Regence
Life and Health Insurance Company

An Independent Licensee of the Blue Cross and Blue Shield Association

InterM℠ Medical Insurance for Oregon Individuals and Families

FOR YOUR CONVENIENCE, YOU WILL FIND THE APPLICATION AND RATES AT THE END OF THIS BROCHURE.

RLH STM OC 04/04

This brochure is designed to give you a very brief description of the important features of the policy. This is not the insurance contract and only the actual policy provisions will govern. Please refer to the policy for a detailed description of the rights and obligations of both you and Regence Life and Health Insurance Company.

This short-term medical policy is non-renewable.

InterM℠

InterM℠ is designed for people who have a temporary need for medical coverage and who are healthy. InterM℠ gives you peace of mind by providing coverage for injuries and sudden-onset illnesses.

MEDICAL COVERAGE FOR 30 TO 185 DAYS

Valuable medical protection on a short-term basis for people who are:
- Between jobs, laid off, or on strike.
- Waiting to be covered under a group medical plan.
- Waiting for issuance of an individual contract.
- Recent graduates.
- Starting a business.
- Taking time off from school.
- In need of temporary medical insurance.

ELIGIBILITY

You are eligible for this policy if you and any family members who apply for coverage:

- Are under age 65 and will remain under age 65 for the term of the policy. Unmarried dependent children must be under age 23 and dependent upon you for support. Generally, the child must live with you. The exception is when you are legally required to pay for part of the child's support and there is no court order requiring that someone else provide insurance for the child.
- Are not eligible for Medicare.
- Are not pregnant. If any member of your family is pregnant, you may not apply for coverage until the pregnancy terminates.
- Are not covered under any other hospital or medical plan.

TEMPORARY COVERAGE

InterM[SM] is designed to provide medical coverage on a temporary basis to fill a temporary need. **It cannot be renewed and is not intended to replace permanent coverage.** However, if the temporary need continues, you may apply for one new policy within a 12-month period.

Important Note: There is **no** continuous coverage between policies. Any condition which may have existed or occurred under one policy will be a pre-existing condition under the subsequent policy, and therefore, will not be covered under the subsequent policy.

CHOICE OF PROVIDERS

You may visit the physician or hospital of your choice. You are not limited to any provider networks or out-of-area service restrictions. No referrals are needed – you have freedom of choice.

SHORT-TERM MAJOR MEDICAL INSURANCE OUTLINE OF COVERAGE

Read the Policy Carefully - This outline of coverage provides a very brief description of the important features of the policy. Please note that this outline is not intended to be a part of the insurance contract. Only the actual policy provisions are final and binding. The policy itself sets forth in detail your rights and obligations as well as those of the insurance company. PLEASE READ THE POLICY CAREFULLY!

Major Medical Expense Coverage - Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services and out-of-hospital care, subject to the deductibles, copayment provisions and other limitations set forth in the policy.

HOW THE POLICY WORKS

You choose the term of coverage - a minimum of 30 days up to the maximum policy term of 185 days. You select the deductible amount - $250, $500, $1,000 or $2,500 per covered person.

After the deductible is met, the policy pays the rate of payment you have selected - either 80% or 50% of the next $5,000 - and then 100% of the balance of covered expenses up to a maximum benefit of $1,000,000 during the policy term.

No family will be required to satisfy more than a total of three times the individual deductible. Covered expenses for all eligible family members may be accrued to satisfy the family deductible.

Important Note: If you become eligible for benefits under any other medical plan during the policy term, your deductible will be equal to the amount of benefits payable for covered expenses under the other plan, if it is greater than the deductible amount you selected.

COVERED EXPENSES

Covered expenses are charges for services or supplies prescribed by a physician for treatment of an illness or injury covered by your policy. The charges must be incurred for medically necessary care while the policy is in effect. A covered expense is incurred on the date a service is rendered or received and may not exceed usual and customary or reasonable as defined in your policy.

