



**InterM<sup>SM</sup> Medical Plan**  
**for Oregon Residents**



**Regence**

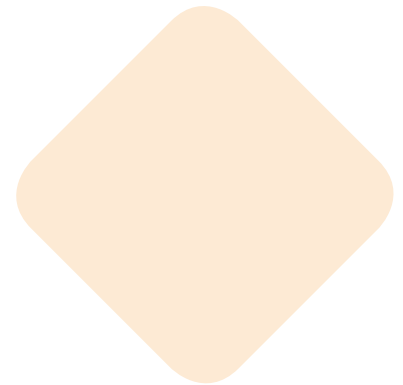
*Life and Health Insurance Company*

Independent Licensee of the Blue Cross and Blue Shield Association

**Things don't feel secure without a medical plan.  
Even a temporary loss of coverage can disrupt  
your peace of mind. With InterM<sup>SM</sup> medical  
coverage, you can live better and worry less.**



**InterM<sup>SM</sup> is an interim medical plan that provides temporary coverage—from 30 to 185 days—for you and your family. With InterM, there's no need to go a single day without coverage.**



**InterM<sup>SM</sup> offers you choice, flexibility, and security. Choose the level of coverage that suits your needs. Visit the physician or hospital of your choice. InterM even provides accidental death benefits for you and your family members. No matter where life takes you, InterM has got you covered.**

### **Who needs InterM?**

InterM is ideal for people who are:

- In need of temporary medical coverage
- Between jobs, laid off, or on strike
- Waiting to be covered under a group medical plan
- Waiting for issuance of an individual policy
- Recent graduates or taking time off from school
- Starting a business

### **Who's eligible?**

You are eligible if you and any family members are:

- Under the age of 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, unless 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
- Not eligible for Medicare
- Not pregnant
- Not covered under any other hospital or medical plan

### **InterM is temporary coverage**

This policy cannot be renewed; however, you may apply for one new policy within a 12-month period. Be aware that any condition that may have existed or occurred under the first policy will be considered a pre-existing condition under the second policy and will not be covered.

### **You can go to any physician or hospital**

Forget about networks, referrals and other restrictions. You can visit the physician or hospital of your choice.

### **InterM has got you covered**

InterM gives you an added level of protection with an accidental death benefit. The benefit is \$25,000 for the insured or Covered Spouse and \$5,000 for a Covered Dependent Child. If the policy is issued for a child under age 18, the benefit will be the same as the \$5,000 payable for a Dependent Child.



## Outline of Coverage

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 YOUR 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, copay 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 percent or 50 percent of the next \$5,000—and then 100 percent 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.

### 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.

# InterM<sup>SM</sup> is designed for healthy people who want interim coverage for injuries and sudden-onset illnesses.

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

- 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)
- Prostate cancer screening examinations, including digital rectal examination and a prostate-specific antigen test (limitations apply)
- Colorectal cancer screening examinations and laboratory tests (limitations apply)
- 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 care agency (see your policy for complete description of benefit)
- Rental (up to purchase price) of wheelchair, hospital-type bed, or other durable medical equipment unique to medical care or treatment
- Placement of a prosthesis required for functional purposes
- Blood and blood products, administration of blood, and blood processing
- Drugs that 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 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 as specifically provided in the section titled “Covered Expenses”), 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 that 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 that exceed usual and customary or reasonable (as defined by 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)
- 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 that 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. A 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 five-year period immediately preceding the effective date of your policy. A condition is also pre-existing if, during the five-year period immediately preceding the effective date of your policy, symptoms existed that would cause a prudent person to seek diagnosis, advice, care or treatment.

# InterM<sup>SM</sup> offers the protection of an accidental death benefit. It's an added layer of security for the people you care about most.

## 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:

<b>For the Insured</b> .....	<b>\$25,000</b>
<b>For the Covered Spouse/ Covered Domestic Partner</b> .....	<b>\$25,000</b>
<b>For a Covered Dependent Child</b> .....	<b>\$5,000</b>
<b>For a policy issued for a child under the age of 18</b> .....	<b>\$5,000</b>

### 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
- 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

Applying for InterM is easy. Whether you choose to apply online at [regencelife.com](http://regencelife.com), submit the included paper application, or enroll through your agent, coverage is just a few steps away.

