Lane County

Group No.: G0020828
Prime Plus S3
Effective: January 1, 2016

Third Party Administrative Services Provided By:

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INTRODUCTION

Lane County has established the Lane County Group Health Plan (referred to as the “Plan”) to provide health care coverage for Eligible Employees and their Dependents. This Plan is established effective January 1, 2016 (the “Effective Date”). Lane County is the Plan Sponsor.

Any words or phrases used in this Plan Document that appear with an initial capital letter, or which are in *italics*, are defined terms. All such words or phrases are defined in the Definitions section of this Plan Document (see the Table of Contents for exact location). The Plan Sponsor highly encourages you to read this Plan Document in its entirety and to ask any questions you may have to ensure you understand your rights, responsibilities, and the benefits available to you under the terms of this Plan.

Nature of the Plan

This Plan is an employee welfare benefit plan. This Plan is not governed by the Employee Retirement Income Security Act (“ERISA”). This Plan is a self-insured medical plan intended to meet the requirements of Sections 105(b), 105(h) and 106 of the Internal Revenue Code so that the portion of the cost of coverage paid by the Employer, and any benefits received by a Covered Individual through this Plan, are not taxable income to the Covered Individual. The specific tax treatment of any Covered Individual will depend on the individual's personal circumstances; the Plan does not guarantee any particular tax treatment. Covered Individuals are solely responsible for any and all federal, state, and local taxes attributable to their participation in this Plan, and the Plan expressly disclaims any liability for such taxes.

This Plan is "self-insured" which means benefits are paid from the Employer's general assets and/or trust funds and are not guaranteed by an insurance company. The Plan Sponsor, which is also the Plan Administrator, has contracted with the Third Party Administrator to perform certain administrative services related to this Plan.

PacificSource Health Plans (“PacificSource”) is the Third Party Administrator and will process Claims, manage the network of Health Care Providers, answer medical benefit and Claim questions, and to generally provide administrative services to the Plan. If anything is unclear to you, please contact the Plan Sponsor or the Third Party Administrator at the number or address available in this Introduction section.

Written Plan Document and SPD

This Plan Document contains both the written Plan Document and the Summary Plan Description (“SPD”). It is very important to review this Plan Document carefully to confirm a complete understanding of the benefits available, as well as your responsibilities, under this Plan.

This Plan Document consists of several pieces, all of which work together. The Summary of Benefits provides an overview of the key benefit provisions of the Plan and can give you a general idea of what the Plan covers and how it works. However, it is important to read the entire Plan Document, including the Definitions, to fully understand the Plan's coverage and benefits.

Non-Grandfathered Status of the Plan Under Health Care Reform

This Plan is not a "grandfathered health plan" under Health Care Reform. Questions regarding the Plan's status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272, or visit www.dol.gov/ebsa/healthreform.

Retention of Fiduciary Duties

The Plan Sponsor has retained all fiduciary duties under the Plan, including all interpretations of the Plan and the benefits and exclusions it contains. This means that the Plan Sponsor is solely responsible for all final decisions regarding what benefits are or will be covered, both now and in the future. The Plan Sponsor is solely responsible for the design of the Plan. Plan Sponsor is solely responsible for setting any and all criteria used to determine enrollment and eligibility.

Questions?

PacificSource's customer service representatives are available to answer questions or concerns regarding the Plan. Phone lines are open from 8 a.m. to 5 p.m. Monday through Friday (excluding holidays). PacificSource's customer service representatives are not authorized to interpret or change the terms of the Plan.

For enrollment or eligibility questions, please contact us.

PacificSource Customer Service Department
Phone (541) 684-5582 or (888) 977-9299
Email cs@pacificsource.com
PacificSource Headquarters
PO Box 7068, Springfield, OR 97475-0068
Phone (541) 686-1242 or (800) 624-6052

Website
PacificSource.com

As used in this Plan Document, the word 'year' refers to the contract year, which is the 12-month period beginning August 1 and ending July 31. The word lifetime as used in this document refers to the period of time you or your eligible family members participate in this Plan or any other plan offered by the Plan Sponsor.

Representations not warranties: In the absence of fraud, all statements made by the Plan Sponsor will be considered representations and not warranties. No statement made for the purpose of effecting coverage will void the coverage or reduce benefits unless it is contained in a written document signed by the Plan Sponsor and a provided to a member.

The Plan Sponsor reserves the right to amend, modify, or terminate this plan in any manner, at any time, which may result in termination or modification of your coverage. If such changes or modifications occur the Plan Sponsor will provide notification within 60 days prior to any changes or modifications to the plan. Any and all changes or modifications will continue to comply with ORS 743 and 743A.

If this plan is terminated, any plan assets will be used to pay for eligible expenses incurred prior to the plan's termination, and such expenses will be paid as provided under the terms of this plan prior to termination. To the extent that any plan assets remain, they will be used for the benefit of members in accordance with ERISA. If there is any conflict between this document and the underlying plan document(s), the plan document(s) control.

Para asistirle en español, por favor llame el nùmero (800) 624-6052, extensión 5456.

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MEDICAL BENEFIT SUMMARY

PLAN INFORMATION

Group Name:	Lane County
Group Number:	G0020828
Plan Name:	Prime Plus S3
Provider Networks:	Prime Network

EMPLOYEE ELIGIBILITY REQUIREMENTS

Minimum Hour Requirement:	20 hours per week
Waiting Period for New Employees:	First of the month following 30 days. If the last day of the waiting period falls on the first calendar day of a month, coverage begins on that day.

Annual Deductible	Per Person, Per Calendar Year	Per Family, Per Calendar Year
All Participating Providers	$250	$750
Out-of-Pocket Limit	**Per Person, Per Calendar Year**	**Per Family, Per Calendar Year**
All Participating Providers	$2,000	$6,000

The member is responsible for the above deductible and the following co-insurance:

Service	Participating Providers:	Non-participating Providers:
Preventive Care		
Well baby/Well child care	No charge	Deductible then 50% co-insurance
Routine physicals	No charge	Deductible then 50% co-insurance
Well woman visits	No charge	Deductible then 50% co-insurance
Routine mammograms	No charge	Deductible then 50% co-insurance
Immunizations	No charge	Deductible then 50% co-insurance
Routine colonoscopy, age 50-75	No charge	Deductible then 50% co-insurance
Prostate cancer screening	No charge	Deductible then 50% co-insurance
Professional Services		
Office and home visits	$25 co-pay/visit*	Deductible then 50% co-insurance
Naturopath office visits	$25 co-pay/visit*	Deductible then 50% co-insurance
Specialist office and home visits	$25 co-pay/visit*	Deductible then 50% co-insurance
Office procedures and supplies	No charge*	Deductible then 50% co-insurance
Surgery	Deductible then 20% co-insurance	Deductible then 50% co-insurance

Outpatient rehabilitation services	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Hospital Services		
Inpatient room and board	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Inpatient rehabilitation services	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Skilled nursing facility care	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Outpatient Services		
Outpatient surgery/services	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Advanced diagnostic imaging	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Diagnostic lab and therapeutic radiology	No charge up to the first $500 then Deductible then 20% co-insurance	Deductible then 50% co-insurance
Urgent and Emergency Services		
Urgent care center visits	$25 co-pay/visit*	Deductible then 50% co-insurance
Emergency room visits – Medical Emergency	$250 co-pay/visit*^	$250 co-pay/visit*^
Emergency room visits – Non-Emergency	$250 co-pay/visit*^	Deductible then 50% co-insurance^
Ambulance, ground	Deductible then 20% co-insurance	Deductible then 20% co-insurance
Ambulance, air	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Maternity Services**		
Physician/Provider services (global charge)	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Hospital/Facility services	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Mental Health/Chemical Dependency Services		
Office visits	$25 co-pay/visit*	Deductible then 50% co-insurance
Inpatient care	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Residential programs	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Other Covered Services		
Allergy injections	$5 co-pay/visit*	Deductible then 50% co-insurance
Durable medical equipment	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Home health care	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Infertility treatment	Deductible then 50% co-insurance	Not Covered
Chiropractic manipulations and Acupuncture	$25 co-pay/visit*	Not Covered
Temporomandibular joint	Deductible then 50% co-insurance	Not Covered
Transplants	Deductible then No Charge	Deductible then 50% co-insurance

^ *Copay waived is admitted into hospital. For emergency medical conditions, non-participating providers are paid at the participating provider level.*

* *Not subject to the annual deductible.*

***Medically necessary services, medication, and supplies to manage diabetes during pregnancy from conception through 6 weeks postpartum will not be subject to a deductible, co-payment, or co-insurance.*

This is a brief summary of benefits. Refer to this Plan Document for additional information or a further explanation of benefits, limitations, and exclusions.

Additional Information

What is the annual deductible?

This Plan's deductible is the amount of money that you pay first, before this Plan starts to pay. You'll see that some services, especially preventive care, are covered by this Plan without you needing to meet the deductible. The individual deductible limit applies only if you enroll without dependents. If you and one or more dependents enroll, the individual deductible applies for each member only until the family deductible has been met. Deductible expense is applied to the out-of-pocket limit.

Participating provider expense and non-participating provider expense apply together toward your deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered medical expenses during the calendar year. Once the out-of-pocket limit has been met, this Plan will pay 100 percent of covered charges for the rest of that year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, the individual out-of-pocket limits apply until the family out-of-pocket limit has been met. Be sure to check this Plan Document, as there are some charges, such as non-essential health benefits, penalties and balance billed amounts that do not count toward the out-of-pocket limit.

Participating provider expense and non-participating provider expense apply together toward your out-of-pocket limits.

CHIROPRACTIC MANIPULATION / ACUPUNCTURE SUMMARY

This Plan allows you to receive services from licensed providers for chiropractic manipulations and acupuncture for medically necessary treatment of illness or injury. The service must be within the scope of the provider's license. Refer to the Medical Benefit Summary for your co-payment and/or co-insurance information.

Covered Services

- Acupuncture from a licensed provider when necessary for treatment of illness or injury.
- Chiropractic manipulations from a licensed provider for medically necessary treatment of illness or injury.

The combined benefit for all chiropractic manipulation and acupuncture care is limited to $500 per person in any calendar year.

Excluded Services

- Any service or supply noted as being excluded or not otherwise covered by the medical plan.
- Homeopathic medicines or homeopathic supplies.
- Massage therapy.

PRESCRIPTION DRUG BENEFIT SUMMARY

The Plan includes coverage for prescription drugs on the Preferred Drug List and certain other pharmaceuticals, subject to the information below. This prescription drug Plan qualifies as creditable coverage for Medicare Part D.

The amount you pay for covered prescriptions at participating pharmacies applies toward this Plan's participating medical out-of-pocket limit, shown on the Medical Benefit Summary. The co-payment and/or co-insurance for prescription drugs obtained from a participating pharmacy are waived during the remainder of a calendar year in which you have satisfied the medical out-of-pocket limit.

Each time a covered pharmaceutical is dispensed, you are responsible for the co-payment and/or co-insurance below:

	Tier 1: Generic	Tier 2: Preferred	Tier 3: Non-preferred
Participating Retail Pharmacy^			
Up to a 30 day supply:	$15 co-pay	$30 co-pay	$35 co-pay
31 to 60 day supply:	$30 co-pay	$60 co-pay	$70 co-pay
61 to 90 day supply:	$45 co-pay	$90 co-pay	$105 co-pay
Participating Mail Order Service			
Up to a 45 day supply:	$15 co-pay	$30 co-pay	$35 co-pay
46 to 90 day supply:	$30 co-pay	$60 co-pay	$70 co-pay
Non-participating Pharmacy or Participating Pharmacy without using the PacificSource Pharmacy Program			
Regardless of tier or day(s) supply:	50% or retail co-pay, whichever is greater		
Specialty Drugs – Participating Specialty Pharmacy			
Up to a 30 day supply:	Same as retail		
Specialty Drugs – Not filled through Participating Specialty Pharmacy			
Regardless of tier or day(s) supply:	50% or retail co-pay, whichever is greater		

^ Remember to show your PacificSource ID Card each time you fill a prescription at a retail pharmacy.

MAC C – Regardless of the reason or medical necessity, if you receive a brand name drug or if your physician prescribes a brand name drug when a generic is available, you will be responsible for the brand name drug's co-payment and/or co-insurance.

This is a brief summary of benefits. Refer to the Plan Document for additional information or a further explanation of benefits, limitations, and exclusions.

VISION BENEFIT SUMMARY

The following shows the vision benefit available under this Plan for enrolled members for all vision exams furnished during any calendar year when performed or prescribed by a licensed ophthalmologist or licensed optometrist. Co-payment and/or co-insurance for covered charges apply to this Plan's medical out-of-pocket limit.

If charges for a service or supply are less than the amount allowed, the benefit will be equal to the actual charge. If charges for a service or supply are greater than the amount allowed, the expense above the allowed amount is the member's responsibility and will not apply toward the member's medical out-of pocket limit.

Member Responsibility

Service/Supply	Participating Providers	Non-Participating Providers
Enrolled Members Through Age 18		
Eye Exam	$15 co-pay*	30% co-insurance*
Enrolled Members Age 19 and Older		
Eye Exam	$15 co-pay*	30% co-insurance*

*Not subject to annual medical deductible.

Benefit Limitations: enrolled members through age 18

- One vision exam every calendar year

Benefit Limitations: enrolled members age 19 and older

- One vision exam every calendar year

Exclusions

- Lenses, frames, or contact lenses
- Special procedures such as orthoptics or vision training
- Visual analysis that does not include refraction
- Services or supplies not listed as covered expenses
- Eye exams required as a condition of employment, required by a labor agreement or government body
- Expenses covered under any worker's compensation law
- Services or supplies received before this Plan's coverage begins or after it ends
- Charges for services or supplies covered in whole or in part under any medical or vision benefits provided by the employer
- Medical or surgical treatment of the eye

Important information about your vision benefits

Participating Providers

This Plan is able to add value to your vision benefits by contracting with a network of vision providers. Those providers offer vision services at discounted rates, which are passed on to you in your benefits.

Paying for Services

Please remember to show your current PacificSource ID card whenever you use this Plan's benefits. PacificSource provider contracts require participating providers to bill PacificSource directly whenever you receive covered services and supplies. Providers normally call PacificSource to verify your vision benefits and then bill PacificSource directly. Participating providers should not ask you to pay the full cost in advance. They may only collect your share of the expense up front, such as copayments and amounts over this Plan's allowances. If you are asked to pay the entire amount in advance, tell the provider you understand they have a contract with PacificSource and should bill PacificSource directly.

Sales and Special Promotions

Vision retailers often use coupons and promotions to bring in new business, such as free eye exams, two-for-one glasses, or free lenses with purchase of frames. Because participating providers already discount their services through their contract with PacificSource, your participating provider benefits cannot be combined with any other discounts or coupons. You can use your participating provider benefits, or you can use your non-participating provider benefits to take advantage of a sale or coupon offer. If you do take advantage of a special offer, the participating provider may treat you as a non-covered customer and require full payment in advance. You can then send the claim to PacificSource yourself, and this Plan will reimburse you according to this Plan's benefits.

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BECOMING ELIGIBLE

Who Pays for Your Benefits

The Plan Sponsor shares the cost of providing benefits for you and your enrolled family members. From time to time, the Plan Sponsor may adjust the amount of contributions required for coverage. In addition, this Plans co-payments and co-insurance may also change periodically. You will be notified by the Plan Sponsor of any changes in the cost this Plan's coverage before they take effect.

Employees

Your status as an Employee is determined by the employment records maintained by the Plan Sponsor. Workers classified by the Plan Sponsor as independent contractors are not eligible for coverage under this Plan under any circumstances. The Plan Sponsor decides the minimum number of hours employees must work each week to be eligible for health benefits. The Plan Sponsor may also require new employees to satisfy a waiting period called the 'probationary waiting period' before they are eligible for benefits. The Plan Sponsor's eligibility requirements, including the length of the probationary waiting period are shown in your Medical Benefit Summary. All employees who meet those requirements are eligible for coverage.

Family members

While you are covered under this Plan, the following family members are also eligible for coverage:

- Your legal spouse or Qualified Domestic Partner.
- Your, your spouse's, or your Qualified Domestic Partner's natural or step children under age 26 regardless of the child's place of residence, marital status, or financial dependence on you.
- Your, your spouse's, or your Qualified Domestic Partner's unmarried dependent children age 26 or over who are mentally or physically disabled. To qualify as dependents, they must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability. The Plan Sponsor requires documentation of the disability from the child's physician, and will review the case before determining eligibility for coverage.
- A child placed for adoption with you, your spouse, or your Qualified Domestic Partner. Placement for adoption means the assumption and retention by you, your spouse, or Qualified Domestic Partner of a legal obligation for full or partial support and care of the child in anticipation of adoption of the child. Coverage will continue assuming continued eligibility under this Plan unless placement is disrupted prior to legal adoption and the child is removed from placement.
- A foster child placed with you, your spouse, or your Qualified Domestic Partner. Placement means an individual who is placed by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. Coverage will continue assuming continued eligibility under this Plan unless placement is disrupted and the child is removed from placement.
- A child placed in your, your spouse's, or your Qualified Domestic Partner's guardianship. To be eligible for coverage, the child must be unmarried; not in a Qualified Domestic

Partnership; related to you by blood, marriage, or Qualified Domestic Partnership; under age 19; AND for whom you are the court appointed legal custodian or guardian with the expectation the child will live in your household for at least a year.

No family or household members other than those listed above are eligible to enroll under your coverage.

Special Rules for Eligibility

At any time the Plan Administrator may require proof that a person qualifies, or continues to qualify, as a dependent as defined by this Plan.

ENROLLING DURING THE INITIAL ENROLLMENT PERIOD

Once you satisfy the Plan Sponsor's probationary waiting period, and meet the hours required for eligibility, you and your eligible family members become eligible for coverage under this Plan. Starting on the date you become eligible, you and your family members have 31 days to enroll. The Plan Sponsor calls this 31 day window the initial enrollment period. To enroll you must submit the completed enrollment application to the Plan Sponsor. The Plan Sponsor will send the application to PacificSource.

If you miss your initial enrollment period, you will not be able to enroll in the Plan later in the year, unless you have a special circumstance, called a 'qualifying event'. (For more information, see 'Special Enrollment Periods' and 'Late Enrollment' under the Enrolling After the Initial Enrollment Period section.)

Coverage for you and your enrolling family members begins on the first day of the month after you satisfy the Plan Sponsor's probationary waiting period. The length of the probationary waiting period is stated in your Medical Benefit Summary. Coverage will only begin if the Plan Sponsor receives your completed enrollment application, and forwards it to PacificSource.

ENROLLING NEW FAMILY MEMBERS

Newborns

Your eligible newborn child is eligible for coverage from the moment of birth for 31 days. To enroll this child, the Plan Sponsor must receive your completed enrollment application and any additional premium within 60 days of the child's birth and prorated for the first month. A claim for maternity care is not considered notification for the purpose of enrolling a newborn child. Anytime there is a delay in providing enrollment information, the Plan Sponsor may ask for legal documentation to confirm validity.

Adopted Children

When a child is placed in your home for adoption, you have 60 days from the date of placement to enroll them in the Plan. To enroll the child, the Plan Sponsor must receive your completed enrollment application within 60 days of the placement. If additional premium is required, it is charged from the date of placement and prorated for the first month. Coverage for your new family members will begin on the date of placement. You may be required to submit a copy of the certificate of adoption or other legal documentation from a court or a child placement agency to complete enrollment.

Foster Children

When a foster child is placed in your home, you have 60 days from the date of placement to enroll them in this Plan. To enroll the child, the Plan Sponsor must receive your completed enrollment application and any additional premium from you within 60 days of the placement. If additional premium is required, it is charged from the date of birth or placement and prorated for the first month. Coverage for your new family members will begin on the date of placement. You may be required to submit a copy of the legal documentation from a court or a child placement agency to complete enrollment.

Family Members Acquired by Marriage

If you marry, you have 60 days from the date of the marriage to enroll your new spouse and any newly eligible dependent children in this Plan. The Plan Sponsor must receive your completed enrollment application and any additional premium from you within 60 days of the marriage. Coverage for your new family members will then begin on the first day of the month after the date of the marriage as evidenced on your marriage certificate. You may be required to submit a copy of your marriage certificate to complete enrollment.

Family Members Acquired by Qualified Domestic Partnership

If you and your same-gender Domestic Partner have been issued a Certificate of Registered Domestic Partnership, your Domestic Partner and your partner's dependent children are eligible for coverage during the 60 day initial enrollment period after the registration of the domestic partnership. The Plan Sponsor must receive your completed enrollment information and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the month after the registration of the Domestic Partnership. You may be required to submit a copy of your Certificate of Registered Domestic Partnership to complete enrollment.

Unregistered Domestic Partners and their children may also become eligible for enrollment. If you and your Unregistered Domestic Partner meet the criteria on the Affidavit of Domestic Partnership supplied by your employer, your Domestic Partner and your partner's dependent children are eligible for coverage during the 60 day initial enrollment period after the requirements of the Affidavit of Domestic Partnership are satisfied. The Plan Sponsor must receive your completed enrollment information, a copy of your Affidavit of Domestic Partnership, and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the month after the Affidavit of Domestic Partnership is received by the Plan Sponsor.

