

Blue Selections PPO

CLARK COUNTY, WASHINGTON

Health care coverage for individuals and families

A black and white photograph of a woman and a young girl. The woman is on the left, looking down and smiling at the girl. The girl is on the right, also smiling. They appear to be in a home setting, possibly near a window or doorway. The image is framed by a thin black border.

FOR YOUR HEALTH

Your partner in health care

Thank you for requesting information about Blue Selections PPO. It's important to have continued protection against unexpected medical costs for yourself and your loved ones. But not all individual and family health care plans are the same. You want to choose coverage that's comprehensive and affordable, from a partner you can trust in times when it matters most. That's why we've developed Blue Selections PPO, a new plan for residents of Clark County, Washington.

We've got you covered

This booklet was created to provide information and answers you'll need to choose Blue Selections PPO as your health care plan. Along with excellent medical coverage, you can enjoy other valuable services you may have thought unaffordable without the help of an employer, like dental coverage, LASIK eye surgery, and access to fitness centers.

Once you've read this booklet and understand your options, applying for coverage is easy. You can simply complete and return the enclosed application, or apply online. Take a look at your application checklist on page 5. Or just turn to the Applying for Coverage section on page 16 for more details and answers to frequently asked questions.

Blue Selections PPO highlights

- Range of \$20 copayment services:
office visits, eye exams, immunizations, well-baby care
- Choice of deductibles: \$1,000, \$2,500, \$5,000
- Maternity care
- Extensive provider network
- Prescription medication coverage without annual maximums
- Coverage when traveling, with the BlueCard® program
- Optional dental coverage provided by Willamette Dental, one of the largest managed-care dental groups in the nation

Contact us today

Toll free: 1 (800) 452-2909

TTY line for people with hearing
impairment: 1 (800) 382-1003

Open: Monday - Friday, 8:30 a.m. - 5 p.m.

www.or.regence.com

Table of Contents

Your Partner in Health Care	3
Review an application checklist	
Plan Highlights	6
Read about valuable plan services	
Summary of Benefits	7
Learn important information about your plan	
Comparing Rates by Deductible	8
View a chart by age to help determine monthly premiums	
Medical Plan Benefit Limitations	9
Read about pre-existing condition waiting periods and contract limitations	
Medical Plan Benefit Exclusions	10
Know some things not included in your plan	
Individual Dentacare	11
Choose an optional dental plan for you and your family	
Applying for Coverage	16
Find answers to frequently asked questions	
Disclosure Statement	18
Read your health care patient bill of rights	
Privacy Practices	24
See how we protect your personal health information	
Glossary of Terms	28
Learn insurance language, defined for your convenience	

Look for your application form

These items are included in your information packet outside of this booklet:

- Blue Selections PPO application form
- Washington State Health Questionnaire (one is required for each covered individual)
- Return envelope for application and health questionnaires
- Information for optional dental coverage through Willamette Dental
- Additional information for other products and discount programs such as the Regence Health Savings Account and TruVision™
- Provider directory for complementary and alternative care

Your Partner in Health Care

Discover affordable, extensive coverage

Regence BlueCross BlueShield of Oregon now offers Blue Selections PPO, an individual and family health care plan for residents of Clark County, Washington. Blue Selections PPO offers affordable coverage with a range of deductible options to help you manage your budget. In this booklet we'll help answer some of your questions so you can decide if Blue Selections PPO is right for you.

Compare health care plans

With so many health care products in the market, it's a good idea to think about what's most important to you when purchasing health insurance. Here are some valuable considerations when comparing plans:

- **How do I choose a plan to fit my budget?** When weighing costs with benefits, many people appreciate the advantages of \$20 copayments for office visits and other services.
- **Can I choose from well-respected doctors and hospitals?** You might consider the size of the provider network for doctors, specialists and hospitals in your area, as well as receiving care when traveling nationwide or around the world.
- **Which plan includes the best customer service?** You'll want coverage from a name you trust, with local experience from a customer service department in your area.
- **Which plan offers more options to augment coverage?** Consider coverage that includes optional Individual Dentacare coverage, and products such as a Health Saving Account to receive tax benefits on dollars used for medical costs.

Receive first-dollar coverage

With Blue Selections PPO, you'll have comprehensive coverage – including office visits for illness, annual women's exams, childhood immunizations and well-baby care – for just a \$20 copayment per visit. You do not have to meet your deductible before receiving this \$20 copay benefit. This is called first-dollar coverage, so your plan can begin paying on day one. More information on deductibles is listed below. Definitions can be found in the glossary on page 28.

Other services are paid at 80 percent when you see physicians or other care providers that are in-network, from our large Preferred Provider Plan network, including services in Washington and Oregon. Please visit us online at www.or.regence.com/member/doctor to see if your doctor is in this network.

Find a plan that fits your budget

You can choose from a range of deductibles – \$1,000, \$2,500, \$5,000. A deductible is the amount you pay before Blue Selections PPO begins paying toward eligible benefits. A higher deductible offers lower monthly rates. This is because you agree to cover more out-of-pocket costs before the plan starts paying expenses. Check the rates associated with each deductible on page 8. With these choices, it's easy to find a plan that fits your budget and lifestyle.



Your Partner in Health Care (continued)

Get Regence Advantages

When you become a Regence member with Blue Selections PPO, you have access to these great discount programs:

- **TruVision™:** Receive discounts for laser vision corrective surgery, including pre- and post-operative care and a retreatment warranty. You also can receive 10 to 15 percent off the average cost of contact lenses when you order by mail.
- **Beltone™ Hearing Care:** Save on hearing care with a free screening, 25 percent discounts on Beltone hearing aids, one-year supply of hearing aid batteries, as well as complimentary testing and follow-up visits.
- **GlobalFit:** Enjoy up to 60 percent off regular monthly rates at participating fitness clubs, as well as discounts on fitness gear, vitamins and supplements, personal care products and more.

Visit us online at www.or.regence.com/member and click “discount services” to learn more about these programs designed to save you money.

Check out our glossary

If you have questions about the way we use certain words, check out our glossary of common terms on page 28.

Call for assistance

If you need more information or if you have questions, please call us at 1 (800) 452-2909, Monday through Friday from 8:30 a.m. to 5 p.m.

Enjoy a traveling companion

Thanks to our BlueCard® program, you can access 80 percent of hospitals and nearly 90 percent of doctors nationwide when traveling outside our service area. So even on the road you can find the best doctors for your emergency needs.



Your Partner in Health Care (continued)

Your application checklist

Washington law requires you to fill out certain forms when applying for coverage. This checklist is a guide to help you complete the required forms for application. These items must be completed and submitted for us to accept and review your application. **If your application and questionnaire are incomplete, the processing of your application will be delayed.**

Be sure to:

- Use a blue or black ink pen when completing the application.
- Complete all sections of the application.
- Complete a Washington Standard Health Questionnaire for each family member applying for coverage. See the box to the right for an explanation of the questionnaire.
- Provide all requested information about all family members.
- Have all adults listed on the application sign where applicable.
- Choose a billing option. If you select automatic bank withdrawal, please pay your paper bill until you are notified that your electronic funds transfer has been initiated. Processing may take up to 60 days.
- We will bill you when you're accepted for coverage. Please do not attach a premium payment with your application.

Filling out forms. It's the law.

Effective January 1, 2001, Washington State law requires that anyone applying for individual health insurance coverage **must complete both an application form from the health plan and a Standard Health Questionnaire for Washington State**. One questionnaire form is required for each family member applying for coverage. Some exceptions apply. If you qualify for an exemption from the questionnaire, be sure to include copies of supporting documents. Please see the Washington Individual and Family Plans Application for details.

Plan Highlights

\$20 copayments

Here's a list of services provided for a \$20 copayment and no deductible. (See the glossary on page 28 for definitions of these terms.)