Subject to the limitations and conditions described in the policy, the following services and supplies will be considered covered expenses under your policy:

COVERED EXPENSES *(cont.)*

- Hospital room, board, and general nursing care, limited to the hospital's average semi-private room charge, unless confined in a coronary or intensive care unit.
- Other hospital services including emergency room, outpatient and ambulatory surgical center charges.
- Skilled nursing facility room, board, and general nursing care, limited to the facility's average semi-private room charge, up to a maximum of 100 days (other limitations apply; see your policy for complete description of benefit).
- Physician services for diagnosis, treatment, and surgery.
- X-rays, radioactive treatment, and laboratory tests.
- Breast and pelvic exams, mammograms, and Pap smear exams (if such exams are related to an annual women's examination).
- Anesthesia and oxygen and their administration.
- Private nursing care by R.N. or L.P.N. in the home (limitations apply).
- Licensed ambulance service, limited to two trips per illness or injury (other limitations apply; see your policy for complete description of benefit).
- Physical, occupational, speech and audiological therapy, up to 30 sessions (other limitations apply).
- Home health care (up to 40 visits) when prescribed by a physician and rendered by a licensed home health agency (see your policy for complete description of benefit).
- Rental (up to purchase price) of wheel chair, hospital type bed, or other durable medical equipment unique to medical care or treatment.
- Initial placement of a prosthesis required for functional purposes.
- Blood and blood products, administration of blood, and blood processing.
- Drugs which require the written prescription of a physician (limitations apply).
- Non-prescription elemental enteral formula for home use if the formula is medically necessary for the treatment of severe intestinal malabsorption (see your policy for complete description of benefit).
- Organ transplants, including heart, kidney, liver and bone marrow transplants, up to a maximum of $250,000 (other limitations apply; see your policy for complete description of benefit).
- Kidney disease.
- AIDS, including AIDS, AIDS Related Complex (ARC) or related immuno deficiency disorders.
- Casts, splints, crutches, orthopedic braces, colostomy bags, catheters, syringes, dressings, and initial contact lens following cataract surgery performed while covered under the policy.

EXTENSION OF BENEFITS WHILE HOSPITALIZED

If a covered person is hospital confined on the date your policy ends, coverage for that person **only** will continue without payment of additional premium. The coverage will continue until the person is discharged from the hospital or until the benefit maximum is reached, whichever occurs first.

EXCLUSIONS

Your policy does not cover:

- **Pre-existing conditions** (see the definition in the section titled “Pre-Existing Conditions”).
- Illness or injury incurred in the course of any employment for wage or profit or for which benefits are available under Workers’ Compensation or similar law.
- Illness or injury covered by Medicare.
- Hospital confinement for medical observation or diagnostic exams.
- Eye refractions, routine physical exams, tests or screening procedures (except breast and pelvic exams, mammograms, and Pap smear exams), well baby care, immunizations, hearing aids, eyeglasses, or hearing tests.
- Treatment of drug abuse or drug addiction.
- Organ transplant or complications resulting from or related to an organ transplant, except as specifically provided in your policy.
- Treatment of intentional self-inflicted injury.
- Elective sterilization, family planning, birth control drugs or devices, artificial insemination, in vitro fertilization, diagnosis or treatment of infertility, reversal of sterilization, or genetic testing or counseling.
- Cosmetic surgery (certain exceptions apply).
- Services or supplies not reasonably intended for treatment of illness or injury or which are not medically necessary (as defined in your policy).
- Acupuncture, massage, or massage therapy.
- Private duty nursing for hospital or skilled nursing facility inpatients.
- Mental, emotional or nervous disorders, or counseling of any type, or treatment of learning disorders or disabilities.
- Any condition caused by or arising out of service in the armed forces of any country, or from war or any act of war, or from participation in a felony, riot, or insurrection.
- Sexual dysfunction or inadequacy, or sex change procedures and any resulting complications.
- Services provided by an immediate family member.
- Treatment for obesity or weight control, including surgery and any resulting complications.
- Charges incurred after your policy ends, except as stated in your policy (see section titled “Extension of Benefits While Hospitalized” for brief description).
- Charges which exceed usual and customary or reasonable (as defined in your policy).
- Services rendered by governmental agencies or facilities, except as provided by law.
- Dental exams, treatment, or orthodontics.
- Services or supplies to change the position of the bone of the upper or lower jaw (certain exceptions apply).
- Services or supplies that are experimental or investigational (see your policy for complete details).