Family Members Placed in Your Guardianship

If a court appoints you custodian or guardian of an eligible dependent child, you have 60 days from the court appointment to enroll them in this Plan. The Plan Sponsor must receive your completed enrollment application and any additional premium from you within 60 days of the court appointment. Coverage will then begin on the first day of the month after the date of the court order. You may be required to submit a copy of the court order to complete enrollment. When the court order terminates or expires, the child is no longer eligible for coverage under this Plan.

Qualified Medical Child Support Orders

This Plan complies with qualified medical child support orders (QMCSO) issued by a state court or state child support agency. A QMCSO is a judgment, decree, or order, including

approval of a settlement agreement, which provides for health benefit coverage for the child of a member of this Plan.

If a court or state agency orders coverage for your spouse, Qualified Domestic Partner, or child, you have 60 days from the date of the court order to enroll them in this Plan. The Plan Sponsor must receive your completed enrollment application and any additional premium from you within 60 days of the court order. Coverage will become effective on the first day of the month after the date of the court order. You may be required to submit a copy of the QMCSO to complete enrollment.

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD

Returning to Work after a Layoff

If you are laid off and then rehired by the Plan Sponsor within six months, you will not have to satisfy another probationary waiting period.

Your health coverage will resume the first day of the month after you return to work AND again meet the Plan Sponsor's minimum hour requirement. If your family members were covered before your layoff, they can resume coverage at that time as well. If your family members were not covered before your layoff, they will have a special enrollment period to enroll on the Plan. You must re-enroll your family members by submitting your enrollment application within the 31 day initial enrollment period following your return to work.

Returning to Work after a Leave of Absence

If you return to work after a Plan Sponsor-approved leave of absence of three months or less, you will not have to satisfy another probationary waiting period. Your health coverage will resume the first day of the month after you return to work AND again meet the Plan Sponsor's minimum hour requirement. If your family members were covered before your leave of absence, they can resume coverage at that time as well. You must re-enroll your family members by submitting your enrollment application to the Plan Sponsor within the 31 day initial enrollment period following your return to work.

Returning to Work after Family Medical Leave

If the Plan Sponsor employs 50 or more people, it is probably subject to the Family Medical Leave Act (FMLA). To find out if you have rights under FMLA, contact your Human Resources Department or health Plan Administrator. Under FMLA, if you return to work after a qualifying FMLA medical leave, you will not have to satisfy another probationary waiting period under this Plan. Your health coverage will resume the day you return to work AND meet your employer's minimum hour requirement. If your family members were covered before your leave, they can also resume coverage at that time if you re-enroll them by submitting a completed enrollment application to the Plan Sponsor within the 31 day initial enrollment period following your return.

Status Change

If you are a part-time employee who has declined coverage, you may enroll if you move to full-time status by submitting an enrollment application to the Plan Sponsor within the 31 days following the change in your employment status. Coverage is effective the first of the month following the change in your employment status. Full-time employees must enroll during their initial enrollment period.

Special Enrollment Periods

If you enroll during your initial enrollment period, your family members may decline coverage, and they may enroll in the Plan later if they qualify under the Special Enrollment Rules below. Employees are allowed to waive medical coverage and enroll in dental only if the employee has an eligible waiver.

- Special Enrollment Rule #1

  If you declined enrollment for yourself or your family members because of other health coverage, you or your family members may enroll in the Plan later if the other coverage ends. To do so, you must submit a completed enrollment application to the Plan Sponsor within 60 days after the other health coverage ends (or within 60 days after the other health coverage ends if the other coverage is through Medicaid or a State Children's Health Insurance Program). Coverage will begin on the first day of the month after the other coverage ends.

- Special Enrollment Rule #2

  If you acquire new family members because of marriage, newly Qualified Domestic Partnership, birth, placement of foster child, or placement for adoption, you may be able to enroll yourself and/or your newly acquired family members at that time. To do so, you must submit a completed enrollment application to the Plan Sponsor within 60 days after the marriage, qualification of the Domestic Partnership, birth, placement of foster child, or placement for adoption. In the case of marriage or Qualified Domestic Partnership, coverage begins on the first day of the month after the marriage or qualification of the Domestic Partnership. In the case of birth, placement of foster child, or placement for adoption, coverage begins on the date of birth or placement.

- Special Enrollment Rule #3

  If you or your family members become eligible for a premium assistance subsidy under Medicaid or a state Children's Health Insurance Program (CHIP), you may be able to enroll yourself and/or your family members at that time. To do so, you must submit a completed enrollment application to the Plan Sponsor within 60 days of the date you and/or your family members become eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Late Enrollment

If you did not enroll during your initial enrollment period and you do not qualify for a special enrollment period, your enrollment will be delayed until the Plan's next designated open enrollment period.

A 'late enrollee' is an otherwise eligible employee or family member who does not qualify for a special enrollment period explained above, and who:

- Did not enroll during the initial enrollment period; or
- Enrolled during the initial enrollment period but discontinued coverage later.

A late enrollee may enroll by submitting a completed enrollment application to the Plan Sponsor during the open enrollment period. When you or your family members enroll during the open enrollment period, coverage becomes effective the first day of the contract year.

PLAN SELECTION PERIOD

If the Plan Sponsor offers more than one benefit plan option and allows you to do so, you may choose another plan option only upon this Plan's anniversary date. You may select a different plan option by completing a selection form or application form and submitting it to the Plan Sponsor. Coverage under the new plan option becomes effective on this Plan's anniversary date.

WHEN COVERAGE ENDS

If you leave your job for any reason or your work hours are reduced below the Plan Sponsor's minimum requirement, coverage for you and your enrolled family members will end. Coverage ends on the last day of the last month in which you worked full time and for which a premium was paid. You may, however, be eligible to continue coverage for a limited time; please see the Continuation section of this Plan Document for more information.

Divorced Spouses

If you divorce, coverage for your spouse will end on the last day of the month in which the divorce decree or legal separation is final. You must notify the Plan Sponsor of the divorce or separation, and continuation coverage may be available for your spouse. If there are special child custody circumstances, contact the Plan Sponsor. Please see the Continuation section for more information.

Dependent Children

When your enrolled child no longer qualifies as a dependent, their coverage will end on the last day of that month. Please see the Eligibility section of this Plan Document for information on when your dependent child is eligible beyond age 25. The Continuation section includes information on other coverage options for those children who no longer qualify for coverage.

Dissolution of Qualified Domestic Partnership

If you dissolve your Qualified Domestic Partnership, coverage for your Qualified Domestic Partner and their children not related to you by birth or adoption will end on the last day of the month in which the dissolution of the Qualified Domestic Partnership is final. You must notify your employer of the dissolution of the Qualified Domestic Partnership. Qualified Domestic Partners and their covered children are not recognized as qualified beneficiaries under federal COBRA continuation laws. Qualified Domestic Partners and their covered children may not continue this Plan's coverage under COBRA independent of the employee.

CONTINUATION OF COVERAGE

Under applicable state and federal law, you and your family members may have the right to continue this Plan's coverage for a specified time. You and your family members may be eligible if:

- Your employment ends or you have a reduction in hours;
- You take a leave of absence for military service;
- You divorce or dissolve your Qualified Domestic Partnership;

- You die;
- You become eligible for Medicare benefits if it causes a loss of coverage for your family members; or
- Your children no longer qualify as dependents.

The following sections describe your rights to continuation under applicable state and federal law, and the requirements you must meet to enroll in continuation coverage.

USERRA CONTINUATION

If you take a leave of absence from your job due to military service, you have continuation rights under the Uniformed Services Employment and Re-employment Rights Act (USERRA).

You and your enrolled family members may continue this Plan's coverage if you, the employee, no longer qualify for coverage under the Plan because of military service. Continuation coverage under USERRA is available for up to 24 months while you are on military leave. If your military service ends and you do not return to work, your eligibility for USERRA continuation coverage will end. Premium for continuation coverage is your responsibility.

The following requirements apply to USERRA continuation:

- Family members who were not enrolled in this Plan cannot take continuation. The only exceptions are newborn babies and newly acquired eligible family members not covered by another group health plan.
- To apply for continuation, you must submit a completed Continuation Election Form to the Plan Sponsor within 31 days after the last day of coverage under this Plan. You must pay continuation premium to the Plan Sponsor by the first of each month. PacificSource cannot accept the premium directly from you.
- The Plan Sponsor must still be self-insured. If the Plan Sponsor discontinues this Plan, you will no longer qualify for continuation.

SURVIVING OR DIVORCED SPOUSES

If your group has 20 or more employees, or this Plan has 20 or more subscribers, and you die, divorce, and your spouse is 55 years or older, your spouse may be able to continue coverage until eligible for Medicare or other coverage. Dependent children are subject to the Plan's age and other eligibility requirements. Some restrictions and guidelines apply; please see the Plan Sponsor for specific details.

COBRA CONTINUATION

This Plan is subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. To find out if you have continuation rights under COBRA, ask your Human Resources Department or health Plan Administrator.

COBRA Eligibility

A ‘qualifying event’ is the event that causes your regular group coverage to end and makes you eligible for continuation coverage. When the following qualifying events happen, you may continue coverage for the lengths of time shown:

Qualifying Event	**Continuation Period**
Employee’s termination of employment or reduction in hours	Employee, spouse, and children may continue for up to 18 months[1]
Employee’s divorce	Spouse and C/children may continue for up to 36 months[2]
Employee’s eligibility for Medicare benefits if it causes a loss of coverage	Spouse and C/children may continue for up to 36 months
Employee’s death	Spouse and C/children may continue for up to 36 months[2]
Child no longer qualifies as a dependent	Child may continue for up to 36 months[2]

[1] If the employee or covered family member is determined disabled by the Social Security Administration within the first 60 days of COBRA coverage, all qualified beneficiaries may continue coverage for up to 29 months.

[2] The total maximum continuation period is 36 months, even if there is a second qualifying event. A second qualifying event might be a divorce, death, or child no longer qualifying as a dependent after the employee’s termination or reduction in hours.

If your family members were not covered prior to your qualifying event, they may enroll in the continuation coverage while you are on continuation. They will be subject to the same rules that apply to active employees, including the late enrollment waiting period.

If your employment is terminated for gross misconduct, you and your family members are not eligible for COBRA continuation.

Qualified Domestic Partner‘s and their covered children may not continue this Plan’s coverage under COBRA independent of the employee.

When Continuation Coverage Ends

Your continuation coverage will end before the end of the continuation period above if any of the following occur:

- Your continuation premium is not paid on time.
- You become entitled to Medicare benefits.
- The Plan Sponsor discontinues this Plan and no longer offers a group health plan to any of its employees.
- Your continuation period was extended from 18 to 29 months due to disability, and you are no longer considered disabled.

Type of Coverage

Under COBRA, you may continue any coverage you had before the qualifying event. If the Plan Sponsor provides both medical and dental coverage and you were enrolled in both, you may continue both medical and dental. If the Plan Sponsor provides only one type of coverage, or if you were enrolled in only one type of coverage, you may continue only that coverage. If the Plan Sponsor offers more than one benefit plan to eligible employees, a member electing COBRA may select enrollment for another plan at the time the member elects COBRA coverage. Members electing COBRA may not add family members at this time unless they otherwise qualify under the 'Special Enrollment' provisions of the policy.

COBRA continuation benefits are always the same as your employer's current benefits. The Plan Sponsor has the right to change the benefits of this Plan or eliminate the Plan entirely. If that happens, any changes to the Plan will also apply to everyone enrolled in continuation coverage.

Your Responsibilities and Deadlines

You must notify the Plan Sponsor within 60 days if you divorce, or if your child no longer qualifies as a dependent. That will allow the Plan Sponsor to notify you or your family members of your continuation rights.

When the Plan Sponsor learns of your eligibility for continuation, it will notify you of your continuation rights and provide a Continuation Election Form. You then have 60 days from that date or 60 days from the date coverage would otherwise end, whichever is later, to enroll in continuation coverage by submitting a completed Election Form to the Plan Sponsor. If continuation coverage is not elected during that 60 day period, coverage will end on the last day of the last month you were an active employee.

If you fail to provide the Plan Sponsor with the Continuation Election Form in the required timeframe, then the Plan Sponsor's obligation to provide you with COBRA coverage will end. PacificSource does not accept any liability for any failure, on your part or the part of the Plan Sponsor, to provide required notices or coverage.

Continuation Premium

Eligible individuals are responsible for the full cost of continuation coverage. The Plan Sponsor uses the services of a third-party COBRA administrator to collect premium for continuation coverage. Please see the Plan Sponsor for more information about the Plan's COBRA administrator. The monthly premium must be paid to the Plan Sponsor's COBRA administrator. You may make your first premium payment any time within 45 days after you return your Continuation Election Form to the Plan Sponsor's COBRA administrator. After the first premium payment, each monthly payment must reach the Plan Sponsor's COBRA administrator within 30 days of your premium due date. If the COBRA administrator does not receive your continuation premium on time, continuation coverage will end. If your coverage is canceled due to a missed payment, it will not be reinstated for any reason. It is solely your responsibility to ensure that the COBRA administrator receives the premium on time.

Keep the Plan Sponsor Informed of Any Address Changes

It is your responsibility to ensure that you keep the Plan Sponsor informed of any changes in your mailing address, and the mailing address of any dependents covered by your health coverage. You should also keep a copy of any notices you send to the Plan Sponsor along with proof of transmission or mailing.

CONTINUATION WHEN YOU RETIRE

If you retire, you and your covered dependents are eligible to continue coverage subject to the following:

- You must apply for continued coverage within 60 days after retirement.
- You must be receiving benefits from PERS (Public Employee Retirement System) or from a similar retirement plan offered by this *Plan Sponsor.*

- You must have been continuously covered under this *Plan Sponsor*'s group benefit Plan for at least 24 consecutive months prior to retirement.
- You must have at least 30 years of continuous service with Lane County.
- You must be at least 55 years of age.
- You must continue on the same benefit Plan you had at the time of retirement and may not transfer to another plan offered by the Policyholder. If the Plan's benefits are changed by the Plan Sponsor, your benefits will change accordingly.
- Your dependents may not elect coverage independent of you. If you do not elect coverage, Continuation coverage may be available for your spouse, Qualified Domestic Partner, and/or dependents (see Continuation of Coverage provisions).
- Except for newly acquired dependents due to marriage, Qualified Domestic Partnership, birth, or adoption, only your dependents who were covered at the time of retirement may continue coverage under this provision. You may add a new spouse, Qualified Domestic Partner, or other newly acquired dependent after retirement if family coverage is available. A completed enrollment application must be submitted within 60 days of the date of marriage, Qualified Domestic Partnership, birth, or adoption. If you do not add your new spouse, Qualified Domestic Partner, or other newly acquired dependent when they are first eligible, they will be subject to the same late enrollment rules as active employees.

Your continuation coverage will end when any one of the following occurs:

- When full premium is not paid or when your coverage is voluntarily terminated, your coverage will end on the last day of the month for which premium was paid.
- When you become eligible for Medicare coverage or turn 65 years of age, your coverage will end on the last day of the month preceding Medicare eligibility or following your 65th birthday.
- When the regular group Plan is terminated, your coverage will end on the date of termination.

Your dependent’s continuation coverage will end when any one of the following occurs:

- When full premium for the dependent is not paid or when the dependent’s coverage is voluntarily terminated by you or your dependent, coverage will end on the last day of the month for which premium was paid.
- When your dependent becomes eligible for Medicare coverage or turns 65 years of age, your dependent's coverage will end on the last day of the month preceding Medicare eligibility or following your dependent's 65th birthday.
- When you die, divorce, or dissolve your domestic partnership, your dependent's coverage will end on the last day of the month following the death, divorce, or dissolution of the Qualified Domestic Partnership.
- When your dependent is otherwise no longer considered a dependent under the group plan, his or her coverage will end on the last day of the month of his or her eligibility. Continuation of coverage may be available under COBRA continuation (see Continuation of Coverage provisions).
- When the regular group Plan is terminated, your dependent’s coverage will end on the date of termination.

WORK STOPPAGE

Labor Unions

If you are a union member, you may have certain continuation rights in the event of a labor strike. Your union or Plan Sponsor is responsible for collecting your premium and can answer questions about coverage during the strike.

USING THE PROVIDER NETWORK

This section explains how this Plan's benefits differ when you use participating or non-participating providers and explains how we apply the reimbursement rate. This information is not meant to prevent you from seeking treatment from any provider if you are willing to take increased financial responsibility for the charges incurred. Your network name is listed at the beginning of the Medical Benefit Summary.

All healthcare providers are independent contractors. Neither the Plan Sponsor or PacificSource cannot be held liable for any claim for damages or injuries you experience while receiving medical care.

PARTICIPATING PROVIDERS

Participating providers contract with PacificSource to furnish medical services and supplies to members enrolled in this Plan for a set fee. That fee is called the contracted allowable fee. Participating providers agree not to charge more than the contracted allowable fee. Participating providers bill PacificSource directly, and are paid directly. When you receive covered services or supplies from a participating provider, you are only responsible for the amounts stated in your Medical Benefit Summary. Depending on the terms of this Plan, those amounts can include a deductible, co-payment, and/or co-insurance payment.

Certain providers have agreed to be part of the network shown at the beginning of the Medical Benefit Summary. To ensure the highest level of benefits access care from a participating provider, including Primary Care Practitioner (PCP), specialists and hospitals, or for other services. See the Medical Summary of Benefits for more details on this Plan.

PacificSource contracts directly and/or indirectly with participating providers throughout the Oregon, Idaho, and Montana service areas and in bordering communities in southwest Washington. They also have an agreement with nationwide provider networks which includes more than 550,000 participating physicians and 5,000 participating hospitals. These providers outside the service area are also considered PacificSource participating providers under this Plan.

It is not safe to assume that when you are treated at a participating medical facility, all services are performed by participating providers. Whenever possible, you should arrange for professional services such as surgery and anesthesiology, to be provided by a participating provider. Doing so will help you maximize your benefits and limit your out-of-pocket expenses.

Risk-sharing Arrangements

By agreement, a participating provider may not bill a member for any amount in excess of the contracted allowable fee. However, the agreement does not prohibit the provider from collecting co-payments, deductibles, co-insurance, and non-covered services from the member.

REFERRALS

When you and your PCP decide that services of a specialist are necessary, your PCP will request a referral on your behalf. Your PCP will contact the appropriate referral management coordinator and request that you be referred to a participating specialist. If the referral is approved, you may see the specialist designated on the referral authorization. The referral authorization will specify which services may be performed by the specialist, such as consultations, tests, or surgery.

Services that Do Not Require a Referral

Referral authorization is not required for the following types of services or treatment, this list of procedures and services requiring referral is subject to revision and update:

- Anesthesia.
- Assistant surgeon.
- Diabetic education providers.
- Diagnostic testing, including but not limited to lab and radiology services, nerve conduction studies, treadmill tests, ECG testing and interpretation. Consultation with a specialist that results in a charge prior to or following diagnostic testing does require a referral. However, some services may require preauthorization.
- Emergency care is care which cannot be delayed due to injury or sudden illness, when a delay for the time required to reach a PCP or participating hospital would mean risking permanent damage to the patient's health.
- Mental health and chemical dependency outpatient services. You do not need a referral for office visits to a participating mental health or chemical dependency provider.
- Obstetric care and delivery. You do not need a referral to access maternity and delivery care from a participating women's healthcare provider. Women's healthcare providers include obstetricians, gynecologists, physician assistants specializing in women's health, and certified nurse midwives.
- Physical, occupational, and speech therapy.
- Routine vision exams and supplies (medical eye services do require referral unless emergency eye care. PacificSource will allow up to two (2) visits in a 30 day period without referral for acute vision changes or injury.)
- Services coordinated and provided within by your PCP.
- Services of a chiropractor or alternative care provider.
- Urgent care.
- Women's routine gynecological exams. You may visit your PCP or any participating women's healthcare provider without a referral for annual preventive gynecological exams.

Accessing Specialist Care without a Referral

If you are willing to pay more out of your own pocket, you may seek the care of a specialist without referral from your PCP. If services are performed by a specialist without an approved

referral authorization, benefits will be paid at the non-participating provider percentage stated in your Medical Benefit Summary. In this case, the non-participating benefit applies even if the specialist is a participating provider for this Plan. Keep in mind that services of non-participating providers are still subject to all the other limitations and exclusions that apply to covered services under this Plan.

URGENT AND EMERGENCY CARE

Your PCP is responsible for providing and arranging all your medical care, including urgent and emergency care whenever possible. This Plan does not cover routine healthcare rendered in a hospital emergency room or urgent care facility. By understanding the difference between urgent care and emergency care and following this Plan's guidelines for accessing treatment, you will maximize this Plan's benefits and keep your out-of-pocket costs to a minimum.

Urgent Care

Urgent care is unscheduled medical care for an illness, injury, or disease that a prudent layperson would consider non life-threatening and treatable at urgent care. Examples of urgent care situations include sprains, cuts, and illnesses that do not require immediate medical attention in order to prevent seriously damaging the health of the person.

In any medical situation when the patient's life or health is not in immediate danger, call your PCP first. If your PCP is unavailable, ask to speak to the physician on call. The physician will advise you where to go for medical treatment.

Emergency Care

Emergency care is care which cannot be delayed due to injury or sudden illness, when a delay for the time required to reach a PCP or participating hospital would mean risking permanent damage to the patient's health.

