2022 BOOKLET FOR:

WASHINGTON FLORAL SERVICE

Regence Expressions[SM]

Group Number: 10030416

Regence BlueShield Dental Benefits

Regence

10030416BD11222

NONDISCRIMINATION NOTICE

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

Regence:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

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

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

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

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

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com

You can also file a civil rights complaint with:

- The U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

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

- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD).

  Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx

Language assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

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

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

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

Introduction

Regence BlueShield

Street Address:
1800 Ninth Avenue
Seattle, WA 98101

Claims Address:
P.O. Box 1106
Lewiston, ID 83501-1106

Customer Service/Correspondence Address:
P.O. Box 1827, MS CS B32B
Medford, OR 97501-9884

Appeals Address:
Attn: Member Appeals
P.O. Box 1408
Lewiston, ID 83501

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

This Booklet describes benefits effective **December 1, 2022**, or the date Your coverage became effective. This Booklet replaces any plan description, Booklet or certificate previously issued by Us and makes it void. The "identification card" issued to You includes Your name and Your identification number for this coverage. Present Your identification card to Your Provider before receiving care.

In this Booklet, the terms "We," "Us" and "Our" refer to Regence BlueShield and the term "Group" means the organization whose employees may participate in this coverage. References to "You" and "Your" refer to the Enrolled Employee and/or Enrolled Dependents. Other terms are defined in the Definitions Section at the back of this Booklet or where they are first used and are designated by the first letter being capitalized.

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

CONTACT INFORMATION

Customer Service: 1 (888) 367-2112
(TTY: 711)

Phone lines are open Monday – Friday 5 a.m. – 8 p.m. and Saturday 8 a.m. – 4:30 p.m. Pacific Time.

Contact Customer Service:

- if You have questions;
- if You would like to learn more about Your coverage;
- if You would like to request written or electronic information regarding any other plan that We offer;
- to talk with one of Our Customer Service representatives;
- via Our Web site, **regence.com**, to submit a claim online or chat live with a Customer Service representative, or to access a list of contracted health care benefit managers acting on Our behalf in the utilization of health care services;
- to request a copy of Your identification card or print a copy via Our Web site if You have not received or have lost Your identification card; or
- for assistance in a language other than English.

Regence Expressions[SM]

ACCESSING PROVIDERS

For each benefit, We indicate the Provider You may choose and Your payment amount for each dental Provider option. See the Definitions Section for a complete description of Participating Dentist and Nonparticipating Dentist. You can go to **regence.com** for further Provider network information.

- **Participating Dentist.** You choose to see a Participating Dentist and save the most in Your out-of-pocket expenses. Choosing this dental provider option means You will not be billed for balances beyond any Deductible and/or Coinsurance for Covered Services.
- **Nonparticipating Dentist.** You choose to see a Nonparticipating Dentist and Your out-of-pocket expenses will generally be higher than a Participating Dentist. Also, choosing this dental provider option means You may be billed for balances beyond any Deductible and/or Coinsurance (sometimes referred to as balance billing).

ADDITIONAL ADVANTAGES OF MEMBERSHIP

Advantages of membership include access to discounts on select items and services, personalized dental care planning information, dental-related events and innovative dental-decision tools, as well as a team dedicated to Your personal dental care needs. You also have access to Our Web site to help You navigate Your way through treatment decisions. **THESE SERVICES ARE VOLUNTARY, NOT INSURANCE AND ARE OFFERED IN ADDITION TO THE BENEFITS IN YOUR BOOKLET.**

- **Go to regence.com.** Use the secure Member Web site to:
  - view recent claims, benefits and coverage;
  - find a contracting dental Provider; and
  - access information about Regence Advantages. Regence Advantages is a discount program that gives You access to savings on a variety of dental-related products and services. We have contracted with several program partners, listed on the secure Web site, to offer discounts on their products and services, such as hearing care, health and wellness products and vision care.*

*Note that if You choose to access these discounts, You may receive savings on an item or service that is covered by Your dental plan, that also may create savings or administrative fees for Us. Any such discounts or coupons are complements to Your dental plan, but are not insurance.

Table of Contents

Understanding Your Benefits

This section provides information to help You understand the terms Maximum Benefits, Deductibles and/or Coinsurance. These terms are types of cost-sharing specific to Your benefits. You will need to refer to the Dental Benefits Section to see what Your benefits are.

MAXIMUM BENEFITS

Some Covered Services may have a specific Maximum Benefit. Those Covered Services will be provided until the specified Maximum Benefit (which may be a number of visits, services, dollar amount or a specified time period) has been reached. Refer to the Dental Benefits Section to determine if a Covered Service has a specific Maximum Benefit.

You will be responsible for the total billed charges for Covered Services that are in excess of any Maximum Benefits. You will also be responsible for charges for any other services or supplies not covered by this plan, regardless of the Provider rendering such services or supplies.

DEDUCTIBLES

The Deductible is the amount You must pay each Calendar Year before We will provide payments for Covered Services. The Deductible is satisfied by incurring a specific amount of expense for Covered Services during the Calendar Year for which the Allowed Amounts total the Deductible.

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

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

COINSURANCE (PERCENTAGE YOU PAY)

Your Coinsurance is the percentage You pay when Our payment is less than 100 percent. The Coinsurance varies, depending on the service or supply You received and who rendered it. Your Coinsurance applies once You have satisfied the Deductible for Covered Services up to any Maximum Benefit. Your Coinsurance will be based upon the lesser of either the billed charges or the Allowed Amount. We do not reimburse Dentists for charges above the Allowed Amount.

A Participating Dentist will not charge You for any balances for Covered Services beyond Your applicable Deductible and/or Coinsurance amount. Nonparticipating Dentists may bill You for any balances over Our payment level in addition to any Deductible and/or Coinsurance amount (referred to as balance billing).

HOW CALENDAR YEAR BENEFITS RENEW

The Deductible and certain Maximum Benefits are calculated on a Calendar Year basis. Each January 1, those Calendar Year maximums begin again. Some benefits have a separate Maximum Benefit based upon a Member's Lifetime and do not renew every Calendar Year.

The Contract is renewed each Contract Year. A Contract Year is the 12-month period following either the Contract's original Effective Date or subsequent renewal date. If Your Contract renews on a day other than January 1 of any year, any Deductible You satisfied or amount accumulated toward a Maximum Benefit before the plan's renewal date will carry over into the next Contract Year. If the Deductible amount increases during the Calendar Year, You will need to meet the new requirement minus any amount already satisfied from the previous Contract during the same Calendar Year.