EXCLUSIONS *(cont.)*

- Confinement in a health facility for custodial or maintenance care, rest, or to change a patient's environment.
- Pregnancy or childbirth, except complications of pregnancy as stated in your policy.
- Treatment of alcoholism, except as stated in your policy.
- Charges which are reimbursed due to third party liability or motor vehicle coverage (see your policy for complete details).

PRE-EXISTING CONDITIONS

There is no coverage for pre-existing conditions under this policy. Pre-existing condition means an illness or injury for which a covered person received any medical diagnosis, advice, treatment, service, supply, or drug prescription during the 5-year period immediately preceding the effective date of your policy. A condition is also pre-existing if, during the 5-year period immediately preceding the effective date of your policy, symptoms existed which would cause a prudent person to seek diagnosis, advice, care, or treatment.

ACCIDENTAL DEATH BENEFIT

HOW THIS BENEFIT WORKS

We will pay the benefit shown below if all of the following conditions are met:

1. The Covered Person's death results from an Accidental Bodily Injury (as defined in your policy):
2. The Accidental Bodily Injury occurs while insured under the policy; and
3. The death occurs within 365 days after the date of the Accidental Bodily Injury.

Once satisfactory proof of death by Accidental Bodily Injury has been submitted, we will provide the following benefit:

For the Insured (age 18 or older)	$25,000
For the Covered Spouse	$25,000
For the Covered Dependent Child (and Insured under age 18)	$ 5,000

EXCLUSIONS

Your policy does not cover accidental death resulting from injury caused by, or occurring as the result of:

- Suicide, intentionally self-inflicted injury, or any attempt to injure oneself, while sane or insane;
- Active participation in a violent disorder or riot. "Active participation" does not include being at the scene of a violent disorder or riot during the performance of official duties;
- Insurrection, war or any act of war, whether declared or undeclared;
- Injury suffered while serving in the armed forces of any country;
- Committing or attempting to commit an assault or felony;
- Any sickness or pregnancy existing at the time of the accident;
- Voluntary use or consumption of any poison, chemical compound or drug, except a prescription drug used or consumed in accordance with the directions of the prescribing physician;
- Heart attack (including but not limited to myocardial infarction) or stroke (including but not limited to cerebral infarction);
- Diagnostic test, medical or surgical treatment; or
- Bodily infirmity or disease from bacterial or viral infections, other than infection caused from an injury sustained while insured under this benefit.

HOW TO APPLY

Please refer to the eligibility section of this brochure to be sure you meet the eligibility requirements.

- Complete the application in full. Missing information may cause your effective date to be delayed. If you have more than four children, please attach a separate list.
- Select the policy term (the number of days this policy will be in effect). The minimum term is 30 days; the maximum term is 185 days.
- Calculate the premium for the policy term, rate of payment, and deductible you select. (Refer to the following rate calculation pages.) If you select a two-party or family policy, the premium rate for the oldest family member will apply. Payment must be made for the full policy term. If the payment received is inadequate, the policy term (the number of days the policy will be in effect) will be shortened.
- Sign the application and the "Authorization For Use And Disclosure Of Protected Health Information" on Page 2 of the application.
- If your application is approved, the policy effective date will be 12:01 a.m. on the **later** of the day **after** the postmark date stamped on the application envelope or the date you request.
- If you answered "Yes" to any of the questions numbered 1 through 4 on the application, **this policy cannot be issued.**
- If you have any questions please call 503-225-6918 or toll-free 1-800-794-5390, ext. 6918.
- Send the application and your check or money order for the full payment amount (made payable to Regence Life and Health Insurance Company) to:

  Regence Life and Health Insurance Company
PO Box 1271, MS E-3A
Portland, OR 97207-1271

- Keep this brochure for your records.

