



Enhancing the lives of citizens by delivering
quality services in a cost-effective manner

Deschutes County

**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

**DESCHUTES COUNTY
EMPLOYEE BENEFIT PLAN**

EFFECTIVE: AUGUST 1, 2000

RESTATED: AUGUST 1, 2016

DC-2016-740

TABLE OF CONTENTS

INTRODUCTION	1
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS	3
ENROLLMENT	7
EFFECTIVE DATE.....	10
TERMINATION OF COVERAGE	10
SCHEDULE OF BENEFITS	15
PARTICIPATING PROVIDER INFORMATION.....	15
PRESCRIPTION DRUG BENEFITS.....	27
DESCHUTES ONSITE CLINIC BENEFITS	30
VISION CARE BENEFITS.....	32
DENTAL BENEFITS.....	33
MEDICAL BENEFITS.....	35
COVERED CHARGES	35
CARE MANAGEMENT SERVICES	51
UTILIZATION MANAGEMENT	51
PRE-NOTIFICATION OF SERVICES.....	51
PRE-NOTIFICATION DETERMINATION AND REVIEW PROCESS	52
CASE MANAGEMENT	53
PRIORITY MATERNITY CARE.....	53
DEFINED TERMS	54
PLAN EXCLUSIONS	61
PRESCRIPTION DRUG BENEFITS.....	65
VISION CARE BENEFITS.....	70
DENTAL BENEFITS.....	71
COORDINATION OF BENEFITS	75
HOW TO SUBMIT MEDICAL CLAIMS	79
WHEN CLAIMS SHOULD BE FILED.....	79
CLAIMS REVIEW PROCEDURES	79
COMPLAINTS AND GRIEVANCES	82
THIRD PARTY RECOVERY PROVISION.....	86
COBRA CONTINUATION COVERAGE.....	88
RESPONSIBILITIES FOR PLAN ADMINISTRATION.....	93
HIPAA PRIVACY STANDARDS.....	94
HIPAA SECURITY STANDARDS.....	96
GENERAL PLAN INFORMATION.....	97

INTRODUCTION

This document is a description of the **Deschutes County Employee Benefit Plan** (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan. The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

The Employer or Plan has the right to rescind any coverage of the Employee, Retired Employee and/or Dependents for cause. In this context, "for cause" includes, but is not limited to, situations where an Employee, Retired Employee, and/or Dependents of an Employee or Retired Employee make a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage or benefits under the Plan. The Employer or Plan may either void coverage for the Employee, Retired Employee and/or covered Dependents for the period of time coverage was in effect, may immediately terminate coverage, or may terminate coverage as of a date to be determined at the discretion of the Employer or Plan. The Employer reserves the right to recover all monies paid for benefits or claims which the Employee, the Retired Employee and/or Dependents of an Employee or Retired Employee were paid which they were not entitled to. Before rescinding or terminating coverage the Employer or Plan will provide at least 30 days advance written notice to the Employee, Retired Employee and/or Dependents.

Employee and/or Dependents Covered in Error – Any Employee and/or Dependent who is enrolled in error under the Plan, or who is enrolled in violation of any of the terms of the Plan, shall not be entitled to any benefits thereunder. The Plan shall have the right to recover from any Employee and/or Dependent the cost of any benefits furnished while such an Employee and/or Dependent was enrolled in error. The Plan shall make proper adjustments for any contributions paid under such circumstances.

Representations, Not Warranties – All statements made by the Employee, the Plan or Covered Persons shall be considered representations and not warranties. All such statements will be made in good faith without any intention of fraud. No statement made while applying for coverage will cancel coverage or reduce benefits unless it is in a written document signed by the Plan or Covered Person. A copy of the document must be given to the person noted.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Care Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

How to Submit Medical Claims. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

COBRA Continuation Coverage. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Elected Officials, Active and certain Retired Employees of the Employers, Deschutes County and Central Oregon Intergovernmental Council (COIC).

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

- (1) Is a full-time or part-time, Active Employee of the Employer, who is regularly scheduled to work at least 20 hours per week.

Note: If a part-time Employee's hours are reduced by a County-approved, temporary reduction in hours, coverage will continue without interruption.
- (2) Is a Retired Employee of the Employer. A Retired Employee must have been enrolled as an active employee in the Plan (or a prior plan sponsored by the Employer) for at least 24 consecutive months immediately prior to retirement, unless otherwise indicated by a management/labor agreement. The Retired Employee must be receiving benefits from the Public Employee Retirement System (PERS) or from a similar retirement Plan offered by the Employer. **Retired Employees are not eligible to continue dental benefits unless they have 30 or more years of service with Deschutes County.** Retired Employees must elect Retiree coverage within 30 days of the date of their retirement to be eligible for this coverage.
- (3) Is in a class eligible for coverage.
- (4) Completes the employment Waiting Period of one month as an Active Employee. A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan. In the case of weekends and holidays, if the Employee starts on the first business day of the month, he or she will be treated as having been hired on the first day of the calendar month or the first shift of the month for certain classes of Employees.

If the Employee is hired into an hourly position and is not designated as a regular full-time or part-time Employee by the Employer at the time of hire, the Employer may use a 12-month look-back measurement period to determine the Full-Time status as defined under the Plan. The Employee must average or be expected to average the required minimum hours of service established by the Employer during the Employee's initial 12-month measurement period or the ongoing 12-month measurement period to qualify for coverage.

An Employee's initial measurement period begins the first day of the first calendar month following the date of hire, with an initial stability period commencing the first day of the second full calendar month following the initial measurement period. If there is a gap between the end of the Employee's first stability period and the start of the Employer's standard stability period, the Employee will remain eligible until the first day of the standard stability period as long as the Employee is actively working for the Employer.

The Employer's standard 12-month measurement period begins each June 1, with a standard stability period commencing each August 1. Coverage is effective the first day of the stability period following the applicable measurement period. To remain eligible for coverage, the Employee must average the required minimum hours of service each week during each subsequent standard measurement period. If there is a gap between the end of the Employee's first stability period and the start of the Employer's standard stability period, the Employee will remain eligible until the first day of the standard stability period as long as the Employee is actively working for the Employer.

If an Employee changes from an on-call or variable hour position to any of the above qualifying classifications as defined under this Plan, the Employee will be credited with time worked toward the employment Waiting Period.

For more information on benefit measurement periods, contact the Employer's Human Resources Department.

Part-Time to Full-Time Conversion. Part-time Employees who waive coverage and then become full-time Employees or have a significant increase in work hours (minimum of 25%), may elect to enroll in the Standard Plan at that time. Coverage will become effective on the first day of the month following application.

Part-time Employees who are enrolled in the High Deductible Plan option who then become full-time Employees may either waive continuation of coverage *OR* enroll in the Standard Plan option at that time.

Coverage will become effective the first day of the calendar month following or coinciding with the date the Employee is considered a full-time Employee.

Full-Time to Part-Time Conversion. Full-time Employees who were covered under the Standard Plan and then become part-time Employees or have a significant decrease in work hours (minimum of 25%) may elect to waive continuation of coverage *OR* enroll in the High Deductible Plan option at that time. Coverage will become effective the first day of the calendar month following or coinciding with the date the Employee is considered a part-time Employee.

Full-time hourly Employees who were covered under the Standard Plan and who experience a change in job status to a part-time position of less than 20 hours per week while in a stability period may continue coverage in the Standard Plan for 3 calendar months following the job status change, if the Employee continues to work in the part-time position and is on the Employer's payroll for that work. The Employee may also choose to enroll in the High Deductible Plan option at the time of the job status change, with coverage effective the first day of the calendar month following or coinciding with the date of the job status change. Starting with the 4th calendar month, the Employee's eligibility will be determined on a month to month basis for the remainder of the stability period.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

- (1) A covered **Employee's Spouse, Domestic Partner, and children** from birth to the limiting age of **26 years**, including adult dependent children of an eligible Employee. When a child reaches the limiting age, coverage will end on the last day of the month of the child's birthday.

A covered Retired Employee's Spouse, Domestic Partner, and children may only continue coverage if they were enrolled under the Plan at the time the Employee retired and continue to meet the eligibility requirements.

The term "**Spouse**" shall mean an individual of the same or opposite sex recognized as the covered Employee's husband or wife under the laws of the state where the marriage was formalized. The Plan Administrator may require documentation proving a legal marital relationship.

The term "**Domestic Partner**" shall mean a person of the same sex who meets all of the criteria stated in the signed "Affidavit of Qualifying Domestic Partnership (ORS 106.300 through 106.340, as amended)." **All references to Spouse will also be applicable to a Domestic Partner.** For the purpose of this plan, the use of the term "marriage" will also be applicable to a domestic partnership.

The term "**children**" shall include natural children or adopted children or a child placed for adoption. Step-children may also be included as long as a natural parent remains married to the Employee and resides in the Employee's household. Children of the Employee's Domestic Partner may also be included as long as the natural parent remains in a Domestic Partner relationship with the Employee and resides in the Employee's household.

If a covered Employee their Spouse or Domestic Partner is the **Legal Guardian** of a child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "**child placed with a covered Employee in anticipation of adoption**" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

A participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

The Plan Administrator may require documentation proving dependency including birth certificates or initiation of legal proceedings severing parental rights.

Please be advised, the definition of "Dependent" may not be the same definition as established by the Internal Revenue Code (IRC) for individuals that the covered Employee is permitted to pay qualified medical expenses from a Health Savings Account (HSA), or individuals that can be enrolled as an eligible Dependent for tax-free benefits.

There may be tax implications for the Employee if he or she enrolls certain eligible Dependent(s) such as a Domestic Partner that is not recognized as the Employee's Spouse by the laws of the state in which the marriage was formalized. The Employee should consult his or her tax advisor with any questions on the tax consequences of benefits for his or her eligible Dependent(s).

- (2) A covered Dependent child who reaches the limiting age and is **Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: Other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated Spouse or divorced former Spouse of the Employee; any person who has permanent residence outside of the United States; *however*, in cases where an Employee and his or her Spouse or Domestic Partner each work at Deschutes County and COIC respectively, each is eligible to be covered as a Dependent of the other.

If both the husband and wife or Domestic Partner are Employees of Deschutes County, each individual will be covered as an Employee only.