Dental Benefits

This section explains Your benefits for Covered Services. Covered Services include Dentally Appropriate services to treat congenital anomalies. Referrals are not required before You can use any of the benefits of this coverage. Nothing contained in this Booklet is designed to restrict Your choice of Provider for dental care or treatment. The benefits in this Booklet include the second opinions of Providers who furnish Covered Services. All benefits are listed alphabetically, with the exception of Preventive and Diagnostic Dental Services.

CALENDAR YEAR DEDUCTIBLES

Per Member: $50
Per Family: $150

Deductible does not apply to the following:

- Preventive and Diagnostic Dental Services

MAXIMUM BENEFITS

Preventive and Diagnostic, Basic and Major Dental Services:

Per Member: $1,000 per Calendar Year

Temporomandibular Joint (TMJ) Disorders:

Per Member: $1,000 per Calendar Year

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

Provider: Participating Dentist	Provider: Nonparticipating Dentist
Payment: You pay 0% of the Allowed Amount.	**Payment:** You pay 0% of the Allowed Amount and You pay any balance of billed charges.

We cover the following preventive and diagnostic dental services:

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

  *A third cleaning may be covered, in the same Calendar Year, for a Member with one or more of the following conditions:

  - coronary atherosclerosis;
  - diabetes;
  - hypertensive heart disease; or
  - pregnancy.

  In this instance, a Member will be entitled to no more than three cleanings in a Calendar Year, whether standard cleaning or periodontal maintenance.

BASIC DENTAL SERVICES

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

We cover the following basic dental services:

- Complex oral surgery procedures including:
  - surgical extractions of teeth;
  - impactions;
  - alveoloplasty;
  - vestibuloplasty; and
  - residual root removal.
- Emergency treatment for pain relief.
- Endodontic services consisting of:
  - apicoectomy;
  - debridement;
  - direct pulp capping;
  - pulpal therapy;
  - pulpotomy; and
  - root canal treatment.
- Fillings consisting of composite and amalgam restorations.
- General dental anesthesia or intravenous sedation administered for:
  - extractions of partially or completely bony impacted teeth; or
  - to safeguard the Member's health (for example, a child under seven years of age or a physically or developmentally disabled individual).
- Periodontal services consisting of:
  - complex periodontal procedures (osseous surgery including flap entry and closure, mucogingivoplastic surgery) limited to once per Member per quadrant in a five-year period;
  - debridement limited to once per Member in a three-year period;
  - gingivectomy and gingivoplasty limited to once per Member per quadrant in a three-year period;
  - scaling and root planing limited to once per Member per quadrant in a two-year period; and
  - periodontal maintenance limited to two* per Member per Calendar Year (however, in any Calendar Year a Member will be entitled to no more than two* cleanings whether periodontal maintenance or standard cleaning).

    *A third periodontal maintenance may be covered, in the same Calendar Year, for a Member with one or more of the following conditions:

    - coronary atherosclerosis;
    - diabetes;
    - hypertensive heart disease; or
    - pregnancy.

    In this instance, a Member will be entitled to no more than three cleanings in a Calendar Year, whether periodontal maintenance or standard cleaning.
- Uncomplicated oral surgery procedures including removal of teeth, incision and drainage.

MAJOR DENTAL SERVICES

Provider: Participating Dentist	Provider: Nonparticipating Dentist
Payment: After Deductible, You pay 50% of the Allowed Amount.	**Payment:** After Deductible, You pay 50% of the Allowed Amount and You pay any balance of billed charges.

We cover the following major dental services:

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

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

Provider: Participating Dentist	Provider: Nonparticipating Dentist
The preventive, basic and major dental services provisions outlined previously will be provided for temporomandibular joint disorders.	
Limit: $1,000 per Member per Calendar Year	

We cover dental office treatment of temporomandibular joint (TMJ) disorders which are characterized by one or more of the following:

- an abnormal range of motion or limitation of motion of the TMJ;
- arthritic problems with the TMJ;
- internal derangement of the TMJ; and/or
- pain in the musculature associated with the TMJ.

Covered Services for the purpose of this TMJ benefit means dental services that are:

- reasonable and appropriate for the treatment of a disorder of the TMJ, under all the factual circumstances of the case;
- effective for the control or elimination of one or more of the following, caused by a disorder of the

TMJ: pain, infection, disease, difficulty in speaking or difficulty in chewing or swallowing food;
- recognized as effective, according to the professional standards of good dental practice; and
- not Experimental or primarily for Cosmetic purposes.

Medical services are not Covered Services under this plan. For the purpose of this TMJ benefit, medical services mean services that are not provided in a dental office and are:

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

General Exclusions

The following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them, are not covered. However, these exclusions will not apply with regard to a Covered Service for an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by law.

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

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

Collection of Cultures and Specimens
Collection of cultures and specimens are not covered, including, but not limited to:

- saliva; or
- tissue of the oral cavity.

Condition Caused by Active Participation in a War or Insurrection
The treatment of any condition caused by or arising out of a Member's active participation in a war or insurrection.

Condition Incurred in or Aggravated During Performances in the Uniformed Services
The treatment of any Member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Connector Bar or Stress Breaker
A device attached to a prosthesis or coping which serves to stabilize and anchor prosthesis.

Cosmetic/Reconstructive Services and Supplies
Except for the following, cosmetic and/or reconstructive services and supplies are not covered:

- Dentally Appropriate services and supplies to treat a congenital anomaly; or
- to restore a physical bodily function lost as a result of Illness or Injury.

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

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

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

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

Duplicate X-Rays

Expenses Before Coverage Begins or After Coverage Ends
Services and supplies incurred before Your Effective Date under the Contract or after Your termination under the Contract.

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

Fees, Taxes, Interest
Except as required by law, the following fees, taxes and interest are not covered:

- charges for shipping and handling, postage, interest or finance charges that a Dentist might bill;
- excise, sales or other taxes;
- surcharges;
- tariffs;
- duties;
- assessments; or
- other similar charges whether made by federal, state or local government or by another entity.

Fractures of the Mandible (Jaw)
Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.

Gold-Foil Restorations

Government Programs
Except as required by state law (such as cases of medical emergency or coverage provided by Medicaid) or for facilities that contract with Us, benefits that are covered (or would be covered in the absence of this plan) by any federal, state or government program are not covered.

Additionally, except as required by law for emergency services, government facilities outside the Service Area are not covered.

Home Visits

Illegal Activity
Services and supplies are not covered for treatment of an Illness, Injury or condition caused or sustained by a Member's voluntary participation in an activity where the Member is found guilty of an illegal activity in a criminal proceeding or is found liable for the activity in a civil proceeding. A guilty finding includes a plea of guilty or a no contest plea. If benefits already have been paid before the finding of guilt or liability is reached, We may recover the payment from the person We paid or anyone else who has benefited from it.