REFUNDS

If you are not satisfied with our InterM℠ Policy, you may return the policy within 10 days of delivery for a full refund of premium. After that time, refunds are not available. Coverage will continue for the full period you selected.

Please note: The application fee of $20 is non-refundable.

Please read your policy carefully and keep it available for future reference.

Instructions for Calculating Your Policy Premium and Total Payment

1. Determine your premium by choosing from the options below:
   A. Rate of Payment - - 80/20% or 50/50%
   B. Deductible - - $250, $500, $1,000 or $2,500
   C. Number of Family Members to be Covered – Single, Two-Party, Family
   D. Age – Age of oldest person to be insured
   E. Term of Coverage (Number of days of coverage you desire)
      Note: You may select from a minimum of 30 days up to a maximum of 185 days.

2. Refer to the following daily rate charts. Find the daily rate for the coverage you desire by using the choices made in options A, B, C and D above.

3. Multiply the daily rate by the Term of Coverage chosen in option E above. This equals your Total Premium.

Example

1. A. Rate of Payment – 80/20%
   B. Deductible - $250
   C. Number of Family Members to be Covered - Family
   D. Age – 45 years
   E. Term of Coverage – 60 days

2. Daily Rate - $10.60

3. Term of Coverage 60 days X Daily Rate $10.60 = $636.00 Total Premium

Your Rate Calculation

1. A. Rate of Payment –________%
   B. Deductible - $__________
   C. Number of Family Members to be Covered - ________
   D. Age –________ years
   E. Term of Coverage – _______days

2. Daily Rate - $_________

3. Term of Coverage ______ X Daily Rate $______ = $_____ Premium
   Add $ 20.00 Application Fee
   $_____ Total Payment Due

