- 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 another plan and without taking the existence of that Other Plan into consideration. (This is also referred to as that plan being "primary" to that Other Plan.) There may be more than one Primary Plan. A plan is a Primary Plan with regard to another plan in any of the following circumstances:

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

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

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

Order of Benefit Determination

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

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

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

If a court decree specifies that Your parent is responsible for Your health care expenses or health care coverage and that parent's plan has actual knowledge of that term of the decree, the plan of that parent is primary to the plan of Your other parent. If the parent with that responsibility has no coverage for You, but that parent's spouse does and the spouse's plan has actual knowledge of that term in the decree, the plan of the spouse shall be primary to the plan of Your other parent. If 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, and
- 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 4208, Portland, OR 97208-4208 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.

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. For Post-Service Appeals, a written notice of Our decision will be sent within 30 days of receipt of the Grievance. For a Grievance involving a Pre-Service preauthorization of a procedure, We will send a written notice of the decision within 14 days of receipt of the Grievance.

Filing Appeals (First and Second Level)

If You don't agree with Our decision after filing a Grievance, You may file an Appeal. You have the right to file up to two Appeals. Appeals are reviewed by a panel who were not involved in, or subordinate to anyone involved in, the prior decision. You or Your Representative, on Your behalf, will be given a reasonable opportunity to personally appear or to provide written materials. 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 14 days of receipt of the Appeal.

VOLUNTARY EXTERNAL APPEAL - IRO

A voluntary Appeal to an Independent Review Organization (IRO) is available only after You have exhausted the initial internal Grievance process and at least one Appeal. 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 Our Customer Service department at 1 (888) 367-2116.

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:

Panel-Level (First-Level) Expedited Appeal

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

Voluntary Expedited Appeal - IRO

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

We coordinate voluntary Expedited Appeals, but the decision is made by an IRO at no cost to You. In order to have the 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 Our Customer Service department at 1 (888) 367-2116.

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 Our Customer Service department at 1 (888) 367-2116 or You can write to Our Customer Service department at the following address: Regence BlueCross BlueShield of Oregon, P.O. Box 30805, Salt Lake City, UT 84130-0805.

You also have the right to file a complaint and seek assistance from the Oregon Insurance Division, Consumer Advocacy Unit; P.O. Box 14480,; Salem, OR 97309-0405 or call 1 (503) 947-7984 or visit its Web site at **www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx**.

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 timeframes:

- 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 a Member Employer 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-Certified 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-Certified Domestic Partner. Oregon-Certified 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-Certified 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 at **www.Regence.com,** or by calling Our Customer Service department at 1 (888) 367-2116.

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-Certified Domestic Partner, an affidavit of qualifying domestic partnership form) to the Group. 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-Certified 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.

MEMBER EMPLOYER TERMINATION

If Your employer ceases to be a Member Employer, coverage ends for You and Your Enrolled Dependents on the date Your employer ceases to participate under the Contract.

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 employer 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 Your portion of the monthly premium through Your employer to the Group on time. The provisions described here will not be available if the Contract terminates or Your employer ceases to be a Member Employer.

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 employer and approved by the Group, You can continue coverage for up to three months. Premiums must be paid through Your employer to 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 Your employer and 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-Certified Domestic Partnership

If the contract with Your Oregon-Certified 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-Certified 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 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 material misrepresentation of fact or established 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 Member Employer), 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 coverage 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 former employer 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 Member Employer 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 Member Employer also must meet certain notification, election and payment deadline requirements. It is therefore very important that You keep Your employer and 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 employer or Group.

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 Member Employer's plan is not subject to the continuation of coverage provisions of COBRA, or if a Member Employer 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 employer 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 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 and Member Employer intend that the Contract be maintained for the exclusive benefit of the employees.

The Group and Member Employer intend to continue this coverage indefinitely, but also reserve the right to discontinue or change this coverage at any time. If the Contract is terminated for any reason and is not replaced 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 the Contract. 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 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 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 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 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, a Member Employer's, or a 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, its Member Employers 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, its Member Employers 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.

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 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 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 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 a Member Employer 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, Injury or Illness, 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.

Member Employer means a business entity qualifying for membership or participation in the Group and choosing to participate under the Contract to provide coverage to its employees and their dependents as Enrolled Employees and Enrolled Dependents, respectively.

Nonparticipating Dentist means a Dentist who does not have an effective participating contract with Us to provide services and supplies to Members.

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 by Us, that falls within the range of average charges for a service or supply billed by most providers or vendors for the same or similar service or supply in Our service area.

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 or you can write to us at 100 SW Market Street, Portland, OR 97201

www.Regence.com

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