Lane County

Retiree
Group No.: G0020828

Medical Plan 35-250D
Effective: July 1, 2018

Third Party Administrative Services Provided By:

This page left intentionally blank.

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 July 1, 2018 (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

The consumer protections of the Patient Protection and Affordable Care Act (PPACA) apply to this Plan.
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 (888) 246-1370
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 July 1 and ending June 30. 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 (866) 281-1464.

CONTENTS

MEDICAL BENEFIT SUMMARY

PLAN INFORMATION

Group Name:	Lane County
Group Number:	G0020828
Plan Name:	Medical Plan 35-250D S3
Provider Networks:	Prime Network Effective July 1, 2018 - December 31, 2018 SmartChoice Network Effective January 1, 2019

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.

Out-of-Pocket Limit	Per Person, Per Calendar Year	Per Family, Per Calendar Year
All Providers	$1,500	$4,500

Please note: Your actual costs for services provided by a non-participating provider may exceed this Plan's out-of-pocket limit for non-participating services. In addition, non-participating providers can bill you for the difference between the amount charged by the provider and the amount allowed by this Plan, and this amount is not counted toward the non-participating out-of-pocket limit.

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	50% co-insurance
Routine physicals	No charge	50% co-insurance
Well woman visits	No charge	50% co-insurance
Routine mammograms	No charge	50% co-insurance
Immunizations	No charge	50% co-insurance
Routine colonoscopy	No charge	50% co-insurance
Prostate cancer screening	No charge	50% co-insurance

Professional Services		
Office and home visits	$35 co-pay/visit	50% co-insurance
Naturopath office visits	$35 co-pay/visit	50% co-insurance
Specialist office and home visits	$35 co-pay/visit	50% co-insurance
Telemedicine visits	$35 co-pay/visit	50% co-insurance
Office procedures and supplies	No charge	50% co-insurance
Surgery	$35 co-pay/visit	50% co-insurance
Outpatient rehabilitation services	$35 co-pay/visit	50% co-insurance
Outpatient habilitation services	$35 co-pay/visit	50% co-insurance
Hospital Services		
Inpatient room and board	$250 co-pay/day>	50% co-insurance
Inpatient rehabilitation services	$250 co-pay/day>	50% co-insurance
Inpatient habilitation services	$250 co-pay/day>	50% co-insurance
Skilled nursing facility care	$250 co-pay/day>	50% co-insurance
Outpatient Services		
Outpatient surgery/services	$250 co-pay/visit	50% co-insurance
Advanced diagnostic imaging	20% co-insurance	50% co-insurance
Diagnostic and therapeutic radiology/lab and dialysis	No charge	50% co-insurance
Urgent and Emergency Services		
Urgent care center visits	$35 co-pay/visit	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^	50% co-insurance^
Ambulance, ground	$50 co-pay	$50 co-pay
Ambulance, air	$50 co-pay	$50 co-pay+
Maternity Services**		
Physician/Provider services (global charge)	$35 co-pay/visit	50% co-insurance
Hospital/Facility services	$250 co-pay/day>	50% co-insurance
Mental Health/Chemical Dependency Services		
Office visits	$35 co-pay/visit	50% co-insurance
Inpatient care	$250 co-pay/day>	50% co-insurance
Residential programs	$250 co-pay/day>	50% co-insurance
Other Covered Services		
Allergy injections	$5 co-pay	50% co-insurance
Durable medical equipment	20% co-insurance	20% co-insurance
Home health services	No charge	No charge
Infertility treatment	50% co-insurance	Not Covered
Chiropractic manipulations and Acupuncture	$35 co-pay/visit	50% co-insurance
Temporomandibular joint (TMJ)	50% co-insurance	Not Covered
Transplants	No Charge	50% co-insurance

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

> Co-pay subject to a 5-day maximum per admit.

\+ *Non-participating air ambulance coverage is covered at 200% of the Medicare allowance. You may be held responsible for the amount billed in excess. Please see the Plan Document for additional information or contact the Customer Service team with questions.*

** *Medically necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six 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 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.

Primary care practitioner

You must select a primary care practitioner (PCP) from the Plan's provider directory. The PCP will coordinate healthcare resources to best meet your needs.

Effective July 1, 2018 through December 31, 2018 a referral from your PCP is required for most services in this Plan. If you receive services without a referral, you will be responsible for the non-participating provider level. Referrals are not required for well baby/well child care, well woman visits, chiropractic manipulations and acupuncture, naturopathic, and/or mental health/chemical dependency office visits.

Effective January 1, 2019, referrals will no longer be required under this Plan.

Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called 'preauthorization'. Preauthorization is necessary to determine if certain services and supplies are covered under this plan and if you meet the plan's eligibility requirements. You'll find the most current preauthorization list on our website, Pacificsource.com/member/preauthorization.aspx.

Payments to providers

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. Participating providers accept the fee allowance as payment in full. Non-participating providers are allowed to balance bill any remaining balance that this Plan did not cover. Services of non-participating providers could result in out-of-pocket expense in addition to the percentage indicated.

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

This Plan includes coverage for prescription drugs on the Preferred Drug List (PDL) and certain other pharmaceuticals, subject to the information below. This Plan complies with federal healthcare reform.

The amount you pay for covered prescriptions at participating and non-participating pharmacies applies toward this Plan's participating medical out-of-pocket limit, which is shown on the Medical Benefit Summary. The co-payment and/or co-insurance for prescription drugs obtained from a participating or non-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 amounts below:

	Tier 1:	Tier 2:	Tier 3:
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			
30 day max fill, no more than three fills allowed per calendar year.	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			
30 day max fill, no more than three fills allowed per calendar year.	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. If your ID Card is not used, your benefits cannot be applied and may result in a higher out-of-pocket.*

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.