Implants
Except as provided in the Major Dental Service benefit, implants and any associated services and supplies are not covered (whether or not the implant itself was covered), including, but not limited to:

- interim endosseous implants;
- eposteal and transosteal implants;
- sinus augmentations or lifts;
- implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis;
- radiographic/surgical implant index; and
- unspecified implant procedures.

Indirect Pulp Capping and Pulp Vitality Tests

Investigational Services
Investigational services are not covered, including, but not limited to:

- services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions); and

- any services or supplies provided under an Investigational protocol.

Refer to the expanded definition of Experimental/Investigational in the Definitions Section in this Booklet.

Medications and Supplies
Charges in connection with medications and supplies are not covered, including, but not limited to:

- take home drugs;
- pre-medications; and
- therapeutic drug injections.

Motor Vehicle No-Fault Coverage
Expenses for services and supplies that have been covered or have been accepted for coverage under any automobile medical personal injury protection ("PIP") no-fault coverage. If Your expenses for services and supplies have been covered or have been accepted for coverage by an automobile medical personal injury protection ("PIP") carrier, We will provide benefits according to the Contract once Your claims are no longer covered by that carrier.

Nitrous Oxide

Non-Direct Patient Care
Non-direct patient care services are not covered, including, but not limited to:

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

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

- occlusal analysis and adjustments; and
- occlusal guards.

Oral Hygiene Instructions

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

Orthodontic Dental Services
Services and supplies provided in connection with orthodontics, including the following:

- correction of malocclusion;
- craniomandibular orthopedic treatment;
- other orthodontic treatment;
- preventive orthodontic procedures;
- procedures for tooth movement, regardless of purpose; and
- repair of damaged orthodontic appliances.

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

Photographic Images

Pin Retention in Addition to Restoration
Small metal rod used to aid in support of a restoration.

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

Prosthesis
Dental prosthesis services and supplies are not covered, including, but not limited to:

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

Provisional Splinting
Interim or temporary stabilization of loose/mobile teeth.

Replacements
Replacement of any lost, stolen or broken dental appliance, including, but not limited to, dentures or retainers.

Self-Help, Self-Care, Training or Instructional Programs
Except for services provided without a separate charge in connection with Covered Services that train or educate a Member, self-help, non-dental self-care and training programs are not covered.

Separate Charges
Services and supplies that may be billed as separate charges (services that should be included in the billed procedure) are not covered, including, but not limited to:

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

Services and Supplies Provided by a Member of Your Family
Services and supplies provided to You by a member of Your immediate family are not covered.

"Immediate family" means:

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

Services Performed in a Laboratory

Surgical Procedures
Services and supplies provided in connection with the following surgical procedures are not covered:

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

Third-Party Liability
Services and supplies for treatment of Illness, Injury or health condition for which a third party is responsible.

Tooth Transplantation
Services and supplies provided in connection with tooth transplantation, including, but not limited to:

- reimplantation from one site to another;
- splinting; or
- stabilization.

Travel and Transportation Expenses

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

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

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

Contract and Claims Administration

This section explains administration of benefits and claims, including situations that may arise when Your health care expenses are the responsibility of a source other than Us.

SUBMISSION OF CLAIMS AND REIMBURSEMENT

When claims are submitted and payment is due, We decide whether to pay You, the Provider, or You and the Provider jointly, subject to any legal requirements.

Participating Dentist Claims and Reimbursement

You must present Your identification card to a Participating Dentist and furnish any additional information requested. The Provider will submit the necessary forms and information to Us for processing Your claim.

We will pay a Participating Dentist directly for Covered Services. These Participating Dentists may require You to pay any Deductible and/or Coinsurance at the time You receive care or treatment. Participating Dentists have agreed not to bill You for balances beyond any Deductible and/or Coinsurance and to accept the Allowed Amount as payment in full for Covered Services.

Nonparticipating Dentist Claims and Reimbursement

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

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

If You use a Nonparticipating Dentist for Covered Services, a check will be sent to the Nonparticipating Dentist, unless You have already paid the Nonparticipating Dentist and We are made aware of that, in which case the check will be sent to You.

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

Timely Filing of Claims

Written proof of loss (submission of a claim) must be received within one year after the date of service. Claims that are not filed in a timely manner will be denied, unless You can reasonably demonstrate that the claim could not have been filed in a timely manner. Benefits or coverage will not be invalidated nor reduced if it can be shown that it was not reasonably possible to file the claim and that the claim was submitted as soon as reasonably possible. You may appeal the denial in accordance with the Appeal process to demonstrate that the claim could not have been filed in a timely manner.

Claim Determinations

Within 30 days of Our receipt of a claim, We will notify You of Our action. However, this 30-day period may be extended by an additional 15 days due to lack of information or extenuating circumstances. We will notify You within the initial 30-day period and provide an explanation of why the extension is necessary.

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

CLAIMS RECOVERY

If We pay a benefit to which You or Your Enrolled Dependent was not entitled, or if We pay a person who is not eligible for benefits at all, We have the right to recover the payment from the person We paid or anyone else who benefited from it, including a Provider of services. Our right to recovery includes the right to deduct the mistakenly paid amount from future benefits We would provide the Enrolled Employee or any Enrolled Dependents, even if the mistaken payment was not made on that person's behalf.

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

This Claims Recovery provision in no way reduces Our right to reimbursement or subrogation. Refer to the Right of Reimbursement and Subrogation Recovery provision for additional information.

RIGHT OF REIMBURSEMENT AND SUBROGATION RECOVERY

This section explains how We treat various matters having to do with administering Your benefits and/or claims, including situations that may arise in which Your health care expenses are the responsibility of a source other than Us.

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

If this plan pays benefits under this Booklet to You for expenses incurred due to Third Party Injuries, then We retain the right to repayment of the full cost, to the extent permitted by law of all benefits provided by this plan on Your behalf that are associated with the Third Party Injuries. Our rights of recovery apply to any recoveries made by or on Your behalf from the following sources, including but not limited to:

- Payments made by a Third Party or any insurance company on behalf of the Third Party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate You for injuries resulting from an accident or alleged negligence.

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

By accepting benefits under this plan, You also specifically acknowledge Our right of reimbursement. This right of reimbursement attaches when this plan has paid health care benefits for expenses incurred due to Third Party Injuries and You or Your representative has recovered any amounts from any sources, including but not limited to: payments made by a Third Party or any payments or awards under an uninsured or underinsured motorist coverage policy; any Workers' Compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and any other payments from a source intended to compensate You for Third Party Injuries. By providing any benefit under this Booklet, We are granted an assignment of the proceeds of any settlement, judgment or other payment received by You to the extent permitted by law of the full cost of all benefits provided by this plan. Our right of reimbursement is cumulative with and not exclusive of Our subrogation right and We may choose to exercise either or both rights of recovery.