If both the husband and wife or Domestic Partner are Employees of COIC, each individual will be covered as an Employee only.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

Dual Coverage. The Plan does not allow "dual Deschutes County coverage." That is, if both the mother and father are Employees of Deschutes County, their children will be covered as Dependents of the mother **or** father, who has been employed by Deschutes County the longest. However, if both the mother and father are Employees of COIC, their children will be covered as Dependents of the mother **and** father.

In cases where the mother **or** father is an Employee of Deschutes County **and** the mother **or** father is an Employee of COIC, their children will be covered as Dependents of the mother **and** father.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

In cases where a Dependent Spouse becomes an Employee, an otherwise eligible Dependent child may be enrolled as a new Dependent if an enrollment form is received by the Plan Administrator in accordance with the “Timely” or “Late” Enrollment provisions of this Plan.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

For Retired Employees: Only those Dependents who are enrolled under the Plan at the time the Employee retired are eligible to continue coverage under the Plan as the Retiree’s Dependents. A Covered Retiree may only add a newborn child, adopted child or child placed for adoption, or a Foster child after his or her retirement date.

FUNDING

Cost of the Plan. Deschutes County shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application. The covered Employee is required to enroll for Dependent coverage if coverage for Dependents is desired.

Separate policies for Deschutes County Employees who are married or have an executed Affidavit of Domestic Partnership will not be allowed.

In the event that a Covered Deschutes County Employee is the Spouse or Domestic Partner of a current Covered Deschutes County Employee, the Spouse or Domestic Partner employed the longest with Deschutes County must enroll his or her Spouse or Domestic Partner by filling out and signing an enrollment application. If coverage is desired for additional, eligible Dependents, the covered Employee is also required to enroll for Dependent coverage at this time.

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee or enrolled Dependent is automatically enrolled in this Plan for 31 days after the date of birth; however, an enrollment application must be submitted to the Plan Administrator within that 31-day period in order to continue coverage.

In the case of a newborn of a male Dependent child, the Employee must supply proof of paternity (at the Plan’s expense).

TIMELY, LATE OR OPEN ENROLLMENT

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage.

If two Employees (mother and father) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

- (2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment, reduction of hours of employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

- (3) **Open Enrollment.** Every July, the annual open enrollment period, Employees and their Dependents who are Late Enrollees or who are otherwise eligible for coverage under the Plan will be able to enroll in the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective August 1.

Plan participants will receive detailed information regarding open enrollment from their Employer.

Enrollment Following the Benefit Measurement Period

Employees who were determined eligible for coverage during the applicable measurement period (and their eligible Dependents) may enroll in the Plan the first day of the first full calendar month of the following stability period. Employees will be credited for time previously satisfied toward the employment Waiting Period.

SPECIAL ENROLLMENT RIGHTS

Generally, plan participants cannot change benefit elections made upon enrollment in the Plan; however, federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself/herself or his/her Dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, execution of an Affidavit of Domestic Partnership, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, execution of an Affidavit of Domestic Partnership, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

- (1) **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent, who is otherwise eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:
- (a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - (b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - (c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.
 - (d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, as described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

For purposes of these rules, a loss of eligibility occurs if:

- (i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e., part-time Employees).
- (ii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
- (iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
- (iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

- (2) **Dependent beneficiaries.** If:

- (a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee), may be enrolled under this Plan.

In the case of the birth or adoption of a child, the Spouse (and any otherwise eligible Dependent children of the covered Employee) may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

In the case of a marriage between two Deschutes County Employees, any otherwise eligible Dependent children of either covered Employee may be enrolled as a Dependent in accordance with the Dual Coverage provisions of this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his or her eligible Dependents to enroll.

In the case of an execution of an Affidavit of Domestic Partnership between two Deschutes County Employees, any otherwise eligible Dependent children of either covered Employee may be enrolled as a Dependent in accordance with the Dual Coverage provisions of this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his or her eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period. The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

- (a) In the case of marriage, the date of marriage, provided that an application for enrollment is submitted prior to the first day of the month in which the marriage takes place. If the enrollment application is submitted after the first day of the month in which the marriage takes place, but within 31 days of the marriage, coverage will take effect on the first day of the month following the marriage;
- (b) In the case of a Dependent's birth, as of the date of birth;
- (c) In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption; or
- (d) In the case of a Domestic Partner, the date that the qualified domestic partnership is established by execution of an Affidavit of Domestic Partnership, provided that an application for enrollment is submitted prior to the first day of the month in which the Affidavit of Domestic Partnership is executed. If the enrollment application is submitted after the first day of the month in which the Affidavit of Domestic Partnership is approved, but within 31 days of execution of the Affidavit of Domestic Partnership, coverage will take effect on the first day of the month following receipt and approval of the enrollment.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Employees and their Dependents who are otherwise eligible for coverage under the Plan but who are not enrolled can enroll in the Plan provided that they request enrollment in writing within sixty (60) days from the date of the following loss of coverage or gain in eligibility:

- The eligible person ceases to be eligible for Medicaid or State Children’s Health Insurance Program (SCHIP) coverage; or
- The eligible person becomes newly eligible for a premium subsidy under Medicaid or SCHIP.

If eligible, the Dependent (and if not otherwise enrolled, the Employee, Spouse, and otherwise eligible Dependent children) may be enrolled under this Plan.

This Dependent Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or SCHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or SCHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this 60-day period.

If a State in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State law is applicable to the Plan, the Employer and its Employees.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

- (1) The date the Plan is terminated;
- (2) The date the covered Employee's Eligible Class is eliminated;
- (3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes, or if applicable, the last day of the stability period for which the covered Employee met the required minimum hours of service established by the Employer. This includes death or termination of Active Employment of the covered Employee. (See the section entitled COBRA Continuation Coverage.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods;
- (4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due; or
- (5) As otherwise specified in the Eligibility section of this Plan.

Note: Except in certain circumstances, a covered Employee may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

Note: If the Employee commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days advance written notice of such action.

Continuation During Periods of Employer-Certified Disability, Leave of Absence, or Paid Administrative Leave. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, Employer-certified leave of absence, or paid administrative leave.

For disability or Employer-certified leave of absence, this continuance will remain in effect until the end of the three calendar month period that next follows the month in which the person last worked as an Active Employee.

For paid administrative leave, this continuance will remain in effect until the date the Employer, in its sole discretion, ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Strike or Lockout. If an Employee is employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, coverage may be continued for up to six months. The Employee must pay the full premium, including any part usually paid by the employer, directly to the union or trust that represents him or her. The union or trust must continue to pay the premiums on the due date. Coverage cannot be continued if fewer than 75% of those normally enrolled continue coverage or if the Employee or Dependent(s) otherwise lose eligibility under the Plan. This six months of continued coverage is in lieu of and not in addition to any continuation of coverage provisions of the Plan.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor and as may be amended from time to time, in fact, FMLA is applicable to the Employer and all of its Employees. This Plan shall also comply with the Oregon Family Leave Act (OFLA) as set forth in statutes enacted by the Oregon legislature and amended from time to time, to the extent that OFLA is applicable to the Employer and all of its Employees. Leave taken under OFLA shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or the OFLA, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA and/or OFLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. If an Employee is laid-off or terminates employment and then returns to employment within six months of the last day of work, coverage will be reinstated on the first day of the month following or coinciding with the employee's return to employment.

Retiree Coverage after COBRA. If Active, full-time work ceases due to disability and following termination of any disability continuation of coverage benefit provided under this Plan, COBRA Continuation Coverage may be elected. If, while covered under COBRA the Employee begins receiving benefits from the Public Employee Retirement System (PERS), he or she may reenroll as a Retired Employee under this Plan. A request for re-enrollment must be received by the Plan Administrator within six (6) months of the effective date of coverage under the PERS plan.

Continuation of Benefits After Termination of Group Health Plan Rules. If a Covered Person is hospitalized on the date that this Plan is terminated and immediately replaced by another group health insurance plan, this Plan shall continue its obligation for benefits under the Plan for that Covered Person until the hospital confinement ends or until the hospital benefits under the Plan are exhausted, whichever is earlier.

Continuation of Benefits After Injury or Illness Covered By Worker's Compensation Insurance. Coverage under this Plan shall be available to eligible employees who are not actively working and are receiving Worker's Compensation insurance payments. Premium contribution amounts/levels will be the same as if the eligible employee was actively at work. This continuation of benefits is administered in accordance with the coverage extensions provision and with any state or Federal continuation requirements. The eligible employee may maintain such coverage until the earlier of:

- The date the eligible employee takes full-time employment with another employer; or
- Twelve months from the date that the payment of premium is made under this provision. This twelve months of continued coverage is in lieu of, not in addition to, any other continuation of insurance provision described in other sections.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
 - (a) The 24 month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA Continuation Coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

- (1) The date the Plan or Dependent coverage under the Plan is terminated;
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled COBRA Continuation Coverage.);
- (3) On the last day of the calendar month a covered Spouse loses coverage due to loss of dependency status. (See the section entitled COBRA Continuation Coverage.);
- (4) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled COBRA Continuation Coverage.);

- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due; or
- (6) As otherwise specified in the Eligibility section of this Plan.

Note: Except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

Note: If a Dependent commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days advance written notice of such action.

When Retired Employee Coverage Terminates. Retired Employee coverage will terminate on the earliest of these dates:

- (1) The date the Plan is terminated;
- (2) The date the covered Retired Employee's Eligible Class is eliminated;
- (3) On the last day of the calendar month the covered Retired Employee reaches age 65;
- (4) The first day of the month the covered Retired Employee becomes entitled to Medicare;
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due; or
- (6) As otherwise specified in the Eligibility section of this Plan.