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Daily Rates

Minimum of 30 Days up to a Maximum of 185 Days

	Rate of Payment - 80/20%			Rate of Payment - 50/50%		
	$250 Deductible			**$250 Deductible**		
Age	**Single**	**Two-party**	**Family**	**Single**	**Two-party**	**Family**
Under 20	$1.80	$3.60	$6.10	$1.40	$2.80	$4.80
20 - 24	$2.00	$4.00	$6.60	$1.60	$3.20	$5.20
25 - 29	$2.20	$4.40	$6.90	$1.70	$3.40	$5.50
30 - 34	$2.40	$4.80	$7.40	$1.90	$3.80	$5.80
35 - 39	$3.10	$6.20	$8.80	$2.40	$4.80	$6.90
40 - 44	$3.30	$6.60	$9.10	$2.60	$5.20	$7.20
45 - 49	$4.00	$8.00	$10.60	$3.10	$6.20	$8.30
50 - 54	$5.20	$10.40	$12.90	$4.10	$8.20	$10.20
55 - 59	$6.70	$13.40	$16.00	$5.30	$10.60	$12.60
60 - 64	$8.90	$17.80	$20.40	$7.00	$14.00	$16.10
	$500 Deductible			**$500 Deductible**		
Age	**Single**	**Two-party**	**Family**	**Single**	**Two-party**	**Family**
Under 20	$1.40	$2.80	$4.60	$1.10	$2.20	$3.70
20 - 24	$1.60	$3.20	$5.00	$1.30	$2.60	$4.10
25 - 29	$1.80	$3.60	$5.40	$1.50	$3.00	$4.40
30 - 34	$2.00	$4.00	$5.90	$1.70	$3.40	$4.80
35 - 39	$2.30	$4.60	$6.50	$1.90	$3.80	$5.30
40 - 44	$2.70	$5.40	$7.30	$2.20	$4.40	$5.90
45 - 49	$3.30	$6.60	$8.50	$2.70	$5.40	$6.90
50 - 54	$4.30	$8.60	$10.50	$3.60	$7.20	$8.60
55 - 59	$5.80	$11.60	$13.40	$4.80	$9.60	$11.00
60 - 64	$7.00	$14.00	$15.90	$5.80	$11.60	$13.00
	$1000 Deductible			**$1000 Deductible**		
Age	**Single**	**Two-party**	**Family**	**Single**	**Two-party**	**Family**
Under 20	$1.10	$2.20	$3.50	$0.90	$1.80	$2.90
20 - 24	$1.30	$2.60	$3.80	$1.10	$2.20	$3.10
25 - 29	$1.30	$2.60	$3.80	$1.10	$2.20	$3.10
30 - 34	$1.50	$3.00	$4.20	$1.20	$2.40	$3.50
35 - 39	$1.70	$3.40	$4.60	$1.40	$2.80	$3.80
40 - 44	$2.00	$4.00	$5.20	$1.70	$3.40	$4.40
45 - 49	$2.60	$5.20	$6.40	$2.20	$4.40	$5.30
50 - 54	$3.30	$6.60	$7.80	$2.70	$5.40	$6.50
55 - 59	$4.10	$8.20	$9.40	$3.40	$6.80	$7.90
60 - 64	$5.50	$11.00	$12.20	$4.60	$9.20	$10.10
	$2500 Deductible			**$2500 Deductible**		
Age	**Single**	**Two-party**	**Family**	**Single**	**Two-party**	**Family**
Under 20	$0.90	$1.80	$2.70	$0.70	$1.40	$2.10
20 - 24	$0.90	$1.80	$2.70	$0.70	$1.40	$2.20
25 - 29	$0.90	$1.80	$2.70	$0.80	$1.60	$2.20
30 - 34	$1.00	$2.00	$2.90	$0.80	$1.60	$2.40
35 - 39	$1.30	$2.60	$3.30	$1.00	$2.00	$2.80
40 - 44	$1.60	$3.20	$4.10	$1.30	$2.60	$3.40
45 - 49	$1.90	$3.80	$4.60	$1.50	$3.00	$3.80
50 - 54	$2.50	$5.00	$5.80	$2.00	$4.00	$4.80
55 - 59	$3.20	$6.40	$7.20	$2.60	$5.20	$5.90
60 - 64	$4.00	$8.00	$8.90	$3.30	$6.60	$7.30

Regence Life and Health Insurance Company

An Independent Licensee of the Blue Cross and Blue Shield Association

InterM℠ APPLICATION

An Interim Medical Insurance Policy

NON-RENEWABLE

REGENCE LIFE AND HEALTH INSURANCE COMPANY
100 SW Market St.
PO Box 1271, MS E-3A
Portland, OR 97207-1271
(503) 225-6918

NOTE: Coverage begins at 12:01 a.m. on the **later** of the day **after** the postmark date stamped on the application envelope or the date you request. Coverage will take effect only upon receipt of full premium.

MISSING INFORMATION MAY CAUSE YOUR EFFECTIVE DATE TO BE DELAYED.

INSURED'S NAME (PRINT LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER	**REQUESTED EFFECTIVE DATE**	
STREET ADDRESS		TELEPHONE NUMBER	
CITY, STATE, ZIP CODE		INSURED'S SEX	INSURED'S BIRTHDATE
SPOUSE'S NAME - IF TO BE INSURED	SPOUSE'S SOCIAL SECURITY NUMBER		SPOUSE'S BIRTHDATE

DEPENDENT CHILDREN MUST BE UNDER 23 YEARS OF AGE AND DEPENDENT ON YOU FOR SUPPORT.