- Doctor and specialist visits
- Eye exam once every 24 months by a Full Service Vision Provider
- Annual women's examinations
- Immunizations
- Well-baby care to age two

Other highlights

- Choice of medical deductibles: \$1,000, \$2,500, \$5,000
- Up to \$2,000,000 in lifetime benefits for each covered family member
- Special provider arrangements limit out-of-pocket expenses
- No claim forms to file for prescriptions at participating pharmacies when ID card is presented at time of purchase
- Coverage when traveling outside of Clark County (see glossary on page 28 for a definition of BlueCard®)

How to use your medical benefit

Basic services such as office visits, annual women's examinations (including related Pap smear and routine mammography), allergy shots, immunization benefits, and well-baby care to age two require only a \$20 copayment and no deductible or coinsurance.

Other services (such as lab or x-rays) provided by an in-network provider are paid at 80 percent after your calendar year deductible is met. Of course, you're not limited to in-network providers. Once your medical deductible is met, you may also seek care from an out-of-network provider and receive benefits at 60 percent.

The same services are covered regardless of which provider you choose; however, when you choose in-network providers we will pay a larger percentage of your covered expenses.

Another advantage of seeing an in-network provider is that you will not be billed for balances over an agreed upon amount. This feature is called hold harmless. See the glossary on page 28 for more details on hold harmless.

How to use your prescription medication benefits

You can access your prescription medication benefits from the first day of your membership on the plan because there is no medication deductible to worry about.

Here are some considerations that will help you receive the maximum benefit from your prescription medication plan:

At your health-care provider's office:

- Ask your health care provider to prescribe a generic medication when available and appropriate.
- Keep in mind, we pay 50 percent for all prescription medications.

At the pharmacy:

- Ask your pharmacist to fill your prescription with a generic medication when available.
- Our individual plan provides a 34-day supply maximum for each prescription filled.



Summary of Benefits

Below is a snapshot of benefits in an easy-to-read table. In-Network refers to our Preferred Provider Plan network. Please check the considerations column below for hints that help further define the benefits. If there's some insurance language that's difficult to follow, just check the Glossary of Terms on page 28. If you have questions on this table or anything else in this booklet, please call us at 1 (800) 452-2909, or contact your agent.

Description	In-Network	Out-of-Network	Considerations
Lifetime Maximum	\$2 million per person		
Deductible Options	\$1,000 \$2,500 \$5,000		Deductibles apply to a maximum of three family members. Deductible does not apply for copayment services. Deductible applies for coinsurance services.
Annual Coinsurance Maximum	\$4,000	\$6,000	Deductibles and covered expenses paid at 100% do not accumulate toward the annual coinsurance maximum, which is your share of the \$20,000 annual stop-loss.
Professional Services			
Home and Office Visits	100% after \$20 copayment		For illness and injury.
Annual Women's Exams	100% after \$20 copayment		Breast and pelvic exams.
Well-baby Care up to Age 2	100% after \$20 copayment		
Immunizations	100% after \$20 copayment		Waived if office visit copayment applies.
Maternity Care	80%	60%	For you or your enrolled spouse. See limitations on page 9.
Hospital Services			
Hospital Stay	80%	60%	Includes Inpatient and Outpatient
Skilled Nursing	80%	60%	See limitations on page 9.
Inpatient Rehabilitation	80%	60%	
Inpatient Mental Illness	80%	60%	
Emergency Room Services	80% after \$100 copayment		If admitted, the copayment is waived for emergency services. The copayment amount does not apply toward the deductible.
Vision Benefits (once every 24 months)			
Eye examinations	100% after \$20 copayment	60%	In-network here refers to Full Service Vision panel providers.
Frames	Up to \$85		
Lens (pair)	Up to \$96 – \$180		
Contacts instead of lenses and frames	Up to \$181		
Other Services and Benefits			
Alternative Providers	80%	Not covered	
Ambulance	80%		Ground and air transportation \$5,000 maximum per calendar year (does not apply to emergent use).
Laboratory and Radiology Services	80%	60%	
Outpatient Rehabilitation	80%	60%	See limitations on page 9.
Durable Medical Equipment and Supplies	80%	60%	
Home Health Services	80%	60%	See limitations on page 9.
Alcoholism	80%	60%	See limitations on page 9.
Transplant Services	100%		Includes facilities contracted with us to provide transplant services. Lifetime maximum of \$250,000. See limitations on page 9.
Prescription Medications			
Coinsurance	50%		
Annual Limit	no limit		

Comparing Rates by Deductible

Effective March 1, 2005

We have four rating categories to choose from: individual, married couple, one adult & child(ren), and family. You can quickly see and compare rates below. All rates listed below are per month.

Age	\$1,000 Deductible		\$2,500 Deductible		\$5,000 Deductible	
	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker
Individual						
under age 25	\$124	\$138	\$103	\$115	\$84	\$94
25-29	\$131	\$147	\$109	\$122	\$89	\$100
30-34	\$156	\$175	\$130	\$145	\$106	\$119
35-39	\$171	\$192	\$142	\$159	\$116	\$131
40-44	\$238	\$267	\$198	\$221	\$162	\$182
45-49	\$283	\$317	\$235	\$263	\$192	\$216
50-54	\$328	\$367	\$272	\$305	\$222	\$250
55-59	\$395	\$442	\$328	\$367	\$268	\$301
60+	\$453	\$508	\$376	\$421	\$307	\$346
Married Couple						
under age 25	\$248	\$276	\$206	\$230	\$168	\$188
25-29	\$262	\$294	\$218	\$244	\$178	\$200
30-34	\$312	\$350	\$260	\$290	\$212	\$238
35-39	\$342	\$384	\$284	\$318	\$232	\$262
40-44	\$476	\$534	\$396	\$442	\$324	\$364
45-49	\$566	\$634	\$470	\$526	\$384	\$432
50-54	\$656	\$734	\$544	\$610	\$444	\$500
55-59	\$790	\$884	\$656	\$734	\$536	\$602
60+	\$906	\$1,016	\$752	\$842	\$614	\$692
One Adult & Child(ren)						
under age 25	\$191	\$213	\$159	\$177	\$129	\$145
25-29	\$202	\$226	\$168	\$188	\$137	\$154
30-34	\$240	\$270	\$200	\$223	\$163	\$183
35-39	\$263	\$296	\$219	\$245	\$179	\$202
40-44	\$367	\$411	\$305	\$340	\$249	\$280
45-49	\$436	\$488	\$362	\$405	\$296	\$333
50-54	\$505	\$565	\$419	\$470	\$342	\$385
55-59	\$608	\$681	\$505	\$565	\$413	\$464
60+	\$698	\$782	\$579	\$648	\$473	\$533
Family						
under age 25	\$397	\$442	\$330	\$368	\$269	\$301
25-29	\$419	\$470	\$349	\$390	\$285	\$320
30-34	\$499	\$560	\$416	\$464	\$339	\$381
35-39	\$547	\$614	\$454	\$509	\$371	\$419
40-44	\$714	\$801	\$594	\$663	\$486	\$546
45-49	\$792	\$888	\$658	\$736	\$538	\$605
50-54	\$853	\$954	\$707	\$793	\$577	\$650
55-59	\$909	\$1,017	\$754	\$844	\$616	\$692
60+	\$1,042	\$1,168	\$865	\$968	\$706	\$796

Use the age of the oldest covered family member to determine your monthly premium. You may be able to reduce your premium rate by insuring family members under separate contracts. Rates may renew once during the plan year. Additionally, you may experience a rate change from one age band to another. If you have questions, please contact your agent or call us at 1 (800) 452-2909.

Medical Plan Benefit Limitations

Pre-existing conditions waiting period

Blue Selections PPO includes a nine-month waiting period for pre-existing conditions. A pre-existing condition is a condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received within the nine-month period immediately before coverage began. We won't impose a pre-existing condition limitation period for a newborn child, an adopted child, or a child placed with you for adoption within 60 days of birth, adoption, or placement, respectively. For maternity care, a pregnancy that began prior to your effective date may be subject to the pre-existing condition waiting periods, but routine prenatal care will not be.