An *emergency medical condition* is an injury or sudden illness so severe that a prudent layperson with an average knowledge of health and medicine would expect that failure to receive immediate medical attention would risk seriously damaging the health of a person or fetus. Examples of emergency medical conditions include (but are not limited to):

- Convulsions or seizures;
- Difficulty breathing;
- Major traumatic injuries;
- Poisoning;
- Serious burns;
- Sudden abdominal or chest pains;
- Sudden fevers;
- Suspected heart attacks;
- Unconsciousness; or
- Unusual or heavy bleeding.

The following services are **not** considered emergency care: routine physical or eye exams, diagnostic work-ups for chronic conditions, routine prenatal care, elective surgery, and scheduled follow-up visits for emergency conditions.

If you need immediate assistance for an emergency medical condition, call 911. If you have an emergency medical condition, you should go directly to the nearest emergency room or appropriate facility and then call your PCP as soon as possible. Care for an emergency medical condition is covered subject to PCP or preferred provider deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary even if you are treated at a non-participating hospital.

If you are admitted to a non-participating hospital after your emergency condition is stabilized, the Plan may require you to transfer to a participating facility in order to continue receiving benefits at the Plan's highest benefit level.

NON-PARTICIPATING PROVIDERS

When you receive services or supplies from a non-participating provider, your out-of-pocket expense is likely to be higher than if you had used a participating provider. If the same services or supplies are available from a participating provider to whom you have reasonable access (explained in the next section), you may be responsible for more than the deductible, co-payment, and/or co-insurance amounts stated in your Medical Benefit Summary.

Allowable Fee for Non-participating Providers

To maximize this Plan's benefits, always make sure your healthcare provider is a participating provider on PacificSource's network. Do not assume all services at a participating facility are performed by participating providers.

PacificSource, as your Third Party Administrator, bases payment to non-participating providers on the 'allowable fee' which is derived from several sources to determine the allowable fee, depending on the service or supply and the geographical area where it is provided. The allowable fee may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), vendors, other nationally recognized databases, or PacificSource, as documented in PacificSource's payment policy.

In PacificSource's service areas the allowable fee for professional services is based on PacificSource's standard non-participating provider reimbursement rate. Outside the PacificSource service area and in areas where members do not have reasonable access to a participating provider through one of the third party provider networks, the allowable fee, depending upon the service and supply, can be based on data collected from PacificSource or other nationally recognized databases. If the service is based on the usual, customary, and reasonable charge (UCR) PacificSource will utilize the 85th percentile. UCR is based on data collected for a geographic area. Provider charges for each type of service are collected and ranked from lowest to highest. Charges at the 85th position in the ranking are considered to be the 85th percentile.

To calculate the payment to non-participating providers, PacificSource determines the allowable fee then subtracts the non-participating provider benefits shown in the 'Non-participating Provider' column of your Medical Benefit Summary. The allowable fee is often less than the non-participating provider's charge. In that case, the difference between the allowable fee and the provider's billed charge is also your responsibility. That amount does not count toward this Plan's out-of-pocket maximum. It also does not apply toward any deductibles or co-payments required by the Plan. In any case, after any co-payments or

deductibles, the amount the Plan pays to a non-participating provider will not be less than 50 percent of the allowable fee for a like service or supply.

To maximize this Plan's benefits, please check with PacificSource before receiving care from a non-participating provider. Their Customer Service Department can help you locate a participating provider in your area.

Example of Provider Payment

The following illustrates how payment could be made for the same service in two different settings: with a participating provider for this Plan, and with a non-participating provider. This is only an example; this Plan's benefits may be different.

	Participating Provider	**Non-participating Provider**
Provider's usual charge……	$120	$120
Billed charge after negotiated provider discounts..	$100	$120
PacificSource's allowable fee……....	$100	$100
Allowable fee less patient co-insurance……	$80	$50
Percent of payment ……..	80%	50%
The Plan's payment……...	**$80**	**$50**
Patient's responsibility:		
Co-insurance……..	20%	50%
Patient's amount of allowable fee……...	$20	$50
Difference between allowable fee and billed charge after discounts……..	$0	$20
Patient's total payment to provider……	**$20**	**$70**

When you receive covered services from a participating provider, you are only responsible for the amounts stated in your Medical Benefit Summary.

NETWORK NOT AVAILABLE

The term 'network not available' is used when a member does not have reasonable geographic access to a participating provider for a covered medical service or supply.

If you live in an area without access to a participating provider for a specific service or supply, this Plan's Network Not Available benefits apply. Here's how that works:

- You seek treatment from a nearby non-participating provider of that service or supply;
- PacificSource determines the allowable fee for that service or supply (the term 'allowable fee' is explained above under the Non-participating Providers section);
- Network Not Available payment is allowed when PacificSource has not contracted with providers in the geographical area of the member's residence or work for a specific service or supply. Payment to providers for Network Not Available is based on the usual, customary, and reasonable charge (see 'allowable fee' in the Definitions section) for the geographical area in which the charge is incurred.
- You are responsible for any co-payments, co-insurance, deductibles, and amounts over the allowable fee.

FINDING PARTICIPATING PROVIDER INFORMATION

You can find up-to-date participating provider information:

- By asking your healthcare provider if he or she is a participating provider for your network.
- On the PacificSource website, PacificSource.com. Simply click on 'Find a Provider' and you can easily look up participating providers, specialists, behavioral health providers, and hospitals. You can also print your own customized directory. PacificSource can even send you a text with the provider's location and contact number.
- By contacting the PacificSource Customer Service Department. Their staff can answer your questions about specific providers.

TERMINATION OF PROVIDER CONTRACTS

PacificSource, on behalf of the Plan Sponsor, will notify you within ten days of learning of the termination of a provider contractual relationship if you have received services in the previous three months from such a provider when:

- A provider terminates a contractual relationship with PacificSource in accordance with the terms and conditions of the provider's agreement;
- A provider terminates a contractual relationship with an organization under contract with PacificSource; or
- PacificSource terminates a contractual relationship with an individual provider or the organization with which the provider is contracted in accordance with the terms and conditions of the agreement.

Note: on the date a provider's contract with PacificSource terminates, they become a non-participating provider and any services you receive from them will be paid at the percentage shown in the 'Non-Participating Provider' column of your Medical Benefit Summary. To avoid unexpected costs, be sure to verify each time you see your provider that they are still participating in the network.

You may be entitled to continue care with an individual provider for a limited period of time after the medical services contract terminates. Contact Customer Service for additional information.

COVERED EXPENSES

Understanding Medical Necessity

This Plan provides comprehensive medical coverage when care is medically necessary to treat an illness, injury, or disease. Be careful – just because a treatment is prescribed by a healthcare professional does not mean it is medically necessary under the terms of this Plan. Also remember that just because a service or supply is a covered benefit under this Plan does not necessarily mean all billed charges will be paid.

Medically necessary services and supplies that are excluded from coverage under this Plan can be found in the Benefit Limitations and Exclusions section of this Plan Document, as well as the section on Preauthorization. If you ever have a question about this Plan's benefits, contact the Plan Administrator or the PacificSource Customer Service Department.

Understanding Experimental/Investigational Services

Except for specified Preventive Care services, the benefits of this Plan are paid only toward the covered expense of medically necessary diagnosis or treatment of illness, injury, or

disease. This is true even though the service or supply is not specifically excluded. All treatment is subject to review for medical necessity. Review of treatment may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. For additional information, see ‘medically necessary’ in the Definitions section of this Plan Document.

Be careful. Your healthcare provider could prescribe services or supplies that are not covered under this Plan. Also, just because a service or supply is a covered benefit does not mean all related charges will be paid.

New and emerging medical procedures, medications, treatments, and technologies are often marketed to the public or prescribed by physicians before FDA approval, or before research is available in qualified peer-reviewed literature to show they provide safe, long term positive outcomes for patients.

To ensure you receive the highest quality care at the lowest possible cost, PacificSource reviews new and emerging technologies and medications on a regular basis and consults with the Plan Sponsor about what procedures, technologies and medications should be covered under the terms of the Plan. The Plan Sponsor has sole and complete authority to determine what is and is not covered under the terms of the Plan.

Eligible Healthcare Providers

This Plan provides benefits only for covered expenses and supplies rendered by a physician (M.D. or D.O.), practitioner, nurse, hospital or specialized treatment facility, durable medical equipment supplier, or other licensed medical provider as specifically stated in this Plan Document. The services or supplies provided by individuals or companies that are not specified as eligible practitioners are not eligible for reimbursement under the benefits of this Plan. For additional information, see ‘practitioner’, ‘specialized treatment facility’, and ‘durable medical equipment supplier’ in the Definitions section of this Plan Document.

To be eligible, the provider must also be practicing within the scope of their license. For example although an Optometrist is an eligible provider for vision exams, they are not eligible to provide chiropractic services.

After Hours and Emergency Care

If you have a medical emergency, always go directly to the nearest emergency room, or call 911 for help.

If you’re facing a non-life threatening emergency, contact your provider’s office, or go to an Urgent Care facility. Urgent Care facilities are listed in PacificSource’s online provider directory at PacificSource.com. Simply enter your city and state or Zip code, and then select Urgent Care in the ‘Specialty Category’ field.

Appropriate Setting

It is important to have services provided in the most suitable and least costly setting. For example, if you go to the Emergency Room to have a throat culture instead of going to a doctor’s office or Urgent Care it could result in higher out-of-pocket expenses for you.

Your Annual Out-of-Pocket Limit

This Plan has an out-of-pocket limit provision to protect you from excessive medical expenses. The Medical Benefit Summary shows this Plan’s annual out-of-pocket limits for

participating and/or non-participating providers. If you incur covered expenses over those amounts, this Plan will pay 100 percent of eligible charges, subject to the allowable fee.

Your expenses for the following do not count toward the annual out-of-pocket limit:

- Charges over the allowable fee for services of non-participating providers;
- Incurred charges that exceed amounts allowed under this Plan;
- Infertility services.

Charges that do not count toward the out-of-pocket limit or that are not covered by this Plan will continue to be your responsibility even after the out-of pocket limit is reached.

Out-of-pocket limits are applied on a calendar year basis. If this Plan renews or is modified mid-calendar, the previously satisfied out-of-pocket amount will be credited toward the renewed Plan. If the out-of-pocket limit increases mid calendar year, you will need to satisfy the difference between the increase and the amount you have already satisfied under the prior Plan's requirement. If the out-of-pocket limit decreases, any excess in the amount credited to the lower amount is not refundable.

PLAN BENEFITS

This Plan provides benefits for the following services and supplies as outlined on your Medical Benefit Summary. These services and supplies may require you to satisfy a deductible, make a co-payment, and/or pay co-insurance, and they may be subject to additional limitations or maximum dollar amounts. For a medical expense to be eligible for payment, you must be covered under this Plan on the date the expense is incurred. Please refer to your Medical Benefit Summary and the Benefit Limitations and Exclusions section of this Plan Document for more information.

PREVENTIVE CARE SERVICES

This Plan covers the following preventive care services when provided by a physician, physician assistant, or nurse practitioner:

- **Routine physicals** for members age 22 and older according to the following schedule:
  - Ages 22+: One exam every calendar year

  Only laboratory work tests and other diagnostic testing procedures related to the routine physical exam are covered by this benefit. Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a routine physical examination are not covered by this preventive care benefit. Please see Outpatient Services in this section.

- **Well woman visits**, including the following:
  - One **routine gynecological exam** each calendar year for women 18 and over. Exams may include Pap smear, pelvic exam, breast exam, blood pressure check, and weight check. Covered lab services are limited to occult blood, urinalysis, and complete blood count.
  - **Routine preventive mammograms** for women as recommended.

- There is no deductible, co-payment, and/or co-insurance for mammograms that are considered ‘routine’ according to the guidelines of the U.S. Preventive Services Task Force.
- Diagnostic mammograms for any woman desiring a mammogram for medical cause. The deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for ‘Outpatient Services – Diagnostic and Therapeutic Radiology and Lab ’applies to diagnostic mammograms related to the ongoing evaluation or treatment of a medical condition.

— **Pelvic exams and Pap smear exams** for women 18 to 64 years of age annually, or at any time when recommended by a women’s healthcare provider.

— **Breast exams** annually for women 18 years of age or older or at any time when recommended by a women’s healthcare provider for the purpose of checking for lumps and other changes for early detection and prevention of breast cancer.

Members have the right to seek care from obstetricians and gynecologists for covered services without preapproval, preauthorization, or referral.

- **Colorectal cancer screening** exams and lab work including the following:

— A fecal occult blood test;

— A flexible sigmoidoscopy;

— A colonoscopy; and

— A double contrast barium enema.

A colonoscopy performed for routine screening purposes is considered to be a preventive service. The deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for ‘Preventive Care – Routine Colonoscopy’ applies to colonoscopies that are considered ‘routine’ according to the guidelines of the U.S. Preventive Services Task Force for age 50 through 75.

A colonoscopy performed for evaluation or treatment of a known medical condition is considered to be Outpatient Surgery. The deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for ‘Professional Services – Surgery’ and for ‘Outpatient Services – Outpatient Surgery/Services’ apply to colonoscopies related to ongoing evaluation or treatment of a medical condition.

A colonoscopy performed for screening purposes on individuals at ‘high risk’ under age 50 is also considered a preventive service. An individual is at high risk for colorectal cancer if the individual has:

— Family medical history of colorectal cancer;

— Prior occurrence of cancer or precursor neoplastic polyps;

— Prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease;

— Crohn’s disease or ulcerative colitis; or

— Other predisposing factors.

- **Prostate cancer screening**, including a digital rectal examination and a prostate-specific antigen test.
- **Well baby/well child care exams** for members age 21 and younger according to the following schedule:

  — At birth: One standard in-hospital exam

  — Ages 0-2: 12 additional exams during the first 36 months of life

  — Ages 3-21: One exam every calendar year

  Only laboratory tests and other diagnostic testing procedures related to a well baby/well child care exam are covered by this benefit. Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a well baby/well child care exam are not covered by this preventive care benefit. Please see Outpatient Services in this section.

- Age-appropriate childhood and adult **immunizations** for primary prevention of infectious diseases as recommended and adopted by the Centers for Disease Control and Prevention, American Academy of Pediatrics, American Academy of Family Physicians, or similar standard-setting body. Benefits do not include immunizations for more elective, investigative, unproven, or discretionary reasons (e.g. travel). Covered immunizations include, but may not be limited to the following:

  — Diphtheria, pertussis, and tetanus (DPT) vaccines, given separately or together;

  — Hemophilus influenza B vaccine;

  — Hepatitis A vaccine;

  — Hepatitis B vaccine;

  — Human papillomavirus (HPV) vaccine;

  — Influenza virus vaccine;

  — Measles, mumps, and rubella (MMR) vaccines, given separately or together;

  — Meningococcal (meningitis) vaccine;

  — Pneumococcal vaccine;

  — Polio vaccine;

  — Shingles vaccine for ages 60 and over; or

  — Varicella (chicken pox) vaccine.

- **Tobacco cessation program services** are covered only when provided by a PacificSource approved program. Specific nicotine therapy will be covered according to the program's description. Prescribed tobacco cessation related medication will be covered to the same extent this Plan covers other prescription medications.

Any Plan deductible, co-payment, and/or co-insurance amounts stated in your Medical Benefit Summary are waived for the following recommended preventive care services when provided by a participating provider:

- Services that have a rating of ‘A’ or ‘B’ from the U.S. Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- Preventive care and screening for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA);
- Preventive care and screening for women supported by the HRSA that are not included in the USPSTF recommendations.

A and B list for preventive services can be found at:
http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

The list of Women’s preventive services can be found at:
http://www.hrsa.gov/womensguidelines/

For enrollees who do not have Internet access, please contact PacificSource Customer Service at the number shown on the first page of this Plan Document for a complete description of the preventive services lists.

Current USPSTF recommendations include the September 2002 recommendations regarding breast cancer screening, mammography, and prevention, not the November 2009 recommendations**.** Cancer risk-reducing medications are covered according to the September 2013 USPSTF recommendations, at no cost, subject to reasonable medical management.

PEDIATRIC SERVICES

This Plan covers the following services for individuals age 18 and younger when provided by a participating provider:

- **Routine vision examinations** are covered on this Plan. Benefits are subject to the deductible, limitations, co-payment, and/or co-insurance stated in your Vision Benefit Summary.

PROFESSIONAL SERVICES

This Plan covers the following professional services when medically necessary:

- Services of a **physician (M.D., D.O., naturopathy, or other provider practicing within the scope of their license),** for diagnosis or treatment of illness, injury, or disease.
- Services of a licensed **physician assistant** under the supervision of a physician.
- Services of a **nurse practitioner**, including certified registered nurse anesthetist (C.R.N.A.) and certified nurse midwife (C.N.M.), or other provider practicing within the scope of their license, for medically necessary diagnosis or treatment of illness, injury, or disease.
- **Urgent care services** provided by a physician. ‘Urgent care’ means services for an unforeseen illness, injury, or disease that requires treatment within 24 hours to prevent serious deterioration of a patient’s health. Urgent conditions are normally less severe than medical emergencies. Examples of conditions that could need urgent care are sprains and strains, vomiting, cuts, and severe headaches.

- **Outpatient rehabilitation services** provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide physical, occupational, or speech therapy within the scope of the provider's license. Services must be prescribed in writing by a licensed physician, dentist, podiatrist, nurse practitioner, or physician assistant. The prescription must include site, modality, duration, and frequency of treatment. Total covered expenses for outpatient rehabilitation and outpatient habilitation services are limited to a combined maximum of 30 visits per calendar year and subject to review for medical necessity, unless medically necessary to treat a mental health diagnosis. Treatment of neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which rehabilitation services would be appropriate are covered when criteria for supplemental services are met. (For information on cardiac rehabilitation see section under 'Other Covered Services, Supplies, and Treatments'.)

  Outpatient habilitation services provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide physical, occupational, or speech therapy within the scope of the provider's license. Services must be prescribed in writing by a licensed physician, dentist, podiatrist, nurse practitioner, or physician assistant. The prescription must include site, modality, duration, and frequency of treatment. Total covered expenses for outpatient habilitation and outpatient rehabilitation services are limited to a combined maximum of 30 visits per calendar year and subject to review for medical necessity, unless medically necessary to treat a mental health diagnosis. Treatment of neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which rehabilitation services would be appropriate are covered when criteria for supplemental services are met.

  Services for speech therapy will only be allowed when needed to correct stuttering, hearing loss, peripheral speech mechanism problems, and deficits due to neurological disease or injury. Speech and/or cognitive therapy for acute illnesses, injuries, and disease are covered up to one year post injury when the services do not duplicate those provided by other eligible providers, including occupational therapists or neuropsychologists. This exclusion does not apply if medically necessary as part of a treatment plan.

  Outpatient pulmonary rehabilitation programs are covered when prescribed by a physician for patients with severe chronic lung disease that interferes with normal daily activities despite optimal medication management.

  For related provisions, see 'motion analysis', 'vocational rehabilitation', and 'speech therapy', and 'temporomandibular joint' under 'Excluded Services – Types of Treatments' in the Benefit Limitations and Exclusions section of this Plan Document.

- Services of a licensed audiologist for medically necessary **audiological (hearing) tests**.

- Services of a dentist or physician to treat **injury of the jaw or natural teeth**. Services must be provided within one year of the injury. Except for the initial examination, services for treatment of an injury to the jaw or natural teeth require preauthorization to be covered.

- Services of a dentist or physician for **orthognathic (jaw) surgery** as follows:

  — When medically necessary to repair an accidental injury. Services must be provided within one year after the accident; or

— For removal of a malignancy, including reconstruction of the jaw within one year after that surgery.

- Services of a board-certified or board-eligible **genetic counselor** when referred by a physician or nurse practitioner for evaluation of genetic disease.
- Treatment of **temporomandibular joint syndrome (TMJ)** for medical reasons only. All TMJ-related services, including but not limited to diagnostic and surgical procedures, must be medically necessary and preauthorized. Services are covered only when medically necessary due to a history of advanced pathologic process (arthritic degeneration) or in the case of severe acute trauma. Benefits for the treatment of TMJ and all related services are subject to the deductible, co-payment, and/or co-insurance stated in your Member Benefit Summary under 'Outpatient Services'.
- Medically necessary **telemedical health services** for health services covered by this Plan when provided in person by a healthcare professional when the telemedical health service does not duplicate or supplant a health service that is available to the patient in person. The location of the patient receiving telemedical health services may include, but is not limited to: hospital; rural health clinic; federally qualified health center; physician's office; community mental health center; skilled nursing facility; renal dialysis center; or site where public health services are provided. Coverage of telemedical health services are subject to the same deductible, co-payment, or co-insurance requirements that apply to comparable health services provided in person.
- Services for **chiropractic manipulation and/or acupuncture** are covered. See your Chiropractic Manipulation and Acupuncture Benefit Summary for benefit details.

HOSPITAL AND SKILLED NURSING FACILITY SERVICES

This Plan covers medically necessary **hospital inpatient services**. Charges for a hospital room are covered up to the hospital's semi-private room rate (or private room rate, if the hospital does not offer semi-private rooms). Charges for a private room are covered if the attending physician orders hospitalization in an intensive care unit, coronary care unit, or private room for medically necessary isolation. Coverage includes **eligible services** provided by a hospital owned or operated by the state, or any state approved mental health and developmental disabilities program.