### Online

**STEP 1:** Visit [www.Regencelife.com](http://www.Regencelife.com)

**STEP 2:** Enter your zip code in the [InterM: Purchase Online] field

**STEP 3:** After reviewing the deductible options, co-insurance options, and coverage details, click [Enroll Online Now]

**STEP 4:** Complete the application\*

**STEP 5:** Select the coverage plan of your choice

**STEP 6:** Select your preferred payment method\*\* and purchase your policy.

If your application is approved, the policy effective date will be the later of 12:01 a.m. on the day after the application is submitted; or the date you request.

\* Missing information may cause your effective date to be delayed. If you answered "Yes" to any of the questions 1 through 4 on the application, this policy cannot be issued.

\*\* You may choose to pay your premium in full or authorize monthly payments via credit card or electronic check. Regence Life and Health accepts most major credit cards.

### Paper Application (Enclosed)

**STEP 1: SELECT YOUR BENEFIT:** \_\_\_\_\_

You can choose a benefit of 80% or 50% after deductible is met.

**STEP 2: SELECT YOUR DEDUCTIBLE:** \_\_\_\_\_

You can choose a deductible of \$250, \$500, \$1,000 or \$2,500. (The family deductible will be three times this amount.)

**STEP 3: LIST HOW MANY PEOPLE WILL BE COVERED** \_\_\_\_\_

Is the policy for an individual, two individuals or a family?

**STEP 4: LIST THE AGE OF THE OLDEST TO BE INSURED** \_\_\_\_\_

**STEP 5: DETERMINE YOUR DAILY RATE** \_\_\_\_\_

Using the included rate table, determine the daily rate of coverage based on the benefit, deductible, number of persons insured, and the age of the oldest insured.

## How to Apply, continued

### **STEP 6: DETERMINE YOUR LENGTH OF COVERAGE \_\_\_\_\_**

Select from a minimum of 30 days up to a maximum of 185 days. Rates are calculated on a daily basis, so you can specify an exact length of coverage.

### **STEP 7: CALCULATE YOUR PREMIUM \_\_\_\_\_**

Multiply your Daily Rate (Step 5) by your Length of Coverage (Step 6).

### **STEP 8: CALCULATE TOTAL AMOUNT DUE \_\_\_\_\_**

Add a \$20 application fee to calculated premium (Step 7).

### **STEP 9: COMPLETE AND SIGN THE APPLICATION AND “AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION” ON PAGES 13 AND 14\***

### **STEP 10: MAIL THE APPLICATION, AUTHORIZATION AND PAYMENT**

Payment must be made for the full policy term. Send the application and your check or money order for the full payment amount (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

If your application is approved, the policy effective date will be the later of 12:01 a.m. on the day after the postmark date stamped on the application envelope; or the date you request.

#### **Refunds**

If you are not satisfied with our InterM policy, you may return it 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.

#### **NEED HELP?**

If you need assistance with the application, contact your insurance representative. Or, call Regence Life and Health at 1 (800) 794-5390.

\* Missing information may cause your effective date to be delayed. If you have more than four children, please attach a separate list. If you answered “Yes” to any of the questions 1 through 4 on the application, this policy cannot be issued.

## Daily Rates

Minimum of 30 days to a maximum of 185 days

Rate of Payment: 80/20%

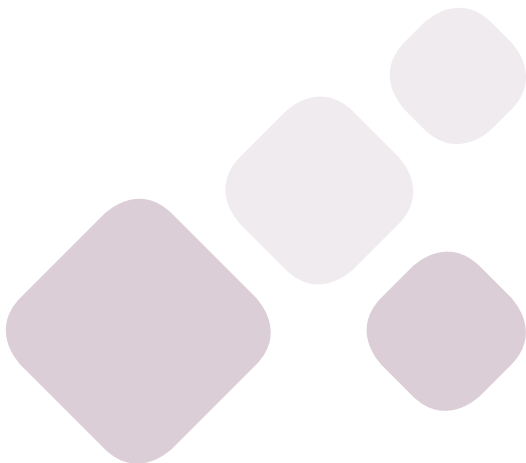
Rate of Payment: 50/50%

\$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

\$1,000 Deductible				\$1,000 Deductible		
AGE	SINGLE	TWO-PARTY	FAMILY	SINGLE	TWO-PARTY	FAMILY
Under 20	\$ 1.10	\$ 2.20	\$ 3.50	\$ .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