Insurance benefits are limited during the first nine months

You must also be covered for at least nine months before we will pay benefits for any of the following:

- Removal of tonsils or adenoids
- Otitis media (ear infection)
- Allergies
- Alcoholism
- Sterilization procedures
- Maternity care

You must be covered for at least 24 months before we pay benefits for transplants.

We'll apply credits month for month toward the limitation periods if you or your enrolled dependent(s) were insured under another individual or group health insurance contract, or other creditable coverage, in the past 63 days. To receive limitation period credit, submit your Certificate of Coverage to us. You can obtain this from your prior insurer.

Limitations

The following is a brief list of the contract limitations. Other than where required by law, we will not duplicate Medicare benefits.

Service	Limitation
Alcoholism Treatment	\$4,500 in any 24-consecutive month period
Mental Health Inpatient Care Outpatient Care	30 days per calendar year no benefit
Rehabilitative Care (physical therapy, occupational therapy, speech therapy, audiology therapy) Inpatient Care Outpatient Care	30 days per calendar year* 30 sessions per calendar year [▲]
Skilled Nursing Facility Care	14 days per stay [†]
Transplant Services	\$250,000 lifetime maximum
Dental Care for accidental injury	Treatment of accidental injury of natural teeth or a fractured jaw within 12 months after the injury

*If preauthorized, we may allow up to 60 days per calendar year for certain conditions.

▲If preauthorized, we may allow up to 60 sessions per calendar year for certain conditions.

†If preauthorized, we may allow up to 100 days per calendar year.

This is a only a summary. Please refer to the contract for a complete list of benefits, limitations and exclusions.

Medical Plan Benefit Exclusions

Benefit exclusions

We believe in full disclosure and providing the information you need to fully understand the scope of your plan. If you have any questions, please contact us at 1 (800) 452-2909.

Here's a brief list of your contract exclusions. Be sure to read your contract carefully for a complete description of coverage. Exclusions include:

- Appliances or equipment primarily for comfort or convenience (e.g. air conditioners)
- Charges over usual and customary or reasonable for services and supplies
- Cosmetic or reconstructive surgery (including complications arising from such services)

- Custodial care (including routine nursing care and rest cures)
- Dental examinations and treatment (except as specifically provided in the "Special Dental Care" section of the contract)
- Drug abuse or addiction treatment
- Experimental or investigational procedures
- Family planning services and supplies (except sterilization)
- Hearing aids
- Orthognathic surgery
- Outpatient treatment for mental illness
- Outpatient counseling (such as marital counseling)
- Routine physical exams, services, or supplies (some exceptions apply)
- Self-help, training, and instructional programs
- Services or supplies you get free or for which no charge is normally made
- Services payable under motor vehicle coverage
- Treatment not medically necessary
- Treatment for obesity or weight control (including surgery)
- Treatment for tobacco addiction
- Treatment of an illness or injury for which a third party is responsible
- Treatment received before coverage begins or after coverage ends (including admission to a hospital, skilled nursing facility, or special facility)
- Work-related injuries and conditions (unless you are exempt from state or federal Workers' Compensation law)



Individual Dentacare – An Optional Individual and Family Dental Plan

Regence BlueCross BlueShield of Oregon is pleased to offer affordable dental coverage to individuals and families purchasing our medical plans. Services for Individual Dentacare are provided by the dentists and staff of Willamette Dental – one of the largest managed dental care groups in the nation.

With Individual Dentacare, you'll work with a plan dentist to maintain your dental health through routine exams and other preventive care services. Services are provided from Willamette Dental offices. To find out if there is an office close to you, view the map below.

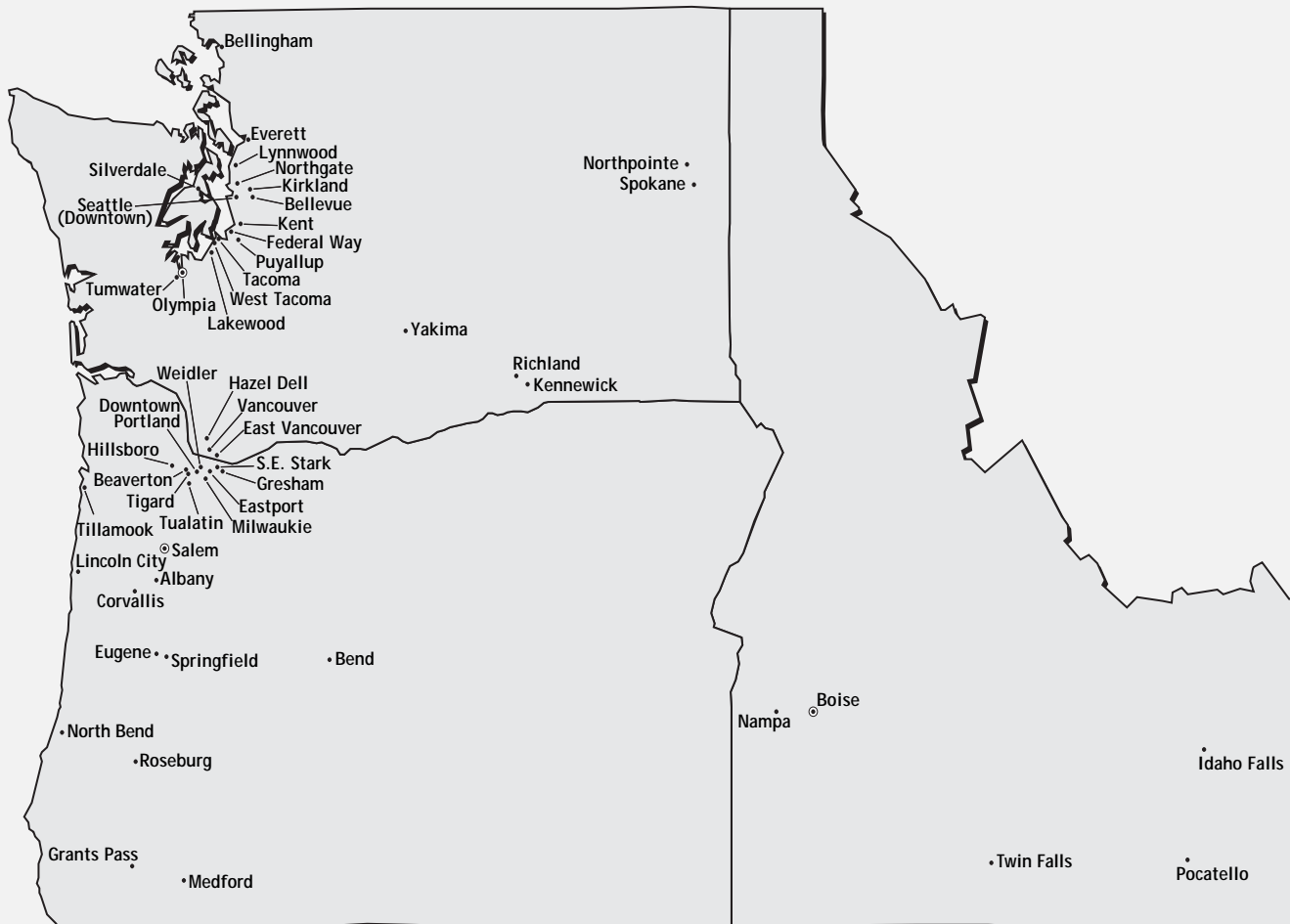
Highlights of the Individual Dentacare plan:

- No deductibles and no annual maximums
- Simple \$15 copayment for office visits
- Some services are covered with no additional service charge, including routine or emergency exams, teeth cleanings, periodontal screening and maintenance
- Orthodontia coverage available for family members
- With a simple service fee, a variety of other dental services are covered. These include fillings, x-rays and more.
- Major services provided after six months
- Individual Dentacare is optional when purchasing Blue Selections PPO.