In addition to the hospital room, covered inpatient hospital services may include (but are not limited to):

- Anesthesia and post-anesthesia recovery;
- Cardiac care unit;
- Dressings, equipment, and other necessary supplies;
- Inpatient medications;
- Lab and radiology services;
- Operating room; or
- Respiratory care.

The Plan does not cover charges for rental of telephones, radios, or televisions, or for guest meals or other personal items.

Services of a **skilled nursing facility and convalescent homes** are covered for up to 60 days per calendar year when preauthorized. For skilled nursing benefits to renew after each stay the member must be discharged and at least 90 consecutive days must pass before readmission. Services must be medically necessary. Confinement for custodial care is not covered.

Inpatient rehabilitation services are covered when services begin within one year of the onset of the condition from which the need for services arises and must be part of a physician's formal written program to improve and restore lost function following illness or injury. This benefit is limited to a maximum of 30 days per calendar year except in cases of head or spinal cord injury. Covered services for rehabilitation after a head or spinal cord injury are limited to 60 visits per condition, when criteria for supplemental services are met. Recreation therapy is only covered as part of an inpatient rehabilitation admission.

OUTPATIENT SERVICES

'Outpatient services are medical services that take place without being admitted to the hospital.' This Plan covers the following outpatient care services:

- **Advanced diagnostic imaging procedures** that are medically necessary for the diagnosis of illness, injury, or disease. For purposes of this benefit, advanced diagnostic imaging procedures include CT scans, MRIs, PET scans, and CATH labs and nuclear cardiology studies. When services are provided as part of a covered emergency room visit, this Plan's emergency room benefit applies. In all other situations and settings, benefits are subject to the deductibles, co-payments, and/or co-insurance stated in your Medical Benefit Summary for Outpatient Services – Advanced Diagnostic Imaging. Please note that the co-payment for these services is 'per test'. For example, if separate MRIs are performed on different regions of the back, there will be a co-payment charged for each region imaged.

- **Diagnostic radiology and laboratory procedures** provided or ordered by a physician, nurse practitioner, alternative care practitioner, or physician assistant. These services may be performed or provided by laboratories, radiology facilities, hospitals, and physicians, including services in conjunction with office visits.

- **Emergency room services**. The emergency room benefit stated in your Medical Benefit Summary covers all emergency medical screening and services, including any diagnostic test necessary for emergency are (including radiology, laboratory work, CT Scans, and MRIs. The benefit does not cover further treatment provided on referral from the emergency room.

  For emergency medical conditions, non-participating providers are paid at the participating provider level.

  Emergency room charges for services, supplies, or conditions excluded from coverage under this Plan are not eligible for payment.

- **Surgery** and other outpatient services. Benefits are based on the setting where services are performed.

  — For surgeries or outpatient services performed in a physician's office, the benefit stated in your Medical Benefit Summary for Professional Services – Office Procedures and Supplies applies.

— For surgeries or outpatient services performed in an ambulatory surgical center or outpatient hospital setting, both the benefits shown on your Medical Benefit Summary for Professional Services – Surgery Charges and the Outpatient Services - Outpatient Surgery/Services apply.

- **Therapeutic radiology services, chemotherapy, and renal dialysis** provided or ordered by a physician. Covered services include a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells. Absent a contracted allowable fee amount based on the Medicare allowable, benefits for members who are receiving renal dialysis are limited to 125 percent of the current Medicare allowable amount for participating and non-participating providers. In all situations and settings, benefits are subject to the deductibles, co-payments, and/or co-insurance stated in your Medical Benefit Summary for Outpatient Services – Diagnostic and therapeutic radiology and lab.
- Other medically necessary **diagnostic services** provided in a hospital or outpatient setting, including testing or observation to diagnose the extent of a medical condition.

EMERGENCY SERVICES

For emergency medical conditions, this Plan covers services and supplies necessary to determine the nature and extent of the emergency condition and to stabilize the patient.

An emergency medical condition is an injury or sudden illness, including severe pain, so severe that a prudent layperson with an average knowledge of health and medicine would expect that failure to receive immediate medical attention would risk seriously damaging the health of a person or fetus in the case of a pregnant woman. Examples of emergency medical conditions include (but are not limited to):

- Convulsions or seizures;
- Difficulty breathing;
- Major traumatic injuries;
- Poisoning;
- Serious burns;
- Sudden abdominal or chest pains;
- Sudden fevers;
- Suspected heart attacks;
- Unconsciousness; or
- Unusual or heavy bleeding.

If you need immediate assistance for a medical emergency, call 911. *If you have an emergency medical condition, you should go directly to the nearest emergency room or appropriate facility. Care for a medical emergency is covered at the participating provider percentage stated in your Medical Benefit Summary even if you are treated at a non-participating hospital.*

If you are admitted to a non-participating hospital after your emergency condition is stabilized, the Plan Sponsor may require you to transfer to a participating facility in order to continue receiving benefits at the participating provider level.

MATERNITY SERVICES

Maternity means, in any one pregnancy, all prenatal services including complications and miscarriage, delivery, postnatal services provided within six weeks of delivery, and routine nursery care of a newborn child. Maternity services are covered subject to the deductible, co-payments and/or co-insurance stated in your Medical Benefit Summary.

Medically necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six weeks postpartum will not be subjected to a deductible, co-payment, or co-insurance.

Services of a physician or a licensed certified nurse midwife for **pregnancy**. Services are subject to the same payment amounts, conditions, and limitations that apply to similar expenses for illness.

Please contact the PacificSource Customer Service Department as soon as you learn of your pregnancy. Their staff will explain the Plan's maternity benefits.

This Plan provides **routine nursery care** of a newborn while the mother is hospitalized and eligible for pregnancy-related benefits under this Plan if the newborn is also eligible and enrolled in this Plan.

Special Information about Childbirth – This Plan covers hospital inpatient services for childbirth according to the Newborns' and Mothers' Health Protection Act of 1996. This Plan does not restrict the length of stay for the mother or newborn child to less than 48 hours after vaginal delivery, or to less than 96 hours after Cesarean section delivery. Your provider is allowed to discharge you or your newborn sooner than that, but only if you both agree. For childbirth, your provider does not need to preauthorize your hospital stay.

MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

This Plan covers medically necessary crisis intervention, diagnosis, and treatment of mental health conditions and chemical dependency the same as any other illness. Refer to the Benefit Limitations and Exclusions section of this Plan Document for more information on services not covered by this Plan.

Providers Eligible for Reimbursement

A mental and/or chemical healthcare provider (see Definitions section of this Plan Document) is eligible for reimbursement if:

- The mental and/or chemical healthcare provider is authorized for reimbursement under the laws of this Plan's state of issuance; and
- The mental and/or chemical healthcare provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities; and

- The patient is staying overnight at the mental and/or chemical healthcare facility (see Definitions section of this Plan Document) and is involved in a structured program at least eight hours per day, five days per week; or
- The mental and/or chemical healthcare provider is providing a covered benefit under this policy.

Eligible mental and/or chemical healthcare providers are:

- A program licensed, approved, established, maintained, contracted with, or operated by the accrediting and licensing authority of the state wherein the program exists;
- A medical or osteopathic physician licensed by the State Board of Medical Examiners;
- A psychologist (Ph.D.) licensed by the State Board of Psychologists' Examiners;
- A nurse practitioner registered by the State Board of Nursing;
- A clinical social worker (L.C.S.W.) licensed by the State Board of Clinical Social Workers;
- A Licensed Professional Counselor (L.P.C.) licensed by the State Board of Licensed Professional Counselors and Therapists;
- A Licensed Marriage and Family Therapist (L.M.F.T.) licensed by the State Board of Licensed Professional Counselors and Therapists; and
- A hospital or other healthcare facility licensed by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities for inpatient or residential care and treatment of mental health conditions and/or chemical dependency.

Medical Necessity and Appropriateness of Treatment

- As with all medical treatment, mental health and chemical dependency treatment is subject to review for medical necessity and/or appropriateness. Review of treatment may involve pre-service review, concurrent review of the continuation of treatment, post-treatment review, or a combination of these. PacificSource will notify the patient and patient's provider when a treatment review is necessary to make a determination of medical necessity.
- A second opinion may be required for a medical necessity determination. PacificSource will notify the patient when this requirement is applicable.
- PacificSource must be notified of an emergency admission within two business days.
- Medication management by an M.D. (such as a psychiatrist) does not require review.
- Treatment of substance abuse and related disorders is subject to placement criteria established by the American Society of Addiction Medicine.

Mental Health Parity and Addiction Equity Act of 2008

This Plan complies with all federal laws and regulations related to the Mental Health Parity and Addiction Equity Act of 2008.

HOME HEALTH AND HOSPICE SERVICES

- This Plan covers **home health services** when preauthorized by PacificSource. Covered services include skilled nursing by a R.N. or L.P.N.; physical, occupational, and speech therapy; and medical social work services provided by a licensed home health agency. Private duty nursing is not covered.
- **Home infusion services** are covered when preauthorized. This benefit covers parenteral nutrition, medications, and biologicals (other than immunizations) that cannot be self-administered. Benefits are paid at the percentage stated in your Medical Benefit Summary for home healthcare.
- This Plan covers **hospice services** when preauthorized. Hospice services are intended to meet the physical, emotional, and spiritual needs of the patient and family during the final stages of illness and dying, while maintaining the patient in the home setting. Services are intended to supplement the efforts of an unpaid caregiver. Hospice benefits do not cover services of a primary caregiver such as a relative or friend, or private duty nurse. The Plan Sponsor has set the following criteria to determine eligibility for hospice benefits:
  - The member's physician must certify that the member is terminally ill with a life expectancy of less than six months;
  - The member must be living at home;
  - A non-salaried primary caregiver must be available and willing to provide custodial care to the member on a daily basis; and
  - The member must not be undergoing treatment of the terminal illness other than for direct control of adverse symptoms.

  Only the following hospice services are covered:

  - Durable medical equipment, oxygen, and medical supplies;
  - Home nursing visits;
  - Home health aides when necessary to assist in personal care;
  - Home infusion therapy;
  - Home visits by a medical social worker;
  - Home visits by the hospice physician;
  - Inpatient hospice care when provided by a Medicare-certified or state-certified program when admission to an acute care hospital would otherwise be medically necessary;
  - Medically necessary physical, occupational, and speech therapy provided in the home;
  - Prescription medications for the relief of symptoms manifested by the terminal illness;
  - Pastoral care and bereavement services; and
  - Respite care provided in a nursing facility to provide relief for the primary caregiver, subject to a maximum of five consecutive days and to a lifetime maximum benefit of 30 days. A member must be enrolled in a hospice program to be eligible for respite care benefits.

The member retains the right to all other services provided under this Plan, including active treatment of non-terminal illnesses, except for services of another provider that duplicate the services of the hospice team.

DURABLE MEDICAL EQUIPMENT

- This Plan covers **prosthetic and orthotic devices** that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. Benefits include coverage of all services and supplies medically necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device. Benefits also include coverage for any repair or replacement of a prosthetic or orthotic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.

- This Plan covers **durable medical equipment** prescribed exclusively to treat medical conditions. Covered equipment includes crutches, wheelchairs, orthopedic braces, home glucose meters, equipment for administering oxygen, and non-power assisted prosthetic limbs and eyes. Durable medical equipment must be prescribed by a licensed M.D., D.O., N.P., P.A., D.D.S., D.M.D., or D.P.M. to be covered. This Plan does not cover equipment commonly used for nonmedical purposes, for physical or occupational therapy, or prescribed primarily for comfort. Please see the Benefit Limitations and Exclusions section for information on items not covered. The following limitations apply to durable medical equipment:

  — This benefit covers the cost of either purchase or rental of the equipment for the period needed, whichever is less. Repair or replacement of equipment is also covered when necessary, subject to all conditions and limitations of the Plan. If the cost of the purchase, rental, repair, or replacement is over $800, preauthorization by PacificSource is required.

  — Only expenses for durable medical equipment, or prosthetic and orthotic devices that are provided by a PacificSource contracted provider or a provider that satisfies the criteria of the Medicare fee schedule for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Other Items and Services are eligible for reimbursement. Mail order or Internet/Web based providers are not eligible providers.

  — Purchase, rental, repair, lease, or replacement of a power-assisted wheelchair (including batteries and other accessories) requires preauthorization by PacificSource and is payable only in lieu of benefits for a manual wheelchair.

  — The durable medical equipment benefit also covers lenses to correct a specific vision defect resulting from a severe medical or surgical problem, such as stroke, neurological disease, trauma, or eye surgery other than refraction procedures. Coverage is subject to the following limitations:

    - The medical or surgical problem must cause visual impairment or disability due to loss of binocular vision or visual field defects (not merely a refractive error or astigmatism) that requires lenses to restore some normalcy to vision.

    - The maximum allowance for glasses (lenses and frames), or contact lenses in lieu of glasses, is limited to one pair per year. Other Plan limitations, such as

exclusions for extra lenses, other hardware, tinting of lenses, eye exercises, or vision therapy, also apply.

  - Benefits for subsequent medically necessary vision corrections to either eye (including an eye not previously treated) are limited to the cost of lenses only.
  - Reimbursement is subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment and is in lieu of, and not in addition to any other vision benefit payable.

— The durable medical equipment benefit also covers hearing aids for members 18 years of age or younger or 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution. Coverage is limited to a maximum benefit of one hearing aid per ear, every 48 months.

— Medically necessary treatment for sleep apnea and other sleeping disorders is covered when preauthorized by PacificSource. Coverage of oral devices includes charges for consultation, fitting, adjustment, follow-up care, and the appliance. The appliance must be prescribed by a physician specializing in evaluation and treatment of obstructive sleep apnea, and the condition must meet criteria for obstructive sleep apnea.

— Manual and electric breast pumps are covered at no cost per pregnancy when purchased or rented from a participating licensed provider, or purchased from a retail outlet. Hospital-grade breast pumps are not covered.

— Wigs following chemotherapy or radiation therapy are covered up to a maximum benefit of $150 per calendar year.

TRANSPLANT SERVICES

This Plan covers certain medically necessary organ and tissue transplants. It also covers the cost of acquiring organs or tissues needed for covered transplants and limited travel expenses for the patient, subject to certain limitations.

All pre-transplant evaluations, services, treatments, and supplies for transplant procedures require preauthorization.

This Plan covers the following medically necessary organ and tissue transplants:

- Bone marrow, peripheral blood stem cell and high-dose chemotherapy when medically necessary;
- Kidney;
- Kidney – Pancreas;
- Heart;
- Heart – Lungs;
- Lungs;
- Liver;
- Pancreas whole organ transplantation; or
- Pediatric bowel.

This Plan only covers transplants of human body organs and tissues. Transplants of artificial, animal, or other non-human organs and tissues are not covered.

Expenses for the acquisition of organs or tissues for transplantation are covered only when the transplantation itself is covered under this contract, and is subject to the following limitations:

- Testing of related or unrelated donors for a potential living related organ donation is payable at the same percentage that would apply to the same testing of a covered recipient.
- Expense for acquisition of cadaver organs is covered, payable at the same percentage and subject to the same limitations, if any, as the transplant itself.
- Medical services required for the removal and transportation of organs or tissues from living donors are covered. Coverage of the organ or tissue donation is payable at the same percentage as the transplant itself if the recipient is a Plan member, to a maximum of $8,000 per transplant.
  - If the donor is not covered by this Plan, only those complications of the donation that occur during the initial hospitalization are covered, and such complications are covered only to the extent that they are not covered by another health plan or government program. Coverage is payable at the same percentage as the transplant itself.
  - If the donor is a Plan member, complications of the donation are covered as any other illness would be covered.
- Transplant related services, including human leukocyte antigen (HLA) typing, sibling tissue typing, and evaluation costs, are considered transplant expenses and accumulate toward any transplant benefit limitations and are subject to PacificSource's provider contractual agreements (see Payment of Transplant Benefits, below).

Travel and housing expenses for the recipient and one caregiver are limited to $5,000 per transplant. Travel and living expenses are not covered for the recipient's family members or the donor.

Payment of Transplant Benefits

If a transplant is performed at a participating Center of Excellence transplantation facility, covered charges of the facility are subject this Plan's deductibles (co-insurance and co-payment amounts after deductible are waived). If the contract with the facility includes the services of the medical professionals performing the transplant (such as physicians, nurses, and anesthesiologists), those charges are also subject this Plan's deductibles (co-insurance and co-payment amounts after deductible are waived). If the professional fees are not included in the contract with the facility, then those benefits are provided according to your Medical Benefit Summary.

Transplant services that are not received at a participating Center of Excellence and/or services of non-participating medical professionals are paid at the non-participating provider percentages stated in your Medical Benefit Summary. The maximum benefit payment for transplant services of non-participating providers is 125 percent of the Medicare allowance.

PRESCRIPTION DRUGS

Using Your PacificSource Pharmacy Benefits

Refer to your Pharmacy Summary for your specific benefit information.

What happens when a brand name drug is selected (Mac C)

Regardless of the reason or medical necessity, if you receive a brand name drug or if your physician prescribes a brand name drug when a generic is available, you will be responsible for the brand name drug's co-payment and/or co-insurance.

Retail Pharmacy Network

To use this Plan's pharmacy benefits, you must show the Plan's pharmacy number on your ID card at the participating pharmacy to receive this Plan's highest benefit level. When obtaining prescription drugs at a participating retail pharmacy, the Plan's pharmacy benefits can only be accessed through the pharmacy number printed on your ID card. That Plan number allows the pharmacy to collect the appropriate deductible, co-payment, and/or co-insurance amount from you and bill the Plan electronically for the balance.

Mail Order Service

This Plan includes a participating mail order service for prescription drugs. Most, but not all, covered prescription drugs are available through this service. Questions about availability of specific drugs may be directed to the PacificSource Customer Service Department or to the Plan's participating mail order service vendor. Forms and instructions for using the mail order service are available from PacificSource and on their website, PacificSource.com.

Specialty Drug Program

PacificSource contracts with a specialty pharmacy services provider for high-cost injectable medications and biotech drugs. A pharmacist-led CareTeam provides individual follow-up care and support to covered members with prescriptions for specialty medications by providing them strong clinical support, as well as the best drug pricing for these specific medications and biotech drugs. The CareTeam also provides comprehensive disease education and counseling, assesses patient health status, and offers a supportive environment for patient inquiries.

Participating provider benefits for specialty drugs are available when you use the specialty pharmacy services provider. Specialty drugs are not available through the participating retail pharmacy network or mail order service. More information regarding the exclusive specialty pharmacy services provider and health conditions and a list of drugs requiring preauthorization and/or are subject to pharmaceutical service restrictions is on their website, PacificSource.com

PacificSource Medication Synchronization Program

To ensure your medication is effective, it's important to take it exactly as prescribed. This can be challenging if you take multiple medications that refill at different times and require many trips to the pharmacy. Through the medication synchronization program, your ongoing prescriptions can be coordinated so refills are ready at the same time. If you wish to have your medication refills synchronized, please ask your doctor or pharmacist to contact the Pharmacy Services Department at (800) 624-6052, ext. 3784, or email pharmacy@pacificsource.com.

PacificSource will work with your providers to evaluate your options and develop your synchronization plan.

Other Covered Pharmaceuticals

Supplies covered under pharmacy benefits are in place of, not in addition to, those same covered supplies under the medical benefits. Member cost share for items in this section are applied on the same basis as for other prescription drugs, unless otherwise noted.

Diabetic Supplies

- Insulin, diabetic syringes, lancets, and test strips are available for the Plan's generic co-payment/co-insurance.
- Glucagon recovery kits for this Plan's preferred brand name co-payment/co-insurance.
- Glucostix and glucose monitoring devices are not covered under this pharmacy benefit, but are covered under your durable medical equipment benefit.

Contraceptives

Any deductible, co-payment, and/or co-insurance amounts are waived for Food and Drug Administration (FDA) approved contraceptive methods for all women with reproductive capacity, as supported by the Health Resources and Services Administration (HRSA), when provided by a participating pharmacy. If a generic exists, preferred brand contraceptives will remain subject to this Plan's regular pharmacy benefits. When no generic exists, preferred brand is covered at no cost. If a generic becomes available, the preferred brand will no longer be covered under preventive care.

Orally Administered Anticancer Medications

Orally administered anticancer medications used to kill or slow the growth of cancerous cells are available. Co-payments for orally administered anticancer medication are applied on the same basis as for other drugs. Orally administered anticancer medications covered under this Plan's pharmacy benefits are in place of, not in addition to, those same covered drugs under this Plan's medical benefits.

Limitations and Exclusions

- This Plan only covers drugs prescribed by a licensed physician (or other licensed practitioner eligible for reimbursement under this Plan) prescribing within the scope of his or her professional license. This Plan does not cover the following:
  - Over-the-counter drugs or other drugs that federal law does not prohibit dispensing without a prescription.
  - Drugs for any condition excluded under this Plan. This includes drugs intended to prevent infertility, improve sexual function unless for treatment of a mental health diagnosis of sexual dysfunction, treatments for obesity or weight loss, experimental or investigational, and drugs available without a prescription (even if a prescription is provided) except for tobacco cessation drugs.
  - Some specialty drugs that are not self-administered are not covered by this pharmacy benefit, but are covered under the Plan's medical office supply benefit.