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

We will not exercise Our rights of recovery and subrogation until You have been fully compensated for Your loss and expense incurred.

This provision applies when You incur health care expenses in connection with an Illness or Injury for which one or more third parties is responsible. In that situation, benefits for otherwise Covered Services are excluded under this Contract to the extent You receive a recovery from or on behalf of the responsible Third Party in excess of full compensation for the loss. If You do not pursue a recovery of the benefits We have advanced, We may choose, in Our discretion, to pursue recovery from another responsible party, including automobile medical no-fault, personal injury protection ("PIP") carrier on Your behalf.

Here are some rules which apply in these Third-Party liability situations:

- By accepting benefits under this plan, You or Your representative agree to notify Us promptly (within 30 days) and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party Injuries sustained by You.
- You or Your representative agrees to cooperate with Us and do whatever is necessary to secure Our rights of subrogation and reimbursement under this Booklet. In addition, You or Your representative agrees to do nothing to prejudice Our subrogation and reimbursement rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the plan.
- If a claim for health care expense is filed with Us and You have not yet received recovery from the responsible Third Party, We may advance benefits for Covered Services if You agree to hold, or direct Your attorney or other representative to hold, the recovery against the Third Party in trust for Us, up to the amount of benefits We paid in connection with the Illness or Injury.
- You and/or Your agent or attorney must agree to serve as constructive trustee and keep any recovery or payment of any kind related to Your Illness or Injury which gave rise to the plan's right of subrogation or reimbursement segregated in its own account, until Our right is satisfied or released.
- Further, You or Your representative give Us a lien on any recovery, settlement, judgment or other source of compensation which may be had from any party to the extent permitted by law to the full cost of all benefits associated with Third Party Injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- You or Your representative also agrees to pay from any recovery, settlement, judgment or other source of compensation, any and all amounts due Us as reimbursement for the full cost of all benefits, to the extent permitted by law, associated with Third Party Injuries paid by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement).
- In the event You and/or Your agent or attorney fails to comply with any of the above conditions, We may recover any benefits We have advanced for any Illness or Injury through legal action against You and/or Your agent or attorney.
- If We pay benefits for the treatment of an Illness or Injury, We will be entitled to have the amount of the benefits We have paid for the condition separated from the proceeds of any recovery You receive out of any settlement or recovery from any source, including any arbitration award, judgment, settlement, disputed claim settlement, uninsured motorist payment or any other recovery related to the Illness or Injury for which We have provided benefits. This is true regardless of whether:

    - the Third Party or the Third Party's insurer admits liability;
    - the health care expenses are itemized or expressly excluded in the Third-Party recovery; or
    - the recovery includes any amount (in whole or in part) for services, supplies or accommodations covered under the Contract. The amount to be held in trust shall be calculated based upon claims that are incurred on or before the date of settlement or judgment, unless agreed to otherwise by the parties.

- Any benefits We advance are solely to assist You. By advancing such benefits, We are not acting as

a volunteer and are not waiving any right to reimbursement or subrogation.

We may recover to the extent permitted by law, the full cost of all benefits paid by this plan under this Booklet without regard to any claim of fault on Your part, whether by comparative negligence or otherwise. You may incur attorney's fees and costs in connection with obtaining recovery. If this Contract is not subject to ERISA, We shall pay a proportional share of such attorney's fees and costs incurred by You at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to Us to less than the full amount of benefits paid by Us. If this plan is subject to ERISA, You may request and We may contribute an amount toward attorney's fees incurred by You at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to Us to less than the full amount of benefits paid by Us. In the event You or Your representative fail to cooperate with Us, You shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by Us in obtaining repayment.

No-Fault Coverage

This provision applies when You incur health care expenses in connection with an Illness or Injury for which no-fault coverage is available. In that situation, benefits for otherwise Covered Services are excluded under this Contract to the extent Your expenses for services and supplies have been covered or have been accepted for coverage by a no-fault carrier.

Motor Vehicle Coverage

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

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

- If a claim for health care expenses arising out of a motor vehicle accident is filed with Us and motor vehicle insurance has not yet paid, We may advance benefits for Covered Services as long as You agree in writing:
  - to give Us information about any motor vehicle insurance coverage which may be available to You; and
  - to otherwise secure Our rights and Your rights.
- If We have paid benefits before motor vehicle insurance has paid, We are entitled to have the amount of the benefits We have paid separated from any subsequent motor vehicle insurance recovery or payment made to or on behalf of You held in trust for Us. The amount of benefits We are entitled to will never exceed the amount You receive from all insurance sources that fully compensates You for Your loss and We will only seek to recover amounts You have received from other insurance sources to the extent those amounts exceed full compensation to You for Your Injuries, losses or damages.
- You may have rights both under motor vehicle insurance coverage and against a third party who may be responsible for the accident. In that case, both this provision and the Right of Reimbursement and Subrogation Recovery provision apply. However, We will not seek double reimbursement.

Workers' Compensation

This provision applies if You have filed or are entitled to file a claim for workers' compensation. Benefits for treatment of an Illness or Injury arising out of or in the course of employment or self-employment for wages or profit are excluded under this Contract. The only exception would be if You or one of Your eligible dependents are exempt from state or federal workers' compensation law.

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

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

Fees and Expenses

You may incur attorney's fees and costs in connection with obtaining recovery. If this plan is not subject to ERISA, We shall pay a proportional share of such attorney's fees and costs incurred by You at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to Us to less than the full amount of benefits paid by Us. If this plan is subject to ERISA, You may request and We may contribute an amount toward attorney's fees incurred by You at the time of any settlement or recovery to otherwise reduce the amount of reimbursement paid to Us to less than the full amount of benefits paid by Us.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when You have health care coverage under more than one Plan. This section is a summary of only a few of the provisions of Your health plan to help You understand COB, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in Your Contract, which determines Your benefits. NOTE: This Section refers to a broad range of benefits, even though this plan is a Dental Only plan.

Coordination of benefits is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common situations. If Your situation is not described, read Your Contract or contact the Washington State Insurance Department.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have Family coverage through both employers. When You are covered by more than one health plan, Washington state law permits issuers to follow a procedure called "coordination of benefits" to determine how much each health plan should pay when You have a claim. The goal is to ensure that the combined payments of all plans do not add up to more than Your covered health care expenses.

Primary or Secondary?