Individual Dentacare's convenient locations

Willamette Dental offices are conveniently located throughout the region. Addresses and maps can be found at www.willamettedental.com.

Individual Dentacare Monthly Rates	
Individual	\$24
Individual and Spouse	\$48
One Adult and Children	\$47
Family	\$71



Individual Dentacare – Summary of Benefits

Individual Dentacare offered by Regence BlueCross BlueShield of Oregon

Services covered through Willamette Dental offices. See locations map on page 11.

Summary of Benefits

Annual maximum	No annual maximum
Deductible	No deductible
Office visit copayment (also known as visit charge)	\$15 per visit
Services provided at no additional charge	
Routine and emergency exams	100% after \$15 visit copayment
Bitewing X-rays	
Teeth cleaning for children and adults	
Fluoride treatment for children through age 12	
Head and neck cancer screening	
Oral hygiene instruction	
Periodontal screening	
Periodontal maintenance	
Services provided with additional \$20 service fee	
Sealants per quadrant	100% after \$15 visit copayment and \$20 service fee
After hours emergency visits	
Panoramic X-rays	
Services provided with additional \$30 service fee	
Restorative fillings, amalgam or anterior composite	100% after \$15 visit copayment and \$30 service fee
Simple extractions	
Simple denture/partial repairs	
Orthodontia	
Pre-orthodontic service	\$150* (per visit copayment applies)
Comprehensive orthodontia – no age limit	\$2,600 (per visit copayment applies)
<i>* \$150 fee credited toward comprehensive orthodontic copayment if patient accepts treatment plan.</i>	
Other	
Local anesthesia (Novocain)	100% covered
Nitrous oxide (per visit)	\$10 copayment
Out-of-area emergency care	You pay applicable copayments and fees. Willamette Dental pays the difference of billed charges.
Other dental services not listed	20% discount on fee-for-service costs. \$15 office visit copayment applies
Six-month waiting period for major services including crowns, bridges, partials, and dentures	
No waiting period applies for orthodontia	
The benefits of this plan are not subject to any coordination of benefits provision	
Services obtained through a non-Willamette Dental provider are not covered	
<i>This is a summary of benefits. Please refer to the contract for a complete description</i>	

Please note: If you cancel Individual Dentacare, there is a 12-month waiting period before you can re-enroll.

Individual Dentacare – Limitations and Exclusions

These benefits are limited

- Other than where required by law, we will not duplicate Medicare benefits.
- We won't replace an existing denture, crown or bridge less than seven years after the date of the most recent placement. Nor will we cover a denture replacement made necessary by loss, theft or breakage.

These services and supplies are not covered

- Services or supplies not received from a Willamette Dental dentist (except as specifically listed)
- Services or supplies you receive before your coverage starts or after your coverage ends. The date artificial teeth are prepared is considered the date of service.
- Services that aren't necessary.
- Services and supplies related to the diagnosis or treatment of the temporomandibular joint
- Dental implants
- Implant supported crowns
- Lost, stolen or broken dental appliances
- Splints, night guards and other appliances used to increase vertical dimensions, restore bite or correct habits such as tongue thrusting or teeth grinding
- Treatments, procedures, equipment, medications, devices and supplies that are experimental or investigational, even when provided by foreign providers
- Surgery for fractures, cysts or tumors
- Models of teeth and surrounding tissue for purposes of study and treatment planning
- Services provided by a dentist or denturist that are beyond the scope of his or her license
- Cosmetic dental services including complications arising out of such services
- General anesthesia, unless recommended by the referring or attending dentist for a medical condition which requires general anesthesia before services can be performed
- Recording of jaw movements or positions
- Services or supplies you receive from a dental or medical department maintained by or on behalf of any employer, a mutual benefit association, labor union, trustee or similar person or group
- Services and supplies not specifically listed

Schedule early for regular appointments

After you sign up for Individual Dentacare, be sure to make your first appointment for preventive care right away. You can see a dentist in as little as three to six weeks.



This is only a summary of the limitations and exclusions. Please refer to the contract for a complete list of benefits, limitations and exclusions.

Individual Dentacare – Frequently Asked Questions

Here are some questions frequently asked by Individual Dentacare members. If you don't find an answer to your specific question, ask your sales agent or visit www.willamettedental.com.

Q. Can I sign up for Individual Dentacare and still go to my own dentist?

A. Your dental care will ONLY be covered when provided by a dentist or specialist at a Willamette Dental office. Your coverage also extends if referred to an outside dentist or specialist by your Willamette Dental dentist. If referred to an outside dentist or specialist, your copayments remain the same as shown in your Summary of Benefits on page 12.

Q. If my spouse is covered by another dental plan, will you coordinate benefits?

A. Yes, based upon the limitations and exclusions listed for each plan.

Q. Do I have a choice of dentists?

A. Yes. You may select any Willamette Dental dentist. Once you select a dentist, all regularly scheduled appointments will be made with your selected dentist. Of course, you are allowed to change dentists or locations at any time.

Q. Can I purchase Individual Dentacare only?

A. No. Individual Dentacare is available only to individuals and families who purchase Blue Selections PPO.

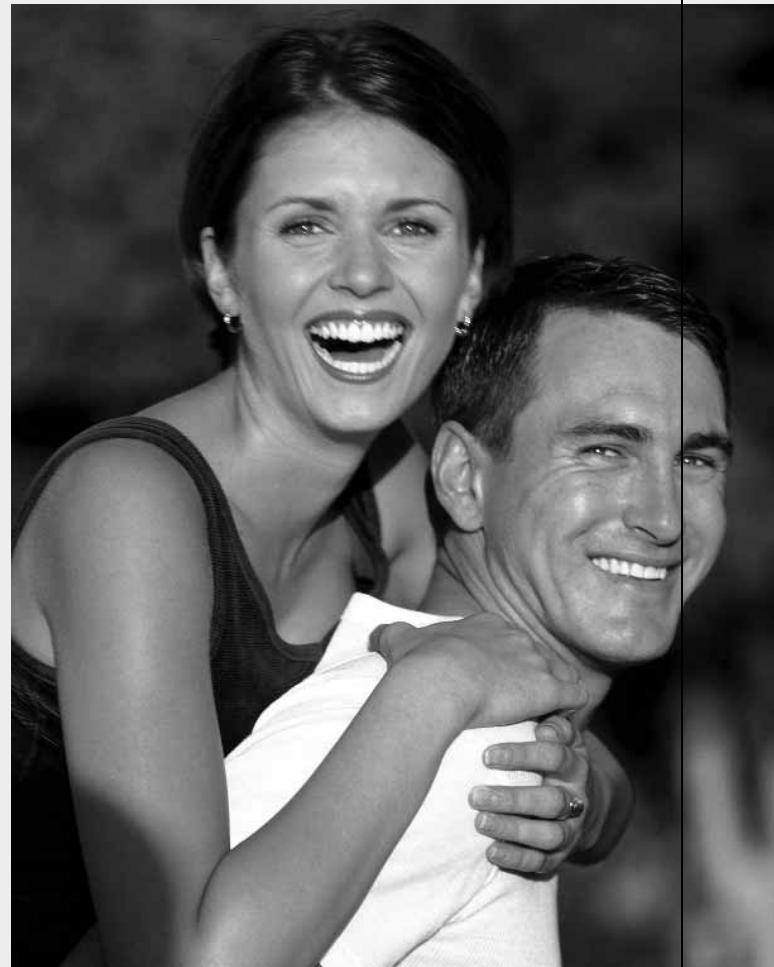
Q. How long does it take to get an appointment?

A. Emergency patients (those experiencing pain, bleeding or swelling) will be seen within 24 hours. New patients are usually seen within three to six weeks. After your initial visit, allow 42 to 90 days for teeth cleanings and non-emergency appointments. It's very important to schedule appointments in advance. Schedules fill up quickly and last-minute appointments are rare.