- Immunizations (although not covered by this pharmacy benefit, immunizations may be covered under the Plan's medical preventive care benefit).
- Drugs and devices to treat erectile dysfunction unless medically necessary to treat a mental health diagnosis.
- Drugs used as a preventive measure against hazards of travel.
- Vitamins, minerals, and dietary supplements, except for prescription prenatal vitamins and fluoride products, and for services that have a rating of 'A' or 'B' from the U.S. Preventive Services Task Force (USPSTF).

- Certain drugs require preauthorization in order to be covered. An up-to-date list of drugs requiring preauthorization is available at PacificSource.com.
- Certain drugs are subject to step therapy protocols. An up-to-date list of drugs subject to step therapy protocols is available on PacificSource.com.
- The Plan Sponsor may limit the dispensing quantity through the consideration of medical necessity, generally accepted standards of medical practice, and review of medical literature and governmental approval status.
- Quantities for any drug filled or refilled are limited to no more than a 30 day supply when purchased at a retail pharmacy or a 90 day supply when purchased through mail order pharmacy service or a 30 day supply when purchased through a specialty pharmacy.
- For drugs purchased at non-participating pharmacies or at participating pharmacies without using the Plan's pharmacy benefits, reimbursement is limited to an allowable fee.
- Non-participating pharmacy charges are not eligible for reimbursement unless you have a true medical emergency that prevents you from using a participating pharmacy. Drugs obtained at a non-participating pharmacy due to a true medical emergency are limited to a five day supply.
- Prescription drug benefits are subject to this Plan's coordination of benefits provision.
- Early refills of prescription eye drops for treatment of glaucoma are allowed under the following circumstances:
  - If the member requests a refill less than 30 days after the date the original prescription was dispensed to the member; and
  - The prescriber indicates on the original prescription that a specific number of refills will be needed; and
  - The refill does not exceed the number of refills that the prescriber indicated; and
  - If the prescription has not been refilled more than once during the 30 day period prior to the request for an early refill.

OTHER COVERED SERVICES, SUPPLIES, AND TREATMENTS

- This Plan covers services of a state certified ground or air **ambulance** when private transportation is medically inappropriate because the acute medical condition requires paramedic support. Benefits are provided for emergency ambulance service and/or transport to the nearest facility capable of treating the condition. Air ambulance service is

covered only when ground transportation is medically or physically inappropriate. Reimbursement to non-participating air ambulance services are based on 200 percent of the Medicare allowance. In some cases Medicare allowance may be significantly lower than the provider's billed amount. The provider may hold you responsible for the amount they bill in excess of the Medicare allowance, as well as applicable deductibles and co-insurance.

- This Plan covers **biofeedback** to treat tension or migraine headaches or urinary incontinence when provided by an otherwise eligible practitioner. Benefits are limited to a lifetime maximum of ten sessions.
- This Plan covers **blood transfusions**, including the cost of blood or blood plasma.
- This Plan covers removal, repair, or replacement of **breast prostheses** due to a contracture or rupture, but only when the original prosthesis was for a medically necessary mastectomy. Preauthorization is required, and eligibility for benefits is subject to the following criteria which have been set by the Plan Sponsor:
  - The contracture or rupture must be clinically evident by a physician's physical examination, imaging studies, or findings at surgery;
  - This Plan covers removal, repair, and/or replacement of the prosthesis; or
  - Removal, repair, and/or replacement of the prosthesis is not covered when recommended due to an autoimmune disease, connective tissue disease, arthritis, allergenic syndrome, psychiatric syndrome, fatigue, or other systemic signs or symptoms.
- This Plan covers **breast reconstruction** in connection with a medically necessary mastectomy. Coverage is provided in a manner determined in consultation with the attending physician and patient for:
  - All stages of reconstruction of the breast on which the mastectomy was performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - Prostheses; and
  - Treatment of physical complications of the mastectomy, including lymphedema.

  Benefits for breast reconstruction are subject to all terms and provisions of the Plan, including deductibles, co-payments, and/or co-insurance stated in your Medical Benefit Summary.
- This Plan covers **cardiac rehabilitation** as follows:
  - Phase I (inpatient) services are covered under inpatient hospital benefits;
  - Phase II (short-term outpatient) services are covered subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for outpatient hospital benefits. Benefits are limited to services provided in connection with a cardiac rehabilitation exercise program that does not exceed 36 lifetime visits and that are considered reasonable and necessary.
  - Phase III (long-term outpatient) services are not covered.

- **Cochlear implants** and bilateral cochlear implants are covered when medically necessary.
- This Plan covers IUD, diaphragm, and cervical cap **contraceptives and contraceptive devices** along with their insertion or removal. Contraceptive devices that can be obtained over the counter or without a prescription, such as condoms are not covered.
- This Plan covers **corneal transplants**. Preauthorization is not required.
- In the following situations, this Plan covers **cosmetic or reconstructive surgery:**
  - When necessary to correct a functional disorder; or
  - When necessary due to a congenital anomaly; or
  - When necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury; or
  - When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery.

  Cosmetic or reconstructive surgery is provided for one attempt and must take place within 18 months after the injury, surgery, scar, or defect first occurred unless determined otherwise through medical necessity evaluation. Preauthorization by PacificSource is required for all cosmetic and reconstructive surgeries covered by this Plan. For information on breast reconstruction, see ‘breast prostheses’ and ‘breast reconstruction’ in this section.
- This Plan covers dental and orthodontic services for the treatment of **craniofacial anomalies** when medically necessary to restore function. Coverage includes but is not limited to physical disorders identifiable at birth that affect the bony structure of the face or head, such as a cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome. Coverage is limited to the least costly clinically appropriate treatment. Cosmetic procedures and procedures to improve on the normal range of functions are not covered. See the exclusions for cosmetic/reconstructive services, dental examinations and treatments, jaw surgery, and orthognathic surgery under the ‘Excluded Services’ section.
- This Plan provides coverage for certain **diabetic equipment, supplies and training** as follows:
  - Diabetic supplies other than insulin and syringes (such as lancets, test strips, and glucostix) are covered subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment. You may purchase those supplies from any retail outlet and send your receipts to PacificSource, along with your name, group number, and member ID number. They will process the claim and mail you a reimbursement check.
  - Insulin pumps are covered subject to preauthorization.
  - Diabetic insulin and syringes are covered under your prescription drug benefit, if this Plan includes prescription coverage. Lancets and test strips are also available under that prescription benefit in lieu of those covered supplies under the Plan’s medical benefits.

- This Plan covers outpatient and self-management training and education for the treatment of diabetes, subject to the deductible, co-payment and/or co-insurance for office visits stated in the Member Benefit Summary. To be covered, the training must be provided by an accredited diabetes licensed health care professional with expertise in diabetes.
- This Plan covers medically necessary telemedical health services provided in connection with the treatment of diabetes (see Professional Services in this section).

- This Plan covers **dietary or nutritional counseling** provided by a registered dietitian under certain circumstances. It is covered under the diabetic education benefit or for management of inborn errors of metabolism (excluding obesity), or for management of anorexia nervosa or bulimia nervosa as determined by medical necessity evaluation.
- This Plan covers nonprescription **elemental enteral formula** ordered by a physician for home use. Formula is covered when medically necessary to treat severe intestinal malabsorption and the formula comprises a predominant or essential source of nutrition. Coverage is subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment.
- This Plan covers routine **foot care** for patients with diabetes mellitus.
- **Hospitalization for dental procedures** is covered when the patient has another serious medical condition that may complicate the dental procedure, such as serious blood disease, unstable diabetes, or severe cardiovascular disease, or the patient is physically or developmentally disabled with a dental condition that cannot be safely and effectively treated in a dental office. Coverage requires preauthorization, and only charges for the facility, anesthesiologist, and assistant physician are covered. Hospitalization because of the patient's apprehension or convenience is not covered.
- This Plan covers treatment for **inborn errors of metabolism** involving amino acid, carbohydrate, and fat metabolism for which widely accepted standards of care exist for diagnosis, treatment, and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage includes expenses for diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. Nutritional supplies are covered subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment.
- **Infertility services** are covered when medically necessary, subject to the co-payments, co-insurance amounts, and/or deductibles stated in the Medical Benefit Summary. In-vitro fertilization and procedures determined to be experimental or investigational in nature are not covered (see Excluded Services section). Infertility services do not accumulate toward the medical out-of-pocket maximum.
- **Injectable drugs and biologicals** administered by a physician are covered when medically necessary for diagnosis or treatment of illness, injury, or disease. This benefit does not include immunizations (see Preventive Care Services in this section) or drugs or biologicals that can be self-administered or are dispensed to a patient.
- This Plan covers **maxillofacial prosthetic services** when prescribed by a physician as necessary to restore and manage head and facial structures. Coverage is provided only when head and facial structures cannot be replaced with living tissue, and are defective because of disease, trauma, or birth and developmental deformities. To be covered,

treatment must be necessary to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing. Coverage is limited to the least costly clinically appropriate treatment, as determined by the physician. Cosmetic procedures and procedures to improve on the normal range of functions are not covered. Dentures, prosthetic devices for treatment of TMJ conditions and artificial larynx are also not covered.

- For **pediatric dental care** requiring general anesthesia, this Plan covers the facility charges of a hospital or ambulatory surgery center.
- **Post-mastectomy care** is covered for hospital inpatient care for a period of time as determined by the attending physician and, in consultation with the patient determined to be medically necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.
- The **routine costs of care associated with approved clinical trials** are covered. Benefits are only provided for routine costs of care associated with approved clinical trials. Expenses for services or supplies that are not considered routine costs of care are not covered. For more information, see 'routine costs of care' in the Definitions section of this Plan Document. A 'qualified individual' is someone who is eligible to participate in an 'approved clinical trial'. If a participating provider is participating in an approved clinical trial, the qualified individual may be required to participate in the trial through that participating provider if the provider will accept the individual as a participant in the trial.
- **Sleep studies** are covered when ordered by a pulmonologist, neurologist, otolaryngologist, or certified sleep medicine specialist, and when performed at a certified sleep laboratory.
- This Plan covers medically necessary therapy and services for the treatment of **traumatic brain injury**.
- This Plan covers **tubal ligation and vasectomy** procedures.
- **Orthopedic shoes** are covered, but only such orthopedic shoes that are an integral part of a leg brace or are individually designed for correction or support of a deformity according to a professional provider's order. If such corrections or support is accomplished by modification of a mass produced shoe, and then covered services will include only the cost of the modification and will not include the original cost of the shoe.
- **Circumcision** is covered regardless of age or medical necessity. This benefit is limited to one circumcision per member per lifetime.
- **Routine vision examinations** are covered for enrolled members age 19 and older on this Plan. Benefits are subject to the deductible, limitations, co-payment, and/or co-insurance stated in your Vision Benefit Summary.
- This Plan covers Weight Watchers benefits up to an annual maximum of $100 per calendar year.

  You must be enrolled in this Plan at the time of your first and last meeting to qualify for reimbursement. You must complete a minimum of ten weeks during a consecutive four month period during the calendar year. Participation verification is required. To be eligible for reimbursement, the Weight Watchers Reimbursement Request Form must be submitted within two months of the last Weight Watchers class attended. If you have questions, please contact PacificSource's Customer Service Department at (541) 684-5582 or email cs@pacificsource.com.

COMMUNITY WELLNESS BENEFITS

This Plan covers Community Wellness Benefits when provided by a hospital that is a preferred provider, up to an annual maximum of $150. Wellness topics usually include matters such as maternity fitness and education, newborn care and parenting skills, nutrition and healthy heart exercises or CPR skills.

Covered services include wellness-related classes; and printed materials required for the class.

After you have completed the class, please provide PacificSource with proof of payment and a completed Community Wellness Reimbursement Form for PacificSource to review for benefit payment consideration based on the Plan Sponsor's criteria. You may obtain the Community Wellness Reimbursement Form from the Plan Sponsor, or PacificSource's Customer Service Department.

BENEFIT LIMITATIONS AND EXCLUSIONS

Least Costly Setting for Services

Covered services must be performed in the least costly setting where they can be provided safely. If a procedure can be done safely in an outpatient setting but is performed in a hospital inpatient setting, this Plan will only pay what it would have paid for the procedure on an outpatient basis.

EXCLUDED SERVICES

Types of Treatment – This Plan does not cover the following:

- Abdominoplasty for any indication.
- Academic skills training. This exclusion does not apply if the program, training, or therapy is part of a treatment plan for a pervasive developmental disorder.
- Any amounts in excess of the allowable fee for a given service or supply.
- Aversion therapy.
- Benefits not stated – Services and supplies not specifically described as benefits under the Plan and/or any Plan Amendment attached hereto,
- Biofeedback (other than as specifically noted under the Covered Expenses – Other covered Services, Supplies, and Treatment section).
- Care and related services designed essentially to assist a person in maintaining activities of daily living, e.g. services to assist with walking, getting in/out of bed, bathing, dressing, feeding, and preparation of meals, homemaker services, special diets, rest crew, day care, and diapers. Custodial care is only covered in conjunction with respite care allowed under this Plan's hospice benefit (see Covered Expenses – Hospital, Skilled Nursing Facility, Home Health, and Hospice Services).
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims.

- Charges over the usual, customary, and reasonable fee (UCR) – Any amount in excess of the UCR for a given service or supply.
- Charges that are the responsibility of a third party who may have caused the illness, injury, or disease or other insurers covering the incident (such as workers' compensation insurers, automobile insurers, and general liability insurers).
- Chelation therapy including associated infusions of vitamins and/or minerals, except as medically necessary for the treatment of selected medical conditions and medically significant heavy metal toxicities.
- Computer or electronic equipment for monitoring asthmatic, diabetic, or similar medical conditions or related data.
- Cosmetic/reconstructive services and supplies – Except as specified in the Covered Expenses – Other Covered Services, Supplies, and Treatments section of this policy. Services and supplies, including drugs, rendered primarily for cosmetic/reconstructive purposes and any complications as a result of non-covered cosmetic/reconstructive surgery. Cosmetic/reconstructive services and supplies are those performed primarily to improve the body's appearance and not primarily to restore impaired function of the body, unless the area needing treatment is a result of congenital anomaly.
- Court-ordered sex offender treatment programs.
- Day care or custodial care – Care and related services designed essentially to assist a person in maintaining activities of daily living, e.g. services to assist with walking, getting in/out of bed, bathing, dressing, feeding, preparation of meals, homemaker services, special diets, rest crews, day care, and diapers. Custodial care is only covered in conjunction with respite care allowed under this Plan's hospice benefit. For related provisions, see 'Hospital and Skilled Nursing Facility Services' and 'Home Health and Hospice Services' in the Covered Expenses section of this Plan Document.
- Dental examinations and treatment – For the purpose of this exclusion, the term 'dental examinations and treatment' means services or supplies provided to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures. This includes services, supplies, hospitalization, anesthesia, dental braces or appliances, or dental care rendered to repair defects that have developed because of tooth loss, or to restore the ability to chew, or dental treatment necessitated by disease. For related provisions, see 'hospitalization for dental procedures' under 'Other Covered Services, Supplies, and Treatments' in the Covered Expenses section of this Plan Document.
- Drugs and biologicals that can be self-administered (including injectables), other than those provided in a hospital emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered.
- Drugs or medications not prescribed for inborn errors of metabolism, diabetic insulin, or autism spectrum disorder that can be self-administered (including prescription drugs, injectable drugs, and biologicals), unless given during a visit for outpatient chemotherapy or dialysis or during a medically necessary hospital, emergency room or other institutional stay.
- Educational or correctional services or sheltered living provided by a school or halfway house, except outpatient services received while temporarily living in a shelter.
- Electronic Beam Tomography (EBT).

- Equine/animal therapy.
- Equipment commonly used for nonmedical purposes or marketed to the general public.
- Equipment used primarily in athletic or recreational activities. This includes exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal problems.
- Experimental or investigational procedures – This Plan does not cover experimental or investigational treatment. This means services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines or the use thereof that are experimental or investigational for the diagnosis and treatment of the patient. It includes treatment that, when and for the purpose rendered: has not yet received full U.S. government agency approval (e.g. FDA) for other than experimental, investigational, or clinical testing; is not of generally accepted medical practice in this Plan's state of issuance or as determined by medical advisors, medical associations, and/or technology resources; is not approved for reimbursement by the Centers for Medicare and Medicaid Services; is furnished in connection with medical or other research; or is considered by any governmental agency or subdivision to be experimental or investigational, not reasonable and necessary, or any similar finding.

  An experimental or investigational service is not made eligible for benefits by the fact that other treatment is considered by your healthcare provider to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.

  When making benefit determinations about whether treatments are investigational or experimental, this Plan relies on the above resources as well as: expert opinions of specialists and other medical authorities; published articles in peer-reviewed medical literature; external agencies whose role is the evaluation of new technologies and drugs; and external review by an independent review organization. The Plan Sponsor retains sole and complete authority to determine what services are covered under the terms of this Plan.

  The following will be considered in making the determination whether the service is in an experimental and/or investigational status: whether there is sufficient evidence to permit conclusions concerning the effect of the services on health outcomes; whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives; whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects; and whether any improved health outcomes from the services are attainable outside an investigational setting.

  If you or your provider has any concerns about whether a course of treatment will be covered, we encourage you to contact PacificSource's Customer Service Department. They will arrange for medical review of your case against the criteria established by the Plan Sponsor, and notify you of whether the proposed treatment will be covered.
- Eye glasses/Contact Lenses – The fitting, provision, or replacement of eye glasses, lenses, frames, contact lenses, or subnormal vision aids intended to correct refractive error.
- Eye exercises and eye refraction - therapy, and procedures – Orthoptics, vision therapy, and procedures intended to correct refractive errors.

- Family planning – Services and supplies for artificial insemination, in vitro fertilization, treatment of infertility, or surgery to reverse voluntary sterilization, and treatment of erectile dysfunction unless medically necessary to treat a mental health diagnosis.
  - Infertility – Services and supplies, surgery, treatment, or prescriptions to prevent, or cure infertility or to induce fertility (including Gamete and/or Zygote Interfallopian Transfer; i.e. GIFT or ZIFT.

    For purposes of this Plan, infertility is defined as:
    - Male: Low sperm counts or the inability to fertilize an egg; or
    - Female: The inability to conceive or carry a pregnancy to 12 weeks.
- Fitness or exercise programs and health or fitness club memberships.
- Food dependencies.
- Foot care (routine) – Services and supplies for corns and calluses of the feet, conditions of the toenails other than infection, hypertrophy or hyperplasia of the skin of the feet, and other routine foot care, except in the case of patients being treated for diabetes mellitus.
- Genetic (DNA) testing – DNA and other genetic tests, except for those tests identified as medically necessary for the diagnosis and standard treatment of specific diseases.
- Growth hormone injections or treatments, except to treat documented growth hormone deficiencies.
- Hearing Aids for individuals 19 and over, including the fitting, provision or replacement of hearing aids. This exclusion does not apply to cochlear implants.
- Homeopathic medicines or homeopathic supplies.
- Hypnotherapy.
- Immunizations when recommended for or in anticipation of exposure through travel or work.
- Instructional or educational programs, except diabetes self-management programs unless medically necessary.
- Jaw – Services or supplies for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants, or improving placement of dentures.
- Learning disorders.
- Maintenance supplies and equipment not unique to medical care.
- Marital/partner counseling.
- Massage, massage therapy or neuromuscular re-education, even as part of a physical therapy program.
- Mattresses and mattress pads are only covered when medically necessary to heal pressure sores.
- Mental health treatments for conditions as listed in the current Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association which, according to the DSM, are not attributable to a mental health disorder or disease

- Mental illness does not include –relationship problems (e.g. parent-child, partner, sibling, or other relationship issues), except the treatment of children five years of age or younger for parent-child relational problems, physical abuse of a child, sexual abuse; neglect of a child, or bereavement.

  The following are also excluded: court-mandated psychological evaluations for child custody determinations; voluntary mutual support groups such as Alcoholics Anonymous; adolescent wilderness treatment programs; mental examinations for the purpose of adjudication of legal rights; psychological testing and evaluations not provided as an adjunct to treatment or diagnosis of a stress management, parenting skills, or family education; assertiveness training; image therapy; sensory movement group therapy; marathon group therapy; and sensitivity training.

- Modifications to vehicles or structures to prevent, treat, or accommodate a medical condition.

- Motion analysis, including videotaping and 3-D kinematics, dynamic surface and fine wire electromyography, including physician review.

- Myeloablative high dose chemotherapy, except when the related transplant is specifically covered under the transplantation provisions of this Plan. For related provisions, see 'Transplant Services' in the Covered Expenses section of this Plan Document.

- Narcosynthesis.

- Naturopathic supplies.

- Nicotine related disorders.

- Obesity or weight control – Surgery or other related services or supplies provided for weight control or obesity (including all categories of obesity), whether or not there are other medical conditions related to or caused by obesity. This also includes services or supplies used for weight loss, such as food supplementation programs and behavior modification programs, regardless of the medical conditions that may be caused or exacerbated by excess weight, and self-help or training programs for weight control. Obesity screening and counseling are covered for children and adults; see the 'dietary or nutritional counseling' section under 'Other Covered Services'.

- Oral/facial motor therapy for strengthening and coordination of speech-producing musculature and structures. This exclusion does not apply if medically necessary as part of a treatment plan.