\$2,500 Deductible				\$2,500 Deductible		
AGE	SINGLE	TWO-PARTY	FAMILY	SINGLE	TWO-PARTY	FAMILY
Under 20	\$ .90	\$ 1.80	\$ 2.70	\$ .70	\$ 1.40	\$ 2.10
20 – 24	\$ .90	\$ 1.80	\$ 2.70	\$ .70	\$ 1.40	\$ 2.20
25 – 29	\$ .90	\$ 1.80	\$ 2.70	\$ .80	\$ 1.60	\$ 2.20
30 – 34	\$ 1.00	\$ 2.00	\$ 2.90	\$ .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



# 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.

## Notice of Privacy Practices

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



## Notice of Privacy Practices

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.

## Notice of Privacy Practices



**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.



# Regence

Life and Health Insurance Company

Independent Licensee of the Blue Cross and Blue Shield Association.

## InterM<sup>SM</sup> APPLICATION An Interim Medical Insurance Policy NON-RENEWABLE

100 SW Market St.  
PO Box 1271, MS E-3A  
Portland, OR 97207-1271  
(503) 721-7161 • (800) 794-5390

**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. If applying by mail, coverage will take effect only upon receipt of full premium. If applying online, automatic monthly payments to a credit card is available.

**Please complete all information on this page and on Page 2, missing information may cause your effective date to be delayed**

Applicant's Name (Last, First, Middle)		<input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Requested Effective Date
Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Married / Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Single		Telephone Number (    )	Email Address
Home Address & Apt. No./Mailing Address			City	State    Zip

We are always searching for ways to better serve your needs. You can help us by answering the following questions.

- Are you :  Hispanic/Latino     Non-Hispanic/Latino
- How would you describe yourself in terms of your racial heritage?  African-American     American Indian or Alaskan Native     Asian or Pacific Islander     Caucasian     Two or More Races

You may choose to not answer this question

**Dependents to be enrolled:** Dependent children must be under 23 years of age and primarily dependent on you for support.

Last Name	First Name	M	SS#	Birth Date	Sex	Relationship (Spouse / Domestic Partner, Child, Child of DP)
Same as above			Same as above	Same as above	M / F	Self
					M / F	
					M / F	
					M / F	
					M / F	
					M / F	

List names as they should appear on your identification card. If enrolling additional dependents, please attach a separate sheet including the information above.

If you are enrolling a non-state certified domestic partner or children of a non-state certified domestic partner please also include the Affidavit of Non-State Certified Domestic Partnership.

<b>DEDUCTIBLE AMOUNT/FAMILY DEDUCTIBLE</b> <input type="checkbox"/> \$250/\$750 <input type="checkbox"/> \$500/\$1,500 <input type="checkbox"/> \$1,000/\$3,000 <input type="checkbox"/> \$2,500/\$7,500		<b>POLICY TERM (30 – 185 DAYS)</b> NO. OF DAYS _____	<b>PREMIUM \$</b> APP. FEE + \$ <b>20.00</b> <b>TOTAL \$</b>
<b>RATE OF PAYMENT AFTER DEDUCTIBLE</b> <input type="checkbox"/> 80% to \$5,000 <input type="checkbox"/> 50% to \$5,000			
1. Are you, or any person to be insured, age 65 or older?		<input type="checkbox"/> YES <input type="checkbox"/> NO <b>If YES, this policy cannot be issued.</b>	
2. Are you, or any person to be insured, eligible for Medicare?		<input type="checkbox"/> YES <input type="checkbox"/> NO <b>If YES, this policy cannot be issued.</b>	
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?		<input type="checkbox"/> YES <input type="checkbox"/> NO <b>If YES, this policy cannot be issued.</b>	
4. Are you, or any family member, now pregnant?		<input type="checkbox"/> YES <input type="checkbox"/> NO <b>If YES, this policy cannot be issued.</b>	



# Regence

Life and Health Insurance Company

Independent Licensee of the Blue Cross and Blue Shield Association.