If your physician prescribes a non-formulary contraceptive due to medical necessity it may be subject to preauthorization for coverage at no charge.

Compounded medications are subject to a preauthorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and compounded ingredients are on the applicable formulary.

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

This page left intentionally blank.

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 of 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 your domestic partner.
- Your, your spouse's, or your 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 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 domestic partner. 'Placed for adoption' means the assumption and retention by you, your spouse, or 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 domestic partner. 'Placed' 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 domestic partner's guardianship. To be eligible for coverage, the child must be unmarried; not in a domestic partnership; related to you by blood, marriage, or 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/or your eligible family members become eligible for 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 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 enrollment information, and forwards it to PacificSource.

ENROLLING NEW FAMILY MEMBERS

Newborns

Your eligible newborn child is eligible from the date of birth for 60 days. To enroll your child, the Plan Sponsor must receive your completed enrollment application within 60 days of the child's birth. Contribution for the first 60 days of coverage and any additional contribution is due 31 days from the date a notice of contribution is provided to you by the Plan Sponsor. A claim for maternity care is not considered notification for the purpose of enrolling a newborn child. The Plan Sponsor may ask for legal documentation to confirm validity.

Adopted Children

Your adopted child is eligible from the date of birth, placement, or finalization for 60 days. To enroll your child, the Plan Sponsor must receive your enrollment change within 60 days of birth, placement, or finalization. Contribution for the first 60 days of coverage and any additional contribution is due 31 days from the date a notice of contribution is provided to you by the Plan Sponsor. Coverage for your new family members will begin on the date of birth, placement, or finalization. The Plan Sponsor may ask for legal documentation to confirm validity.

Foster Children

When a foster child is placed in your home, you have 60 days from the date of placement to enroll them on the Plan. To enroll the child, the Plan Sponsor must receive your enrollment change within 60 days of the placement. Contribution for the first 60 days of coverage and any additional contribution is due 31 days from the date a notice of contribution is provided to you by the Plan Sponsor. Coverage for your new family members will begin on the date of placement. The Plan Sponsor may ask for legal documentation to confirm validity.

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 on the Plan. The Plan Sponsor must receive your enrollment change and any additional contribution 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. The Plan Sponsor may ask for legal documentation to confirm validity.

Family Members Acquired by Domestic Partnership

If you and your 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 enrollment period after the registration of the domestic partnership. The Plan Sponsor must receive your completed enrollment information and additional contribution during the 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. The Plan Sponsor may ask for legal documentation to confirm validity.

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 on this Plan. The Plan Sponsor must receive your enrollment change and any additional contribution 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. The Plan Sponsor may ask for legal documentation to confirm validity. 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 Plan Member.

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 on this Plan. The Plan Sponsor must receive your completed enrollment application and any additional contribution 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. The Plan Sponsor may ask for legal documentation to confirm validity.

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 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. You must re-enroll your family members by submitting an enrollment change within the 31 day 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 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 an enrollment change to the Plan Sponsor within the 31 day 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 as well. You must re-enroll your family members by submitting an enrollment change to the Plan Sponsor within the 31 day enrollment period following your return to work.

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

You and your family members may decline coverage during your initial enrollment period. To find out if this Plan allows employees to decline coverage, ask your Plan Sponsor. If you wish to do so, you must submit a completed Waiver of Coverage form to the Plan Sponsor. You and your family members may enroll in this Plan later if you qualify under the Special Enrollment Rules below.

Retirees and COBRA members may waive coverage for any reason. However, if they waive coverage, they will not be able to re-enroll at a future date.

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.

All special enrollment provisions assume that the employee has satisfied any probationary periods required and each individual is eligible as stated in this Plan Document.

- 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 involuntarily. To do so, you must request enrollment within 60 days after the other health coverage ends. Coverage will begin on the day after the other coverage ends.

- Special Enrollment Rule #2

  If you acquire new family members because of marriage, registration of domestic partnership, birth, placement of foster child, or placement for or finalization of adoption, you may be able to enroll yourself and/or your eligible family members at that time. To do so, you must request enrollment within 60 days after the marriage, registration of the domestic partnership, birth, placement of foster child, or placement for adoption. In the case of marriage or registration of domestic partnership, coverage begins on the first day of the month after the marriage or registration of the domestic partnership. In the case of birth, placement of foster child, or placement for adoption, coverage begins on the date of birth, placement, or finalization.

- 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 request enrollment 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, which is October 1st thru November 30th, coverage becomes effective on the first day of January in the following 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 enrolled individuals will end. Coverage ends on the last day of the last month in which you worked full time and for which a contribution was paid. You may, however, be eligible to continue coverage for a limited time. (See the Continuation of Coverage section).

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, please contact the Plan Sponsor. (See the Continuation of Coverage section).

Dependent Children

When your enrolled child no longer qualifies as a dependent, their coverage will end on the last day of the month they become ineligible. Please see the Becoming Eligible section for information on when your dependent child is eligible beyond age 25. The Continuation of Coverage section includes information on other coverage options for those children who no longer qualify for coverage.

Dissolution of Domestic Partnership

If you dissolve your 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 domestic partnership is final. You must notify your employer of the dissolution of the domestic partnership. Domestic partners and their covered children are not recognized as qualified beneficiaries under federal COBRA continuation laws. 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 covered 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;

- You die;
- You become eligible for Medicare benefits if it causes a loss of coverage for your family members.
- 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).

Enrolled individuals 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:

- Only family members who were enrolled in the Plan can 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 your employer within 60 days after the last day of coverage under the 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.