- Orthognathic surgery – Services and supplies to augment or reduce the upper or lower jaw, except as specified under 'Professional Services' in the Covered Expenses section of this Plan Document.

- Osteopathic manipulation, except for treatment of disorders of the musculoskeletal system.

- Over-the-counter medications or nonprescription drugs.

- Panniculectomy for any indication.

- Paraphilias.

- Personal items such as telephones, televisions, and guest meals during a stay at a hospital or other inpatient facility.
- Physical or eye examinations required for administrative purposes such as participation in athletics, admission to school, or by an employer.
- Private nursing service.
- Programs that teach a person to use medical equipment, care for family members, or self-administer drugs or nutrition (except for diabetic education benefit).
- Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present.
- Recreation therapy – Outpatient.
- Rehabilitation – Functional capacity evaluations, work hardening programs, vocational rehabilitation, community reintegration services, and driving evaluations and training programs.
- Replacement costs for worn or damaged durable medical equipment that would otherwise be replaceable without charge under warranty or other agreement.
- Scheduled and/or non-emergent medical care outside of the United States, unless, unless specified in the Covered Expenses – Other Covered Services, Supplies, and Treatments section for this Plan Document.
- Screening tests – Services and supplies, including imaging and screening exams performed for the sole purpose of screening and not associated with specific diagnoses and/or signs and symptoms of disease or of abnormalities on prior testing (including but not limited to total body CT imaging, CT colonography and bone density testing).This does not include preventive care screenings listed under 'Preventive Care Services' in the Covered Expenses section of this Plan Document.
- Self-help or training programs.
- Sensory integration training. This exclusion does not apply if the program, training, or therapy is part of a treatment plan for a pervasive developmental disorder.
- Services for individuals 18 years of age or older with intellectual disabilities which are generally provided by your State Department of Health and Welfare for those with Developmental Disabilities.
- Services of providers who are not eligible for reimbursement under this Plan. An individual organization, facility, or program is not eligible for reimbursement for services or supplies, regardless of whether this Plan includes benefits for such services or supplies, unless the individual, organization, facility, or program is licensed by the state in which services are provided as an independent practitioner, hospital, ambulatory surgical center, skilled nursing facility, durable medical equipment supplier, or mental and/or chemical healthcare facility. To the extent PacificSource maintains credentialing requirements the practitioner or facility must satisfy those requirements in order to be considered an eligible provider.
- Services or supplies available to you from another source, including those available through a government agency.
- Services or supplies for which no charge is made, for which the member is not legally required to pay, or for which a provider or facility is not licensed to provide even though

the service or supply may otherwise be eligible. This exclusion includes services provided by the member, or by an immediate family member.

- Services or supplies with no charge, or which your employer would have paid for if you had applied, or which you are not legally required to pay for. This includes services provided by yourself or an immediate family member.

- Services otherwise available – These include but are not limited to:

  — Services or supplies for which payment could be obtained in whole or in part if the member applied for payment under any city, county, state (except Medicaid), or federal law; and

  — Services or supplies the member could have received in a hospital or program operated by a federal government agency or authority, except otherwise covered expenses for services or supplies furnished to a member by the Veterans' Administration of the United States that are not military service-related.

  This exclusion does not apply to covered services provided through Medicaid or by any hospital owned or operated by the Plan's state of issuance or any state-approved community mental health and developmental disability program.

- Services required by state law as a condition of maintaining a valid driver license or commercial driver license.

- Services, supplies, and equipment not involved in diagnosis or treatment but provided primarily for the comfort, convenience, intended to alter the physical environment, or education of a patient. This includes appliances like adjustable power beds sold as furniture, air conditioners, air purifiers, room humidifiers, heating and cooling pads, home blood pressure monitoring equipment, light boxes, conveyances other than conventional wheelchairs, whirlpool baths, spas, saunas, heat lamps, tanning lights, and pillows.

- Sexual disorders – Services or supplies for the treatment of sexual dysfunction or inadequacy unless medically necessary to treat a mental health diagnosis. For related provisions, see the exclusions for 'family planning', and 'mental illness' in this section.

- Sex reassignment – Procedures, services or supplies related to a sex reassignment unless medically necessary. For related provisions, see exclusions for 'mental illness' in this section.

  Excluded procedures include, but are not limited to: staged gender reassignment surgery, including breast augmentation; penile implantation; liposuction, thyroid chondroplasty, laryngoplasty, or shortening of the vocal cords, and/or hair removal specifically to assist the appearance of other characteristics of gender reassignment.

- Snoring – Services or supplies for the diagnosis or treatment of snoring and/or upper airway resistance disorders, including somnoplasty.

- Social skill training. This exclusion does not apply if the program, training, or therapy is part of a treatment plan for a pervasive developmental disorder.

- Speech therapy – Oral/facial motor therapy for strengthening and coordination of speech-producing muscles and structures, except as medically necessary in the restoration or improvement of speech following a traumatic brain injury or for individuals diagnosed with a pervasive developmental disorder.

- Support groups.
- Training or self-help health or instruction.
- Transplants – Any services, treatments, or supplies for the transplantation of bone marrow or peripheral blood stem cells or any human body organ or tissue, except as expressly provided under the provisions of this Plan for covered transplantation expenses. For related provisions see 'Transplant Services' in the Covered Expenses section of this Plan Document.
- Treatment after coverage ends – Services or supplies a member receives after the member's coverage under this Plan ends, except as follows:
  - If this Plan is replaced by another group health policy while the member is hospitalized, this Plan will continue paying covered hospital expenses until the member is released or benefits are exhausted, whichever occurs first.
- Treatment not medically necessary – Services or supplies that are not medically necessary for the diagnosis or treatment of an illness, injury, or disease. For related provisions, see 'medically necessary' in the Definitions section and 'Understanding Medical Necessity' in the Covered Expenses section of this Plan Document.
- Treatment of any illness, injury, or disease resulting from an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement other than with local supervisory authority while pending disposition of charges.
- Treatment of any work-related illness, injury, or disease, except in the following circumstances:
  - You are the owner, partner, or principal of the Plan Sponsor, and are otherwise exempt from the applicable state or federal workers' compensation insurance program;
  - You have timely filed an application for coverage with the appropriate state or federal workers' compensation insurance program and are awaiting a determination of coverage from that entity; or
  - The appropriate state or federal workers' compensation insurance program has determined that coverage is not available for your injury.
- Treatment of intellectual disabilities.
- Treatment prior to enrollment – Services or supplies a member received prior to enrolling in coverage provided by this Plan, such as inpatient stays or admission to a hospital, skilled nursing facility or specialized facility that began before the patient's coverage under this Plan.
- Unwilling to release information – Charges for services or supplies for which a member is unwilling to release medical or eligibility information necessary to determine the benefits payable under this Plan.
- Vocational rehabilitation, functional capacity evaluations, work hardening programs, community reintegration services, and driving evaluations and training programs, except as medically necessary in the restoration or improvement of speech following a traumatic brain injury or for individuals diagnosed with a pervasive development disorder.

PREAUTHORIZATION

Coverage of certain medical services and surgical procedures requires a benefit determination before the services are performed. This process is called 'preauthorization'. PacificSource will utilize the criteria adopted by the Plan Sponsor and, where necessary, will coordinate review with the Plan Sponsor, to render a determination based on the Plan.

Preauthorization is necessary to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements.

Your medical provider can request preauthorization by making the request to the PacificSource Health Services Department by phone, fax, mail, or email. If your provider will not request preauthorization for you, you may contact PacificSource yourself. In some cases, they may ask for more information or require a second opinion before the Plan will authorize coverage.

The list of procedures and services requiring preauthorization is subject to constant, on-going revision and update by the Plan Sponsor. ***The list is not intended to suggest that all the items included are necessarily covered by the benefits of this Plan.*** You'll find the most current preauthorization list on their website, PacificSource.com.

Services requiring preauthorization however this is subject to change so please see the preauthorization list at PacificSource.com:

- All inpatient admissions to a hospital (not including emergency room care), skilled nursing facility or a rehabilitation facility, all emergency hospitalizations (PacificSource must be notified as soon as reasonably possible) and all hospital birthing center admissions for maternity/delivery services;
- All outpatient surgical procedures;
- All inpatient, residential and day or partial hospitalization treatment services for Mental Health and Chemical dependency conditions;
- All human organ/tissue transplant related services;
- All restoration of head/facial structures: Limited dental services;
- All PET, CT, CTA, MRI and MRA imaging and nuclear cardiac study services;
- All home healthcare services;
- All hospice services;
- All medical supplies, appliances, prosthetic and orthotic devices, and durable medical equipment in excess of $800;
- All outpatient hospitalization and anesthesia for dental; or
- All outpatient cardiac rehabilitation services.

If your treatment is not preauthorized, you can still seek treatment, but you will be held responsible for the expense if it is not medically necessary or is not covered by this Plan. Remember, any time you are unsure if an expense will be covered, contact the PacificSource Customer Service Department.

Notification of the Plan's benefit determination will be communicated by letter, fax, or electronic transmission to the hospital, the provider, and you. If time is a factor, notification will be made by telephone and followed up in writing.

PacificSource reserves the right to employ a third party to perform preauthorization procedures on its behalf.

In a medical emergency, services and supplies necessary to determine the nature and extent of the emergency condition and to stabilize the patient are covered without preauthorization requirements. PacificSource must be notified of an emergency admission to a hospital or specialized treatment center as an inpatient within two business days.

If your provider's preauthorization request is denied as not medically necessary or as experimental, your provider may appeal our benefit determination. You retain the right to appeal our benefit determination independent from your provider.

CASE MANAGEMENT

Case management is a service provided by Registered Nurses who are Certified Case Managers with specialized skills to respond to the complexity of a member's healthcare needs. Case management services may be initiated by PacificSource when there is a high utilization of health services or multiple providers, or for health problems such as, but not limited to, transplantation, high risk obstetric or neonatal care, open heart surgery, neuromuscular disease, spinal cord injury, or any acute or chronic condition that may necessitate specialized treatment or care coordination. When case management services are implemented, the Nurse Case Manager will work in collaboration with the patient's PCP, PacificSource Medical Director and, where necessary, the Plan Sponsor, to enhance the quality of care and maximize available benefits of this Plan. This does not apply if services or setting are deemed medically necessary.

PacificSource reserves the right to employ a third party to assist with, or perform the function of, case management.

INDIVIDUAL BENEFITS MANAGEMENT

Individual benefits management addresses, as an alternative to providing covered services, PacificSource's consideration of economically justified alternative benefits. The decision to allow alternative benefits will be made by on a case-by-case basis. The determination to cover and pay for alternative benefits for an individual shall not be deemed to waive, alter or affect the Plan Sponsor's or PacificSource's right to reject any other or subsequent request or recommendation. The Plan Sponsor may provide alternative benefits if PacificSource and the individual's attending provider concur in the request for and in the advisability of alternative benefits in lieu of specified covered services, and, in addition, PacificSource concludes that substantial future expenditures for covered services for the individual could be significantly diminished by providing such alternative benefits under the individual benefit management program (See Case Management above).

UTILIZATION REVIEW

PacificSource has a utilization review program based on the criteria adopted by the Plan Sponsor to determine coverage of hospital admissions. This program is administered by their Health Services Department. All hospital admissions are reviewed by PacificSource Nurse Case Managers, who are all registered nurses and Certified Case Managers. Questions

regarding medical necessity, possible experimental or investigational services, appropriate setting, and appropriate treatment are forwarded to the PacificSource Medical Director for review and benefit determination based on the criteria established by the Plan Sponsor.

PacificSource reserves the right to delegate a third party to assist with or perform the function of utilization management.

Authorization of Hospital Admissions

When a Plan member is admitted to a hospital within the area covered by PacificSource's provider networks (see the Using the Provider Network – Coverage While Traveling section), the hospital calls PacificSource to verify the patient's eligibility and benefits. The hospital gives PacificSource information about the patient's diagnosis, procedure, and attending physician and they use this information to evaluate how long each patient is expected to remain hospitalized.

This is called the 'target length of stay.' PacificSource will use the target length of stay to monitor the patient's progress and plan for any necessary follow-up care after the patient is discharged.

The PacificSource Health Services Department assigns the target length of stay based on the patient's diagnosis and/or procedure, and any other criteria adopted by the Plan Sponsor. For standard hospitalizations, they use written procedures that were developed based on the following guidelines:

- Milliman Care Guidelines;
- Standard of practice in the State where the Plan was issued; and
- Any additional criteria adopted by the Plan Sponsor.

If they are unable to assign a target length of stay based on those guidelines, their Nurse Case Manager contacts the hospital for more specific information about the case. They will then use that information to assign a target length of stay for the patient.

Extension of Hospital Stays

If a patient's hospital stay extends beyond the targeted length of stay, a Nurse Case Manager contacts the hospital to obtain current information about the patient's medical progress and assign a new target length of stay or begin planning for the patient's discharge. The PacificSource Medical Director may review the case to determine if extended hospitalization meets coverage criteria as defined in the previous section.

Occasionally, patients choose to extend their hospital stay beyond the length the attending physician considers medically necessary. Charges for hospital days and services beyond those determined to be medically necessary are the member's responsibility.

Timeliness for Responding to Coverage Request

When PacificSource receives a request for coverage of an admission or extension of a hospital stay, they are generally able to provide an answer that same day. If they do not have enough information to make a benefit determination based on criteria, they may request further information, coordinate with the Plan Sponsor as necessary, and attempt to provide a determination on the day they receive that information. If a member is discharged before they

receive the information we need, the case is reviewed retrospectively by the Nurse Case Manager and the Medical Director for a determination regarding coverage.

Questions About Specific Utilization Review Decisions

If you would like information on how PacificSource reached a particular utilization review benefit determination, please contact PacificSource's Health Services Department by phone at (541) 684-5584 or (888) 691-8209, or by email at healthservices@pacificsource.com.

CLAIMS PAYMENT

How to File a Claim

When a participating provider treats you, your claims are automatically sent to PacificSource and processed. All you need to do is show your ID card to the provider.

If you receive care from a non-participating provider, the provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to them for processing. Your claim must include a copy of your provider's itemized bill. It must also include your name, ID number or social security number, group name, group number, and the patient's name. If you were treated for an accidental injury, please include the date, time, place, and circumstances of the accident.

All claims for benefits must be turned in to PacificSource within 90 days of the date of service. If it is not possible to submit a claim within 90 days, turn in the claim with an explanation as soon as possible. In some cases PacificSource may accept the late claim. The Plan will never pay a claim that was submitted more than a year after the date of service.

All claims should be sent to:

PacificSource
Attn: Claims
PO Box 7068
Springfield, OR 97475-0068

Claim Handling Procedures

A claim for benefits under this Plan will be examined by PacificSource on a pre-service, concurrent, and/or a post-services basis. Each time your claim is examined, a new claims determination will be made regarding the category (pre-service, concurrent, or post-service) into which the claim falls at that particular time. In each case, PacificSource, on behalf of the Plan Sponsor, must render a claim determination within a prescribed period of time.

Pre-service claims – This Plan subjects the receipt of benefits for some services or supplies to a preauthorization review. Although a preauthorization review is generally done on a pre-service basis, it may in some case be conducted on a post-service basis. Unless a response is needed sooner due to the urgency of the situation, a pre-service preauthorization review will be completed and notification made to you and your medical provider within two working days within receipt of the request.

Urgent care claims – If the time period for making a non-urgent care determination could seriously jeopardize your life, health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is

proposed, a preauthorization review will be completed as soon as possible, generally within 24 hours, but no later than 72 hours of receipt of the request.

Concurrent care review – Inpatient hospital or rehabilitation facilities, skilled nursing facilities, intensive outpatient, and residential behavioral healthcare require concurrent review for a benefit determination with regard to an appropriate length of stay or duration of service. Benefit determinations will be made as soon as possible but no later than one working day of receipt of all the information necessary to make such a determination.

Post-service claims – A claim determination that involves only the payment of reimbursement of the cost of medical care that has already been provided will be made as soon as reasonably possible but no later than 30 days from the day after receiving the claim.

Retrospective review – A claim for benefits for which the service or supply requires a preauthorization review but was not submitted for review on a pre-service basis will be reviewed on a retrospective basis within 30 working days after receipt of the information necessary to make a claim determination.

Extension of time – Despite the specified timeframes, nothing prevents the member from voluntarily agreeing to extend the above timeframes. Unless additional information is needed to process your claim, PacificSource will make every effort to meet the timeframes stated above. If a claim cannot be paid within the stated timeframes because additional information is needed, they will acknowledge receipt of the claim and explain why payment is delayed. If they do not receive the necessary information within 15 days of the delay notice, they will either deny the claim or notify you every 45 days while the claim remains under investigation. No extension is permitted for urgent care claims.

Payment of claims – PacificSource, on behalf of the Plan, has the sole right to pay benefits to the member, the provider, or both jointly. Neither the benefits of this Plan nor a claim for payment of benefits under the Plan are assignable in whole or in part to any person or entity.

Adverse benefit determinations – A decision made to reduce or deny benefits applied on a pre-service, post-service, or concurrent care basis may be appealed in accordance with the Plan's Appeals procedures (see Complaints, Grievances, and Appeals section below).

Questions About Claims

If you have questions about the status of a claim, you are welcome to contact the PacificSource Customer Service Department. You may also contact Customer Service if you believe a claim was denied in error. They will review your claim and this Plan benefits to determine if the claim is eligible for payment. Then PacificSource will either reprocess the claim for payment, or contact you with an explanation.

Benefits Paid in Error

If PacificSource makes a payment to you that you are not entitled to, or pays a person who is not eligible for payment, we may recover the payment. PacificSource, on behalf of the Plan Sponsor, may also deduct the amount paid in error from your future benefits.

In the same manner, if PacificSource applies medical expense to the Plan's deductible that would not otherwise be reimbursable under the terms of this policy; PacificSource, on behalf of the Plan Sponsor, may deduct a like amount from the accumulated deductible amount and/or recover payment of medical expense that would have otherwise been applied to the deductible. Examples of amounts recoverable under this provision include, but are not limited to benefits provided for incurred expense for the treatment of an excluded medical condition.

The fact that a medical expense was applied to the Plan's deductible or a drug was provided under the Plan's prescription drug program does not in itself create an eligible expense or infer that benefits will continue to be provided for an otherwise excluded condition.

COORDINATION OF BENEFITS

This is a summary of only a few of the provisions of this Plan to help you understand coordination of benefits which can be very complicated. This is not a complete description of all of the coordination rules.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, the law permits your insurers to follow a procedure called 'coordination of benefits' to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. PacificSource will need this information to determine whether we are the 'primary' or 'secondary' benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your COB rules will always be primary.

When This Plan is Primary

If you or a family member are covered under another plan in addition to this one, this Plan will be primary when:

Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child's Expenses

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

Other Situations

The Plan will be primary when any other provisions of federal law require it to be.

How this Plan Pays Claims When it is Primary

When this Plan is the primary plan, we will pay the benefits in accordance with the terms of this Plan, just as if you had no other health care coverage under any other plan.

How this Plan Pays Claims When it is Secondary

This Plan will be secondary whenever the rules do not require it to be primary.

When this Plan is the secondary plan, it does not pay until after the primary plan has paid its benefits. This Plan will then pay part or all of the allowable expenses left unpaid, as explained below. An 'allowable expense' is a health care expense covered by one of the plans, including copayments, coinsurance and deductibles.

- If there is a difference between the amounts the plans allow, this Plan will base its payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in the contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their providers.
- This Plan will determine its payment by calculating the amount it would have paid if it had been primary, and apply that calculated amount to any allowable expense that is left unpaid by the primary plan. This Plan may limit its payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your claim. This Plan will credit any amount it would have paid in the absence of your other health care coverage toward this Plan's deductible.
- If the primary plan covers similar kinds of health care expenses, but allows expenses that this Plan does not cover, it may pay for those expenses.
- This Plan will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, as required by that plan, this Plan will not pay the amount of the reduction, because it is not an allowable expense.

Questions About Coordination of Benefits?
Contact the Plan Sponsor or PacificSource's Customer Service Department

Coordination with Medicare

- *Employers with 20 or more employees:* If you are Medicare eligible due to age, this Plan is usually the primary payer and Medicare is secondary. This rule applies to you and your enrolled individuals only if you are an active employee.
- Medicare eligibility due to age:

  For employer groups with 20 or more employees, this Plan pays benefit without regard to the benefits available from Medicare for active employees and their enrolled family members.

  For employer groups with 19 or fewer employees and for individuals on COBRA continuation, the benefits of this Plan are paid after amounts payable by Medicare are deducted. This limitation applies whether or not a Medicare-eligible individual is enrolled in both Part A and Part B. In order to maximize the benefits available under this Plan and

avoid unnecessary out-of-pocket expense, a Medicare-eligible individual should enroll in both Medicare Part A and Part B. PacificSource will notify those Medicare-eligible individuals for whom Medicare becomes primary payer for their medical expense.

- *Medicare disabled and end-stage renal disease (ESRD) patients*: The rules above may not apply to disabled people under 65 and ESRD patients enrolled in Medicare, please see Medicare.gov for more information. For information on coordination of benefits in those situations, please contact PacificSource.