Note: If a Retired Employee commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Retired Employee for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days advance written notice of such action

When Dependent of a Retired Employee Coverage Terminates. When a Retired Employee's coverage terminates under this Plan due to reaching age 65 or becoming entitled to Medicare, his/her Dependents may remain eligible for benefits until the Dependent's coverage terminates as outlined below. ***The Plan Administrator must be notified that Dependent coverage is to continue within 31 days of the Retired Employee's termination.***

A Retired Employee's Dependent's coverage will terminate on the earliest of these dates:

- (1) The last day of the calendar month the Plan or Dependent coverage under the Plan is terminated;
- (2) On the last day of the calendar month a covered Spouse or Domestic Partner of a Retired Employee loses coverage due to loss of dependency status. (See the section entitled COBRA Continuation Coverage.);
- (3) On the last day of the calendar month the Dependent Spouse or Domestic Partner reaches age 65;
- (4) The first day of the month the covered the Dependent Spouse or Domestic Partner becomes entitled to Medicare;
- (5) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled COBRA Continuation Coverage.);

- (7) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due; or
- (8) As otherwise specified in the Eligibility section of this Plan.

Note: Except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

Note: If a Dependent of a Retired Employee commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent of a Retired Employee for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days advance written notice of such action

Special Notice. If a participant is a surviving, divorced, or legally separated Spouse of an enrolled Employee, and at least 55 years old at the time of death or at the time of the dissolution or legal separation, the Spouse may be eligible to continue coverage. Please contact the Plan Administrator for additional information.

If a participant is an eligible Dependent child of the Employee and the Employee's surviving, divorced or legally separated Spouse who is at least 55 years old at the time of death or at the time of dissolution or legal separation, the Dependent child may be eligible to continue coverage. Please contact the Plan Administrator for additional information. This state-mandated continuation of coverage will terminate upon the earliest of any of the following:

- (1) The failure to pay premiums when due, including any grace period;
- (2) The date that this Plan is terminated;
- (3) The date on which the surviving, divorced or legally separated Spouse remarries and becomes covered under another group health plan; or
- (4) The date on which the surviving, divorced or legally separated spouse becomes eligible for federal Medicare coverage.

Cover Oregon. If a Covered Person's medical coverage under this Plan terminates and the Covered Person has exhausted continuation coverage (COBRA), he or she may be eligible for coverage through Cover Oregon.

For information on Cover Oregon and the options available for individuals and families, visit: www.coveroregon.com.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Allowable Charge; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Participating Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Participating Provider is used. It is the Covered Person's choice as to which Provider to use.

To access a listing of Participating Providers, please refer to the Participating Provider website and/or toll free number listed on the Deschutes County Employee Benefit Plan identification card. Prior to receiving medical care services, the Covered Person should confirm with the provider and the Participating Provider Organization (PPO) that the provider is a participant in this organization.

Under the following circumstances, the higher Participating Provider payment will be made for certain Non-Participating Provider services:

- If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care. If admitted as an inpatient, covered services will continue to be provided at the higher Participating Provider benefit level until discharged.
- If a Covered Person has no choice of Participating Providers in the specialty that the Covered Person is seeking within the PPO service area.
- If a Covered Person resides outside of the PPO service area.
- If a Covered Person receives ancillary Physician services by a Non-Participating Provider when the Covered Person has no choice of that provider (such as, but not limited to, Physician, laboratory, radiologist, anesthesiologist, pathologist or emergency room Physician).
- If a Covered Person is receiving care from a Participating Provider and that provider's Participating Provider status terminates, the Covered Person is entitled to continue care with that provider; however, benefits for services furnished after the Participating Provider's status change will be covered at the Non-Participating Provider benefit level.

Deductibles/Copayments/Coinsurance payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A **deductible** is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each **January 1st**, a new deductible amount is required.

Deductibles will accrue toward the medical maximum out-of-pocket amount.

A **copayment** is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

Copayments do not accrue toward the deductible amount. Copayments (not including Prescription Drug copayments) will accrue toward the medical maximum out-of-pocket amount.

Coinsurance is the percentage amount remaining after the Plan pays the reimbursement rate as shown in the Schedule of Benefits, and is the Covered Person's responsibility. Coinsurance *does not* apply to the deductible and *does not* include copayment amounts.

Coinsurance is payable by the Covered Person until the medical maximum out-of-pocket amount, as shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges which do not apply to the medical maximum out-of-pocket amount) for the remainder of the Calendar Year.

PLAN OPTIONS

Standard Plan

The Standard Plan option is available to all Employees (and Retired Employees).

High Deductible Plan*

The High Deductible Plan option is only available to Retirees and those Employees considered part-time Employees.

** This High Deductible Plan option does not satisfy the statutory requirements with respect to deductibles and maximum out-of-pocket expenses set forth by the U.S. Department of Treasury for contribution to a Health Savings Account.*

Pre-notification of certain services is required by the Plan. Pre-notification of other services is **strongly recommended**. Pre-notification provides information regarding coverage before the Covered Person receives treatment, services and/or supplies. A pre-notification of services by CareLink is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided. *A denial of a pre-notification request may be appealed under the Plan's Internal and External Claims Review Procedures.*

Failure to notify CareLink of an inpatient admission prior to the inpatient claims being received by the Claims Administrator will result in the benefit payment being reduced by a maximum of \$1,000. The maximum penalty, if needed, shall be adjusted so as not to reduce the benefit more than 50%. Any reduction of Covered Charges will not apply toward the medical maximum out-of-pocket amount.

STANDARD PLAN SCHEDULE OF BENEFITS

STANDARD PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
MAXIMUM ANNUAL BENEFIT AMOUNT	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	\$500	
Per Family Unit	\$1,500	
MEDICAL MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	\$2,000	\$4,000
Per Family Unit	\$6,000	\$12,000
<p>Note: The Participating Provider and Non-Participating Provider medical maximum out-of-pocket amounts will apply toward each other.</p> <p>The Plan will pay the designated percentage of Covered Charges until the medical maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.</p> <p>The following charges do not apply toward the medical maximum out-of-pocket amounts and are never paid at 100%:</p> <ul style="list-style-type: none"> - Cost containment penalties - Prescription Drug copayments - Charges not covered by the Plan - Amounts that exceed the Allowable Charge 		
COVERED CHARGES		
<p><i>Note: The maximums listed below are the total for Participating Provider and Non-Participating Provider expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Participating and Non-Participating Providers.</i></p>		
Hospital Services		
Room and Board	80% after deductible and \$100 copayment per admission Limited to the semiprivate room rate	60% after deductible and \$100 copayment per admission Limited to the semiprivate room rate
Inpatient services	80% after deductible	60% after deductible
Outpatient services	80% after deductible	60% after deductible
Intensive Care Unit	80% after deductible and \$100 copayment per admission Limited to the Hospital's ICU charge	60% after deductible and \$100 copayment per admission Limited to the Hospital's ICU charge
<p><i>Note: Pre-notification is required prior to any inpatient admission to avoid a penalty.</i></p>		
Emergency room services		
Medical Emergency	80% after deductible and \$100 copayment; <i>Emergency room services copayment waived if admitted</i>	
Non-Medical Emergency	Not Covered	Not Covered
<p><i>Note: Pre-notification is required within two business days after an admission from the Emergency Room to avoid a penalty.</i></p>		
Pre-Admission Testing	80% after deductible	60% after deductible
Skilled Nursing Facility	80% after deductible Limited to the semiprivate room rate	60% after deductible Limited to the semiprivate room rate
<p><i>Note: Pre-notification is required prior to any inpatient admission to avoid a penalty.</i></p>		

STANDARD PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Urgent Care Services		
Facility	80% after deductible	60% after deductible
Office visit	100% after \$25 copayment, no deductible applies	80% after \$25 copayment, no deductible applies
<i>Note: The Urgent Care office visit copayment benefit includes the visit charge only. All other services performed during the office visit are payable per normal Plan provisions.</i>		
Physician Services		
Inpatient visit	80% after deductible	60% after deductible
Outpatient visit	80% after deductible	60% after deductible
Office visit	100% after \$25 copayment, no deductible applies	80% after \$25 copayment, no deductible applies
<i>Note: The office visit copayment benefit includes the visit charge only. All other services performed during the office visit are payable per normal Plan provisions.</i>		
Skin lesion removal in the Physician's office	80%, no deductible applies	60%, no deductible applies
Surgery (includes surgical suite and supplies)	80% after deductible	60% after deductible
Diagnostic lab and x-ray		
Inpatient	80% after deductible	60% after deductible
Outpatient	80%, no deductible applies	60%, no deductible applies
Colonoscopy/Sigmoidoscopy	100%, no deductible applies	80%, no deductible applies
Allergy injections	100%, after \$5 copayment, no deductible applies	80%, after \$5 copayment, no deductible applies
Allergy serum	80% after deductible	60% after deductible
Therapeutic Injections	80% after deductible	60% after deductible
Home Health Care	80% after deductible 2 visits per day maximum 180 visits Calendar Year maximum	60% after deductible 2 visits per day maximum 180 visits Calendar Year maximum
Hospice Care	80% after deductible	60% after deductible
Bereavement Counseling	80% after deductible	60% after deductible
<i>Note: Pre-notification is required prior to any inpatient admission to avoid a penalty.</i>		
Home Infusion Therapy	80% after deductible	60% after deductible
Inborn Errors of Metabolism	80% after deductible	60% after deductible
Chemotherapy or Radiation Therapy	80% after deductible	60% after deductible
Ambulance Service	80% after deductible 400 miles per condition maximum	
Jaw Joint/TMJ	50% after deductible \$2,000 Lifetime maximum	50% after deductible \$2,000 Lifetime maximum
Care of the Mouth Teeth and Gums within 120 days of Injury	80% after deductible	