Please note: Some office locations are in higher demand than others. If you are flexible with locations, times and dates, your appointment needs can be accommodated more quickly.

Q. What if I have an emergency?

A. Willamette Dental provides emergency services 24 hours a day, 365 days a year. If you experience an emergency situation (pain, bleeding or swelling), just call the Appointment Center at (503) 644-3200 in the Portland metro area or 1 (800) 461-8994 toll free. If necessary, you will be able to see a dentist within 24 hours. If during regular office hours, you will pay the usual office-visit charge. After hours, the visit charge is usually higher.



Individual Dentacare – Frequently Asked Questions (continued)

Q. What if I have an emergency while I'm out of town?

- A. Emergency dental treatment is reimbursed up to the stated amount listed in your plan's Summary of Benefits.
- *In Oregon, Washington or Idaho* – If you're traveling in our tri-state service area, first call the Appointment Center at 1 (800) 461-8994 to schedule an appointment at the nearest Willamette Dental office.
 - *Outside our service area* – If you cannot get to a Willamette Dental office, or if you are traveling outside our service area, you may go to any licensed dentist to obtain emergency treatment (relief from pain, bleeding or swelling). Upon arriving home, simply contact Willamette Dental for reimbursement (up to \$100). Schedule your follow-up care with your Willamette Dental dentist.

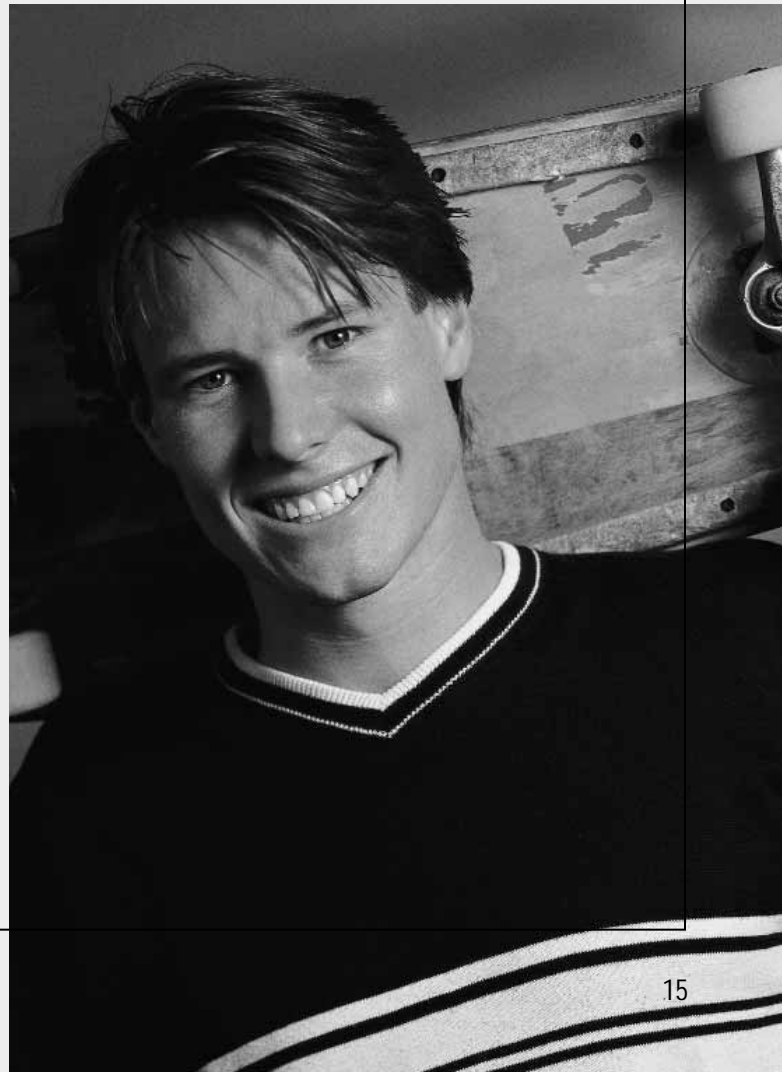
Q. What happens if I change offices?

- A. Dentacare members have the freedom to receive dental care at any Willamette Dental location. To change offices and/or dentists, call Willamette Dental's Appointment Center at (503) 644-3200 in the Portland metro area or 1 (800) 461-8994 toll free.

Please be aware that changing your dentist may result in a treatment delay.

Q. Do I have to pay an office-visit charge every time I see a dentist or specialist?

- A. The visit charge applies to all office visits, including visits for orthodontia. Note that the visit charge is in addition to any other copays you may accrue. Please be prepared to pay your visit charges and copayments each time you visit a Willamette Dental office. Payments may be made in cash or by personal check, debit card or any major credit card.



Applying for Blue Selections PPO

Apply for coverage

Once you've decided on the coverage you want, simply complete and submit the application form that was included in your packet of information. Or apply online at www.or.regence.com. Here are some answers to frequently asked questions.

Q. Who can apply for coverage?

A. Individuals and families who are not eligible for Medicare can apply for coverage under these plans if they reside in Clark County. Eligible family members may include you, your legal spouse, and any unmarried dependent children under age 23.

Q. How do I apply?

A. Simply complete the enclosed application (one per family). Then, complete a Standard Health Questionnaire for Washington State (**one per person**, see application for exceptions). Then return the application along with the state required forms to us. Once we receive your application with any other required forms, we will begin our review process. Your application may be accepted or declined.

Q. Can I apply online? What other online services do you provide?

A. Yes, you can apply online. Online shopping is quickly growing in popularity. Compare plans, get a rate quote, find a participating provider, and complete an application form online, including electronic signature. Our Web site makes it easy to find or match a doctor and hospital to the plan you are considering. To find out more, visit our Web site at www.or.regence.com. Then click on "Shop for Individual Coverage."

Q. By completing the application and health questionnaire will I automatically be approved for coverage?

A. We review the health history of each applicant before we accept them for coverage. If we are unable to offer coverage to you or one of your family members, we'll provide you with contact information for the state program that provides medical insurance coverage for Washington residents who are unable to obtain insurance because of health conditions.

Q. Does it cost more to buy through an insurance agent?

A. No. There's never an extra cost or obligation to you associated with using an appointed agent. Agents appointed to represent Regence BlueCross BlueShield of Oregon products provide a valuable service to their clients. Insurance agents can help you decide which of our products is best for your situation.

Q. When will my coverage begin?

A. Your contract will be effective on the first or the fifteenth of the month after your application is approved. We'll begin to process your application immediately upon receipt. If we need to request additional information, processing could be delayed. We will send you a contract so that you may review the details of your plan. Additionally, your ID card will be mailed to you.

Q. Will my rate change?

A. The rates for individual plans are re-evaluated each year. The annual change may happen before you've been enrolled for a full year. Additionally, you may experience a rate change as you get older and move from one age category to another.

Q. What about prior Coverage Credit?

A. If your application is received within 63 days of discontinuing similar coverage with any insurance carrier, we will credit the time you were covered by the other company to the nine month limitation for pre-existing conditions and the nine month exclusion period. We need to receive a copy of your Certificate of Coverage from your previous insurance carrier in order to apply credits.

Creditable coverage means any of the following types of coverage:

- group coverage (including FEHBP and Peace Corps)
- individual coverage (including student health plans)
- Medicaid
- Medicare
- CHAMPUS/Tricare
- Indian Health Service or tribal organization coverage
- public health plans

Applying for Blue Selections PPO (continued)

Q. How do I pay for my plan?

- A. Choose from three convenient billing options: monthly automatic bank deduction, quarterly billing, or monthly paper billing. Do not send money with the application. We'll bill you for the premium payment.

If you choose monthly automatic bank deduction, it may take a month or two to get your bank deduction set up. So, please be sure to pay monthly bills that are mailed to you until the bank deduction is finalized.

Q. What if I want to add a dependent in the future?

- A. As a member, you may add newborns or recently adopted children to your policy within 60 days of the event. Complete details are provided in your contract.