THIRD PARTY LIABILITY

Third party liability means claims that are the responsibility of someone other than this Plan. The liable party may be a person, firm, or corporation. Auto accidents and 'slip-and-fall' property accidents are examples of common third party liability cases. If you use this Plan's benefits for an illness or injury you think may involve another party, contact PacificSource immediately.

A third party includes liability and casualty insurance, and any other form of insurance that may pay money to or on behalf of a member, including but not limited to uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, Personal Injury Protection (PIP) coverage, homeowner's insurance, and workers' compensation insurance.

If you use this Plan's benefit for an illness or injury you think may involve another party, contact PacificSource right away.

When PacificSource receives a claim that might involve a third party, it will send you a questionnaire to help determine responsibility.

In all third party liability situations, this Plan's coverage is secondary. By enrolling in this Plan, you automatically agree to the following terms regarding third party liability situations:

- If this Plan pays any claim determined to be the responsibility of another party, you will hold the right of recovery against the other party in trust for the Plan.
- The Plan is entitled to reimbursement for any paid claims if there is a settlement or judgment from the other party. This is so regardless of whether the other party or insurer admits liability or fault.
- The Plan may subtract a proportionate share of the reasonable attorney's fees you incurred from the money you are to pay back to the Plan.
- The Plan may ask you to take action to recover medical expenses we have paid from the responsible party. The Plan may also assign a representative to do so on your behalf. If there is a recovery, the Plan will be reimbursed for any expenses or attorney's fees out of that recovery.
- If you receive a third party settlement, that money must be used to pay your related medical expenses incurred both before and after the settlement. If you have ongoing medical expenses after the settlement, the Plan may deny your related claims until the full settlement (less reasonable attorney's fees) has been used to pay those expenses.
- In a third party liability situation, the Plan will ask you to agree to the third party liability terms of this Plan by signing an agreement. The Plan is not required to pay benefits until that agreement is signed and returned.

Motor Vehicle and Other Accidents

If you are involved in a motor vehicle accident or other accident, your related medical expenses are not covered by this Plan if they are covered by any other type of insurance policy.

The Plan may pay your medical claims from the accident if an insurance claim has been filed with the other insurance company and that insurance has not yet paid. But before that occurs, you must sign a written agreement to reimburse the Plan out of any money you recover.

By enrolling in this Plan, you agree to the terms in the previous section regarding third party liability.

On-the-Job Illness or Injury and Workers' Compensation

This Plan does not cover any work-related illness, injury, or disease that is caused by any for-profit activity, whether through employment or from self-employment. The only exceptions would be if:

- You are the owner, partner, or principal of the Plan Sponsor, are injured in the course of employment, and are otherwise exempt from the applicable, and not covered by, state or federal workers' compensation insurance program;.
- You have timely filed an application for coverage with the appropriate state or federal workers' compensation insurance program and are awaiting a determination of coverage from that entity; or
- The appropriate state or federal workers' compensation insurance program has determined that coverage is not available for your injury.

Claims submitted for coverage under this section are processed in accordance with the terms of this Plan.

If you are not the owner, partner, or principal of this group then the Plan may pay your medical claims if a workers' compensation claim has been denied on the basis that the illness or injury is not work related, and the denial is under appeal. But before that occurs, you must sign a written agreement to reimburse the Plan out of any money you recover from the workers' compensation coverage.

The contractual rules for third party liability, motor vehicle and other accidents, and on-the-job illness or injury are complicated and specific. Please refer to this Plan for complete details, or contact the PacificSource Third Party Claims Department.

This Plan will remain in effect upon timely payment of the full premium until whichever of the following events first occurs:

- The employee takes full-time employment with another employer; or
- Six months from the date the employee first makes payment under this provision.

COMPLAINTS, GRIEVANCES, AND APPEALS

Questions, Concerns, or Complaints

The Plan Sponsor understands that you may have questions or concerns about your benefits, eligibility, the quality of care you receive, or how we reached a claim determination or handled a claim. PacificSource will try to answer your questions promptly and give you clear, accurate answers based on the criteria established by the Plan Sponsor.

If you have a question, concern, or complaint about your coverage, please contact the Customer Service Department. Many times the Customer Service staff can answer your question or resolve an issue to your satisfaction right away. If you feel your issues have not been addressed, you have the right to submit a grievance and/or appeal in accordance with this section.

GRIEVANCE PROCEDURES

If you are dissatisfied with the availability, delivery, or the quality of healthcare services; or claims payment, handling or reimbursement for healthcare services; or matters pertaining to the contractual relationship between you and the Plan, you may file a grievance in writing. PacificSource will attempt to address your grievance, generally within 30 days of receipt (see How to Submit Grievances or Appeals below).

APPEAL PROCEDURES

First Internal Appeal: If you believe the Plan Sponsor, or PacificSource acting on behalf of the Plan Sponsor, has improperly reduced or terminated a healthcare item or service, or failed or refused to provide or make a payment in whole or in part for a healthcare item or service, that is based on any of the reasons listed below, you or your authorized representative (see Definition section) may appeal (request a review) that decision. The request for appeal must be made in writing and within 180 days of the adverse benefit determination (see How to Submit Grievances or Appeals below). You may appeal if there is an adverse benefit determination based on a:

- Denial of eligibility for or termination of enrollment in a healthcare plan;
- Rescission or cancellation of your coverage;
- Imposition of a network exclusion, annual benefit limit or other limitation on otherwise covered services or items;
- Determination that a healthcare item or service is experimental, investigational or not medically necessary, effective or appropriate; or
- Determination that a course or plan of treatment you are undergoing is an active course of treatment for the purpose of continuity of care.

Any staff involved in the initial adverse benefit determination will not be involved in the internal appeal.

You or your authorized representative may submit additional comments, documents, records and other materials relating to the adverse benefit determination that is the subject of the appeal. If an authorized representative is filing on your behalf, your appeal is not considered

to be filed until such time as PacificSource has received the Authorization to Use / Disclose PHI and the Designation of Personal Representative.

You may receive continued coverage under the Plan for otherwise covered services pending the conclusion of the internal appeals process. If the Plan makes payment for any service or item on your behalf that is later determined not to be a covered service or item, you will be expected to reimburse the Plan for the non-covered service or item.

Second Internal Appeal: If you are not satisfied with the first internal appeal decision, you may request an additional review. Your appeal and any additional information not presented with your first internal appeal should be forwarded to PacificSource within 60 days of the first appeal response.

Any staff involved in the first internal appeal decision will not be involved in the second internal appeal.

Request for Expedited Response: If there is a clinical urgency to do so, you or your authorized representative may request in writing or orally, an expedited response to an internal or external review of an adverse benefit determination. To qualify for an expedited response, your attending physician must attest to the fact that the time period for making a non-urgent benefit determination could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the healthcare service or treatment that is the subject of the request. If your appeal qualifies for an expedited review and would also qualify for external review (see External Independent Review below) you may request that the internal and external reviews be performed at the same time.

External Independent Review: If your dispute with the Plan relates to an adverse benefit determination that a course or plan of treatment is not medically necessary; is experimental or investigational; is not an active course of treatment for purposes of continuity of care; or is not delivered in an appropriate healthcare setting and with the appropriate level of care, you or your authorized representative may request an external review by an independent review organization (see How to Submit Grievances or Appeals below).

Your request for an independent review must be made within 180 days of the date of the second internal appeal response. External independent review is available at no cost to you, but is generally only available when coverage has been denied for the reasons stated above and only after all internal grievance levels are exhausted. The Plan will pay for any cost associated with the external independent review.

If you have questions regarding Oregon's external review process, you may contact the Oregon Insurance Division at (503) 947-7984 or the toll-free message line at (888) 877-4894.

Timelines for Responding to Appeals

You will be afforded two levels of internal appeal and, if applicable to your case, an external review. PacificSource will acknowledge receipt of an appeal no later than seven days after receipt. A decision in response to the appeal will be made within 30 days after receiving your request to appeal.

The above time frames do not apply if the period is too long to accommodate the clinical urgency of a situation, or if you do not reasonably cooperate, or if circumstances beyond your or our control prevent either party from complying with the time frame. In the case of a delay, the party unable to comply must give notice of delay, including the specific circumstances, to the other party.

Information Available with Regard to an Adverse Benefit Determination

The final adverse benefit determination will include:

- A reference to the specific internal rule or guideline used in the adverse benefit determination; and
- An explanation of the scientific or clinical judgment for the adverse benefit determination, if the adverse benefit determination is based on medical necessity, experimental treatment, or a similar exclusion.

Upon request, PacificSource will provide you with any additional documents, records or information that are relevant to the adverse benefit determination.

HOW TO SUBMIT GRIEVANCES OR APPEALS

Before submitting a grievance or appeal, we suggest you contact PacificSource's Customer Service Department with your concerns. You can reach it by phone or email at the contact information found on the first page of this Plan Document. Issues can often be resolved at this level. Otherwise, you may file a grievance or appeal by:

Writing to:

PacificSource
Attn: Grievance Review
PO Box 7068
Springfield, OR 97475-0068

Emailing cs@pacificsource.com, with 'Grievance' as the subject

Faxing (541) 225-3628

If you are unsure of what to say or how to prepare a grievance, please call PacificSource's Customer Service Department. They will help you through the grievance process and answer any questions you have.

Assistance Outside PacificSource

You have the right to file a complaint or seek other assistance from the Oregon Insurance Division. Assistance is available:

By calling (503) 947-7984 or the toll-free message line at (888) 877-4894

By writing to:

The Oregon Insurance Division
Consumer Advocacy Unit
PO Box 14480
Salem, OR 97309-0405

Through the Internet at
http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx

Or by email at cp.ins@state.or.us

RESOURCES FOR INFORMATION AND ASSISTANCE

Assistance in Other Languages

Plan members who do not speak English may contact PacificSource's Customer Service Department for assistance. PacificSource can usually arrange for a multilingual staff member or interpreter to speak with them in their native language.

Information Available from PacificSource

The Plan makes the following written information available to you free of charge. You may contact PacificSource's Customer Service Department by phone, mail, or email to request any of the following:

- A directory of participating healthcare providers under this Plan;
- Information about the drug formulary;
- A description (consistent with risk-sharing information required by the Centers for Medicare and Medicaid Services, formerly known as Health Care Financing Administration) of any risk-sharing arrangements the Plan or PacificSource has with providers;
- A description of the Plan and/or PacificSource's efforts to monitor and improve the quality of health services;
- Information about how PacificSource checks the credentials of its network providers and how you can obtain the names and qualifications of your healthcare providers;
- Information about preauthorization and utilization review procedures; and
- Information about any healthcare plan offered by PacificSource.

Information Available from the Oregon Insurance Division

The following consumer information is available from the Oregon Insurance Division:

- The results of all publicly available accreditation surveys;
- A summary of our health promotion and disease prevention activities;
- Samples of the written summaries delivered to PacificSource policyholders;
- An annual summary of grievances and appeals against PacificSource;
- An annual summary of our utilization review policies;
- An annual summary of our quality assessment activities; and
- An annual summary of the scope of our provider network and accessibility of healthcare services.

You can request this information by contacting the Oregon Insurance Division by writing to the Oregon Insurance Division, Consumer Advocacy Unit, PO Box 14480, Salem, OR 97309-

0405 or by phone at (503) 947-7984, or toll-free message line at (888) 877-4894, on the internet at http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx, or by email at cp.ins@state.or.us.

RIGHTS AND RESPONSIBILITIES

The Plan and PacificSource are committed to providing you with the highest level of service. By respecting your rights and clearly explaining your responsibilities under this Plan, we will promote effective healthcare.

Your Rights as a Member:

- You have a right to receive information about the Plan and PacificSource, our services, our providers, and your rights and responsibilities.
- You have a right to expect clear explanations of this Plan's benefits and exclusions.
- You have a right to be treated with respect and dignity.
- You have a right to impartial access to healthcare without regard to race, religion, gender, national origin, or disability.
- You have a right to honest discussion of appropriate or medically necessary treatment options. You are entitled to discuss those options regardless of how much the treatment costs or if it is covered by this Plan.
- You have a right to the confidential protection of your medical records and personal information.
- You have a right to voice complaints about the Plan, PacificSource or the care you receive, and to appeal decisions you believe are wrong.
- You have a right to participate with your healthcare provider in decision-making regarding your care.
- You have a right to know why any tests, procedures, or treatments are performed and any risks involved.
- You have a right to refuse treatment and be informed of any possible medical consequences.
- You have a right to refuse to sign any consent form you do not fully understand, or cross out any part you do not want applied to your care.
- You have a right to change your mind about treatment you previously agreed to.
- You have a right to make recommendations regarding this member rights and responsibilities policy.

Your Responsibilities as a Member:

- You are responsible for reading this Plan Document and all other communications from the Plan and PacificSource, and for understanding this Plan's benefits. You are responsible for contacting the Plan and/or PacificSource Customer Service if anything is unclear to you.

- You are responsible for making sure your participating provider obtains preauthorization for any services that require it before you are treated.
- You are responsible for providing the Plan and PacificSource with all the information required to provide benefits under this Plan.
- You are responsible for giving your healthcare provider complete health information to help accurately diagnose and treat you.
- You are responsible for telling your providers you are covered by the Plan and showing your ID card when you receive care.
- You are responsible for being on time for appointments, and calling your provider ahead of time if you need to cancel.
- You are responsible for any fees the provider charges for late cancellations or 'no shows'.
- You are responsible for contacting the Plan or PacificSource if you believe you are not receiving adequate care.
- You are responsible to supply information to the extent possible that the Plan or PacificSource needs in order to administer your benefits or your medical providers need in order to provide care.
- You are responsible to follow plans and instructions for care that you have agreed to with your doctors.
- You are responsible for understanding your health problems and participating in developing mutually agreed upon goals, to the degree possible.

PRIVACY AND CONFIDENTIALITY

The Plan and PacificSource have strict policies in place to protect the confidentiality of your personal information, including your medical records. Your personal information is only available to the staff members who need that information to do their jobs.

Disclosure outside the Plan and PacificSource is allowed only when necessary to provide your coverage, or when otherwise allowed by law. Except when certain statutory exceptions apply, the law requires us to have written authorization from you (or your representative) before disclosing your personal information outside the Plan or PacificSource.

PLAN ADMINISTRATION

Name of Plan:

The Lane County Group Health Plan (the "Plan").

Name and Address of the Plan Sponsor:

Lane County
125 E 8th Avenue
Eugene, OR 97401
Phone: (541) 685 4221
Fax: (541) 682 4290
Mary.miller@co.lane.or.us

Plan Sponsor's Employer Identification / Tax Identification Number:

93-6002303

Contract Year:

August 1 to July 31

Type of Plan:

Group Health Plan (self-funded)

Type of Administration:

The Plan is administered by employees of the Plan Sponsor and under an administrative services agreement with a third-party administrator.

Name and Address of Third Party Administrator:

PacificSource Health Plans
P.O. Box 7068
Springfield, OR 97475-0068
Phone: (888) 977-9299
Fax: (541) 684-5264

Name and Address of Designated Agent for Service of Legal Process:

Lane County
125 E 8th Avenue
Eugene, OR 97401

Funding Method and Contributions:

This Plan is self-insured, meaning that benefits are paid from the general assets and/or trust funds of the Plan Sponsor and are not guaranteed under an insurance policy or contract. The cost of the Plan is paid with contributions by the Plan Sponsor and participating employees. The Plan Sponsor determines the amount of contributions to the Plan, based on estimates of claims and administration costs. The Plan Sponsor may purchase insurance coverage to guard against excess loss incurred by allowed claims under the Plan, but such coverage is not included as part of the Plan.

Plan Changes

The terms, conditions, and benefits of this Plan may be changed from time to time. The following people have the authority to accept or approve changes or terminate this Plan:

- The Plan Sponsor's board of directors or other governing body;
- The owner or partners of the Plan Sponsor; or
- Anyone authorized by the above people to take such action.

The Plan Administrator is authorized to make Plan changes on behalf of the Plan Sponsor.

If this Plan terminates and the Plan Sponsor does not replace the coverage with another group policy, the Plan Sponsor is required by law to advise you in writing of the termination.

Legal Procedures

You may not take legal action against the Plan Sponsor or PacificSource to enforce any provision of the Plan until 60 days after your claim is properly submitted in accordance with established procedures. Also, you must exhaust this Plan's claims procedures, and grievance and appeals procedures, before filing benefits litigation. You may not take legal action against the Plan Sponsor or PacificSource more than three years after the deadline for claim submission has expired.

DEFINITIONS

Wherever used in this Plan, the following definitions apply to the terms listed below, and the masculine includes the feminine and the singular includes the plural. For the purpose of this Plan, 'employee' includes the employer when covered by this Plan. Other terms are defined where they are first used in the text.

Accident means an unforeseen or unexpected event causing injury that requires medical attention.

Advanced diagnostic imaging means diagnostic examinations using CT scans, MRIs, PET scans, CATH labs, and nuclear cardiology studies.

Adverse benefit determination means the Plan Sponsor's denial, reduction, or termination of a healthcare item or service, or the Plan Sponsor's failure or refusal to provide or to make a payment in whole or in part for a healthcare item or service that is based on the Plan Sponsor's:

- Denial of eligibility for or termination of enrollment in a health benefit plan;
- Rescission or cancellation of a policy or coverage;
- Imposition of a network exclusion, annual benefit limit or other limitation on otherwise covered items or services;
- Determination that a healthcare item or service is experimental, investigational, or not medically necessary, effective, or appropriate; or
- Determination that a course or plan of treatment that a member is undergoing is an active course of treatment for purposes of continuity of care.

Allowable fee is the dollar amount established for reimbursement of charges for specific services or supplies provided by non-participating providers. Depending on the service or supply and the geographical area in which it is provided, the allowable fee may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), a vendor, other nationally recognized databases, or PacificSource, as documented in PacificSource's payment policy and adopted by the Plan Sponsor.

Ambulatory surgical center means a facility licensed by the appropriate state or federal agency to perform surgical procedures on an outpatient basis.

Appeal means a written or verbal request from a member or, if authorized by the member, the member's representative, to change a previous decision made by the Plan Sponsor concerning;

- Access to healthcare benefits, including an adverse benefit determination made pursuant to utilization management;
- Claims payment, handling or reimbursement for healthcare services;
- Matters pertaining to the contractual relationship between a Member and the Plan;
- Rescissions of member's benefit coverage by the Plan Sponsor; and
- Other matters as specifically required by law.

Approved clinical trials are Phase I, II, III, or IV clinical trials for the prevention, detection, or treatment of cancer or another life-threatening condition or disease; or:

- Funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs;
- Supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs;
- Conducted as an investigational new drug application, an investigational device exemption or a biologics license application subject to approval by the United States Food and Drug Administration; or
- Exempt by federal law from the requirement to submit an investigational new drug application to the United States Food and Drug Administration.

Authorized representative is an individual who by law or by the consent of a person may act on behalf of the person. An authorized representative *must* have the member complete and execute an Authorization to Use / Disclose PHI form and a Designation of Authorized Representative form, both of which are available at Pacificsource.com and which will be supplied to you upon request. These completed forms must be submitted to PacificSource before PacificSource can recognize the authorized representative as acting on behalf of the member.

Benefit determination means the activity taken to determine or fulfill the Plan Sponsor's responsibility for provisions under this Plan and provide reimbursement for healthcare in accordance with those provisions. Such activity may include:

- Eligibility and coverage determinations (including coordination of benefits), and adjudication or subrogation of health benefit claims;
- Review of healthcare services with respect to medical necessity (including underlying criteria), coverage under this Plan, appropriateness of care, experimental/investigational treatment, justification of charges; and
- Utilization review activities, including precertification and preauthorization of services and concurrent and retrospective review of services.

Calendar year means the 12 month period beginning January 1 of any year through December 31 of the same year.

Cardiac rehabilitation refers to a comprehensive program that generally involves medical evaluation, prescribed exercise, and cardiac risk factor modification. Education, counseling, and behavioral interventions are sometimes used as well. Phase I refers to inpatient services that typically occur during hospitalization for heart attack or heart surgery. Phase II refers to a short-term outpatient program, usually involving ECG-monitored exercise. Phase III refers to a long-term program, usually at home or in a community-based facility, with little or no ECG monitoring.

Chemical dependency means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological, or physical adjustment to common problems on a recurring basis. Chemical dependency does not include addiction to, or dependency on, tobacco products or foods.

Chemical dependency treatment facility means a treatment facility that provides a program for the treatment of alcoholism or drug addiction pursuant to a written treatment plan approved and monitored by a physician or addiction counselor licensed by the state; and is licensed or approved as a treatment center by the department of public health and human services, is licensed by the state where the facility is located.

Co-insurance means a defined percentage of the allowable fee for covered services and supplies the member receives. It is the percentage the member is responsible for, not including co-pays and deductible. The co-insurance the member is responsible for is listed in the Medical Benefit Summary for participating and non-participating providers.

Complaint means an expression of dissatisfaction directly to the Plan Sponsor or PacificSource that is about a specific problem encountered by a member, or about a benefit determination by the Plan Sponsor or an agent acting on behalf of the Plan Sponsor, including PacificSource, and that includes a request for action to resolve the problem or change the benefit determination. Complaint does not include an inquiry.