CHILD'S FULL NAME - IF TO BE INSURED	SEX	BIRTHDATE	FULL NAME	SEX	BIRTHDATE
(1)			(3)		
(2)	SEX	BIRTHDATE	(4)	SEX	BIRTHDATE

DEDUCTIBLE AMOUNT/FAMILY DEDUCTIBLE	**POLICY TERM (30 – 185 DAYS)**	**PREMIUM** $
☐ $250/$750 ☐ $500/$1,500 ☐ $1,000/$3,000 ☐ $2,500/$7,500	**NO. OF DAYS** ________	**APP. FEE** + 20.00 **TOTAL** $

RATE OF PAYMENT AFTER DEDUCTIBLE ☐ 80% to $5,000 ☐ 50% to $5,000

Question		
1. Are you, or any person to be insured, age 65 or older?	☐ YES ☐ NO	**If YES, this policy cannot be issued.**
2. Are you, or any person to be insured, eligible for Medicare?	☐ YES ☐ NO	**If YES, this policy cannot be issued.**
3. Do you, or any person to be insured, now have any hospital, major medical, group health or medical insurance coverage that will not terminate prior to the beginning of this policy?	☐ YES ☐ NO	**If YES, this policy cannot be issued.**
4. Are you, or any family member, now pregnant?	☐ YES ☐ NO	**If YES, this policy cannot be issued.**

I understand that:

(1) if my application for coverage is accepted, the Effective Date will be 12:01 a.m. on the later of the day after the postmark date or the requested effective date;
(2) if my application for coverage is not accepted, any premium I paid will be promptly refunded;
(3) this is not a continuation of any previous medical plan, including any prior Short Term Medical Plan;
(4) this policy is not renewable; and
(5) this insurance will not cover Pre-Existing Conditions. Pre-Existing Conditions are defined as any sickness or injury for which any medical advice, treatment, service, supply or drug prescription has been received, or for which symptoms have been shown, during the 5 years immediately preceding the Effective Date of this coverage.

I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief, and I understand that the answers to the above questions shall be the basis of any coverage issued, and that any incorrect answer may operate to void this coverage.

INSURED'S SIGNATURE	**DATE**	LICENSED AGENT'S SIGNATURE
PARENT OR GUARDIAN'S SIGNATURE	AGENT NUMBER	LICENSED AGENT NAME (Please print)

*****PLEASE COMPLETE THE AUTHORIZATION ON THE FOLLOWING PAGE *****

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize any physician, health care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to Regence Life and Health Insurance Company (RLH) or its representatives health information (including alcohol, chemical dependency, mental health treatment, genetic testing or HIV treatment) pertaining to me and/or my eligible dependents. I acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan and eligibility for benefits or payment of claims. Health information may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

If I choose to not sign this authorization, RLH may be unable to enroll my family or me in the health plan or to pay claims that were incurred while we had insurance coverage with RLH.

I may cancel this authorization at any time by sending a written request to RLH. Cancellation of this authorization will not affect any action RLH took before it received this request. If I do not revoke this authorization, it will automatically expire when I am no longer covered under this policy and all claims arising from the policy have been settled, or in 24 months from the date below, whichever comes first. A photocopy of this authorization is as valid as the original.

Federal law requires RLH to tell me that if the party to whom RLH discloses my personal information shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are protected by federal confidentiality rules (42 CFR, part 2). Federal law prohibits redisclosure of this information without specific written authorization.

SIGNATURE*: ______________________________ **DATE:** ____________________

NAME: ____ **(Please print)**

*If signature by a personal representative of the Insured, please complete the following:

Personal Representative's Name: ______________________________________

Relationship to Insured: ☐ Parent ☐ Legal Guardian* ☐ Holder of Power of Attorney*

*Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.

APPLICANT SPOUSE SIGNATURE: ______________________ **DATE:** ____________________

APPLICANT NAME: ____ **(Please print)**

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES
(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of conversation during a counseling session.)

DISCLOSURE: If you have a broker or agent, they may receive bonuses, commissions, administrative service fees or other compensation, including non-cash compensation, from RLH. Incentives may be based on any of several factors, including the size of group business, the products you buy, your broker or agent's volume of business with RLH and the other services your agent or broker provides to you. These incentives may have a direct or indirect impact on your rates. For more information, please contact your broker or agent.

