Regence

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

ENDORSEMENT TO YOUR MEDICAL PLAN BOOKLET

This Endorsement makes certain changes to Your Regence Medical Plan Booklet effective **January 1, 2018**, or the date on which Your medical plan becomes effective or renews with Us.

Regence BlueShield agrees to provide Members the following benefits in accordance with and subject to the provisions, terms, conditions, limitations and exclusions set forth in this Endorsement and the Booklet to which this Endorsement is attached. If there is any inconsistency between this Endorsement and the Booklet, the terms of this Endorsement will prevail.

To accomplish the above, the following changes are made to Your Booklet:

On the first page of the **Medical Benefits** section, the third and fourth paragraphs are replaced in their entirety with the following:

> Reimbursement may be available for new medical supplies, equipment, and devices You purchase from a Provider or from an approved commercial seller, even though that seller is not a Provider. New medical supplies, equipment, and devices, such as a breast pump or wheelchair, purchased through an approved commercial seller are covered at the In-Network level, with reimbursement based on the lesser of either the amount paid to a preferred Provider for that item or the retail market value for that item. To learn more about how to access an approved commercial seller and reimbursable new retail medical supplies, equipment, and devices, please visit Our Web site or contact Customer Service.
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> Please note that if You choose to access new medical supplies, equipment, and devices through Our Web site, We may receive administrative fees or similar compensation from the commercial seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to the group health plan, but are not insurance.

In the **Preventive Care and Immunizations** benefit, the first two paragraphs are replaced in their entirety with the following:

> **PREVENTIVE CARE AND IMMUNIZATIONS**
> Benefits will be covered under this Preventive Care and Immunizations benefit, not any other benefit in this Booklet, if services are in accordance with age limits and frequency guidelines according to, and as recommended by, the USPSTF, the HRSA or by the CDC. In the event any of these bodies adopts a new or revised recommendation, this plan has up to one year before coverage of the related services must be available and effective under this benefit. For a complete list of services covered under this benefit, including information about how to access an approved commercial seller, obtaining a breast pump and instructions for obtaining reimbursement for a new breast pump purchased from an approved commercial seller, retailer, or other entity that is not a Provider, please visit Our Web site or contact Customer Service.
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> Please note that if You choose to access new medical supplies, equipment, and devices through Our Web site, We may receive administrative fees or similar compensation from the commercial seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to the group health plan, but are not insurance.

In the **Preventive Care and Immunizations** benefit, the bullet point relating to one non-Hospital grade breast pump under the **Preventive Care** benefit table is replaced in its entirety with the following:

- one non-Hospital grade breast pump including its accompanying supplies per pregnancy, when obtained from a Provider (including a Durable Medical Equipment supplier), or a comparable new breast pump obtained from an approved commercial seller, even though that seller is not a Provider; and

In the **Medical Services and Supplies** provision of the **Professional Services** benefit, the second paragraph is replaced in its entirety with the following:

Additionally, We cover some general medical services and supplies, such as compression stockings, active wound care supplies, and sterile gloves, when Medically Necessary. Reimbursement for covered medical supplies may be available under Your Booklet when these new supplies are obtained from an approved commercial seller, even though that seller is not a Provider. Eligible new general medical supplies purchased through an approved commercial seller are covered at the In-Network level, with Your reimbursement based on the lesser of either the amount paid to a preferred Provider for that item or the retail market value for that item. To learn more about how to access an approved commercial seller and reimbursable new general medical supplies, please visit Our Web site or contact Customer Service.

In the **Durable Medical Equipment** benefit, the second paragraph is replaced in its entirety with the following:

To be covered, Durable Medical Equipment must be rendered by a Provider practicing within the scope of his or her license and must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). In some cases, We may limit benefits or coverage to a less costly and Medically Necessary alternative item. Reimbursement may also be available under Your Booklet for new Durable Medical Equipment when obtained from an approved commercial seller, even though this entity is not a Provider. Eligible new Durable Medical Equipment purchased through an approved commercial seller is covered at the In-Network level, with Your reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item or the retail market value for that item. To find ways to access new Durable Medical Equipment, including how to access an approved commercial seller, please visit Our Web site or contact Customer Service. Please note that if You choose to access new Durable Medical Equipment through Our Web site, We may receive administrative fees or similar compensation from the commercial seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to the Group health plan, but are not insurance.