**InterM<sup>SM</sup> APPLICATION**  
An Interim Medical Insurance Policy  
**NON-RENEWABLE**

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 acknowledge and understand Regence Life and Health Insurance Company may request or disclose health information about me or my dependents (persons who are listed for benefit coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

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

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

**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.

**PLEASE NOTE:** InterM is an individual insurance plan and cannot be purchased by employers for their employees.

**INSURANCE FRAUD WARNING:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members that all entitlements to benefits are void and the contract may be canceled or modified retroactively to its effective date.

Insured’s Signature	Parent’s or Guardian’s Signature	
Date Signed	Agent Number	Licensed Agent’s Name (Please Print)

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



**Regence**

Life and Health Insurance Company

Independent Licensee of the Blue Cross and Blue Shield Association.

100 SW Market Street  
P.O. Box 1271 E-3A  
Portland, OR 97207-1271  
(503) 721-7161 (800) 794-5390

## ***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.

**APPLICANT SIGNATURE\*:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**APPLICANT'S 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.

**SPOUSE / DOMESTIC PARTNER SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SPOUSE / DOMESTIC PARTNER 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.)



# Regence

Life and Health Insurance Company

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100 SW Market St.  
P.O. Box 1271, MS E-3A  
Portland, OR 97207-1271  
(503) 721-7161 • 1 (800) 794-5390

## AFFIDAVIT OF NON-STATE CERTIFIED DOMESTIC PARTNERSHIP

An Affidavit of Non-State Certified Domestic Partnership is required before any domestic partner benefits may be granted for non-state certified domestic partners. One affidavit may be used for any of the insurance benefits available to domestic partners.

Name of Policyholder: \_\_\_\_\_

Domestic Partner's Name: \_\_\_\_\_ Date Domestic Partnership Began \_\_\_\_\_

I certify that (name of Domestic Partner) \_\_\_\_\_ and I are domestic partners and that we meet the following criteria:

- We are each 18 years of age or older;
- We share a close personal relationship and are responsible for each other's common welfare;
- We are each other's sole domestic partner;
- We share the same regular and permanent residence, with the current intent to continue doing so indefinitely;
- We are jointly financially responsible for "basic living expenses" including food, shelter, and medical expenses;
- We are not legally married to anyone, nor have had another domestic partner within the previous 30 days;
- We are not related by blood closer than would bar marriage in our state of residence; and
- We were both mentally competent to contract when our domestic partnership began.

### CHANGE IN DOMESTIC PARTNERSHIP:

I (name of Policyholder) \_\_\_\_\_ agree to inform Regence Life and Health Insurance Company within 30 days of any change in our domestic partnership status that would make the domestic partner no longer eligible for benefits by filing a *Termination of Non-State Certified Domestic Partnership Statement*.

Upon termination or dissolution of this domestic partnership, the policyholder named herein agrees that he/she cannot file another affidavit for a minimum of 90 days from the date of termination.

### ACKNOWLEDGEMENT:

We understand that this information will be held confidential and will be subject to disclosure only upon express written authorization, in any action involving the enrollment or eligibility of the domestic partner, or if otherwise required by law. We understand that this declaration of responsibility for our common welfare may have legal implications under State law. We further understand that a civil action may be brought against us for any losses, including reasonable attorney's fees, arising from false or misleading statements contained in the Affidavit of Non-State Certified Domestic Partnership. We also certify under penalty of perjury, under our State laws, that the foregoing is true and correct.

\_\_\_\_\_  
POLICYHOLDER'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DOMESTIC PARTNER'S SIGNATURE

\_\_\_\_\_  
DATE

Policyholder and Domestic Partner's Home Address:

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY

\_\_\_\_\_  
STATE

\_\_\_\_\_  
ZIP

Return your signed Affidavit of Non-State Certified Domestic Partnership to Regence Life and Health Insurance Company. Your completed affidavit should accompany any necessary applications.

**If you have questions about InterM<sup>SM</sup>,  
please contact your agent or local  
Regence sales representative,  
or call us at 1 (800) 794-5390**



**Regence**

*Life and Health Insurance Company*

Independent Licensee of the Blue Cross and Blue Shield Association

[www.regencelife.com](http://www.regencelife.com)

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