NOTICE OF PRIVACY PRACTICES

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

We, at Regence Life and Health Insurance Company, know you value your privacy. That is why we are committed to the confidentiality and security of your personal information. We maintain physical, administrative, and technical safeguards to protect against unauthorized access, use, or disclosure of your personal information.

We collect personal information, such as your name, contact information, and health information, from you, your health care providers, and other insurers that provide you coverage. We are required by law to maintain the privacy of this protected health information and to explain our legal duties and privacy practices. We provide the protections and apply the practices described in this notice to all personal information that we maintain, including to personal information of former members who are no longer covered by us. We hope this notice will clarify our responsibilities to you and give you an understanding of your rights. We abide by the notice that is currently in effect. This notice is in effect as of January 1, 2006.

Your Rights

Inspection and Copies. You have the right to request an inspection or copies of protected health information that we maintain about you in a "designated record set" except psychotherapy notes and information that we compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding. A "designated record set" is a group of records that is used to administer your health benefits, including enrollment information and claims. We may limit the information that you can inspect or copy if we have reason to believe that is necessary to protect you or another person from harm. If we limit your right to inspect or copy, you can ask for a review of that decision.

Amendment. If you believe that protected health information we maintain about you in a designated record set is inaccurate or incomplete, you have the right to request an amendment to correct or complete the information. You must submit your request in writing and explain the reason for the amendment. If the amendment is made, we will make reasonable efforts to inform others, including people you identify, that the information has been amended and we will use our best efforts to include the amendment with any future disclosure. We may decline to amend information under certain circumstances. This is likely to occur if we did not create the original record. If we decline to amend the information, you have the right to submit a statement of disagreement. You should know that we are allowed to attach a rebuttal statement in response to your statement of disagreement.

Notice. You have the right to receive a paper copy of this notice upon request.

Accounting. You have the right to request a list of certain disclosures of protected health information. The list will not include disclosures made for treatment, payment, or health care operations. It also will not include disclosures made pursuant to an authorization, made prior to six years before the date of the request, incidental disclosures, disclosures made for national security or intelligence, disclosures made to a correctional facility or disclosures made prior to April 14, 2003. The list will include the date of any accountable disclosure, to whom that disclosure was made, a brief description of the information disclosed, and the purpose for that disclosure (provided this information is known to us). We will supply this list free of charge once a year at your request. If you request an accounting more than once in a 12-month period, we may charge a reasonable fee.

Special Handling. You have the right to request restrictions on our use or disclosure of protected health information in addition to the restrictions imposed by law. We are not required to agree to your request and we may be unable to do so. If we do agree, we will comply with your request except in the case of emergency. You also have the right to request that we communicate with you in confidence. We will make every effort to accommodate your request if it is reasonable and you provide an alternate means to communicate. You should know that redirecting communication may not prevent others on your policy from discovering that you sought medical care. Accumulated deductibles and co-payment information may reveal that you obtained services. In addition, historic claims reports may include services which were obtained during the time communications were redirected.

Complaints. You have the right to submit a complaint if you believe we have violated your privacy rights. To submit a complaint, write to: The Regence Group, Privacy Office, P.O. Box 1071, Mailstop E12B, Portland, OR 97207 or call us at the phone number provided at the end of this notice. You also have the right to submit a complaint to the Secretary of the U.S. Department of Public Health & Human Services. Be assured that we will not retaliate against you for submitting a complaint.

Permitted Uses and Disclosures

To administer health benefits, we collect, use and disclose protected health information for a variety of purposes:

Treatment. We may disclose protected health information to a health care provider in order for the provider to treat you. We may also use or disclose protected health information in an effort to provide preventive health, early detection, and case management programs.

Payment. We may use or disclose protected health information for payment purposes, including to adjudicate claims, issue Explanation of Benefits, or coordinate benefits with other entities responsible for paying your claims.