STANDARD PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Rehabilitation Services Inpatient (includes speech, physical, occupational, and vision therapy)	80% after deductible 30 days (combined) Calendar Year maximum	60% after deductible 30 days (combined) Calendar Year maximum
Outpatient (includes speech, physical, occupational, and vision therapy)	80% after deductible 30 visits (combined) Calendar Year maximum	60% after deductible 30 visits (combined) Calendar Year maximum
<i>Note: Up to 30 additional outpatient visits will be allowed for head and spinal injury, cardiovascular accident, stroke or major injury.</i>		
<i>Note: Pre-notification is required prior to any inpatient admission to avoid a penalty.</i>		
Durable Medical Equipment	80% after deductible	60% after deductible
<i>Note: Durable Medical Equipment will be reimbursed based on monthly rental versus purchase price, unless the purchase of such equipment would be more cost effective to the Plan, with the cost not to exceed the fair market value of the equipment at the time of purchase, and only if agreed to in advance by the Plan Administrator.</i>		
Orthotics	80% after deductible	60% after deductible
Prosthetics	80% after deductible	60% after deductible
Hearing Aids - Birth through age 24 years	80% after deductible One hearing aid per impaired ear every 4 Calendar Years maximum	60% after deductible One hearing aid per impaired ear every 4 Calendar Years maximum
Mental Health Care		
Inpatient	80% after deductible	60% after deductible
Residential treatment or partial hospitalization	80% after deductible	60% after deductible
Outpatient/Office	100% after \$25 copayment, no deductible applies	80% after \$25 copayment, no deductible applies
<i>Note: Pre-notification is required prior to any inpatient admission or within two days after an admission from the Emergency Room to avoid a penalty.</i>		
Chemical Dependency		
Inpatient	80% after deductible	60% after deductible
Residential treatment or partial hospitalization	80% after deductible	60% after deductible
Outpatient/Office	100% after \$25 copayment, no deductible applies	80% after \$25 copayment, no deductible applies
<i>Note: Pre-notification is required prior to any inpatient admission or within two days after an admission from the Emergency Room to avoid a penalty.</i>		
Pervasive Developmental Disorder (PDD) Treatment – Birth to age 18	Payable per normal Plan provisions	Payable per normal Plan provisions

STANDARD PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Preventive Care Routine Well Care (birth through adult)	100%, no deductible applies	80%, no deductible applies
Routine Well Care services and Women's Preventive Services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA), <i>unless otherwise specifically stated in this Schedule of Benefits</i> , and which can be located using the following websites:		
<p style="text-align: center;"> https://www.healthcare.gov/what-are-my-preventive-care-benefits/; http://www.hrsa.gov/womensguidelines; http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ </p>		
<p><u>Routine Well Care services will include, but will not be limited to, the following routine services:</u> Office visits, routine physical exams, prostate screening, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well child care examinations.</p>		
<p><u>Women's Preventive Services, will include, but will not be limited to, the following routine services:</u> Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity (<i>this does not include birthing classes</i>), preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.</p>		
Nutritional Education Counseling	100%, no deductible applies	80%, no deductible applies
Obesity Interventions for Covered Persons age 18 and older with a body mass index (BMI) of 30 kg/m ² or higher	100%, no deductible applies	80%, no deductible applies
<p><i>Note: Please see the Nutritional Education Counseling benefit in the Covered Charges section for additional information on Nutritional Education Counseling and Obesity Interventions.</i></p>		
Diabetes Education	100%, no deductible applies	80%, no deductible applies
<p><i>Note: Diabetes Education includes an initial program of assessment and training, and up to 3 hours per Calendar Year of additional assessment and training.</i></p>		
Diabetes Management for Pregnant Women (conception through six weeks postpartum)	100%, no deductible applies	80%, no deductible applies
Tobacco Cessation	100%, no deductible applies	80% no deductible applies
Routine Electron Beam Tomography (EBT)	100%, no deductible applies	80%, no deductible applies
Alternative Care (includes chiropractic treatment, massage therapy, and acupuncture)	100% after \$15 copayment, no deductible applies \$45 massage therapy visit maximum \$1,500 (combined) Calendar Year maximum	
<p><i>Note: Diagnostic x-rays ordered by a chiropractor will be payable subject to the separate Diagnostic lab and x-ray benefit.</i></p>		
Naturopathic Treatment	100% after \$25 copayment, no deductible applies	80% after \$25 copayment, no deductible applies

STANDARD PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Sleep Studies for Sleep Disorders	80% after deductible	60% after deductible
<i>Note: Medically Necessary, prescribed equipment related to sleep studies for sleep disorders is covered under the Durable Medical Equipment benefit.</i>		
Organ and/or Tissue Transplants	Payable per normal Plan provisions	Payable per normal Plan provisions
Travel and lodging	80% after deductible \$10,000 per transplant maximum \$200 per day maximum	Not Covered
<i>Note: Refer to the separate Organ Transplant benefit listed within the Covered Charges section for more information on transplants, including travel and lodging expenses.</i>		
Pregnancy	Payable per normal Plan provisions	Payable per normal Plan provisions
Routine prenatal office visits	100%, no deductible applies <i>If global maternity fee:</i> 40% of Covered Charges will be payable at 100%, no deductible applies; thereafter, payable per normal Plan provisions	Payable per normal Plan provisions
Routine Well Newborn Nursery Care (while Hospital confined)	80% after deductible	60% after deductible
<i>Note: Pre-notification is required to avoid a penalty related to a maternity admission that exceeds 48 hours following a vaginal delivery or 96 hours following a cesarean section.</i>		
All Other Covered Charges	80% after deductible	60% after deductible

HIGH DEDUCTIBLE PLAN SCHEDULE OF BENEFITS

HIGH DEDUCTIBLE PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
MAXIMUM ANNUAL BENEFIT AMOUNT	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	\$2,500	
Per Family Unit	\$5,000	
MEDICAL MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	\$5,000	\$10,000
Per Family Unit	\$10,000	\$20,000
Note: The Participating Provider and Non-Participating Provider medical maximum out-of-pocket amounts will apply toward each other.		
The Plan will pay the designated percentage of Covered Charges until the medical maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the medical maximum out-of-pocket amounts and are never paid at 100%: <ul style="list-style-type: none"> - Cost containment penalties - Prescription Drug copayments - Charges not covered by the Plan - Amounts that exceed the Allowable Charge 		
COVERED CHARGES		
<i>Note: The maximums listed below are the total for Participating Provider and Non-Participating Provider expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Participating and Non-Participating Providers.</i>		
Hospital Services		
Room and Board	80% after deductible and \$100 copayment per admission Limited to the semiprivate room rate	60% after deductible and \$100 copayment per admission Limited to the semiprivate room rate
Inpatient services	80% after deductible	60% after deductible
Outpatient services	80% after deductible	60% after deductible
Intensive Care Unit	80% after deductible and \$100 copayment per admission Limited to the Hospital's ICU charge	60% after deductible and \$100 copayment per admission Limited to the Hospital's ICU charge
Note: Pre-notification is required prior to any inpatient admission to avoid a penalty.		
Emergency room services		
Medical Emergency	80% after deductible and \$100 copayment; <i>Emergency room services copayment waived if admitted</i>	
Non-Medical Emergency	Not Covered	Not Covered
Note: Pre-notification is required within two business days after an admission from the Emergency Room to avoid a penalty.		
Pre-Admission Testing	80% after deductible	60% after deductible
Skilled Nursing Facility	80% after deductible Limited to the semiprivate room rate	60% after deductible Limited to the semiprivate room rate
Note: Pre-notification is required prior to any inpatient admission to avoid a penalty.		
Urgent Care Services		
Facility	80% after deductible	60% after deductible
Office visit	100% after \$25 copayment, no deductible applies	80% after \$25 copayment, no deductible applies
Note: The Urgent Care office visit copayment benefit includes the visit charge only. All other services performed during the office visit are payable per normal Plan provisions.		

HIGH DEDUCTIBLE PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Physician Services		
Inpatient visit	80% after deductible	60% after deductible
Outpatient visit	80% after deductible	60% after deductible
Office visit	100% after \$25 copayment, no deductible applies	80% after \$25 copayment, no deductible applies
<i>Note: The office visit copayment benefit includes the visit charge only. All other services performed during the office visit are payable per normal Plan provisions.</i>		
Skin lesion removal in the Physician's office	80%, no deductible applies	60%, no deductible applies
Surgery (includes surgical suite and supplies)	80% after deductible	60% after deductible
Diagnostic lab and x-ray		
Inpatient	80% after deductible	60% after deductible
Outpatient	80%, no deductible applies	60%, no deductible applies
Colonoscopy/Sigmoidoscopy	100%, no deductible applies	80%, no deductible applies
Allergy injections	100%, after \$5 copayment, no deductible applies	80%, after \$5 copayment, no deductible applies
Allergy serum	80% after deductible	60% after deductible
Therapeutic Injections	80% after deductible	60% after deductible
Home Health Care	80% after deductible 2 visits per day maximum 180 visits Calendar Year maximum	60% after deductible 2 visits per day maximum 180 visits Calendar Year maximum
Hospice Care	80% after deductible	60% after deductible
Bereavement Counseling	80% after deductible	60% after deductible
<i>Note: Pre-notification is required prior to any inpatient admission to avoid a penalty.</i>		
Home Infusion Therapy	80% after deductible	60% after deductible
Inborn Errors of Metabolism	80% after deductible	60% after deductible
Chemotherapy or Radiation Therapy	80% after deductible	60% after deductible
Ambulance Service	80% after deductible 400 miles per condition maximum	
Jaw Joint/TMJ	50% after deductible \$2,000 Lifetime maximum	50% after deductible \$2,000 Lifetime maximum
Care of the Mouth Teeth and Gums within 120 days of Injury	80% after deductible	
Rehabilitation Services		
Inpatient (includes speech, physical, occupational, and vision therapy)	80% after deductible 30 days (combined) Calendar Year maximum	60% after deductible 30 days (combined) Calendar Year maximum
Outpatient (includes speech, physical, occupational, and vision therapy)	80% after deductible 30 (combined) visits Calendar Year maximum	60% after deductible 30 (combined) visits Calendar Year maximum
<i>Note: Up to 30 additional outpatient visits will be allowed for head and spinal injury, cardiovascular accident, stroke or major injury.</i>		
<i>Note: Pre-notification is required prior to any inpatient admission to avoid a penalty.</i>		