In the **Emergency Room (Including Professional Charges)** benefit, the paragraph is replaced in its entirety with the following:

We cover emergency room services and supplies, including outpatient charges for patient observation, medical screening exams and treatment, and routinely available ancillary evaluative services, that are required for the stabilization of a patient experiencing an Emergency Medical Condition. For the purpose of this benefit, "stabilization" means to provide Medically Necessary treatment: 1) to assure, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during, or to result from, the transfer of the Member from a facility; and 2) in the case of a covered female Member, who is pregnant, to perform the delivery (including the placenta). Emergency room services do not need to be pre-authorized. If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered at the In-Network benefit level. In addition to usual cost-sharing, You may remain responsible for any amount by which billed charges exceed the Allowed Amount. If You are admitted as an inpatient directly from the emergency room and services were not covered at the In-Network level,

as described above, please contact Customer Service for an adjustment to Your claims. See the Hospital Care benefit in this Medical Benefits Section for coverage of inpatient Hospital admissions.

In the **Orthotic Devices** benefit, the second paragraph is replaced in its entirety with the following:

To be covered, orthotic devices must be rendered by a Provider practicing within the scope of his or her license and must be Medically Necessary for the treatment of an Illness or Injury (except for any covered preventive care). In some cases, We may limit benefits or coverage to a less costly and Medically Necessary alternative item. Reimbursement may also be available under Your Booklet for new orthotic devices when obtained from an approved commercial seller, even though that seller is not a Provider. Eligible new orthotic devices purchased through an approved commercial seller are covered at the In-Network level, with Your reimbursement based on the lesser of either the amount paid to an In-Network Provider for that item or the retail market value for that item. To learn more about how to access reimbursable new retail orthotic devices, including how to access an approved commercial seller, please visit Our Web site or contact Customer Service. Please note that if You choose to access new orthotic devices through Our Web site, We may receive administrative fees or similar compensation from the commercial seller and/or You may receive discounts or coupons for Your purchases. Any such discounts or coupons are complements to the group health plan, but are not insurance.

In the **Temporomandibular Joint (TMJ) Disorders** benefit, the language under the benefit table is replaced in its entirety with the following:

We cover inpatient and outpatient services for treatment of temporomandibular joint (TMJ) disorders which have one or more of the following characteristics:

- 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 Medical Services" for the purpose of this TMJ benefit, mean those 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 medical practice; and
- not Experimental or primarily for Cosmetic purposes.

Dental Services are not Covered Services by this plan. "Dental Services" for the purpose of this TMJ benefit, mean those 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.

In the **Expedited Appeals** subsection in the **Appeal Process** section, the paragraph under the bullet points is replaced in its entirety with the following:

> 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.

In the **Special Enrollment** subsection of the **Who is Eligible, How to Enroll and When Coverage Begins** section, the third paragraph is replaced by the following:

> If You are already enrolled or if You declined coverage when first eligible and subsequently have one of the following qualifying events, You (unless already enrolled), Your spouse (or Your domestic partner) and any eligible children are eligible to enroll for coverage under the Contract within 30 days from the date of the qualifying event (except that where the qualifying event is involuntary loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP), You have 60 days from the date of the qualifying event to enroll):
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> - You and/or Your eligible dependents lose coverage under another group or individual health benefit plan due to one of the following:
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> - an employer's contributions to that other plan are terminated;
> - exhaustion of federal COBRA or any state continuation; or
> - loss of eligibility, for instance, due to legal separation, divorce, termination of domestic partnership, death, termination of employment or reduction in hours, or meeting or exceeding the lifetime limit on all benefits on a former plan.
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> - You and/or Your eligible dependent lose coverage due to no longer residing, living, or working in the service area of that coverage (and, if the coverage is in the group market, no other benefit package was available through the sponsoring entity).
> - You involuntarily lose coverage under Medicare, CHAMPUS/Tricare, Indian Health Service or a publicly sponsored or subsidized health plan (other than the Children's Health Insurance Program (CHIP), see below).
> - You lose coverage under Medicaid or the Children's Health Insurance Program (CHIP).

In the **Termination of Domestic Partnership** subsection of the **When Group Coverage Ends** section, the following sentence is removed:

> You may not file another affidavit of qualifying domestic partnership for a non-registered domestic partner within 90 days after a request for termination of a domestic partnership has been received.

All other terms and conditions of the Booklet remain unchanged.

IN WITNESS WHEREOF, We, by Our duly authorized officer, have executed this Endorsement.

Tim Lieb
President
Regence BlueShield