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

Domestic partners 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 Continuation 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, or when your family member lost eligibility.

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

Enrolled 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. Premium rates are established annually and may be adjusted if the Plan's benefits or costs change.

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 Plan Sponsor. 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, domestic partner, and/or dependents (see Continuation of Coverage provisions).
- Except for newly acquired dependents due to marriage, registration of 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, 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, registration of domestic partnership, birth, or adoption. If you do not add your new spouse, 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 of the 65th birthday, or the last day of the month prior to Medicare eligibility, whichever occurs first.
- 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 of the 65th birthday, or the last day of the month prior to Medicare eligibility, whichever occurs first.
- 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 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 contribution 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 nor PacificSource can be held liable for any claim for damages or injuries you experience while receiving medical care.

PARTICIPATING PROVIDERS

Participating providers contract with PacificSource to provide 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 collect 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 deductibles, co-payments, and/or co-insurance payments.

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 amounts for non-covered services from the member.

REFERRALS

Under this Plan, referrals will be required effective July 1, 2018 through December 31, 2018. As of January 1, 2019, referrals will no longer be required.

Through December 31, 2018, a referral from your PCP is required as outlined below:

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:

- Acupuncture.
- Anesthesia.
- Assistant surgeon.
- Chiropractic manipulation
- 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.
- Naturopathic services.
- 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.
- Preventive colonoscopy.
- Physical, occupational, and speech therapy.
- Services coordinated and provided within by your PCP.

- 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.

MEMBERS RESIDING OUTSIDE THE PLAN SERVICE AREA

If a member lives outside of the service area they are not required to use the services of a Primary Care Practitioner to receive benefits from this Plan. These members may access the highest level of benefits by using the service of a PacificSource participating provider or nationwide provider. (See Finding Participating Provider Information.)

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, prescription refills, 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 deductibles, co-payments, 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), contracted 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 team 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**

COVERAGE WHILE TRAVELING

This Plan is powered by the network shown at the beginning of the Medical Benefit Summary. You can save out of pocket expense by using a participating provider in your service area. Your network covers Oregon, Idaho, Montana, southwest Washington, and eastern Washington. When you need medical services outside of your network, you can save out-of-pocket expense by using the participating providers identified on the website at providerdirectory.pacificsource.com.

Nonemergency Care While Traveling

To find a participating provider outside the regions covered by your network, go to the providerdirectory.pacificsource.com website. Nonemergency care outside of the United States is not covered.

- If a participating provider is available in your area, the Plan's participating provider benefits will apply if you use a participating provider.
- If a participating provider is available but you choose to use a non-participating provider, this Plan's non-participating provider benefits will apply.

Emergency Services While Traveling

In medical emergencies (see Covered Expenses – Emergency Services section), this Plan pays benefits at the participating provider level regardless of your location. Your covered expenses are based on our allowable fee. If you are admitted to a hospital as an inpatient following the stabilization of your emergency condition, your physician or hospital should contact the PacificSource Health Services team at (888) 691-8209 as soon as possible to make a benefit determination on your admission. If you are admitted to a non-participating hospital, this Plan may require you to transfer to a participating facility once your condition is stabilized in order to continue receiving benefits at the participating provider level.

FINDING PARTICIPATING PROVIDER INFORMATION

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

- Ask your healthcare provider if they are a participating provider for your network.
- On the PacificSource website, PacificSource.com. Go to 'Find a Doctor or Drug' to easily look up participating providers, specialists, behavioral health providers, and hospitals. You can also print your own customized directory.
- Contact the PacificSource Customer Service Team. Their staff can answer your questions about specific providers.

TERMINATION OF PROVIDER CONTRACTS

PacificSource, on behalf of the Plan Sponsor, will use best efforts to notify you within 30 days of learning about 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 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 the Customer Service team 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 team.

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.

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. PacificSource's internal committees and Health Services team make decisions about this Plan's coverage of these methods and medications based on literature reviews, standards of care and coverage, consultations, and review of evidence-based criteria with medical advisors and experts. 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.), Nurse Practitioner, hospital or specialized treatment facility, durable medical equipment supplier, or other licensed medical providers 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.

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 providerdirectory.pacificsource.com. Simply enter your City and State or Zip code, 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 Benefit Summaries 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 Benefit Summaries. The following list of benefits is exhaustive. 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 (maximum dollar amounts do not apply to Essential Health Benefits (EHB)). 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 Benefit Summaries and the Benefit Limitations and Exclusions section 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** including appropriate screening, radiology and laboratory tests, and other screening procedures for members age 22 and older are covered once per calendar year. Screening exams and laboratory tests may include, but are not limited to, blood pressure checks, weight checks, occult blood tests, urinalysis, complete blood count, prostate exams, cholesterol exams, stool guaiac screening, EKG screens, blood sugar tests, and tuberculosis skin tests.

  Only laboratory 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. (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, if received from a participating provider.

    - 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/lab and dialysis’ apply 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 or preauthorization.

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

  — A colonoscopy, including removal of polyps during the screening procedure if a positive result on any fecal test assigned either a grade ‘A’ or ‘B’;

  — A fecal occult blood test;

- A flexible sigmoidoscopy; or
- A double contrast barium enema.

A colonoscopy performed for routine screening purposes is considered to be a preventive service, according to the guidelines of the U.S. Preventive Services Task Force that have a rating of 'A' or 'B' for age 50 and older. The deductibles, co-payments, 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. 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. Please see prescription drugs section for information on essential health benefit preventive care drug coverage.

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' younger than 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
— 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. (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 (for example 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 recommended adult age groups; or
- Varicella (chicken pox) vaccine.

- **Tobacco cessation program services and drugs** are covered at no charge. 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.