HIGH DEDUCTIBLE PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Durable Medical Equipment	80% after deductible	60% after deductible
<i>Note: Durable Medical Equipment will be reimbursed based on monthly rental versus purchase price, unless the purchase of such equipment would be more cost effective to the Plan, with the cost not to exceed the fair market value of the equipment at the time of purchase, and only if agreed to in advance by the Plan Administrator.</i>		
Orthotics	80% after deductible	60% after deductible
Prosthetics	80% after deductible	60% after deductible
Hearing Aids - Birth through age 24 years	80% after deductible One hearing aid per impaired ear every 4 Calendar Years maximum	60% after deductible One hearing aid per impaired ear every 4 Calendar Years maximum
Mental Health Care		
Inpatient	80% after deductible	60% after deductible
Residential treatment or partial hospitalization	80% after deductible	60% after deductible
Outpatient/Office	100% after \$25 copayment, no deductible applies	80% after \$25 copayment, no deductible applies
<i>Note: Pre-notification is required prior to any inpatient admission or within two days after an admission from the Emergency Room to avoid a penalty.</i>		
Chemical Dependency		
Inpatient	80% after deductible	60% after deductible
Residential treatment or partial hospitalization	80% after deductible	60% after deductible
Outpatient/Office	100% after \$25 copayment, no deductible applies	80% after \$25 copayment, no deductible applies
<i>Note: Pre-notification is required prior to any inpatient admission or within two days after an admission from the Emergency Room to avoid a penalty.</i>		
Pervasive Developmental Disorder (PDD) Treatment – Birth to age 18	Payable per normal Plan provisions	Payable per normal Plan provisions
Preventive Care		
Routine Well Care (birth through adult)	100%, no deductible applies	80%, no deductible applies
<p>Routine Well Care services and Women’s Preventive Services will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA), <i>unless otherwise specifically stated in this Schedule of Benefits</i>, and which can be located using the following websites:</p> <p style="text-align: center;"> https://www.healthcare.gov/what-are-my-prventive-care-benefits/; http://www.hrsa.gov/womensguidelines; http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ </p> <p><u>Routine Well Care services will include, but will not be limited to, the following routine services:</u> Office visits, routine physical exams, prostate screening, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well child care examinations.</p>		

HIGH DEDUCTIBLE PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
<p><u>Women's Preventive Services, will include, but will not be limited to, the following routine services:</u></p> <p>Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity (<i>this does not include birthing classes</i>), preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.</p>		
<p>Nutritional Education Counseling</p> <p>Obesity Interventions for Covered Persons age 18 and older with a body mass index (BMI) of 30 kg/m² or higher</p>	<p>100%, no deductible applies</p> <p>100%, no deductible applies</p>	<p>80%, no deductible applies</p> <p>80%, no deductible applies</p>
<p><i>Note: Please see the Nutritional Education Counseling benefit in the Covered Charges section for additional information on Nutritional Education Counseling and Obesity Interventions.</i></p>		
<p>Diabetes Education</p>	<p>100%, no deductible applies</p>	<p>80%, no deductible applies</p>
<p><i>Note: Diabetes Education includes an initial program of assessment and training and up to 3 hours per Calendar Year of additional assessment and training.</i></p>		
<p>Diabetes Management for Pregnant Women (conception through six weeks postpartum)</p>	<p>100%, no deductible applies</p>	<p>80%, no deductible applies</p>
<p>Tobacco Cessation</p>	<p>100%, no deductible applies</p>	<p>80% no deductible applies</p>
<p>Routine Electron Beam Tomography (EBT)</p>	<p>100%, no deductible applies</p>	<p>80%, no deductible applies</p>
<p>Alternative Care (includes chiropractic treatment, massage therapy, and acupuncture)</p>	<p>100% after \$15 copayment, no deductible applies \$45 massage therapy visit maximum \$1,500 (combined) Calendar Year maximum</p>	
<p><i>Note: Diagnostic x-rays ordered by a chiropractor will be payable subject to the separate Diagnostic lab and x-ray benefit.</i></p>		
<p>Naturopathic Treatment</p>	<p>100% after \$25 copayment, no deductible applies</p>	<p>80% after \$25 copayment, no deductible applies</p>
<p>Sleep Studies for Sleep Disorders</p>	<p>80% after deductible</p>	<p>60% after deductible</p>
<p><i>Note: Medically Necessary, prescribed equipment related to sleep studies for sleep disorders is covered under the Durable Medical Equipment benefit.</i></p>		
<p>Organ and/or Tissue Transplants</p> <p>Transportation and lodging</p>	<p>Payable per normal Plan provisions</p> <p>80% after deductible \$10,000 per transplant maximum \$200 per day maximum</p>	<p>Payable per normal Plan provisions</p> <p>Not Covered</p>
<p><i>Note: Refer to the separate Organ Transplant benefit listed within the Covered Charges section for more information on transplants, including travel and lodging expenses.</i></p>		

HIGH DEDUCTIBLE PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Pregnancy	Payable per normal Plan provisions	Payable per normal Plan provisions
Routine prenatal office visits	100%, no deductible applies <i>If global maternity fee:</i> 40% of Covered Charges will be payable at 100%, no deductible applies; thereafter, payable per normal Plan provisions	Payable per normal Plan provisions
Routine Well Newborn Nursery Care (while Hospital confined)	80% after deductible	60% after deductible
<i>Note: Pre-notification is required to avoid a penalty related to a maternity admission that exceeds 48 hours following a vaginal delivery or 96 hours following a cesarean section.</i>		
All Other Covered Charges	80% after deductible	60% after deductible

PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefit Maximum Out-of-Pocket Amounts

Standard Plan

Per Covered Person.....	\$1,200
Per Family Unit.....	\$3,600

Prescription Drug Benefit Maximum Out-of-Pocket Amounts

HDHP Plan

Per Covered Person.....	\$1,200
Per Family Unit.....	\$3,200

Prescription Drug benefit copayments/coinsurance will accumulate to the Prescription Drug benefit maximum out-of-pocket amount until the out-of-pocket amount, as shown above, is reached for the Calendar Year. Then, Covered Charges for Prescription Drug expenses incurred by a Covered Person will be payable at 100% for the remainder of the Calendar Year.

Prescription Drug copayments/coinsurance amounts do not apply toward the medical maximum out-of-pocket amount.

Pharmacy Option - Northwest Pharmacy Services (800) 998-2611 – Limited to a 34-day supply

Generic Drugs Copayment.....	\$20
Generic Drugs Reimbursement.....	100%
Formulary Drugs Copayment.....	Greater of 20% or \$50 up to a maximum of \$100
Formulary Drugs Reimbursement.....	100%
Non-Formulary Drugs Copayment	Greater of 20% or \$75 up to a maximum of \$125
Non-Formulary Drugs Reimbursement.....	100%

Pharmacy Option Diabetes management (i.e., diabetic medications and supplies) for covered Pregnant women:

Copayment	\$0
Reimbursement	100%
 Expense Submitted by Employee – Limited to a 34-day supply	
Copayment	50%

Note: If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the Covered Person will be required to pay 100% at the point of sale, no discount will be given, and the Covered Person must submit the prescription receipt directly to Northwest Pharmacy Services for reimbursement less any applicable copayment as shown in the Schedule of Benefits.

Mail Order Prescription Drug Option – WellPartner (877) 935-5797 – Limited up to a 100-day supply

Generic Drugs Copayment.....	\$40
Generic Drugs Reimbursement.....	100%
Formulary Drugs Copayment.....	Greater of 20% or \$100 up to a maximum of \$200
Formulary Drugs Reimbursement.....	100%
Non-Formulary Copayment	Greater of 20% or \$150 up to a maximum of \$300
Non-Formulary Reimbursement	100%

Mail Order Option Diabetes management (i.e., diabetic medications and supplies) for covered pregnant women:

Copayment	\$0
Reimbursement	100%

Note: If the Physician prescribes a Generic drug, but a brand name drug is purchased, the Covered Person must pay the copayment plus the difference in the Generic and brand name cost.

The following will be covered at 100%, no copayment required.

- (1) Physician-prescribed tobacco cessation products or medications. Limited to a 168-day supply per Calendar Year of nicotine replacement products (nicotine patch, gum, lozenges) and a 168-day supply per Calendar Year of Physician-prescribed medications (Zyban, Chantix).
- (2) Physician-prescribed contraceptive methods (Food and Drug Administration (FDA) approved) including but not limited to oral contraceptive medications, transdermals, devices (diaphragms, cervical caps), vaginal contraceptives, and injectables. This also includes physician-prescribed over-the-counter (OTC) contraceptives (such as female condoms, spermicides, and sponges); for all female Covered Persons with reproductive capacity.

Refer to the Medical Benefits section of this Plan regarding additional coverage for intrauterine devices (IUDs), and implantables.

- (3) Additional Physician-prescribed medications as recommended by the U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations will be covered at 100%, no prescription copayment, coinsurance or deductible will be required, and will only be available when utilizing a participating pharmacy.

Please note, the USPSTF grades A and B recommendations are subject to change as new medications become available and other recommendations may change. Coverage of new recommended medications will be available following the one (1) year anniversary date of the adoption of the USPSTF grade A and B recommendation.

Refer to the following link for more information regarding USPSTF grade A and B recommendations or contact *Northwest Pharmacy Services* for more information regarding which medications are available. *Note: Age and/or quantity limitations may apply.*

<http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations>

Additional information on Prescription Drug coverage may be found in the Prescription Drug Benefit section of this document.

DESCHUTES ONSITE CLINIC BENEFITS

Deschutes Onsite Clinic (“DOC”) benefits apply when care, treatment, or services are provided by a contracted **Deschutes Onsite Clinic** provider to a Covered Person ages two and older, enrolled in the Deschutes County Employee Benefit Plan.

The Coordination of Benefits provision will not apply to services provided at the Deschutes Onsite Clinic.

Deschutes Onsite Clinic Eligibility

A person’s eligibility for **Deschutes Onsite Clinic** benefits (including enrollment, terminations and COBRA rights) is subject to the terms and conditions as stated within the *Eligibility, Funding, Effective Date and Termination Provisions* of this Plan.

Deschutes Onsite Clinic Benefits

The **Deschutes Onsite Clinic** provides a wide range of health services focused on wellness, including treatment for Illnesses and Injuries, exams, labs, immunizations, and other preventive services with no out-of-pocket cost to the Covered Person. Services provided at the **Deschutes Onsite Clinic** are not subject to a deductible, and will not be applied to the deductible or maximum out-of-pocket amount(s) applicable under the medical benefits of this Plan.

Included in the **Deschutes Onsite Clinic** benefits is the **Well Connect** program that provides Covered Persons access to information on wellness programs and other additional resources including nutrition counseling, fitness programming, tobacco/smoking cessation, health and wellness coaching, and more.