You will be asked to identify all the plans that cover members of Your Family. To avoid delays in claim processing, if You are covered by more than one plan, You should promptly report to Your Providers and plans any changes in Your coverage. We need this information to determine whether We are the "primary" or "secondary" benefit payer. The primary plan always pays first when You have a claim. Any plan that does not contain Your state's COB rules will always be primary.

When This Plan is Primary

If You or a family member is covered under another plan in addition to this one, We will be primary when:

- **Your Own Expenses.** The claim is for Your own health care expenses, unless You are covered by Medicare and both You and Your spouse are retired.
- **Your Spouse's Expenses.** The claim is for Your spouse, who is covered by Medicare, and You are not both retired.
- **Your Child's Expenses.** The claim is for the health care expenses of Your child who is covered by this plan; and

- You are married and Your birthday is earlier in the year than Your spouse's, or You are living with another individual (regardless of whether or not You have ever been married to that individual) and Your birthday is earlier in the year than that other individual's birthday. This is known as the "birthday rule"; or
- You are separated or divorced, and You have informed us of a court decree that makes You responsible for the child's health care expenses; or
- There is no court decree, but You have custody of the child.

- **Other Situations.** We will be primary when any other provisions of state or federal law require Us to be.

How We Pay Claims When We Are Primary
When We are the primary plan, We will pay the benefits according to the terms of the Contract, just as if You had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary
When We are knowingly the secondary plan, We will make payment promptly after receiving payment information from Your primary plan. As Your secondary plan, We may ask You and/or Your Provider for information in order to make payment. To expedite payment, be sure that You and/or Your Provider supply all required information in a timely manner.

If Your primary plan fails to pay within 60 calendar days of receiving all necessary information from You and Your Provider, You and/or Your Provider may submit the claim to Us as if We were the primary plan. In such situations, We are required to pay those claims within 30 calendar days of receiving Your claim and the notice that Your primary plan has not paid. **This provision does not apply if Medicare is the primary plan.**

We may recover from the primary plan any excess amount paid under the Right of Recovery provision.

- If there is a difference between the amounts the plans allow, We will base our payment on the higher amount. However, if the primary plan has a contract with the Provider, our combined payments will not be more than the amount called for in Our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their Providers as do some other plans.
- We will determine Our payment by subtracting the amount paid by the primary plan from the amount We would have paid if We had been the primary plan. We must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal to 100% of the total allowable expense (the highest of the amounts allowed under each plan involved) for Your claim. We are not required to pay an amount in excess of Our maximum benefits, plus any accrued savings. If Your Provider negotiates reimbursement amounts with the plan(s) for the service provided, Your Provider may not bill You for any excess amounts once the Provider has received payment for the highest of the negotiated amounts. When Our deductible is fully credited, We will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid. For example, if the primary plan covers similar kinds of health care expenses, but allows expenses that We do not cover, We may pay for those expenses.

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

If You are covered by more than one health benefit plan, and You do not know which is Your primary plan, You or Your provider should contact any one of the health plans to verify which plan is primary. The health plan You contact is responsible for working with the other plan to determine which is primary and will let You know within 30 calendar days.

CAUTION: All health plans have timely claim filing requirements. If You or Your provider fail to submit Your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim.

If You experience delays in the processing of Your claim by the primary health plan, You or Your provider will need to submit Your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claim processing, if You are covered by more than one plan You should promptly report to Your providers and plans any changes in Your coverage.

If the Group or You have questions about this Coordination of Benefits provision, please contact the Washington State Insurance Department.

Appeal Process

If You or Your Representative (any Representative authorized by You) has a concern regarding a claim denial or other action by Us under the Contract and wish to have it reviewed, You may Appeal. There is one level of Internal Appeal, as well as an External Appeal with an Independent Review Organization You may pursue. Certain matters requiring quicker consideration may qualify for a level of Expedited Appeal and are described separately later in this section.

For Grievances or complaints not involving an Adverse Benefit Determination, refer to the Grievance Process.

APPEALS

Appeals can be initiated through either written or verbal request. A verbal Appeal request can be made by calling Customer Service. A written Appeal request can be made by:

- completing the form available on **regence.com**;
- submitting the form via e-mail to MemberAppeals@regence.com;
- submitting the form via fax to 1 (888) 496-1542; or
- mailing the form to Us at: Attn: Member Appeals, Regence BlueShield, P.O. Box 1408, Lewiston, ID 83501.

Each level of Appeal, including Expedited Appeals, must be pursued within 180 days of Your receipt of Our determination (or, in the case of the Internal Appeal, within 180 days of Your receipt of Our original adverse decision that You are Appealing). If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeopardize Your ability to pursue the matter in any forum. When We receive an Appeal request, We will send a written acknowledgement within 72 hours of receiving the request.

Upon request and free of charge, You, or Your Representative, have the right to review copies of all documents, records and information relevant to any claim that is the subject of the determination being appealed.

If You or Your treating Provider determines that Your health could be jeopardized by waiting for a decision under the regular Appeal process, You or Your Provider may specifically request an Expedited Appeal. See Expedited Appeals later in this section for more information.

If We reverse Our initial Adverse Benefit Determination, which We may do at any time during the review process, We will provide You with written or electronic notification of the decision immediately, but in no event more than two business days of making the decision.

If You request a review of an Adverse Benefit Determination, We will continue to provide coverage for disputed inpatient care benefits or any benefit for which a continuous course of treatment is Dentally Appropriate, pending outcome of the review. If We prevail in the Appeal, You may be responsible for the cost of coverage received during the review period. The decision at the external review level is binding unless other remedies are available under state or federal law.

Internal Appeals

Internal Appeals are reviewed by an employee or employees who were not involved in the initial decision that You are Appealing. You or Your Representative, on Your behalf, will be given a reasonable opportunity to provide written materials, including written testimony. In Appeals that involve issues requiring medical judgment, the decision is made by Our staff of health care professionals. If the Appeal involves a Post-Service investigational issue, a written notice of the decision will be sent within 20 working days after receiving the Appeal. For all other Appeals, the written notice will be sent within 14 days of receipt. You will be notified if, for good cause, We require additional time. An extension cannot delay the decision beyond 30 days without Your informed written consent.

VOLUNTARY EXTERNAL APPEAL – IRO

A voluntary Appeal to an Independent Review Organization (IRO) is available to You if the Appeal involves an Adverse Benefit Determination based on Dental Appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria and only after You have exhausted the internal level of Appeal, or We have failed to provide You with an Internal Appeal decision within the requirements of the Internal Appeal process.