The A and B list for preventive services can be found on the USPSTF website: uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

The list of women's preventive services can be found on the HRSA website: hrsa.gov/womensguidelines2016/.For members who do not have internet access, please contact the PacificSource Customer Service team at the number shown on page four of this Plan Document for a complete description of the preventive services lists.

USPSTF recommendations include the January 2016 recommendations regarding breast cancer screening, mammography, and prevention**.** Cancer risk-reducing medications are covered according to the September 2013 USPSTF recommendations, at no cost, subject to reasonable medical management.

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 headaches.
- **Outpatient rehabilitation services** provided by a licensed physical therapist, occupational therapist, or 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. Covered services are for the purpose of restoring certain functional losses due to disease, illness or injury only and do not include maintenance services. Total covered expenses for outpatient rehabilitation services are limited to a maximum of 30 visits per calendar year 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 individual benefits 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, and injuries 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.

- **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 services are limited to a 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 habilitation services would be appropriate are covered when criteria for individual benefits are met.

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

- Services of a dentist or physician to treat **injury of the jaw or natural teeth**. Services must be provided within 18 months 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 'Other Covered Services – Temporomandibular Joint'.

- Medically necessary **telemedical health services** for health services covered by this Plan when provided by a healthcare professional.

- 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;
- Dressings, equipment, and other necessary supplies;
- Inpatient medications;
- Intensive and/or specialty care units;
- Lab services provided by hospital;
- Operating room;
- Radiology services; 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. If care is necessary beyond 60 days, this Plan may authorize up to 100 additional days per calendar year. 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 medically necessary to restore and improve lost body functions after illness, injury, or disease. These services must be consistent with the condition being treated, and must be part of a formal written treatment program prescribed by a physician and subject to preauthorization by PacificSource. Total covered expenses for inpatient rehabilitation services are limited to a maximum of 30 days per calendar year subject to review for medical necessity, unless medically necessary to treat a mental health diagnosis. Recreation therapy is only covered as part of an inpatient rehabilitation admission.

Inpatient habilitation services are covered when medically necessary to help a person keep, restore, or improve skills and functioning for daily living related to skills that have been lost or impaired because a person was sick, injured or disabled. These services must be consistent with the condition being treated, and must be part of a formal written treatment program prescribed by a physician and subject to preauthorization by PacificSource. Total covered expenses for inpatient habilitation services are limited to a maximum of 30 days per calendar year subject to review for medical necessity, unless medically necessary to treat a mental health diagnosis. Recreation therapy is only covered as part of an inpatient rehabilitation admission.

OUTPATIENT 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.

- **Diagnostic radiology and laboratory procedures.** Benefits are based on the setting where services are performed.

  For services performed in a physician's office, the benefit stated in your Medical Benefit Summary for 'Professional Services – Office procedures and supplies' applies.

  For services performed in an ambulatory surgical center or outpatient hospital setting, the benefits stated in your Medical Benefit Summary for Outpatient Services – 'Diagnostic and therapeutic radiology /lab and dialysis' apply.

- **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.

- **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 and home visits' 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' 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 the Medical Benefit Summary for 'Outpatient Services – Diagnostic and therapeutic radiology/lab and dialysis'.

- 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 (see Definitions section), this Plan covers services and supplies necessary to evaluate and treat an emergency condition.

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. Emergency and non-emergency services are subject to the deductibles, co-payments and/or co-insurance stated in your Medical Benefit Summary.*

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 deductibles, 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 other provider practicing within the scope of their license 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 team as soon as you learn of your pregnancy. Their staff will explain the Plan's maternity benefits and help you enroll in our free prenatal care program.

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 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 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) 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 (PhD) licensed by the State Board of Psychologists' Examiners;
- A Nurse Practitioner registered by the State Board of Nursing;
- A Licensed Clinical Social Worker (LCSW) licensed by the State Board of Clinical Social Workers;
- A Licensed Professional Counselor (LPC) licensed by the State Board of Licensed Professional Counselors and Therapists;
- A Licensed Marriage and Family Therapist (LMFT) licensed by the State Board of Licensed Professional Counselors and Therapists;
- A Board Certified Assistant Behavior Analyst (BCaBA) licensed by the State Board of Behavior Analysis;
- A Board Certified Behavior Analyst (BCBA) licensed by the State Board of Behavior Analysis;
- A Board Certified Behavior Analyst, Doctoral level (BCBA-D) licensed by the State Board of Behavior Analysis;

- A Behavior Analyst Interventionist (BAI) licensed by the State Board of Behavior Analysis; and
- A hospital or other healthcare facility accredited by The Joint Commission 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.
- A hospital or other healthcare facility must notify PacificSource of an emergency admission within two business days.
- Medication management by a licensed physician (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, Third Edition (ASAM)'.

Mental Health Parity and Addiction Equity Act of 2008

This Plan complies with all federal and state 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 by PacificSource. 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 health services.
- This Plan covers **hospice services** when preauthorized by PacificSource. Hospice services, including respite care, 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; and

— 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. (See 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 $1,000, 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 when surgery or treatment is performed on either eye. 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 once 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 by PacificSource.

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 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 to this Plan's deductibles (co-insurance and co-payment amounts after deductibles are waived). If our contract with the facility includes the services of the medical professionals performing the transplant (such as physicians, nurse practitioners, and anesthesiologists), those charges are also subject to this Plan's deductibles (co-insurance and co-payment amounts after deductibles are waived). If the professional fees are not included in our 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 Prescription Drug Benefit 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 after the deductible is met.