**DESCHUTES ONSITE CLINIC
BENEFIT SCHEDULE**

MAXIMUM ANNUAL BENEFIT AMOUNT	Unlimited
DEDUCTIBLE, PER CALENDAR YEAR	
Per Covered Person	none
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR	
Per Covered Person	none
Covered Charges	Covered Person Pays
Routine Well Care	\$ 0
Office visits / minor office visit procedures	\$ 0
Laboratory Services	\$ 0
All Other Covered Deschutes Onsite Clinic Services	\$ 0

To make an appointment or for additional information regarding the Deschutes Onsite Clinic (DOC)
Call: 541-317-3189

Or access their website at:
<http://www.deschutes.org/benefits/page/deschutes-onsite-clinic-doc>

Contact information specific to Well Connect
Call: 541-330-4613

Or access their website at:
<http://www.deschutes.org/benefits/page/doc-wellness>

DESCHUTES ONSITE CLINIC PHARMACY

Covered Charges	Covered Person Pays (per prescription)	
	30-day supply	90-day supply
Generic drugs	\$ 2 copayment	\$ 4 copayment
Formulary Brand	\$20 copayment	\$40 copayment
Non-Formulary Brand	\$40 copayment	\$80 copayment
<p>Note: Prescriptions filled through the Deschutes Onsite Clinic Pharmacy are available at a 30-day or a 90-day supply. Mail order maintenance medications are excluded in certain locations. <i>Prescriptions for female contraceptives, tobacco cessation drugs or products, and certain vaccines and immunizations are available at no cost to the Covered Person.</i></p>		

For additional information regarding the Deschutes Onsite Clinic Pharmacy
 Call: 541-385-1071

Or access their website at:
<http://www.deschutes.org/benefits/page/doc-pharmacy>

General Limitations and Exclusions

The following services are not available at the Deschutes Onsite Clinic:

- (1) **Before covered.** Care, treatment or supplies incurred before a person was covered under this Plan.
- (2) **Chronic Pain Management Services**, for pain that lasts beyond the term of an injury or painful stimulus including but not limited to pain from a chronic or degenerative disease, and pain from an unidentified cause.
- (3) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.
- (4) **Excluded under Medical.** Services that are excluded under Plan Exclusions as stated in this document.
- (5) **Obstetrics**, to include all services typically provided during pregnancy (prenatal period), childbirth and the postnatal period.
- (6) **Radiology** procedures.
- (7) **Services outside the scope of the license** for a family practice physician, general practitioner, or mid-level provider, as determined by the laws of the state in which the services are provided.

VISION CARE BENEFITS

Routine Vision Exam and Hardware Benefit for Dependent children under age 19

Eye exam, one exam, per person, per Calendar Year 100%

Frames and lenses, one set, per person, per Calendar Year 100%
(Or a 12-month supply of: disposable contact lenses or Medically Necessary (as indicated below) contact lenses, in lieu of glasses).

Routine Vision Exam and Hardware Benefit for Covered Persons age 19 and over

Eye exam, one exam, per person, per Calendar Year 100%, after \$25 copayment

Frame-type lenses, per pair, per Calendar Year (or a 12-month supply of cosmetic/disposable contact lenses up to a maximum of \$190, in lieu of glasses)

Single vision..... \$100
Bi-focal \$140
Tri-focal \$180
Lenticular \$220
Frames, one pair, per person, per Calendar Year \$90

Medically Necessary contact lenses (in lieu of lenses) if prescribed in one of these cases:

- (1) A person's vision cannot be corrected to 20/70 in the better eye except by use of contact lenses; or
- (2) A person needs contact lenses after cataract surgery.

Calendar Year maximum \$200

Radial Keratotomy – for all Covered Persons

Lifetime maximum \$250, per eye, up to \$500

Includes: All surgical procedures that alter the refractive character of the eye, including but not limited to, radial keratotomy, myopic keratomileusis, and other surgical procedures of the refractive keratoplasty type which cures or reduces myopia or astigmatism. This includes reversals or revisions or the surgical procedure and any complications of all of the aforementioned procedures.

Additional information on Vision coverage may be found in the Vision Care Benefit section of this document.

DENTAL BENEFITS

Participation in the Dental Benefits of this Plan requires a separate enrollment election.

Class A Services – Preventive and Diagnostic Dental Procedures

Class B Services – Basic Dental Procedures

Class C Services – Major Dental Procedures

Class D Services – Orthodontic Treatment and Appliances

Copayment

For Class A, Services:

Copayment, per person, per visit.....\$15

For Class B and C Services:

Copayment, per person, per visit.....\$25

Maximum Benefit Amount –

For Class A services, age 18 and under:

Per person, per Calendar Year No maximum

For Class A services for Covered Persons age 19 and over; and Class B and C services for all Covered Persons:

Per person, per Calendar Year \$2,000

For Class D-Orthodontia:

Lifetime maximum, per person..... \$2,000

PLAN I - FIRST YEAR OF COVERAGE, based on a Calendar Year

Dental Percentage Payable

Class A Services - Preventive 80%, after \$15 copayment

Class B Services - Basic..... 80%, after \$25 copayment

Class C Services - Major..... 80%, after \$25 copayment

Class D Services - Orthodontia 50%

PLAN II - SECOND/SUBSEQUENT YEARS OF COVERAGE, based on a Calendar Year

Dental Percentage Payable

Class A Services - Preventive 100%, after \$15 copayment

Class B Services - Basic..... 100%, after \$25 copayment

Class C Services - Major..... 100%, after \$25 copayment

Class D Services - Orthodontia 50%

Additional information on Dental coverage may be found in the Dental Benefit section of this document.

EMERGENCY MEDICAL CONDITION

If the Employee or covered Dependent should experience an emergency medical condition, he or she should seek medical attention from the nearest appropriate facility (Physician's office, clinic, urgent care center, Hospital emergency room) or call **9-1-1**.

Benefits for an emergency medical condition are provided as covered services at the higher Participating Provider benefit level from any Hospital emergency room.

An emergency medical condition is one that manifests itself by 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 a fetus in the case of a pregnant woman, in serious jeopardy.

Covered Charges for an emergency medical condition include the emergency medical screening exam consisting of the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition, admissions on the day of, or within two days after, the onset of treatment, and stabilization of an emergency medical condition. If admitted as an inpatient, Covered Charges will continue to be provided at the higher Participating Provider benefit level until discharged.

Some examples of emergency medical conditions are:

- Heart Attack
- Stroke
- Poisoning
- Loss of Consciousness
- Acute abdominal pain
- Severe chest pain
- Serious burn
- Bleeding that does not stop

If an emergency situation should occur, take immediate action and seek prompt medical care. Call **9-1-1** or the emergency number listed in the local telephone directory or go to the nearest Hospital emergency department.

Covered Charges do not include services for the inappropriate (non-emergency) use of an emergency room. This means services that could be delayed until the Covered Person could be seen in his or her attending Physician's office. For example; treatment of minor illnesses such as flu, sore throats, check-ups, follow-up visits and Prescription Drug requests.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

This amount will accrue toward the medical maximum out-of-pocket amount.

Family Unit Limit. When the medical maximum out-of-pocket amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT AND COINSURANCE

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the percentage rate shown in the Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

Once the Plan has made the applicable benefit payment, the remaining percentage owed is the Covered Person's "coinsurance" responsibility. For example, if the Plan's reimbursement rate is 80%, the Covered Person's responsibility (or coinsurance) is 20%.

Coinsurance *does not* include any deductible or copayment amounts. Coinsurance will apply to the medical maximum out-of-pocket amount.

MEDICAL MAXIMUM OUT-OF-POCKET AMOUNT

Covered Charges are payable at the percentages shown each Calendar Year until the medical maximum out-of-pocket amount shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges which do not apply to the medical maximum out-of-pocket amount) for the rest of the Calendar Year.

When a Family Unit reaches the medical maximum out-of-pocket amount, Covered Charges for that Family Unit will be payable at 100% (except for any charges which do not apply to the medical maximum out-of-pocket amount) for the rest of the Calendar Year.

COVERED CHARGES

Covered Charges are the Allowable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be payable at the average private room rate of that facility.

Note: Pre-notification is required for all inpatient admissions. Please contact **CareLink** toll-free at (866) 894-1505 to satisfy pre-notification requirements.

- (2) **Coverage of Pregnancy.** The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness and will be payable as stated in the Schedule of Benefits.

Note: Routine prenatal office visits will be payable as stated under the Pregnancy benefit as shown in the Schedule of Benefits section.

The following services will continue to be payable per normal Plan provisions:

Pregnancy-related ultrasounds, lab screenings (not otherwise specified), Complications of Pregnancy (as defined under this Plan), delivery, and post-partum care.

Note: Pre-notification is required for all inpatient maternity admissions that exceed 48 hours for a vaginal delivery, or 96 hours following a cesarean section. Please contact **CareLink** toll-free at **(866) 894-1505** to satisfy pre-notification requirements.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

- (3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

- (a) The patient is confined as a bed patient in the facility; and
- (b) The confinement starts within 7 days of a Hospital confinement of at least 3 days; and
- (c) The attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
- (d) The attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Room charges made by a Hospital having only private rooms will be payable at the private room rate of that facility.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

Covered charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

Note: Pre-notification is required for all inpatient admissions. Please contact **CareLink** toll-free at **(866) 894-1505** to satisfy pre-notification requirements.

- (4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

- (a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the reasonable and customary charge that is allowed for the primary procedures; 50% of the reasonable and customary charge will be allowed for each additional procedure performed through the same incision or during the same operative session. Any procedure that would not be an integral part of the primary procedure or is unrelated to the

diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

- (b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the reasonable and customary charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the reasonable and customary percentage allowed for that procedure; and
 - (c) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's reasonable and customary allowance.
- (5) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness. The diagnosis, care, and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.
- (6) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent children). Bereavement services must be furnished within six months after the patient's death.