To add a spouse or other children, you can send us a completed application form. Upon receipt of your dependent's application, we will begin the review process. Also, an application may be completed online at www.or.regence.com.

If the dependent's application is approved, benefits for pre-existing and other specified conditions will be subject to limitation periods.

Q. Can I purchase Individual Dentacare only?

- A. No. Individual Dentacare is available only to individuals and families who purchase Blue Selections PPO.

Q. Can individual family members decline dental coverage?

- A. If more than one family member is applying for a health plan and Individual Dentacare, all family members will have dental coverage. If individual family members apply for medical coverage separately, they may decline dental coverage.

Q. What should I do if I have questions?

- A. Please remember that this brochure is a summary of the Blue Selections PPO, and you may find it useful if you need a quick answer to a question about your coverage. The plan contract will provide complete details about your plan.

If you have questions, please call us at 1 (800) 452-2909. Members may call Customer Service at 1 (800) 777-3168. The TTY line for people with a hearing impairment is 1 (800) 382-1003. If you prefer, an agent appointed to represent our products can help you apply for a Regence BlueCross BlueShield of Oregon plan.

For the most up-to-date list of providers, please visit our Web site at www.or.regence.com.

Q. Can my employer pay for my coverage?

- A. No. Individual plans are not intended for sale as an employer-sponsored health plan for employees. You are required to certify on your application for individual coverage that your employer is not paying the premium for your plan. For information on employer health benefit plans, contact our Group Sales department at 1 (800) 452-7278.

Disclosure Statement

Health Care Patient Bill of Rights

Senate Bill 6199 (also known as the Health Care Patient Bill of Rights) was passed by the 2000 Washington State Legislature to assure that patients and providers are fully informed about the benefits and policies of their health insurance plans.

As a means of informing our members, Regence BlueCross BlueShield of Oregon has put together this Q & A outlining many of the terms and conditions of our plan.

Please note: As you read this information, keep in mind that the references to "you" refer to both you and your enrolled dependents (if applicable), unless specifically noted otherwise.

How Can I Get a List of Preferred and Participating Physicians and Specialists?

Call Customer Service at 1 (800) 777-3168 to request any provider directories. For the most up-to-date provider information, visit our Web site at **www.or.regence.com**.

How Will I Know if My Benefits Change or are Terminated?

If you have an individual policy, we will send you notification of any benefit change(s) through the mail. In addition, you can always contact Customer Service and ask a representative about your current benefits.

How Can I Find Out What My Copayments and/or Coinsurance Responsibilities are for My Health Benefits Plan?

Refer to your benefit summary, your contract or benefits booklet that outlines your health benefits. Customer Service is also available to answer your benefit questions. They may be reached Monday through Friday from 7:30 a.m. to 6 p.m. by calling 1 (800) 777-3168.

How Can I Find Out What My Premium Costs Are?

If you have individual health plan benefits, please refer to your Individual Products Brochure, or call Individual Customer Service at 1 (800) 777-3168.

What is Your Prior Authorization Criteria?

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

This teamwork helps save thousands of dollars in premiums each year, which then translates into savings for you. And, preauthorization is your assurance that your medical services won't be denied because they don't meet the contract definition of "medical necessity."

Disclosure Statement (continued)

What Does the Term “Medical Necessity” Mean?

Medical necessity means those services and supplies required for the diagnosis or treatment of an illness or injury and which, in our judgement, are:

- appropriate by treatment setting and level of care in amount, duration, and frequency of care and consistent with the symptoms or diagnosis and treatment of your or your enrolled dependent’s condition;
- appropriate with regard to widely accepted standards of good medical practice;
- not primarily for the convenience of you or your enrolled dependent or a provider of services or supplies; and
- the least costly of the treatment settings, alternative supplies, or levels of service that can be safely provided to a patient.

This means, for example, that care rendered in a hospital inpatient setting or by a nurse in the patient’s home is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility, without harm to the patient.

With respect to treatment of chemical dependency, medical necessity means the level of care indicated in the most current version of the Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders as published by the American Society of Addiction Medicine.

Please note: The fact that a professional provider furnished, prescribed, ordered, recommended, or approved a service or supply does not, in itself, make the service or supply medically necessary. We will determine whether the services are necessary. We will consult with professional consultants, peer review committees, or other appropriate sources for recommendations regarding the necessity of the services or supplies received by enrollees.

What is Provider Risk-Sharing?

Your plan includes certain risk-sharing arrangements with providers. A risk-sharing arrangement is one in which the physician, physician organization, or hospital that is responsible for delivering health-care services bears some financial risk or reward for the services they deliver. An example of a risk-sharing arrangement is a contract between an insurer and a group of heart surgeons in which the surgeons agree to provide all of the heart operations needed by plan members and the insurer agrees to pay a fixed monthly amount for those services.

For additional information about our risk-sharing arrangements, contact Customer Service.

How are Important Documents (such as my medical records) Kept Confidential?

Regence BlueCross BlueShield of Oregon has a written policy to protect the confidentiality of health information. Only employees who have a need to know in order to do their jobs may access enrollee personal information. Disclosure outside the company is permitted only when necessary to perform functions related to providing your coverage and/or when otherwise allowed by law. Note that with certain limited exceptions, Washington law requires insurers to obtain a written authorization from the enrollee or his or her representative before disclosing personal information. One exception to the need for a written authorization is disclosure to a designee acting on behalf of the insurer for the purpose of utilization management, quality assurance, or peer review.

Disclosure Statement (continued)

If I am Not Satisfied with My Health Plan or Practitioner/Provider, What Can I Do to Voice a Complaint or Appeal My Issue?

At any time, you may receive assistance filing your grievance. You also have the right to name someone you trust to file an appeal for you. However, you must give your permission in writing.

There are three steps to our grievance and appeal process. The first level of review is filing a grievance. You may file your grievance by writing us a letter, filling out a grievance form, or by contacting Customer Service to provide your information over the phone. We'll send you an acknowledgement letter outlining your issues, as well as advising you of your rights. Within 30 days, you'll receive a response from our grievance coordinator.

After the initial grievance review, you have the right to file an appeal verbally or in writing within 180 days of our decision. Your issue will be reviewed by someone not previously involved in your case. For clinical issues, a practitioner that specializes in your medical condition or procedure will be involved in the review of your appeal. A panel of representatives will evaluate your case and your appeal coordinator will notify you of the outcome in writing within 30 days, or less.

The third and final level of appeal may be filed verbally or in writing within 180 days of our decision. You have the right to an independent review of final decisions made by us. The appeal will be conducted by an independent review organization (IRO). An IRO is not connected in any way with Regence BlueCross BlueShield of Oregon and you are not responsible for the costs of the independent review. A written response to your appeal will be sent to you within 20 days.

If you are not sure whether your appeal is eligible or you want more information, please contact Customer Service at 1 (800) 777-3168.

If you or your representative believes that a decision denying preauthorization or a referral for a service will jeopardize your life, health or ability to regain maximum function, you or your representative may request an expedited appeal. You can do this by contacting Customer Service and requesting an expedited review of your case. A decision will be made within 72 hours or less.

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

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

or call: 1 (800) 562-6900 (toll-free in WA only)
(360) 407-0409 (TDD)

or visit their Web site at www.insurance.wa.gov

How Can I Participate in the Development of Your Corporate Policies and Practices?

Your feedback is very important to us. If you have suggestions for improvements about your plan or our services, we would like to hear from you.

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

Regence BlueCross BlueShield of Oregon
ATTN: Vice President, Customer Service, C7A
P.O. Box 1271
Portland, OR 97207-1271

Or send your comments to us over the internet at:
www.or.regence.com

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

Disclosure Statement (continued)

What Additional Information Can I Get from You Upon Request?