We coordinate voluntary External Appeals, but the decision is made by an IRO at no cost to You. We will provide the IRO with the Appeal documentation, which is available to You or Your Provider upon request. You will also be provided five business days to submit additional written information directly to the IRO for consideration. A written notice of the IRO's decision will be sent to You within 15 days after the IRO receives the necessary information or 20 days after the IRO receives the request. Choosing the voluntary External Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision, except to the extent other remedies are available under state or federal law.

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.

EXPEDITED APPEALS

An Expedited Appeal is available if one of the following applies:

- You are currently receiving or are prescribed treatment for a medical condition; or
- Your treating Provider believes the application of regular Appeal time frames on a Pre-Service or concurrent care claim could seriously jeopardize Your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- the Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where You have not been discharged.

You may request concurrent expedited internal and external reviews of Adverse Benefit Determinations (meaning the reviews will be done simultaneously). When concurrent expedited reviews are requested, We will not extend the timelines by making the determinations consecutively. The requisite timelines will be applied concurrently.

Internal Expedited Appeal

The internal Expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. Internal Expedited Appeals are reviewed by employees who were not involved in, or subordinate to anyone involved in, the initial denial determination. Reviewers will include an appropriate clinical peer in the same or similar specialty as would typically manage the case. You or Your Representative, on Your behalf, will be given the opportunity (within the constraints of the Expedited Appeals time frame) to provide written materials, including written testimony on Your behalf. Verbal 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 Appeal. This will be followed by written notification within 72 hours of the date of decision.

Voluntary Expedited Appeal – IRO

If You disagree with the decision made in the internal Expedited Appeal and You or Your Representative reasonably believes that preauthorization or concurrent care (Pre-Service) remains clinically urgent, 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. You may request a voluntary Expedited External Appeal at the same time You request an Expedited Appeal from Us.

We coordinate voluntary Expedited Appeals, but the decision is made by an IRO at no cost to You. We will provide the IRO with the Expedited Appeal documentation, which is available to You or Your Provider upon request. 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 the IRO's receipt of the necessary information. This will be followed by written notification within 48 hours of the verbal notice. Choosing the

voluntary Expedited Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision, except to the extent other remedies are available under state or federal law.

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.

INFORMATION

If You have any questions about the Appeal Process outlined here, contact Customer Service, or write to Customer Service at the following address: Regence BlueShield, MS CS B32B, P.O. Box 1827, Medford, OR 97501-9884.

ASSISTANCE

For assistance with internal claims and Appeals and the external review process, contact:

Office of the Insurance Commissioner
Consumer Protection Division
PO Box 40256
Olympia, WA 98504-0256
Toll-Free: 1 (800) 562-6900
TDD: 1 (360) 586-0241
Olympia: 1 (360) 725-7080
Fax: 1 (360) 586-2018
E-mail: **cap@oic.wa.gov**
Web: **www.insurance.wa.gov**

DEFINITIONS SPECIFIC TO THE APPEAL PROCESS

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Dentally Appropriate.

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;
- rescissions of Your benefit coverage by Us; and
- other matters as specifically required by state law or regulation.

Expedited Appeal means an Appeal where:

- You are currently receiving or are prescribed treatment for a medical condition; and
- Your treating Provider believes the application of regular Appeal time frames on a Pre-Service or concurrent care claim could seriously jeopardize Your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain; or
- the Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where You have not been discharged.

Experimental or Investigational means a Health Intervention that We have classified as Experimental or Investigational. For a full definition of Experimental and Investigational, refer to Experimental/Investigational in the Definitions Section.

External Appeal means a review of an Adverse Benefit Determination performed by an Independent Review Organization to determine whether Regence's Internal Appeal decisions are correct.

Grievance means a written or oral complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

Independent Review Organization (IRO) is an independent Physician review organization that acts as the decision-maker for voluntary External Appeals and voluntary External Expedited Appeals and that is not controlled by Us.

Internal Appeal means a review and reconsideration of an Adverse Benefit Determination performed by Us.

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

Pre-Service means any claim for benefits 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 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 Appeal. No authorization is required from the parent(s) or legal guardian of a Member who is a 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 without additional authorization. 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 Appeal level). If no authorization exists and is not received in the course of the Appeal, the determination and any personal information will be disclosed to You, Your personal Representative or treating Provider only.

Grievance Process

If You or Your Representative (any Representative authorized by You) has a complaint not involving an Adverse Benefit Determination and wishes to have it resolved, You may submit a Grievance to Us. Grievances may be submitted orally or in writing through either of the following contacts:

Call Customer Service at 1 (888) 367-2112 or You can write to Our Customer Service department at the following address: Regence BlueShield, MS CS B32B, P.O. Box 1827, Medford, OR 97501-9884.

A Grievance may be registered when You or Your Representative expresses dissatisfaction with any matter not involving an Adverse Benefit Determination, including but not limited to Our customer service or quality or availability of a health service. Once received, Your Grievance will be responded to in a timely and thorough manner. Grievances will also be collectively evaluated by Us, on a quarterly basis, for improvements. If You would like a written response or acknowledgement of Your Grievance from Us, request at the time of submission.

For any complaints involving an Adverse Benefit Determination, refer to the Appeals Process Section.

DEFINITIONS SPECIFIC TO THE GRIEVANCE PROCESS

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Dentally Appropriate.

Grievance means a written or oral complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

Eligibility and Enrollment

This section explains how to enroll Yourself and/or Your eligible dependents when first eligible or during an annual open enrollment period. It describes when coverage under the Contract begins for You and/or Your eligible dependents. Payment of any corresponding monthly premiums is required for coverage to begin on the indicated dates.

INITIALLY ELIGIBLE AND WHEN COVERAGE BEGINS

You will be entitled to enroll in coverage for Yourself and Your eligible dependents within 30 days of initially becoming eligible for coverage per 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 open enrollment period to enroll.

Employees

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

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. Dependents are limited to the following:

- The person to whom You are legally married (spouse).
- Your registered domestic partner or non-registered domestic partner for whom You have submitted an accurate and complete affidavit of qualifying domestic partnership.
- Your (or Your spouse's or Your domestic partner's) child who is under age 26 and who meets any of the following criteria:

    - Your (or Your spouse's or Your domestic partner's) natural child, stepchild, adopted child or child legally placed with You (or Your spouse or Your domestic partner) for adoption;
    - a child for whom You (or Your spouse or Your domestic partner) have court-appointed legal guardianship; and
    - a child for whom You (or Your spouse or Your domestic partner) are required to provide coverage by a legal qualified medical child support order (QMCSO).

- Your (or Your spouse's or Your domestic partner's) otherwise eligible child who is age 26 or over and incapable of self-support because of developmental or physical disability that began before the child's 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:

    - the child is an enrolled child immediately before their 26th birthday; or
    - the child's 26th birthday preceded Your Effective Date and the child has been continuously covered as Your dependent on group coverage since that birthday.