*Note: Pre-notification is required for inpatient Hospice admissions. Please contact **CareLink** toll-free at (866) 894-1505 to satisfy pre-notification requirements.*

- (7) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:
- (a) **Alternative Care.** Chiropractic by a D.C.; care or services by a licensed acupuncturist; or care or services by a massage therapist, up to the maximum stated in the Schedule of Benefits.
 - (i) Charges for chiropractic treatment, massage therapy and acupuncture, subject to the maximum(s) shown in the Schedule of Benefits. Services must be furnished by a licensed provider, practicing within the scope of his or her license.
 - (ii) Benefits are provided for:
 - Office visits to providers of chiropractic, acupuncture and massage therapy; and
 - Diagnostic x-rays (except CT scans) and laboratory services ordered by a chiropractor (payable as shown in the Schedule of Benefits).
 - (iii) Benefits are not subject to deductible and are payable as shown in the Schedule of Benefits. A copayment will be required for each covered visit, as shown in the Schedule of Benefits.
 - (iv) A referral from a medical doctor is not required to make an appointment with an alternative care provider.
 - (v) Chiropractic benefits *do not* include:
 - Minor surgery
 - Proctology
 - OB-GYN services

(vi) Acupuncture benefits *do not* include:

- Intradermal needles or non-FDA approved disposable needles.

(vii) Massage therapy benefits *do not* include:

- Any massage therapy outside the massage therapist's scope of license; or
- Educational programs, non-medical self-care, self-help training, or any related diagnostic training, except that which occurs during the normal course of covered massage therapy treatment.

(viii) Specifically excluded from coverage under the alternative care benefit (comprehensive of chiropractic treatment, massage therapy and acupuncture) are the following:

- All Plan limitations and exclusions as explained in the Medical Plan Limitations and Exclusions, portion of this document;
- Any services in excess of those necessary for maximum improvement. This includes maintenance care and supportive care when Physician dependence somatization, illness behavior, or secondary gain exists.
- Behavioral training and modification, including but not limited to biofeedback, hypnotherapy, play therapy and sleep therapy;
- Cosmetics, dietary supplements, recreation, health or beauty classes, aids or equipment;
- Expenses incurred as a result of treatment for pre-employment, school entrance or athletic physical examinations;
- Over-the-counter drugs, medications (prescription or non-prescription) including vitamins, minerals, nutritional or dietary supplements or any other supply or product whether or not prescribed;
- Preventive care;
- Public facility care in which services or care are required by federal, state or local law;
- Radiological procedures performed on equipment not certified, registered or licensed by the state where the treatment is performed and/or radiological procedures that, when reviewed by the Plan or its designee are determined to be of such poor quality that they cannot safely be utilized in diagnosis or treatment;
- Services and charges for the condition under treatment from the time the patient refuses for personal reasons to accept a recommended treatment or procedure after being advised that the covered provider believes that no professionally acceptable alternative exists;
- Services provided in an emergency room;
- Services provided on an inpatient basis;
- Services requiring anesthesia;
- Services or costs exceeding the maximum allowable benefit as shown in the Schedule of Benefits;
- Thermography, hair analysis, heavy metal screening and mineral screenings;
- Transportation services, including ambulance and care cars; and
- Treatment for purposes of obesity or weight control, including any weight control supplies or products.

(b) **Ambulance.** Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility (up to a 400 mile maximum) where necessary treatment can be provided, but in any event, no more than ground and air miles from the place of pickup, unless the Plan Administrator finds a longer trip was Medically Necessary.

(c) **Anesthetic;** oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(d) **Breast pump, breast pump supplies, lactation support and counseling.**

Breast pump, breast pump supplies

A standard electric breast pump or a manual breast pump for initiation or continuation of breastfeeding may be bought rather than rented, with the cost to rent not to exceed the actual purchase price.

- Rental of a heavy duty/hospital grade breast pump may be considered Medically Necessary only for the period of time that a Newborn remains inpatient in the Hospital. Purchase of a heavy duty/hospital grade breast pump is not considered Medically Necessary or a Covered Charge under this Plan.
- For female Covered Persons using a breast pump from a prior Pregnancy, a new set of breast pump supplies will be covered with each subsequent Pregnancy.
- Replacement of either a standard electric breast pump or a manual breast pump, but not both, will be covered every (3) three Calendar Years following a subsequent Pregnancy.

Covered Charges for the purchase or rental of a breast pump and supplies will be payable subject to the Preventive Care benefits as shown in the Schedule of Benefits section.

Note: Breast pumps and breast pump supplies when purchased through a retail store (for example, through Target, Wal-Mart, Walgreens) will be considered payable at the Participating Provider benefit level only for the purposes of this benefit. The Claims Administrator will require the following documentation: claim form with proof of purchase to include purchase price and item description.

Lactation support and counseling

Covered Charges include inpatient and outpatient comprehensive prenatal and postnatal lactation support and counseling for female Covered Persons for the duration of the breastfeeding. Services must be rendered by a Physician acting within the scope of their license or certification under applicable State law.

Note: Covered Charges for lactation support and counseling will be payable subject to the Participating Provider Preventive Care benefit level as shown in the Schedule of Benefits section, for the purpose of this benefit.

- (e) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion, coronary bypass surgery, or other cardiac condition; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
- (f) **Chemotherapy or Radiation treatment** with radioactive substances. The materials and services of technicians are included.

Pre-notification of services, by the Plan Participant, for cancer treatment services is strongly recommended. The pre-notification request must include the Covered Person's plan of care and treatment protocol. Pre-notification of services should occur at least seven days prior to the initiation of treatment.

For pre-notification of services, call CareLink at the following numbers:

Toll Free in the United States: (866) 894-1505

Local Call in Billings, Montana: (406) 245-3575

A pre-notification of services by CareLink is not a determination by the Plan that claims will be paid. All claims are subject to the terms and conditions, limitations and exclusion of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits, and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures.

- (g) **Circumcision** (not performed during the initial hospital stay), if performed within two weeks of birth, or if otherwise deemed Medically Necessary.
- (h) **Clinical Trial Routine Cost of Care.** The Plan shall provide coverage for the routine costs of the care of Covered Persons enrolled in and participating in qualifying clinical trials, approved and sponsored by the federal government.

Routine patient services will include costs for Medically Necessary services received during the course of a clinical trial, which are the usual costs for medical care, such as Physician visits, Hospital stays, clinical laboratory tests and x-rays that a Covered Person would receive whether or not he or she were participating in a clinical trial.

For the purposes of this benefit a qualifying clinical trial means a clinical trial that is:

- Listed on www.clinicaltrials.gov, and is sponsored by the National Institutes of Health (NIH) and other federal agencies, private industry, and nonprofit organizations;
- 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.

Routine patient services do not include and reimbursement will not be provided for:

- The drug, device or service being tested in the clinical trial ***unless*** the drug, device or service would be covered for the Covered Person's condition by the Plan if provided outside of a clinical trial;
- Items or services required solely for the provision 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 or 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.

- (i) **Cochlear implants.** Charges for a Medically Necessary cochlear implant or Medically Necessary bilateral cochlear implants.
- (j) Initial **contact lenses** or glasses required following cataract surgery.
- (k) **Contraceptive methods.** All Food and Drug Administration approved contraceptive methods when prescribed by a Physician, including but not limited to intrauterine devices (IUDs) and implants (including insertion and removal, when applicable), and any related Physician or facility charges, (including complications), and will be payable under the Routine Well Care benefits of this Plan.

Refer to the separate Prescription Drug Benefit of this Plan regarding prescription coverage of oral contraceptive medications, devices, transdermals, vaginal contraceptives, and injectables, including Physician-prescribed over-the-counter (OTC) contraceptives for female Covered Persons.

- (l) **Craniofacial anomaly.** “Craniofacial anomaly” shall include any congenital anomaly affecting the face or head, including but not limited to cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome.

Covered Charges will include Hospital, surgical or dental services, coverage of dental and orthodontic services for the treatment of craniofacial anomalies if the services and treatment is deemed Medically Necessary to improve or restore function.

- (m) **Diabetes Self-Management benefit.** This Plan shall provide payment and coverage in accordance with ORS 743A.184 for supplies, equipment, and diabetes self-management programs prescribed by a health care professional legally authorized to prescribe such items.

This coverage includes:

- (i) Charges for supplies, equipment and diabetes self-management programs associated with the treatment of:
 - Insulin-dependent diabetes
 - Insulin-using diabetes
 - Gestational diabetes
 - Non-insulin-dependent diabetes
- (ii) Benefits are limited to one program of assessment and training following initial diagnosis, and up to three (3) hours per Calendar Year of additional, ongoing assessment and training, when there is a material change of condition.
- (iii) Services must be furnished by a credentialed or accredited education program or a Physician, a registered nurse, a nurse practitioner, a certified diabetes educator, or a licensed dietitian with demonstrated expertise in diabetes.

- (n) **Diabetes management for covered Pregnant women.** Charges for health services which are Medically Necessary for a covered Pregnant woman to manage her diabetes from conception through six weeks postpartum and will be payable as stated in the Schedule of Benefits.

It is strongly recommended for a covered Pregnant woman to notify the Claims Administrator in a timely manner that she is both diabetic and Pregnant or has given birth and is within six weeks postpartum.

Note: Medications and diabetic supplies will be payable under the separate Prescription Drug Benefit section under this Plan.

- (o) **Durable Medical Equipment (DME).** Charges for Durable Medical Equipment and supplies necessary for the maintenance and operation of the Durable Medical Equipment that meet all of the following criteria:

- Medically Necessary;
- Prescribed by a Physician for outpatient use;
- Is NOT primarily for the comfort and convenience of the Covered Person;
- Does NOT have significant non-medical uses (i.e. air conditioners, air filters, humidifiers, environmental control devices).

If more than one item of Durable Medical Equipment can meet a Covered Person's needs, Plan benefits are only available for the least cost alternative as determined by the Plan Administrator. Benefits are not available for certain convenience or luxury features that are considered non-standard.

Rental of a Durable Medical Equipment item will be a Covered Charge up to a maximum of the lesser of 24 months or the warranty period of the item, commencing on the date the item is first delivered to the Covered Person.

A Durable Medical Equipment item may be purchased, rather than rented, with the cost not to exceed the actual acquisition cost of the item to the Covered Person if the Covered Person were to purchase the item directly. The acquisition cost of the item may be prorated over a six-month period, subject to prior approval by the Plan Administrator.