The following documents are available by calling Customer Service:

- Rules related to our drug formulary, including information on whether a particular medication is included or excluded from the formulary
- A description of our risk-sharing arrangements with physicians and other providers consistent with risk-sharing information required by the Centers for Medicare and Medicaid Services
- Information about our prior authorization procedures
- A list of covered benefits, including prescription medication benefits
- A list of the limitations and exclusions of your contract
- A statement of premiums costs and cost-sharing requirements
- A more detailed notice regarding information practices is available upon request

Prescription Medication Plan Information Your Right To Safe And Effective Pharmacy Services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please contact us at 1 (800) 452-7390.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Offices of Insurance Commissioner at 1 (800) 562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at (360) 236-4825.

Does my prescription plan limit or exclude certain medications that my health-care provider may prescribe, or encourage substitutions for some medications?

Coverage for medications is described in your contract. As described, certain medications that your health-care provider may prescribe are excluded or have limited coverage. Some examples of exclusions or limitations are:

- Compounded medications
- Medications used for cosmetic purposes
- Coverage for brand name medications when a generically equivalent medication is available
- Some medications may require preauthorization
- Medications with maximum quantity or dose limits
- Medications dispensed by non-participating pharmacies.

What is the process for developing coverage standards, formularies and preferred medications?

Information from practicing physicians and pharmacists, established national treatment guidelines, widely accepted medical literature and cost are all used to determine which medications will be included on the Preferred Medication List (PML). Medications which are recognized as a first choice or first step are included on the PML. Sometimes scientific information demonstrates that two or more products have similar effectiveness. When these choices exist, the medication products which are the best value are available on the PML for the preferred copayment. Physicians and pharmacists at Regence BlueCross BlueShield of Oregon make the final decisions for the medication products included on the PML. Please visit our Web site at www.or.regence.com for the most current PML.

Disclosure Statement (continued)

What are preauthorization requirements, or quantity or dose limits?

Certain medications may need to be preauthorized. This means we will need to review information from your physician before the medication is covered. For a list of medications which need to be preauthorized, please visit our Web site at www.or.regence.com or contact our Customer Service department at the telephone number listed on the back of your medical identification card.

Medications may require preauthorization if:

- The medication is not a first step in therapy or is a secondary choice.
- The medication is part of a group of medications that have been clinically proven to work very similarly, but differ considerably in cost.
- The medication is prone to use which is longer in duration or in doses/quantities that are higher than recommended.

What does the term "medical necessity" mean?

Coverage for medications which require preauthorization is based on medical necessity and any applicable terms of your benefit plan. Medical necessity means the medication is required for the diagnosis or treatment of an illness or injury and in the judgement of Regence BlueCross BlueShield of Oregon is:

- In an amount, duration, and frequency that is consistent with the symptoms or diagnosis and treatment of your condition.
- Appropriate with regard to widely accepted standards of good medical practice.
- Not primarily for convenience.
- The least costly, safe alternative.

What are the coverage standards for substitute medications (generic, therapeutic)?

Your contract and/or benefit summary describes your coverage, copayments/coinsurance for generic, brand name, preferred, and non-preferred medications.

Generic medications are medications that are equivalent to the brand name version, are marketed and sold by more than one source, and are listed in widely accepted references as a generic product. The US Food and Drug Administration (FDA) makes sure that the generic product is equivalent to the brand name version. The FDA ensures that the generic product:

- Has the same active ingredients found in the brand name version.
- Meets the same manufacturing and testing standards as the brand name version.
- Has the same amount of active ingredients absorbed into the bloodstream over the same amount of time as the brand name version.

Under most benefit plans, if a generic equivalent is available, but you obtain the brand name version, you will be responsible for paying the difference between the price of the generic medication and the price of the brand name medication in addition to the applicable copayment.

When can my plan change the approved medication list?

Changes to the medication list will be made annually. An annual notification will be sent to members, agents, employee benefits administrators, physicians and pharmacists.

Disclosure Statement (continued)

If my health plan makes a change to the approved medication list, will I have to pay more to use a prescription medication I'm already taking?

Yes, if you continue taking the same prescription medication. Member copayments are driven by the benefit you and/or your employer selected.

Medications that were removed from the PML are either now available generically or have one or more less costly alternatives available. We suggest you review the PML with your physician or other medical provider to determine if another medication would be appropriate for you.

What should I do if I want a change from the limitations, exclusions, substitutions or cost increases for medications specified in this plan?

If you receive your health-care benefits through your employer group, contact your employee benefits administrator to discuss other coverage options.

Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan?

Yes. There are 914 participating pharmacies in Washington. For the most current listing of participating pharmacies, please visit our Web site at www.or.regence.com.

How many days supply of most medications can I get without paying another copayment?

According to the benefits of our prescription plans, members are allowed to purchase up to a 34-day supply of a medication for one copayment. Our group only plans allow for a vacation supply one time per year. You or your pharmacist will need to call us for authorization for up to a 3-month supply of a medication for a vacation. You would be required to pay one copayment for each month's supply of the medication.

What other pharmacy services does my health plan cover?

Your health plan may cover any of the following services or supplies. However, please refer to your benefits booklet for a list of the covered benefits of your plan.

- Oral contraceptives
- Smoking cessation
- Diabetic supplies*
- Weight loss

Please note: Cosmetic medications and over-the-counter medications are not covered.

* Outpatient diabetic instruction is a medical benefit of your plan, and is not considered a pharmacy service.



THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting Your Personal and Health Information

Regence BlueCross BlueShield of Oregon (we, us, our) is committed to protecting the privacy of your personal information. We are required by applicable federal and state laws to maintain the privacy of your personal and health information. This notice explains our privacy practices, our legal duties, and your rights concerning your personal and health information. Personal and health information (referred to in this notice as "personal information") means any information that is identifiable to you as your personal information, including information regarding your health care and treatment; identifiable factors including your name, age, address, income or other financial information. We will follow the privacy practices that are described in this notice while it is in effect.

Why do we collect your personal information?

We collect personal information from you for a number of reasons, including to help us determine the appropriate products to offer to our members, to pay claims, to provide case management services, and to provide quality improvement services.

How do we collect your personal information?

We collect your personal information through you and your health-care providers. For example, we receive personal information from you on your insurance application and from your health-care providers through insurance transactions, such as the submission of claims for reimbursement of covered benefits.

How do we protect your personal information?

We protect your personal information by:

- Treating all of your personal information that we collect as confidential;
- Stating confidentiality policies and practices in our employee handbooks as well as disciplinary measures for privacy violations;
- Restricting access to your personal information only to those employees who need to know your personal information in order to provide our services to you, such as paying a claim for a covered benefit;
- Only disclosing your personal information that is necessary for a service company to perform its function on our behalf, and the company agrees to protect and maintain the confidentiality of your personal information; and
- Maintaining physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your personal information.

How do we use and disclose your personal information?

We won't disclose your personal information unless we are allowed or required by law to make the disclosure, or if you (or your authorized representative) give us permission. Uses and disclosures, other than those listed below, require your authorization. If there are other legal requirements under applicable state laws that further restrict our use or disclosure of your personal information, we'll comply with those legal requirements as well. Following are the types of disclosure we may make as allowed or required by law:

- **Treatment:** We may use and disclose your personal information for our treatment activities or for the treatment activities of a health-care provider. Treatment activities include disclosing your personal information to a provider in order for that provider to treat you.
- **Payment:** We may use and disclose your personal information for our payment activities, including the payment of claims from physicians, hospitals and other providers for services delivered to you.