Retail Pharmacy Network

To use your Plan's pharmacy benefits, at this Plan's highest benefit level, you must show the Plan's pharmacy number on your ID card at the participating pharmacy. This Plan's pharmacy benefits can only be accessed through the pharmacy plan number printed on your ID card. That Plan number allows the pharmacy to collect the appropriate deductibles, co-payments, and/or co-insurance amounts 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 team 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/member/mail-order-rx.aspx.

Specialty Drug Program

PacificSource contracts with a specialty pharmacy provider for high-cost injectable medications and biotech drugs. A pharmacist-led Care Team 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 overall value for these specific medications. The Care Team also provides comprehensive disease education and counseling, assesses patient health status, and offers a supportive environment for patient inquiries.

Specialty drugs are not available through the participating retail pharmacy network, mail order service, or non-contracted Specialty pharmacies without a preauthorization exception. More information regarding the exclusive specialty pharmacy provider and a list of drugs requiring preauthorization and/or are subject to restrictions is available on the website, PacificSource.com/drug-list.

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 team at (844) 877-4803, 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

Refer to the applicable Drug List at PacificSource.com/drug-list to see which diabetic supplies are only covered under your pharmacy benefit. Some diabetic supplies, such as glucose monitoring devices, may only be covered under your medical 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, non-formulary contraceptives will remain subject to this Plan's regular pharmacy plan benefits unless deemed medically necessary by your attending provider. Providers must request formulary exceptions by contacting the Pharmacy Services team. When no generic exists, non-formulary are covered

at no cost. If a generic becomes available, the preferred brand will no longer be covered under the preventive care benefit unless deemed medically necessary by your attending provider.

If an initial three month supply is tried, then a 12 month refill of the same contraceptive is covered, regardless if the initial prescription was covered under this Plan. Prescription contraceptives can be filled through a participating retail pharmacy for up to a three month supply or a participating mail-order pharmacy for up to a 12 month supply.

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.
  - Over-the-counter tobacco cessation drugs are covered under this Plan, but will require a prescription from your doctor.
  - Drugs for any condition excluded under this Plan. This includes drugs intended to prevent infertility, treat obesity or weight loss, improve cosmetic conditions (such as hair loss or wrinkles) and drugs that are deemed experimental or investigational.
  - Some specialty drugs that are not self-administered are not covered by this pharmacy benefit, but may be covered under the Plan's medical office supply benefit. For a list of drugs that are covered under your Medical Benefit and which require preauthorization, please refer to the Medical Drug and Diabetic Supply formulary on the website PacificSource.com/drug-list. If you have additional questions about your medical drug benefit or if your drug is not listed on the website, please contact PacificSource's Customer Service team.
  - Some Immunizations may be covered under either your medical or pharmacy benefit. Vaccines covered under the pharmacy benefit include: influenza, hepatitis B, herpes zoster (shingles), and pneumococcal. Most other immunizations must be provided by your doctor under your medical benefit.
  - Drugs and devices to treat erectile or sexual dysfunction unless defined in the 'Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition' (DSM-5).
  - 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 (PA), which means that the Plan Sponsor and/or PacificSource will need to review documentation from your doctor before a drug will be

covered. An up-to-date list of drugs requiring preauthorization, along with the requirements, is available at PacificSource.com/drug-list.

- Certain drugs are subject to step therapy (ST) protocols, which means you may be required to try a pre-requisite drug before the Plan will pay for the requested drug. An up-to-date list of drugs requiring step therapy, along with all of the requirements, is available on PacificSource.com/drug-list. Step therapy decisions can be appealed.
- Certain drugs have quantity limits (QL), which means the Plan will generally not pay for quantities above the FDA approved maximum dosing without an approved exception. An up-to-date list of drugs with quantity limits is available on the website PacificSource.com/drug-list. This Plan has limitations on the quantity of medication that can be filled or refilled. This quantity depends on the type of pharmacy you are using and the day's supply of the prescription.
  - Retail pharmacies: you can get up to a 30 day supply.
  - Mail order pharmacies: you can get up to a 90 day supply.
  - Specialty pharmacies: you can get up to a 30 day supply.
- For drugs purchased at non-participating pharmacies or at participating pharmacies without using the Plan's pharmacy benefits, reimbursement is limited to PacificSource's in-network contracted rates. This means you may not be reimbursed the full cash price you pay to the pharmacy.
- Non-participating pharmacy charges, including non-participating specialty pharmacy charges, are limited to a 30 day supply per fill, up to a 90 day supply per calendar year.
- Prescription drug benefits are subject to this Plan's coordination of benefits provision.
- For most prescriptions, you may refill your prescription only after 75 percent of the previous supply has been taken. This is calculated by the number of days that have elapsed since the previous fill and the days' supply entered by the pharmacy. Early refills will generally not be approved, except under the following circumstances:
  - The request is for ophthalmic solutions or gels which are susceptible to spillage.
  - The member will be on vacation in a location that does not allow for reasonable access to a network pharmacy for subsequent refills.
  - All early refills are subject to standard co-payments and/or co-insurance and are reviewed on a case by case basis.

Formulary Exception and Coverage Determination Process

A separate benefit may apply to some drugs, such as specialty drugs. If you have questions about your coverage, please contact the PacificSource Customer Service team.

Requests for formulary exceptions can be made by the member or practitioner by contacting the PacificSource Pharmacy Services team by telephone, fax, or on-line. Standard exception requests are determined within 72 hours, expedited requests are determined within 24 hours. Formulary exceptions and coverage determinations must be based on medical necessity, and information must be submitted to support the medical necessity including all of the following:

- A reasonable number of similar drugs that are on the formulary have been tried;

- Formulary drugs were tried with an adequate dose and duration of therapy;
- Formulary drugs were not tolerated or were not effective;
- Formulary or preferred drugs would reasonably be expected to cause harm or not produce equivalent results as the requested drug;
- The requested drug therapy is evidenced-based and generally accepted medical practice; and
- Special circumstances and individual needs, including the availability of service providers in the patients' region.

