies in Our service area; or
- 40% of the Nonparticipating Dentist's billed charges.

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

Scientific Evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of a Health Intervention on Health Outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the Health Intervention and Health Outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

For more information call Us at 1 (888) 367-2116

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is an Independent Licensee of the BlueCross and
BlueShield Association