Privacy Practices (continued)

- **Health-Care Operations:** We may use and disclose your personal information for our internal operations, including our customer service activities.
- **Business Associates:** We may also share your personal information with third party "business associates" who perform certain activities for us. We require these business associates to afford your personal information the same protections afforded by us.
- **Plan Sponsors:** If you are enrolled in a group health plan, we may disclose your personal information to the plan sponsor to permit it to perform administrative activities.
- **Underwriting:** We may receive, use and disclose your personal information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits.
- **To You or Your Authorized Representative:** Upon your request, we'll disclose your personal information to you or your authorized representative. If you authorize us to do so, we may use your personal information or disclose it to the person or entity you name on your signed authorization. Once you provide us with an authorization, you may revoke it in writing at any time. Your revocation won't affect any use or disclosures permitted by your authorization while it was in effect. In certain situations when disclosure of your information could be harmful to you or another person, we may limit the information available to you, or use an alternative means of meeting your request.
- **To Your Parents, if You are a Minor:** Some state laws concerning minors permit or require disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of the state where the treatment is provided, and will make disclosures consistent with such laws.
- **Your Family and Friends:** If you are unable to consent to the disclosure of your personal information, such as in a medical emergency, we may disclose your personal information to a family member or friend to the extent necessary to help with your health care or with payment for your health care. We'll only do so if we determine that the disclosure is in your best interest.
- **Marketing:** We may use your personal information to contact you with information about health-related products and services or about treatment alternatives that may be of interest to you.
- **Research; Death; Organ Donation:** We may use or disclose your personal information for research purposes in limited circumstances. We may disclose the personal information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.
- **Public Health and Safety:** We may disclose your personal information if we believe disclosure is necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your personal information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.
- **Required by Law:** We must disclose your personal information when we are required to do so by law.
- **Process and Proceedings:** We may disclose your personal information in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **Law Enforcement:** We may disclose limited information to law enforcement officials.
- **Military and National Security:** We may disclose to military authorities the personal information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials personal information required for lawful intelligence, counterintelligence, and other national security activities.

Privacy Practices (continued)

What rights do you have as an individual regarding our use and disclosure of your personal information?

You have the right to request all of the following:

- **Access to Your Personal Information:** You have the right to review and receive a copy of your personal information. We may charge you a nominal fee for providing you with copies of your personal information. This right doesn't include the right to obtain copies of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to other state or federal laws that prohibit us to release such information. We may also limit your access to your personal information if we determine that providing the information could possibly harm you or another person. If we limit access based upon the belief that it could harm you or another person, you have the right to request a review of that decision.
- **Amendment:** You have the right to request that we amend your personal information. Your request must be in writing, and it must identify the information that you think is incorrect and explain why the information should be amended. We may decline your request for certain reasons, including if you ask us to change information that we didn't create. If we decline your request to amend your records, we'll provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you have authorized, of the amendment and to include the changes in any future disclosures of that information.
- **Accounting of Disclosures:** You have the right to receive a report of instances in which we or our business associates disclosed your personal information for purposes other than for treatment, payment, health-care operations, and certain other activities. You are entitled to such an accounting for the 6 years prior to your request, though not for disclosure made prior to April 14, 2003. We'll provide you with the date on which we made a disclosure, the name of the person or entity to whom we disclosed your

personal information, a description of the personal information we disclosed, the reason for the disclosure, and other applicable information. If you request this list more than once in a 12-month period, we may charge you a reasonable fee for creating and sending these additional reports.

- **Restriction Requests:** You have the right to request that we place additional restrictions on our use or disclosure of your personal information for treatment, payment, health-care operations or to persons you identify. We may be unable to agree to your requested restrictions. If we do, we'll abide by our agreement (except in an emergency).
- **Confidential Communication:** You have the right to request that we communicate with you in confidence about your personal information by alternative means or to an alternative location. If you advise us that disclosure of all or any part of your personal information could endanger you, we will comply with any reasonable request provided you specify an alternative means of communication.
- **Electronic Notice:** If you receive this notice on our Web site or by electronic mail (e-mail), you're also entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Can you "opt out" of certain disclosures?

You may have received notices from other organizations that allow you to "opt out" of certain disclosures. The most common type of disclosure that applies to "opt outs" is the disclosure of personal information to a non-affiliated company so that company can market its products or services to you. As a health plan, we must follow many federal and state laws that prohibit us from making these types of disclosures. Because we don't make disclosures that apply to "opt outs," it isn't necessary for you to complete an "opt out" form or take any action to restrict such disclosures.

Privacy Practices (continued)

When is this notice effective?

This notice takes effect April 1, 2003, and will remain in effect until we revise it.

What if this notice of privacy practices changes?

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. For your convenience, a copy of our current notice of privacy practices is always available on our Web site at www.or.regence.com, and you may request a copy at any time by contacting us at the number below.

How can you reach us?

If you want additional information regarding our Privacy Practices, or if you believe we have violated any of your rights listed in this notice, please contact our Customer Service Department toll-free at 1 (800) 777-3168. If you have a complaint, you also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. Your privacy is one of our greatest concerns and there's never any penalty to you if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.



Glossary of Common Terms

BlueCard®

A national program that allows members who have health coverage from any Blue Cross and/or Blue Shield plan to pay the same amount for health care services, regardless if they receive the services in the state they live, are visiting another state, or traveling outside the United States.

Calendar Year

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

Coinsurance

Coinsurance is a way for members to share the cost of health care with us to keep premiums affordable. For example, when we pay 80 percent of health care costs, the member pays the remaining 20 percent.

Coinsurance Maximum

The total amount that the member must pay for coinsurance in a calendar year before the plan covers the full cost (100 percent) of eligible expenses.

Copayment

A copayment is a flat amount paid for a particular service. For example, a member may pay \$20 each time he or she visits a doctor.

Deductible

A specified dollar amount the member is required to pay in a calendar year before we begin to pay for benefits. For example, a member with a \$1,000 deductible plan will pay for health expenses up to \$1,000 before the plan pays for additional expenses.

Dependents

This term applies to the spouse and children of a subscriber. A subscriber is the person who originally purchases the health plan policy.

Emergency

A sudden, serious, and unexpected illness, injury, or condition (including sudden and unexpected severe pain) in which the member believes his or her health is in danger if medical treatment is not received immediately.

Exclusions

Health plans do not cover all health-care services. Exclusions are those services not covered by the health plan.

Hold Harmless

A provider who contracts with us cannot bill the member more than the amount agreed upon if the provider has a “hold harmless” provision in his or her contract. For instance, a provider may bill us \$100 for an office visit. However, if we have agreed to pay \$75 for the office visit based on the contract with the provider, under the “hold harmless” provision, the provider cannot bill the member the difference of \$25. **Non-participating providers have no “hold harmless” agreement with us and may charge members for balances not paid by us.**

In-Network Provider

A facility, professional provider, home health-care agency, home infusion therapy agency, or hospice care program contracted with us through the network associated with your plan.

Lifetime Maximum Benefit

This is the largest dollar amount that the health plan will pay toward all health care services. If you change plans, the amount accumulated toward this amount will transfer to the new plan.

Limitation

We may pay part of a service but limit full coverage. For instance, mental health benefits are limited to 30 days of inpatient care per calendar year.

Member

This is the term used to describe a person who has health plan coverage. A member can be the policyholder or a covered dependent.

Out-of-Network Provider

A facility, professional provider, home health-care agency, home infusion therapy agency, or hospice care program not contracted with us through the network associated with your plan.

Glossary of Common Terms (continued)

Outpatient Services

These are the services a member receives in a doctor's office, outpatient department of a hospital, or in another setting.

Premium (Rate)

This is the rate or amount you pay each month or quarter for health plan coverage.

Preventive Care

Health care that emphasizes prevention, early detection, and early treatment of conditions is called preventive care. Preventive care benefits include routine laboratory tests, such as Pap smears or mammograms, and immunizations.

Stop-loss

After the deductible is paid, a specified amount for eligible health-care expenses that are shared by us and the member before the health plan pays 100 percent of any additional expenses. The stop-loss dollar amount is based on a calendar year and begins on January 1.





An Independent Licensee of the Blue Cross and Blue Shield Association

Toll-Free
1 (800) 452-2909

TTY Line for People With Hearing Impairments
(503) 375-4289 (Salem) or
toll-free 1 (800) 382-1003

www.or.regence.com