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. Whenever possible, you should seek services from an air ambulance service that participates in PacificSource's network of providers. Reimbursement to non-participating air ambulance services are based on 200 percent of the Medicare allowance. In some cases 200 percent of Medicare may be significantly lower than the provider's billed amount. Your participating provider deductibles and co-insurance will apply when out-of-network ground or air ambulance is part of medically necessary emergency services, and the provider may still bill you for the amounts in excess of this Plan's allowable charge. Non-emergency medically necessary travel, other than transportation by a licensed ambulance service, to the nearest facility qualified to treat the patient's medical condition is covered when approved in advance by PacificSource. Non-emergency ground or air ambulance travel between facilities requires preauthorization.
- This Plan covers **biofeedback** to treat 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 by PacificSource 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; and
    - 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 deductibles, co-payments, and/or co-insurance amounts 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.

- This Plan covers **child abuse medical assessments** which includes the taking of a thorough medical history, a complete physical examination and interview by or under the direction of a licensed physician or other licensed health care professional trained in the evaluation, diagnosis and treatment of child abuse. Child abuse medical assessments are covered when performed at a community assessment center. Community assessment center means a neutral, child-sensitive community-based facility or service provider to which a child from the community may be referred to receive a thorough child abuse medical assessment for the purpose of determining whether the child has been abused or neglected.

- This Plan covers single or bilateral **cochlear implants** when medically necessary.

- This Plan covers at no charge for all women with reproductive capacity; IUD, diaphragm, and cervical cap **contraceptives and contraceptive devices** along with their insertion or removal, as well as hormonal contraceptives including oral, patches and rings prescribed by your physician or a pharmacist. 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 deductibles, co-payments, 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 by PacificSource.

  — 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 deductibles, co-payments and/or co-insurance for office visits stated in the Medical Benefit Summary. To be covered, the training must be provided by a licensed healthcare professional with expertise in diabetes.

  — This Plan covers medically necessary telemedical health services via two-way electronic communication provided in connection with the treatment of diabetes.

- This Plan covers **dietary or nutritional counseling** provided by a registered dietitian under certain circumstances. It is covered under benefits for diabetic education, or 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 deductibles, co-payments, 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 by PacificSource, 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 deductibles, co-payments, 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), 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. Benefits are limited to one visit annually, and are subject to preauthorization by PacificSource.
- **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. For more information, see 'routine costs of care' in the Definitions section. 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, internist, family practitioner, or certified sleep medicine specialist.
- This Plan covers medically necessary therapy and services for the treatment of **traumatic brain injury**.
- This Plan covers **tubal ligation and vasectomy** procedures.
- 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 team.

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 team.

BENEFIT LIMITATIONS AND EXCLUSIONS

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).
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims unless otherwise contracted.
- 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, 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. Services and supplies, including drugs, rendered primarily for cosmetic/reconstructive purposes (does not apply to emergency services). 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 or gender dysphoria.
- 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, such as 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. (This does not include rehabilitative or habilitative services that are covered under the 'Professional Services' section.) 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.
- 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.
- Drugs and biologicals that can be self-administered (including injectables) are excluded from the medical benefit, except those provided in a hospital emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered. Covered drugs and biologicals that can be self-administered are otherwise available under the pharmacy benefit, subject to the Plan requirements.

- 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.
- Durable medical equipment available over the counter and/or without a prescription.
- 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. By that, we mean 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 (for example 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 have any concerns about whether a course of treatment will be covered, we encourage you to contact PacificSource's Customer Service team. They will

arrange for medical review of your case against the criteria established by the Plan Sponsor, and notify you of whether or not 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 in vitro fertilization or surgery to reverse voluntary sterilization, as well as supplies, surgery, treatment or prescriptions determined to be experimental or investigational in nature are not covered.
- 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.
- 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. Individuals age 19 to 25 must be enrolled in a secondary school or an accredited education institution. 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.
- Maintenance supplies and equipment not unique to medical care.
- Marital/partner counseling.
- Massage or massage therapy, 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 defined in the ‘Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition’ (DSM-5), that are not attributable to a mental health disorder or disease.
- Mental illness does not include –relationship problems (for example 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; and assertiveness 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.
- Narcosynthesis.
- Naturopathic supplies.
- Nicotine related disorders, other than those covered through tobacco cessation program services.
- Obesity or weight reduction control – Surgery or other related services or supplies provided for weight reduction 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 reduction control. Obesity screening and counseling are covered for children and adults. (See '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.
- Orthopedic shoes, diabetic shoes, and shoe modifications.
- Osteopathic manipulation, except for treatment of disorders of the musculoskeletal system.
- Over-the-counter medications or nonprescription drugs. Does not apply to tobacco cessation medications covered under USPSTF guidelines.
- Panniculectomy for any indication.
- 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, except as specified in the Covered Expenses – Other Covered Services, Supplies, and Treatments section.
- 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.
- 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 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 provided by or payable under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law.
- Services or supplies with no charge, or for which your employer or the Plan Sponsor has paid for, or 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 any services provided by the member, or by any licensed professional that is directly related to the member by blood or marriage.