Our affidavit of dependent eligibility form is available by visiting Our Web site or by calling Customer Service. We may request updates on the child's disability at reasonable times as We consider necessary (but this will not be more often than annually following the dependent's 28th birthday).

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 a non-registered domestic partner, an affidavit of qualifying domestic partnership form) to Us. Application 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 if payment of additional premium is required to provide coverage for the child. Application 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. For a new child by birth, the Effective Date is the date of birth. For a new child adopted or placed for adoption within 60 days of birth, the Effective Date is the date of birth, if any associated additional premium has been paid within 60 days of birth. The Effective Date for any other child by adoption or Placement for Adoption is the date of Placement for Adoption. For other newly eligible dependents, the Effective Date is the first day of the month following receipt of the application for enrollment.

ANNUAL OPEN ENROLLMENT PERIOD

The annual open 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, in the case of a non-registered domestic partner, a completed 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 provide (or coordinate) any necessary and appropriate information to determine the eligibility of a dependent. We must receive such information before enrolling a person as a dependent under the Contract.

When 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 benefits 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.

WHAT HAPPENS WHEN YOU ARE NO LONGER ELIGIBLE

If You are no longer eligible as explained in the following paragraphs, coverage ends for You and Your Enrolled Dependents on the last day of the month 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 COBRA Continuation of Coverage, Non-COBRA Continuation of Coverage, or the Other Continuation Options provisions.

Termination of Your Employment or You are 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, coverage will end for You and all Enrolled Dependents on the last day of the month in which eligibility ends.

Nonpayment of Premium

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

WHAT HAPPENS WHEN YOUR ENROLLED DEPENDENTS ARE NO LONGER ELIGIBLE

If Your dependent is no longer eligible as explained in the following paragraphs, coverage ends for Your Enrolled Dependents on the last day of the month in which their eligibility ends. However, it may be possible for an ineligible dependent to continue coverage under the Contract according to the COBRA Continuation of Coverage, Non-COBRA Continuation of Coverage, or the Other Continuation Options provisions.

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 month following the date a divorce or annulment is final.

Death of the Enrolled Employee

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

Termination of Domestic Partnership

If Your 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 month 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. This termination provision does not apply to any termination of domestic partnership that occurs as a matter of law because the parties to

the domestic partnership enter into a marriage (including any entry into marriage by virtue of an automatic conversion of the domestic partnership into a marriage).

Loss of Dependent Status

- Eligibility ends on the last day of the month in which an enrolled child exceeds the dependent age limit.
- Eligibility ends on the date in which an enrolled child is removed from Placement due to disruption of Placement before legal adoption.

OTHER CAUSES OF TERMINATION

Members terminated for the following reasons may be able to continue coverage under the Contract according to the COBRA Continuation of Coverage or the Non-COBRA Continuation of Coverage provisions.

Fraudulent Use of Benefits

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

Fraud or Misrepresentation in Application

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

FAMILY AND MEDICAL LEAVE

If Your Group grants You a leave of absence under an applicable state or federal family and medical leave law the following rules will apply. The federal Family and Medical Leave Act is generally applicable to private employers of 50 or more employees and public employers of any size. But state law may be applicable more broadly. You will be entitled to continued coverage under this provision only to the extent You are eligible for leave under the terms of the applicable law:

- You and Your Enrolled Dependents will remain eligible to be enrolled under the Contract during the leave for a period of up to 12 weeks, or as required by law, during a 12-month period for one of the following:
    - to care for Your newly born child;
    - to care for Your spouse, domestic partner, child or parent with 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 leave, You must continue to pay the monthly premium through the Group on time. The provisions described here will not be available if the Contract terminates.

If You and/or Your Enrolled Dependents elect not to remain enrolled during the leave, You (and/or Your Enrolled Dependents) will be eligible to be reenrolled under the Contract on the date You return from the leave. In order to reenroll after You return from a leave, You must sign a new enrollment form 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 leave and You will not have to re-serve any probationary period under the Contract.

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 leave does not constitute a qualifying event for COBRA continuation. However, a person who does not return to active employment following 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 leave.

The provisions and administration described here are based on the requirements of, and will be governed by, the applicable law and any subsequent amendments and regulations. If any conflicts arise between the provisions described here and applicable law, the minimum requirements of the law 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 an applicable leave.

LEAVE OF ABSENCE

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

A leave of absence is an employer-granted period off work made at Your request during which You are still considered to be employed and are carried on the Group's employment records. A leave can be granted for any reason acceptable to the Group. If You are on a family and medical leave under applicable law, You remain eligible under the Contract only for a period equivalent to legally required leave and may not also continue coverage under a non-family and medical 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 open enrollment period.

COBRA Continuation of Coverage

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

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

- Your employment is terminated (unless the termination is for gross misconduct);
- Your hours of work are reduced;
- You die;
- You and Your spouse divorce, the marriage is annulled, or Your registered domestic partnership is terminated;
- You and Your non-registered 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 per certain conditions if You are retired and Your Group files for bankruptcy.)

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

General Rules

You or Your Enrolled Dependents are responsible for payment of the full premium for COBRA continuation, plus an administration fee, even if the Group contributes toward the premiums of those not on COBRA continuation. The administration fee is two 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 registered or non-registered 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 per Social Security 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 per Social Security, You or Your Enrolled Dependent must provide the Group notice of that determination within 30 days of the date it is made.)

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

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

Notice

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

Non-COBRA Continuation of Coverage

You and Your Enrolled Dependents are entitled to continuation of Group coverage benefits upon loss of eligibility for coverage.

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

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

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

- You and/or Your Enrolled Dependents fail to make payment of premiums for the coverage to the Group within its established time frame;
- six months of coverage has elapsed from the effective date of continuation coverage; or
- the Group's coverage is terminated.

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

If Your Group is required to offer COBRA continuation of coverage, You may continue group coverage under both COBRA and this non-COBRA continuation of coverage. In almost all cases, COBRA offers greater benefits with fewer restrictions than this continuation of coverage. However, administration will be according to whichever law offers the greatest benefit to You. The maximum number of months You may continue coverage will never be more than the number available under COBRA.

After You and/or Your Enrolled Dependents exhaust non-COBRA continuation coverage, an individual policy may be available.

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.

Availability of Other Coverage

When eligibility under the Contract terminates at the end of or in lieu of any available COBRA continuation coverage period, or otherwise upon termination of this coverage, an individual insurance policy is available through us. The policy or plan will have equal or lesser benefits than this coverage.