Congenital anomaly means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. The term significant deviation is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

Contract year means a 12-month period beginning on the date this Plan is issued or the anniversary of the date this Plan was issued. The specific dates for the contract year applicable to this Plan are reflected in the introductory section at the beginning of this Plan Document. If changes are made to the Plan on a date other than the anniversary of issuance, a new contract year may start on the date the changes become effective if so agreed by the Plan Sponsor and PacificSource. A contract year may or may not coincide with a calendar year.

Contracted allowable fee is an amount the Plan agrees to pay a participating provider for a given service or supply through direct or indirect contract.

Co-payment (also referred to as 'co-pay') is fixed up-front dollar amount the member is required to pay for certain covered services. The co-pay applicable to a specific covered service is listed under that specific benefit in the Medical Benefit Summary.

Covered expense is an expense for which benefits are payable under by this Plan subject to applicable deductible, co-payment, co-insurance, out-of-pocket maximum, or other specific limitations.

Deductible means the portion of the healthcare expense that must be paid by the member before the benefits of this Plan are applied.

Dependent children means any natural, step, adopted or eligible child you, your spouse, or your Qualified Domestic Partner are legally obligated to support or contribute support for. This may include eligible siblings, nieces, nephews, foster children, children of an enrolled dependent, or grandchildren/ newborn children born to a covered dependent if you are the court appointed legal custodian or guardian. Eligible dependent children may be covered under the Plan only if they meet the eligibility requirements of the Plan (see Becoming Covered – Eligibility).

Domestic Partner means an individual who is in a committed relationship with an Employee who is eligible for benefits under the terms of this Plan and is not the Employee's spouse. A Domestic Partner may or may not be the same gender. A Certificate of Domestic Partnership, which is available from the Human Resources Department, must be completed and approved by the Plan Administrator before any individual will be recognized as a Qualified Domestic Partner under the terms of this Plan.

Drug List is a list of approved brand name medications used to treat various medical conditions. The Drug List is developed by the pharmacy benefits management company and PacificSource.

Durable medical equipment means equipment that can withstand repeated use; is primarily and customarily used to serve a medical purpose rather than convenience or comfort; is generally not useful to a person in the absence of an illness or injury; is appropriate for use in the home; and is prescribed by a physician. Examples of durable medical equipment include but are not limited to hospital beds, wheelchairs, crutches, canes, walkers, nebulizers, commodes, suction machines, traction equipment, respirators, TENS units, and hearing aids.

Durable medical equipment supplier means a PacificSource contracted provider or a provider that satisfies the criteria in the Medicare Qualify Standards for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Other Items and Services noted in this Plan Document.

Elective surgery or procedure refers to a surgery or procedure for a condition that does not require immediate attention and for which a delay would not have a substantial likelihood of adversely affecting the health of the patient.

Eligible employee means an employee who has met the Plan Sponsor's minimum eligibility requirements as defined in the Medical Benefit Summary.

Emergency medical condition means a medical condition:

- That manifests itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:
  - Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;
  - Result in serious impairment to bodily functions; or

- Result in serious dysfunction of any bodily organ or part.

- With respect to a pregnant woman who is having contractions, for which there is inadequate time to affect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency medical screening exam means the medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an emergency medical condition.

Emergency services means, with respect to an emergency medical condition:

- An emergency medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

- Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to stabilize the patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.

Employee means any individual employed by the Employer.

Employer means the Plan Sponsor.

Enrollee means an employee, family member of the employee, or individual otherwise eligible and enrolled for coverage under this Plan. In this policy, enrollee is referred to as subscriber or member.

Experimental or investigational procedures means services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines, or the use thereof, that are experimental or investigational for the diagnosis and treatment of illness, injury, or disease.

- Experimental or investigational services and supplies include, but are not limited to, services, supplies, procedures, devices, chemotherapy, drugs or medicines, or the use thereof, which at the time they are rendered and for the purpose and in the manner they are being used:

  - Have not yet received full U.S. government agency required approval (e.g., FDA) for other than experimental, investigational, or clinical testing;

  - Are not of generally accepted medical practice in this Plan's state of issue or as determined by medical advisors, medical associations, and/or technology resources;

  - Are not approved for reimbursement by the Centers for Medicare and Medicaid Services;

  - Are furnished in connection with medical or other research; or

  - Are considered by any governmental agency or subdivision to be experimental or investigational, not considered reasonable and necessary, or any similar finding.

- When making decisions about whether treatments are investigational or experimental, the Plan Sponsor relies on the above resources as well as:

  - Expert opinions of specialists and other medical authorities;

  - Published articles in peer-reviewed medical literature;

- External agencies whose role is the evaluation of new technologies and drugs; and
- External review by an independent review organization.

- The following will be considered in making the determination whether the service is in an experimental and/or investigational status:
  - Whether there is sufficient evidence to permit conclusions concerning the effect of the services on health outcomes;
  - Whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;
  - Whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects; and
  - Whether any improved health outcomes from the services are attainable outside an investigational setting.

External appeal or review means the request by an appellant for an independent review organization to determine whether the Plan Sponsor's internal appeal decisions are correct.

Generic drugs are drugs that, under federal law, require a prescription by a licensed physician (M.D. or D.O.) or other licensed medical provider and are not a brand name medication. By law, generic drugs must have the same active ingredients as the brand name medication and are subject to the same standards of their brand name counterpart.

Global charge means a lump sum charge for maternity care that includes prenatal care, labor and delivery and post-delivery care. Ante partum services such as amniocentesis, cordocentesis, chorionic villus sampling, fetal stress test, and fetal non-stress test are not considered part of global maternity services and are reimbursed separately.

Grievance means:

- A request submitted by a member or an authorized representative of a member;
  - In writing, for an internal appeal or an external review; or
  - In writing or orally, for an expedited internal review or an expedited external review; or
- A written complaint submitted by a member or an authorized representative of a member regarding:
  - The availability, delivery, or quality of a healthcare service;
  - Claims payment, handling, or reimbursement for healthcare services and, unless the member has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or
  - Matters pertaining to the contractual relationship between a member and the Plan Sponsor.

Habilitation services are those designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings.

Health benefit plan means any hospital expense, medical expense, or hospital or medical expense policy or certificate, healthcare contractor or health maintenance organization subscriber contract, or any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974.

Hearing aids mean any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords. Hearing aids include any amplifying device that does not produce as its output an electrical signal that directly stimulates the auditory nerve. For the purpose of this definition, such amplifying devices include air conduction and bone conduction devices, as well as those that provide vibratory input to the middle ear.

Home healthcare means services provided by a licensed home health agency in the member's place of residence that is prescribed by the member's attending physician as part of a written plan of care. Services provided by home healthcare include:

- Home health aide services;
- Hospice therapy;
- Medically necessary personal hygiene, grooming and dietary assistance;
- Medical supplies and equipment suitable for use in the home;
- Nursing;
- Occupational therapy;
- Physical therapy; and
- Speech therapy.

Homebound means the ability to leave home only with great difficulty with absences infrequently and of short duration. Infants and toddlers will not be considered homebound without medical documentation that clearly establishes the need for home skilled care. Lack of transportation is not considered sufficient medical criterion for establishing that a person is homebound.

Hospital means an institution licensed as a 'general hospital' or 'intermediate general hospital' by the appropriate state agency in the state in which it is located.

Illness includes a physical or mental condition that results in a covered expense. Physical illness is a disease or bodily disorder. Mental illness is a psychological disorder that results in pain or distress and substantial impairment of basic or normal functioning.

Incentive drugs are approved medications used to treat certain chronic conditions for a reduced co-payment. The incentive drug list is developed by the pharmacy benefits management company and PacificSource.

Incurred expense means charges of a healthcare provider for services or supplies for which a member becomes obligated to pay. The expense of a service is incurred on the day the service is rendered, and the expense of a supply is incurred on the day the supply is delivered.

Initial enrollment period means a period of days set by your employer that determines when an individual is first eligible to enroll.

Injury means bodily trauma or damage that is independent of disease or infirmity. The damage must be caused solely through external and accidental means and does not include muscular strain sustained while performing a physical activity. (For muscular strain, see definition of 'illness'.)

Inquiry means a written request for information or clarification about any subject matter related to the Plan.

Internal appeal means a review of an adverse benefit determination.

Leave of absence is a period of time off work granted to an employee by the Plan Sponsor at the employee's request and during which the employee is still considered to be employed and is carried on the employment records of the Plan Sponsor.

Lifetime maximum or lifetime benefit means the maximum benefit that will be provided toward the expenses incurred by any one person while the person is covered by the Plan. If any covered expense that includes a lifetime maximum benefit amount is deemed to be an 'essential health benefit' as determined by the Secretary of the U.S. Department of Health and Human Services, and such is determined to apply to the Plan, the lifetime maximum amount will not apply to that covered expense in accordance with the standards established by the Secretary.

Mastectomy is the surgical removal of all or part of a breast or a breast tumor suspected to be malignant.

Medical supplies means items of a disposable nature that may be essential to effectively carry out the care a physician has ordered for the treatment or diagnosis of an illness, injury, or disease. Examples of medical supplies include but are not limited to syringes and needles, splints and slings, ostomy supplies, sterile dressings, elastic stockings, enteral foods, drugs or biologicals that must be put directly into the equipment in order to achieve the therapeutic benefit of the durable medical equipment or to assure the proper functioning of this equipment (e.g. Albuterol for use in a nebulizer).

Medically necessary means those services and supplies that are required for diagnosis or treatment of illness, injury, or disease and that are:

- Consistent with the symptoms or diagnosis and treatment of the condition;
- Consistent with generally accepted standards of good medical practice in this Plan's state of issue, or expert consensus physician opinion published in peer-reviewed medical literature, or the results of clinical outcome trials published in peer-reviewed medical literature;
- As likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any other service or supply, both as to the illness, injury, or disease involved and the patient's overall health condition;
- Not for the convenience of the member or a provider of services or supplies; and
- The least costly of the alternative services or supplies that can be safely provided. When specifically applied to a hospital inpatient, it further means that the services or supplies cannot be safely provided in other than a hospital inpatient setting without adversely affecting the patient's condition or the quality of medical care rendered.

Services and supplies intended to diagnose or screen for a medical condition in the absence of signs or symptoms, or of abnormalities on prior testing, including exposure to infectious or toxic materials or family history of genetic disease, are not considered medically necessary under this definition (see General Exclusions – Screening tests).

Member means an individual covered under this Plan.

Mental and/or chemical healthcare facility means a corporate or governmental entity or other provider of services for the care and treatment of chemical dependency and/or mental or nervous conditions which is licensed or accredited by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities for the level of care which the facility provides.

Mental and/or chemical healthcare program means a particular type or level of service that is organizationally distinct within a mental and/or chemical healthcare facility.

Mental and/or chemical healthcare provider means a person that has met the applicable credentialing requirements, is otherwise eligible to receive reimbursement under the Plan and is:

- A healthcare facility;
- A residential program or facility where appropriately licensed or accredited by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities;
- A day or partial hospitalization program;
- An outpatient service; or
- An individual behavioral health or medical professional authorized for reimbursement under state law.

Mental or nervous conditions means all disorders listed in the 'Diagnostic and Statistical Manual of Mental Disorders, DSM-5, Fifth Edition' except for:

- Intellectual Development Disorder, Global Developmental Delay, and Unspecified Intellectual Disability;
- Learning Disorders related to difficulties in learning and using academic skills which include impairment in reading, written expression, and mathematics;
- Paraphilias which include criminal offenses and are generally treated in correctional settings; and
- Mental health treatments for conditions as listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association which, according to the DSM, are not attributable to a mental health disorder or disease**,** except the treatment of children five years of age or younger for parent-child relational problems, physical abuse of a child, sexual abuse; neglect of a child, or bereavement.

Network Not Available means a member does not have reasonable geographic access to a participating provider for a medical service or supply.

Non-participating provider is a provider of covered medical services or supplies that does not directly or indirectly hold a provider contract or agreement with PacificSource.

Non-preferred drugs are covered brand name medications not on the applicable state drug list which can be found on the PacifcSource.com website.

Orthotic devices means rigid or semirigid devices supporting a weak or deformed leg, foot, arm, hand, back or neck or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck. Benefits for orthotic devices include orthopedic appliances or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. An orthotic device differs from a prosthetic in that, rather than replacing a body part, it supports and/or rehabilitates existing body parts. Orthotic devices are usually customized for an individual's use and are not appropriate for anyone else. Examples of orthotic devices include but are not limited to Ankle Foot Orthosis (AFO), Knee Ankle Foot Orthosis (KAFO), Lumbosacral Orthosis (LSO), and foot orthotics.

Participating provider means a physician, healthcare professional, hospital, medical facility, or supplier of medical supplies that directly or indirectly holds a provider contract or agreement with PacificSource.

Physical/occupational therapy is comprised of the services provided by (or under the direction and supervision of) a licensed physical or occupational therapist. Physical/occupational therapy includes emphasis on examination, evaluation, and intervention to alleviate impairment and functional limitation and to prevent further impairment or disability.

Physician means a state-licensed Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.).

Physician assistant is a person who is licensed by an appropriate state agency as a physician assistant.

Plan Amendment is a written attachment that amends, alters or supersedes any of the terms or conditions set forth in this Plan Document.

Practitioner means Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Licensed Nurse Practitioner (including Certified Nurse Midwife (C.N.M.) and Certified Registered Nurse Anesthetist (C.R.N.A.)), Registered Physical Therapist (R.P.T.), Speech Therapist, Occupational Therapist, Psychologist (Ph.D.), Licensed Clinical Social Worker (L.C.S.W.), Licensed Professional Counselor (L.P.C.), Licensed Marriage and Family Therapist (LMFT), Licensed Psychologist Associate (LPA), Physician Assistant (PA), Audiologist, Acupuncturist, , and Licensed Massage Therapist.

Prescription drugs are drugs that, under federal law, require a prescription by a licensed physician (M.D. or D.O.) or other licensed medical provider.

Preventive care drugs are medications available for a reduced co-payment. The preventive care drug list is developed by the pharmacy benefits management company and PacificSource, and adopted by the Plan Sponsor.

Primary Care Physician or Primary Care Practitioner (PCP) means a designated family practitioner, pediatrician, internist, nurse practitioner, or women's care specialist on the PacificSource provider panel chosen by an enrolled person to be responsible for the enrolled person's continuing medical care. The PCP is responsible for coordinating use of healthcare resources to best meet the enrolled person's healthcare needs.

Prosthetic devices (excluding dental) means artificial limb devices or appliances designed to replace in whole or in part an arm or a leg. Benefits for prosthetic devices include coverage of

devices that replace all or part of an internal or external body organ, or replace all or part of the function of a permanently inoperative or malfunctioning internal or external organ, and are furnished on a physician's order. Examples of prosthetic devices include but are not limited to artificial limbs, cardiac pacemakers, prosthetic lenses, breast prosthesis (including mastectomy bras), and maxillofacial devices.

Qualified Domestic Partner or Partnership means:

- **Registered Domestic Partner** means a same gender individual, age 18 or older, who is joined in a Domestic Partnership, and whose Domestic Partnership is legally registered in any state.
- **Unregistered Domestic Partner** means an individual of same or opposite gender who is joined in a Domestic Partnership with the subscriber and meets the following criteria:
  - Is age 18 or older;
  - Not related to the policyholder by blood closer than would bar marriage in the state where they have permanent residence and are domiciled;
  - Shares jointly the same permanent residence with the policyholder for at least six months immediately preceding the date of application to enroll and intent to continue to do so indefinitely;
  - Has an exclusive Domestic Partnership with the policyholder and has no other Domestic Partner;
  - Does not have a legally binding marriage nor has had another Domestic Partner within the previous six months;
  - Was mentally competent to consent to contract when the Domestic Partnership began and remains mentally competent.

Rehabilitation services and devices are those medically necessary to aid in re-learning skills or functions necessary to overcome or recover from an illness or diagnosis that is covered by this Plan.

Rescind or rescission means to retroactively cancel or discontinue coverage under a health benefit plan or group or individual health insurance policy for reasons other than failure to timely pay required premiums or required contributions toward the cost of coverage.

Routine costs of care mean medically necessary services or supplies covered by the Plan in the absence of a clinical trial. Routine costs of care do not include:

- The drug, device, or service being tested in the clinical trial unless the drug, device, or service would be covered for that indication by the Plan if provided outside of a clinical trial;
- Items or services required solely for the provisions of the drug, device, or service being tested in the clinical trial;
- Items or services required solely for the clinically appropriate monitoring of the drug, device, or service being tested in the clinical trial;
- Items of services required solely for the prevention, diagnosis, or treatment of complications arising from the provision of the drug, device, or service being tested in the clinical trial;

- Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- Items or services customarily provided by a clinical trial sponsor free of charge to any participant in the clinical trial; or
- Items or services that are not covered by the Plan if provided outside of the clinical trial.

Skilled nursing facility or convalescent home means an institution that provides skilled nursing care under the supervision of a physician, provides 24-hour nursing service by or under the supervision of a registered nurse (R.N.), and maintains a daily record of each patient. Skilled nursing facilities must be licensed by an appropriate state agency and approved for payment of Medicare benefits to be eligible for reimbursement.

Specialized treatment facility means a facility that provides specialized short-term or long-term care. The term specialized treatment facility includes ambulatory surgical centers, birthing centers, chemical dependency/substance abuse day treatment facilities, hospice facilities, inpatient rehabilitation facilities, mental and/or chemical healthcare facilities, organ transplant facilities, psychiatric day treatment facilities, residential treatment facilities, skilled nursing facilities, substance abuse treatment facilities, and urgent care treatment facilities.

Specialty drugs are high dollar oral, injectable, infused or inhaled biotech medications prescribed for the treatment of chronic and/or genetic disorders with complex care issues that have to be managed. The major conditions these drugs treat include but are not limited to: cancer, HIV/AIDS, hemophilia, hepatitis C, multiple sclerosis, Crohn's disease, rheumatoid arthritis, and growth hormone deficiency.

Specialty pharmacies specialize in the distribution of specialty drugs and providing pharmacy care management services designed to assist patients in effectively managing their condition.

Spouse means any individuals who are lawfully married under any state law, including individuals married to a person of the same sex who were legally married in a state that recognizes such marriages, but who are domiciled in this Plan's state of issuance. Similarly, the term 'marriage' will be read to include a same-sex marriage that is legally recognized as a marriage under any state law. The terms 'spouse' and 'marriage,' however, do not include individuals in a Qualified Domestic Partnership, (see 'Qualified Domestic Partner' in this definitions section0.

Stabilize means to provide medical treatment as necessary to ensure that, 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 patient from a facility; and with respect to a pregnant woman who is in active labor, to perform the delivery, including the delivery of the placenta.

Step therapy means a program that requires the member to try lower-cost alternative medications (Step 1 drugs) before using more expensive medications (Step 2 drugs). The program will not cover a brand name, or second-line medication, until less expensive, first-line/generic medications in the same therapeutic class have been tried first.

Subscriber means an employee or former employee covered under the Plan. When a family unit that does not include an employee or former employee is covered under a policy, the oldest family member is referred to as the subscriber.

Surgical procedure means any of the following listed operative procedures:

- Procedures accomplished by cutting or incision;
- Suturing of wounds;
- Treatment of fractures, dislocations, and burns;
- Manipulations under general anesthesia;
- Visual examination of the hollow organs of the body including biopsy, or removal of tumors or foreign body;
- Procedures accomplished by the use of cannulas, needling, or endoscopic instruments; or
- Destruction of tissue by thermal, chemical, electrical, laser, or ultrasound means.

Telemedical means the use of interactive audio, video, or other telecommunications technology in compliance with HIPAA 42 USC 1320d. Telemedical does not include the use of audio-only telephone, email, or facsimile transmissions.

Third Party Administrator means an organization that processes claims and performs administrative functions on behalf of a plan sponsor pursuant to the terms of a contract or agreement. In the case of this Plan, the term Third Party Administrator refers solely to PacificSource.

Tobacco cessation program means a program recommended by a physician that follows the United States Public Health Services guidelines for tobacco cessation. Tobacco cessation program includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products. Note: only approved tobacco cessation programs are covered under this Plan when benefits are provided for tobacco cessation.

Tobacco use means use of tobacco on average four or more times per week within no longer than the past six months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco by American Indians or Alaska Natives.

Urgent care treatment facility means a healthcare facility whose primary purpose is the provision of immediate, short-term medical care for minor, but urgent, medical conditions.

Usual, customary, and reasonable fee (UCR) is the dollar amount established by PacificSource, and adopted by the Plan Sponsor, for reimbursement of eligible charges for specific services or supplies provided by non-participating providers. PacificSource uses several sources to determine UCR. Depending on the service or supply and the geographical area in which it is provided, UCR may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), a vendor, other nationally recognized databases, or PacificSource, as documented in PacificSource's payment policy.

A non-participating provider may charge more than the limits established by the definition of UCR. Charges that are eligible for reimbursement but exceed the UCR are the member's responsibility (see Non-participating Providers in the Using the Provider Network section).

Waiting period means the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the Plan.

Women's healthcare provider means an obstetrician, gynecologist, physician assistant or nurse practitioner specializing in women's health, or certified nurse midwife practicing within the applicable scope of practice.

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SIGNATURE PAGE

The effective date of the Lane County Prime Plus Plan S3 is January 1, 2016.

It is agreed by Lane County that the provisions of this document are correct and will be the basis for the administration of Prime Plus Plan S3.

Dated this 29 day of February, 2016

By Mary P. Miller

Title Mary Miller

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