- 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 erectile or sexual dysfunction unless defined in the "Diagnostic and Statistical manual of Mental Disorders, Fifth Edition" (DSM-5).
- Sex reassignment – Procedures, services or supplies related to a sex reassignment unless medically necessary to treat a mental health diagnosis.
- Snoring – Services or supplies for the diagnosis or treatment of snoring and/or upper airway resistance disorders, including somnoplasty unless medically necessary to treat a mental health diagnosis.
- Social skills 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.
- 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.
- 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, were injured in the course of employment, and are otherwise exempt from the applicable state or federal workers' compensation insurance program;
- The appropriate state or federal workers' compensation insurance program has determined that coverage is not available for your injury. This exclusion includes any illness, injury, or disease that is caused by any for-profit activity, whether through employment or self-employment; or
- If you are employed by an Oregon based group and have timely filed an application for coverage with the State Accident Insurance Fund or other Worker's Compensation Carrier and are waiting for determination of coverage from that entity.

- 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 members diagnosed with a pervasive development disorder.
- War-related conditions – The Treatment of any condition caused by or arising out of an act of war, armed invasion, or aggression, or while in the service of the armed forces unless not covered by the member's military or veteran's coverage.

PREAUTHORIZATION

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource 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 from the PacificSource Health Services team. 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.

Because of the changing nature of medicine, PacificSource continually reviews new technologies and standards of medical practice. The list of procedures and services requiring preauthorization is therefore subject to 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/member/preauthorization.aspx.

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 team.

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. A hospital or other healthcare facility must notify PacificSource of an emergency admission 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 and Licensed Behavioral Health Clinicians 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 Case Manager will work in collaboration with the patient's provider and the PacificSource Medical Director and, where necessary, the Plan Sponsor, to enhance the quality of care and maximize available health plan benefits. A case manager may authorize benefits for supplemental services not otherwise covered by this Plan. (See Individual Benefits Management in this section.) 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 PacificSource, on behalf of the Plan Sponsor, on a case-by-case basis. PacificSource's determination to cover and pay for alternative benefits for a member 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. PacificSource, on behalf of the *Plan Sponsor,* may elect to provide alternative benefits if PacificSource and the member'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 member 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 team. All hospital admissions are reviewed by PacificSource Case Managers, who are all Registered Nurses or Licensed Behavioral Health Clinicians. 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 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 team 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:

- American Society of Addiction Medicine, Third Edition (ASAM);
- MCG™;
- MCG™ Goal Length of Stay (GLOS);
- Standard of practice in the Plan's state of issuance; 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 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 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.

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, 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 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 team 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 PacificSource participating provider treats you, your claims are automatically sent to PacificSource and processed. All you need to do is show your member 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, member 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.

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 review – 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 review – 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 48 hours of receipt of the request.

Concurrent care review – Inpatient hospital or rehabilitation facilities, skilled nursing facilities, chemical dependency/substance abuse and psychiatric day treatment facilities, partial hospitalization, 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 –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.)

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 if PacificSource receives an agreement from you in writing.

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. If your situation is not described, contact our Customer Service team or the Division of Financial Regulation.

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 or Domestic Partner's Expenses

- The claim is for your spouse or your domestic partner, 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 your domestic partner'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 state or 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 deductibles.
- 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 preauthorization, 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 Division of Financial Regulation
(See 'Information Available from the Division of Financial Regulation' in the Resources for Information and Assistance section.)

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.
- *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 the Medicare website, 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, they will send you a questionnaire to help them 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 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.

Surrogacy Health Services

The Plan Sponsor is entitled to reimbursement for any paid claims out of the compensation a member receives or is entitled to receive under a surrogacy agreement. A member who enters into a surrogacy agreement must reimburse the Plan Sponsor for covered expenses related to conception, pregnancy, delivery, or postpartum care that are received in connection with the surrogacy agreement. A member who enters into a surrogacy agreement must inform PacificSource, on behalf of the Plan Sponsor, of that agreement within 30 days of entering that agreement and provide a copy of the agreement to PacificSource.

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.

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, state or federal workers' compensation insurance program;.
- The appropriate state or federal workers' compensation insurance program has determined that coverage is not available for your injury: or
- You are employed by an Oregon based group, have timely filed an application for coverage with the State Accident Insurance Fund or other Workers' Compensation carrier, and are awaiting for determination of coverage from that entity.

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.

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 team.

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 team. Many times the Customer Service team 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; 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 Third Party Liability, 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 or Disclose PHI” and the ‘Designation of Authorized Representative’ forms.

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, health, 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.

PacificSource, on behalf of the Plan Sponsor, may, at its discretion and with your consent, waive the requirements of compliance with the internal appeals process and have a dispute referred directly to external review. You shall be deemed to have exhausted internal appeals if the Plan Sponsor fails to strictly comply with its appeals process and with state and federal requirements for internal appeals. *If the Plan Sponsor fails to comply with the decision of the independent review organization assigned under Oregon law, you have a private right of action (sue) against the Plan Sponsor for damages arising from an adverse benefit determination subject to the external 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, the Plan will provide you with any additional documents, records or information that is relevant to the adverse benefit determination at no cost.

HOW TO SUBMIT GRIEVANCES OR APPEALS

Before submitting a grievance or appeal, we suggest you contact PacificSource's Customer Service team 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 team. 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 Division of Financial Regulation. Assistance is available:

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

By writing to:

Division of Financial Regulation
Consumer Advocacy Unit
PO Box 14480
Salem, OR 97309-0405

Through their website at http://dfr.oregon.gov

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 team 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 team to request any of the following:

- A directory of participating healthcare providers under this Plan;
- Information about the drug list (also known as a 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 Division of Financial Regulation about PacificSource

The following consumer information is available from the Division of Financial Regulation:

- 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; or
- An annual summary of the scope of our provider network and accessibility of healthcare services.