Health Care Operations. We may use or disclose protected health information to facilitate operations, including underwriting, customer service, and detection or prevention of fraud or abuse.

Business Associates. Occasionally, we contract with business associates to perform insurance-related functions on our behalf. We may disclose protected health information to these business associates in order to allow them to perform these functions. They also may collect, use or disclose protected health information on our behalf. We contractually obligate our business associates to provide the same privacy protections that we provide.

Plan Sponsors and Group Health Plans. If you are enrolled in a group health plan, we may disclose protected health information to the group health plan or plan sponsor to facilitate administration of the plan. For example, we supply enrollment lists so that premiums can be paid appropriately.

As Permitted or Required by Law. We use or disclose protected health information as permitted or required by law. For example, some laws require that we disclose protected health information to your personal representatives or to certain government agencies.

Public Health Activities. We may disclose protected health information for public health activities. These activities include prevention and control of disease, activities performed by coroners, activities performed by organ or tissue donation and transplantation services, activities performed by the Food and Drug Administration, medical research, research intended to improve the health care system, activities necessary to avert a serious threat to the health or safety of a person, and activities relating to workers' compensation benefits.

Health Oversight. We may disclose protected health information to health oversight agencies. These agencies are authorized by law to conduct audits; perform inspections and investigations; license health care providers, insurers and facilities; and to enforce regulatory requirements. These agencies include: State Commissioner of Insurance, State Board of Medicine, and the U.S. Department of Labor.

Health Related Services. We may use protected health information to provide information about treatment alternatives or other health related benefits or services that may be of interest to you. This may include enhancements to your health plan and health related products or services available only to health plan members that add value to, but are not a part of, your benefit plan.

Legal Proceedings. We may disclose protected health information in the course of a judicial or administrative proceeding, and in response to a court order, subpoena, discovery request, or other lawful process.

Law Enforcement. We may disclose protected health information to law enforcement officials in response to an administrative subpoena, a warrant, or an administrative request intended to identify or locate a suspect, victim or witness. We also may disclose protected health information for the purpose of reporting a crime on our premises.

Military and National Security. We may disclose protected health information to armed forces personnel for military activities and to authorized federal officials for national security and intelligence activities.

Correctional Institution. If you are an inmate, we may disclose protected health information to your correctional institution for treatment purposes or to ensure the safety of yourself and others.

Marketing. We do not use or disclose protected health information for marketing purposes without your authorization. However, we may communicate with you face-to-face about products or services that may interest you or we may send you a promotional gift of nominal value.

Others Involved in Your Health Care. We may disclose protected health information to personal representatives such as appointed guardians, executors, conservators, and in many cases parents of minor children, as well as to attorneys in fact when a valid power of attorney exists. In addition, if you give us verbal permission or if your permission can be implied (for example, while you are unconscious during an emergency), we may disclose protected health information to family members or others who call on your behalf. This permission is valid only for a limited time. If you want to authorize on-going disclosures to family members or friends, you must submit written authorization.

Authorizations. You may give us written authorization to use protected health information or disclose protected health information about yourself to anyone for any purpose. An authorization remains valid for two years unless the authorization states otherwise or you revoke it. You may revoke an authorization at any time by submitting a written revocation, but a revocation will not affect any use or disclosure permitted by the authorization while it was in effect. An authorization is required for us to use or disclose your protected health information for purposes other than those described in this notice.

Future Changes

We reserve the right to change our privacy practices and this notice at any time without advance notice. If we make a material change to our privacy practices, we will send a new, updated notice. The new notice will apply to all protected health information in our possession, including any information created or received before the revised notice became effective.

Contacting Us

You may reach us during regular business hours by calling us toll-free at (800) 794-5390. For more information about this notice or to file a written privacy-related complaint, you may write to: Privacy Official, The Regence Group, P.O. Box 1071, MS E12B, Portland, OR 97207.