Strike, Lockout or Other Labor Dispute

If the Enrolled Employee's compensation is suspended or terminated directly or indirectly as the result of a strike, lockout or other labor dispute, the Enrolled Employee and Enrolled Dependents may continue coverage under the Contract during the dispute for a period not exceeding six months, by paying the necessary premiums for Your coverage through the Group. This provision will not apply if the Enrolled Employee and Enrolled Dependents are eligible for COBRA.

If You are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, Your coverage can be continued for up to six months. You must pay the full premium, including any part usually paid by the Group, directly to the union or trust that represents You. The union or trust must continue to pay Us the premiums according to the Contract. This six months of continued coverage is instead of and not in addition to any continuation of coverage provisions of the Contract.

General Provisions and Legal Notices

This section explains various general provisions and legal notices 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 Washington.

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

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

Rights and Protection
Employees are entitled to certain rights and protection per 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 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 their rights per ERISA.

If an employee's claim for a welfare benefit is denied (or ignored) in whole or in part, the employee 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. According to ERISA, there are steps they can take to enforce the above rights. For instance, if an employee submits a written request for certain materials from the plan administrator and does not receive the materials 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 the 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, the employee may file suit in a state or federal court. An employee may also do so if they disagree 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 their 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, they should contact the plan administrator.

If You Need More ERISA Information

If an employee has any questions about this statement or their rights per ERISA, or if they need 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 AND BENEFIT ADMINISTRATION

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 Washington without regard to its conflict of law rules. We are not the plan administrator, but are a health care service contractor that provides health care coverage to this benefit plan and makes determinations for eligibility and the meaning of terms subject to Member rights under this benefit plan that include the right to appeal, review by an Independent Review Organization and civil action.

GROUP IS AGENT

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

LIMITATIONS ON LIABILITY

You have the exclusive right to choose a dental care Provider. Since We do not provide any dental care services, We cannot be held liable for any claim or damages connected with Injuries You suffer while receiving dental services or supplies provided by professionals who are neither Our employees nor agents. We are responsible for the quality of dental care You receive only as provided by law. In addition, We will not be liable to any person or entity for the inability or failure to procure or provide the benefits in this Booklet by reason of epidemic, disaster or other cause or condition beyond Our control.

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 as required by law) after written notice has been given to Members or to the Group. The 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.

NONASSIGNMENT

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

NOTICES

Any notice to Members or to the Group required in the Contract will be considered to be properly given if written notice is deposited in the United States mail or with a private carrier. Notices to an Enrolled Employee or to the Group will be addressed to the last known address appearing in Our records. If We receive a United States Postal Service change of address (COA) form for an Enrolled Employee, We will update Our records accordingly. Additionally, We may forward notice for an Enrolled Employee to the Group administrator if We become aware that We don't have a valid mailing address for the Enrolled Employee. Any notice to Us required in the Contract may be mailed to Our Customer Service address. However, 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 in advance to Us by the Group on or before the premium due date. Failure by the Group to make timely payment of premiums may result in Our terminating the Group's or Member's coverage on the last day of the month through which premiums are paid or such later date as 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 BlueShield, 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 Shield Service Mark in the state of Washington, for those counties designated in Our Service Area, and that We are not contracting as the agent of the Association. The Group on behalf of itself and its Members further acknowledges and agrees that it has not entered into the Contract based upon representations by any person or entity other than Regence BlueShield and that no person or entity other than Regence BlueShield will be held accountable or liable to the Group or the Members for any of Our obligations to the Group or the Members created under the Contract. This paragraph will not create any additional obligations whatsoever on the part of Regence BlueShield 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 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.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION AND DENTAL RECORDS

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

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

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

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

- billing statements;
- claim records;
- correspondence;
- dental records;
- diagnostic imaging reports;

- hospital records (including nursing records and progress notes);
- laboratory reports; and
- medical records.

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

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

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

TAX TREATMENT

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

WHEN BENEFITS ARE AVAILABLE

In order for dental expenses to be covered, 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 in 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, other terms are defined where they are first used.

Allowed Amount means:

- For Participating Dentists, the amount Participating Dentists have agreed to accept as payment in full for Covered Services.
- For Nonparticipating Dentists, reasonable charges for Covered Services. The Allowed Amount may be based upon billed charges for some services, as determined by Us or as otherwise required by law.

Charges in excess of the Allowed Amount are not considered reasonable charges and are not reimbursable. For questions regarding the basis for determination of the Allowed Amount, contact Customer Service.

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

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

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

Dentist means an individual who is licensed to practice dentistry (including a doctor of medical dentistry, doctor of dental surgery, or a denturist) or to practice as a dental hygienist who is permitted by their 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.

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

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

Experimental/Investigational means a Health Intervention that We have classified as Experimental or Investigational. 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 to determine if it is Experimental or Investigational. A Health Intervention not meeting all of the following criteria, is, in Our judgment, Experimental or Investigational:

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

Upon receipt of a fully documented claim or request for preauthorization related to a possible Experimental or Investigational Health Intervention, a decision will be made and communicated to You within 20 working days. Contact Us for details on the information needed to satisfy the fully documented claim or request requirement. You may also have the right to an Expedited Appeal. Refer to the Appeal Process Section for additional information on the Appeal process.

Family means an Enrolled Employee and any Enrolled Dependents.

Health Intervention is a medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following:

- disease;
- Illness or Injury;
- genetic or congenital anomaly;
- pregnancy;
- 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;
- condition, disease, ailment or bodily disorder, other than an Injury; or
- pregnancy.

Injury means physical damage to the body caused by:

- a foreign object;
- force;
- temperature;
- a corrosive chemical; or
- the direct result of an accident, independent of Illness or any other cause.

An Injury does not mean bodily Injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

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

Member means an Enrolled Employee or an Enrolled Dependent.

Nonparticipating Dentist means a Dentist who is not in Your Provider network. Refer to the Dental Benefits section for an explanation of the Covered Services Nonparticipating Dentists can provide.

Participating Dentist means a contracted dentist who is in Your Provider network. A Participating Dentist will not bill You for the amount above the Allowed Amount for a Covered Service. The Provider network for a Participating Dentist is: Participating Dental.

Placement for Adoption means an assumption of a legal obligation for total or partial support of a child in anticipation of adoption of the child. Upon termination of all legal obligation for support, placement ends.

Provider means an individual health professional or organization duly licensed to provide the services covered in this Booklet.

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.

Service Area means the geographic area in Washington state where We have been authorized by the State of Washington to sell and market this plan. The Service Area for this plan is the following counties:

Clallam, Columbia, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, Walla Walla, Whatcom, and Yakima.

For more information call Us at 1 (888) 367-2112

regence.com

Regence

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the BlueCross and BlueShield Association