You can request this information by contacting the Division of Financial Regulation:

By writing to:

Division of Financial Regulation

Consumer Advocacy Unit

PO Box 14480

Salem, OR 97309-0405

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

Through their website at http://dfr.oregon.gov

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 in the industry. 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 team 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 for supplying 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 for following 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. An example of one exception is that we do not need written authorization to disclose information to a designee performing utilization management, quality assurance, or peer review on our behalf.

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) 682-4392
Fax: (541) 682-4290
Mary.miller@co.lane.or.us

Plan Sponsor's Employer Identification / Tax Identification Number:

93-6002303

Contract Year:

July 1 to June 30

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 change based on changes in law, administrative decision, or qualifying events. The following people have the authority to accept or approve such 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 plan, 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 submitted to us. Also, you must exhaust this Plan's claims procedures before filing benefits litigation. No action shall be brought against the Plan Sponsor or PacificSource after the expiration of any applicable statutes of limitations.

DEFINITIONS

Wherever used in this Plan, the following definitions apply to the masculine and feminine and singular plural forms of terms. 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 Third Party Liability, 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 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. PacificSource uses several sources to determine the allowable fee. 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), contracted vendors, 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;
- 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 or 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.

Behavioral health assessment means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization.

Behavioral health crisis means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health.

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 deductibles. The co-insurance the member is responsible for is listed in the Benefit Summary.

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. It includes a request for action to resolve the problem or change the benefit determination. The 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 a 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 Benefit Summary.

Covered expense is an expense for which benefits are payable under this Plan subject to applicable deductibles, co-payments, co-insurance, out-of-pocket limit, 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. A Plan may include more than one deductible.

Dependent children means any natural, step, adopted or eligible child you, your spouse, or your domestic partner are legally obligated to support or contribute support. This may include eligible dependent children for which 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:

- **Registered domestic partner** means an 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 (employee) and meets the following criteria:
    - Is age 18 or older;
    - Not related to the subscriber 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 subscriber 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 subscriber 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.

Drug List (also known as a formulary) is a list of covered medications used to treat various medical conditions. PacificSource, on behalf of the Plan Sponsor, uses a variety of drug lists. Please refer to PacificSource.com/drug-list to determine which drug list applies to your coverage. The drug lists are developed and maintained by a committee of regional healthcare providers, including doctors, who are not employed by the Plan Sponsor or PacificSource. All PacificSource drug lists are available on the website, PacificSource.com/drug-list.

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 section.

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, and who is otherwise eligible under this Plan.

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.

- That is a behavioral health crisis

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 generally means the Plan Sponsor unless otherwise noted.

Essential health benefits are services defined as such by the Secretary of the U.S. Department of Health and Human Services. Essential health benefits fall into the following categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Laboratory services;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Pediatric services, including oral and vision care.
- Prescription drugs;
- Preventive and wellness services and chronic disease management; and
- Rehabilitation and habilitation services and devices.

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 (for example, 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 medications. By law, generic drugs must have the same active ingredients as the brand name medications and are subject to the same standards of their brand name counterparts. Generic drugs must be approved by the FDA through an Abbreviated New Drug Application and generally cannot be limited to a single manufacturer.

Geographical area – PacificSource has direct and indirect provider contracts to offer services to members in Oregon, Idaho, Montana, and bordering communities in southwest Washington. PacificSource also has an agreement with a nationwide provider network to offer services to members while traveling throughout the United States.

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.

- A written complaint submitted by a member or an authorized representative of a member regarding:
  - The availability, delivery, or quality of a healthcare service; or
  - 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.

Habilitation services means healthcare services that help a person keep, learn or improve skills and functioning of daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient 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, as amended, to the extent that plan is subject to state regulation.

Hearing aid means 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 health care 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;
- Medical supplies and equipment suitable for use in the home;
- Medically necessary personal hygiene, grooming and dietary assistance;
- 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.

Incurred expense means charges of a healthcare provider for services or supplies for which the 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.

Infertility means:

- Male: Low sperm counts or the inability to fertilize an egg; or
- Female: The inability to conceive or carry a pregnancy to 12 weeks.

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. A leave can be granted for any reason acceptable to the employer, including disability and pregnancy.

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. Lifetime maximums and lifetime benefits are not applicable to services or supplies that are deemed 'Essential Health Benefits'.

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 (for example, 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 Excluded Services – 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 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 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 condition means all disorders defined in the 'Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition' (DSM-5).

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.

Orthotic devices means rigid or semi rigid devices supporting a weak or deformed leg, foot, arm, hand, back, 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, Naturopathic Physician, Licensed Massage Therapist, and Pharmacist.

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.

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.

Rehabilitation services means healthcare services and devices that help a person keep, get back, or improve skills and functioning for daily living to overcome or recover from an illness or diagnosis that is covered by this Plan. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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 costs for medically necessary services or supplies which would normally be covered by the Plan if the member were not enrolled in an approved 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 is any individual who is legally married under current state law.

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 or 3 drugs). The program will not cover a brand name, or second-line medication, until less expensive, first-line/generic medications have been tried first.

Subscriber means an employee or former employee covered under the Plan. When a family 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 is the use of technology for the exchange of information when medically necessary.

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.

Tobacco use means use of tobacco on average four or more times per week within 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 and/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), contracted vendors, 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, naturopathic physician, nurse practitioner specializing in women's health, or certified nurse midwife practicing within the applicable scope of practice.

SIGNATURE PAGE

The effective date of the Lane County Retiree Medical Plan 35-250D is July 1, 2018.

It is agreed by Lane County that the provisions of this document are correct and will be the basis for the administration of Retiree Medical Plan 35-250D.

Dated this 24 day of September, 2018

By Mary P. Miller

Title Benefits & Wellness Manager

This page left intentionally blank.