Replacement of a Durable Medical Equipment item, rented or purchased, will be a Covered Charge limited to once every four Calendar Years.

- Subject to prior approval of the Plan Administrator, replacement for a *purchased* Durable Medical Equipment item may be available for damage beyond repair with normal wear and tear, when repair costs exceed the acquisition cost, or when a change in the Covered Person's medical condition occurs sooner than the four Calendar Year period.
- Subject to prior approval of the Plan Administrator, replacement for a *rented* Durable Medical Equipment item may be available when a change in the Covered Person's medical condition occurs sooner than the four Calendar Year period.

Repair of a Durable Medical Equipment item including the replacement of essential accessories such as hoses, tubing, mouth pieces, etc., are Covered Charges only when necessary to make the item serviceable and the total estimated repair and replacement costs do not exceed the acquisition cost of the item. Rental charges for a temporary replacement Durable Medical Equipment item are Covered Charges up to a maximum of two consecutive months. Requests to repair a Durable Medical Equipment item are not subject to the four Calendar Year limit.

The Plan Administrator may require documentation, including but not limited to the make and model number of the Durable Medical Equipment item, the acquisition cost to the provider, and documentation to support Medical Necessity.

- (p) **Emergency Medical Care.** Emergency care is covered as any other covered medical condition under this Plan subject to the requirements of ORS 743A.012. Prior authorization notification or Physician referral is not required prior to receiving emergency medical care. If the Employee or Dependent covered under this Plan needs immediate assistance for a medical emergency, he or she should seek medical attention from the nearest appropriate facility (Physician's office, clinic, urgent care center, Hospital emergency room) or call 9-1-1.
- (q) **Growth Hormone.** Treatment, services, and supplies for Growth Hormone when deemed Medically Necessary.
- (r) **Hearing Aid.** The Plan shall provide payment, up to the limits stated in the Schedule of Benefits, for one hearing aid per hearing impaired ear. Benefit includes eligible charges for:

A hearing aid (monaural or bi-aural) of an approved function design, including ear molds and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords.

Note: Related hearing exam, prescription, and fitting of the hearing aid will be payable under the office visit benefit and will not be subject to the hearing aid maximum stated in the Schedule of Benefits.

In addition to other limitations and exclusions elsewhere in this document, the following supplies and services are not covered by this benefit:

- Replacement of a hearing aid for any reason more often than once in a three-year period;
- Batteries, cords, or other ancillary equipment other than that obtained upon purchase of the hearing aid; and
- Repairs, servicing or alteration of hearing aid equipment.

- (s) **Home Infusion Therapy.** The Plan will cover home infusion therapy services and supplies when provided by an accredited home infusion therapy agency, which is not a licensed Home Health Agency. These services must be Medically Necessary and are required for the administration of a home infusion therapy regimen when ordered by and are part of a formal written plan prescribed by a Physician.

The benefit will include all Medically Necessary services and supplies including the nursing services associated with patient and/or alternative care giver training, visits to monitor intravenous therapy regimen, emergency care, Prescription Drugs, administration of therapy and the collection, analysis and reporting of the results of laboratory testing services required to monitor a response to therapy.

(t) **Inborn Errors of Metabolism**

- (i) Medically Necessary medical foods for supplementation or dietary replacement for the treatment of inborn errors of metabolism.
- (ii) Charges for treatment by a covered provider for inborn errors of metabolism. Examples of inborn errors of metabolism (e.g., galactosemia, maple sugar urine disease (MSUD), phenylketonuria (PKU), fructose intolerance).
- (iii) Covered expenses include treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage shall include expenses of 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.
- (iv) Medical foods are defined as foods that are formulated to be consumed or administered internally under strict medical supervision, for the treatment of inborn errors of metabolism (e.g., PKU, homocystinuria, citrullinemia, MSUD, pyruvate dehydrogenase deficiency).
- (v) This benefit includes coverage for a non-prescription elemental enteral formula for home use, if the formula is Medically Necessary for the treatment of severe intestinal malabsorption and a Physician has issued a written order for the formula and the formula comprises the sole source, or an essential source of nutrition.

(u) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome**, up to the limits as stated in the Schedule of Benefits.

(v) **Laboratory studies.**

(w) Treatment of **Mental Disorders and Substance Abuse**, including treatment for alcoholism. Covered charges are payable for care, supplies and treatment of Mental Disorders and Substance Abuse.

*Note: Pre-notification is required for all inpatient admissions. Please contact **CareLink** toll-free at (866) 894-1505 to satisfy pre-notification requirements.*

(x) Injury to or care of **mouth, teeth and gums** within 120 days of the Injury (unless a delay is Medically Necessary). Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Emergency repair due to Injury to sound natural teeth.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

The Plan will pay for the charges for a semiprivate room and covered Hospital ancillary services in a Hospital if the Covered Person has a hazardous medical condition (such as heart disease, which requires that you have an otherwise non-covered dental procedure performed in the Hospital). The Plan will not pay for the services of the Physician, Dentist, or oral surgeon in relation to that non-covered dental procedure even if the Hospital charges are paid.

(y) **Naturopathic Treatment.**

(z) **Non-prescription elemental enteral formula** for home use, if the formula is Medically Necessary for the treatment of severe intestinal malabsorption and a Physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition.

(a1) **Nutritional Education Counseling.** Care, treatment, and services when provided by Physician, or a registered dietician, up to the limits as stated in the Schedule of Benefits.

Obesity Interventions. Covered Charges include Physician-directed intensive, multicomponent behavioral interventions for weight management for Covered Persons age 18 and older with a body mass index (BMI) of 30 kg/m² or higher.

Intensive, multicomponent behavioral interventions for weight management will include group and individual sessions of high intensity, (limited to 26 visits per Calendar Year), encompassing the following:

- Behavioral management activities such as setting weight loss goals
- Improving diet or nutrition and increasing physical activity
- Addressing barriers to change

- Self-monitoring
- Strategizing how to maintain lifestyle changes

Non-surgical care or treatment and Physician prescribed weight loss medications *will not* be a covered benefit.

This Plan *will not* cover nutritional supplements, gym memberships, or dues for participation in weight loss programs (e.g., Weight Watchers, Jenny Craig, etc.) whether or not prescribed by a Physician.

(b1) Organ transplant benefits. Medically Necessary charges incurred for the care and treatment due to an organ or tissue transplant that are not considered Experimental or Investigational, are subject to the following criteria:

- The transplant must be performed to replace an organ or tissue.
- Organ transplant benefit period: A period of 365 continuous days beginning five (5) days immediately prior to an approved organ transplant procedure. In the case of a bone marrow transplant, the date the transplant begins will be defined as either the earlier of the date of the beginning of the preparatory regimen (marrow ablation therapy) or the date the marrow/stem cells is/are infused.
- Organ procurement limits. Charges for obtaining donor organs or tissues are Covered Charges under the Plan only when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The donor benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:
 - (i) Evaluating the organ or tissue;
 - (ii) Removing the organ or tissue from the donor;
 - (iii) Transportation of the organ or tissue from within the United States or Canada to the facility where the transplant is to be performed;
 - (iv) Charges incurred in the screening and candidacy determination process;
 - (v) Charges for organ procurement from a living donor for costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, and the medical services provided to the donor in the interim and for follow-up care; and
 - (vi) If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the person's own bone marrow (autologous), or donated marrow (allogenic). Coverage will also be provided for the costs of treatment and storage of the marrow up to the time of reinfusion, and for search charges to identify an unrelated match.

Note: Expenses related to the purchase of any organ will not be covered.

As soon as reasonably possible, but in no event more than ten (10) days after a Covered Person's attending Physician has indicated that the Covered Person is a potential candidate for a transplant, the Covered Person or his or her Physician must contact CareLink at (866) 894-1505.

- (i) In the event a Participating Provider transplant facility is utilized, benefits will be payable at the Participating Provider benefit level.

- (ii) In the event a Participating Provider transplant facility is unavailable and the providing transplant facility is a Center of Excellence (COE) facility, benefits will be payable at the Participating Provider benefit level.
- (iii) In the event a Non-Participating Provider transplant facility is utilized and the providing transplant facility **is not** a (COE) facility, benefits will be payable at the Non-Participating Provider benefit level.

There is no obligation to the Covered Person to use either a Participating Provider or a COE facility; however, benefits for the transplant and related expenses will vary depending upon whether services are provided by a Participating Provider or a Non-Participating Provider and whether or not a COE facility is utilized.

A **Center of Excellence** is a licensed healthcare facility that has entered into a participation agreement with a national transplant network to provide approved transplant services, at a negotiated rate, to which the Plan has access. A Covered Person may contact CareLink to determine whether or not a facility is considered a Center of Excellence.

Travel and Lodging Expenses

If a transplant is performed at a Participating Provider transplant facility or a Center of Excellence facility and the Covered Person resides 50 miles or more from the transplant facility, the Plan will pay for the following services incurred during the transplant benefit period (subject to the maximum benefit amounts as specifically stated in the Schedule of Benefits):

A. Transportation expenses to and from the Participating Provider transplant facility or Center of Excellence facility for the following individuals:

- The Covered Person; and
 - One or both parents of the Covered Person (only if the Covered Person is a Dependent minor child), or
 - One adult to accompany the Covered Person; and
- The living donor (if applicable under the Plan).

Transportation expenses include commercial transportation (coach class only).

B. Reasonable lodging and meal expenses incurred for the living donor, Covered Person, and one or both parents of the Covered Person (only if the Covered Person is a Dependent minor child), or one adult companion who is accompanying the Covered Person, only while the Covered Person is receiving transplant-related services at a Participating Provider transplant facility or Center of Excellence facility.

Lodging, for purposes of this Plan, will not include private residences.

Special Transplant Benefits

Under certain circumstances, there may be special transplant benefits available when the group health plan and/or a Covered Person participates in a special transplant program and/or contracts with a specific transplant network. Therefore, it is very important to contact CareLink at (866) 894-1505 as soon as reasonably possible so that the Plan can advise the Covered Person or his or her Physician of the transplant benefits that may be available.

What's Not Covered under the Transplant Benefit

Coverage for the following procedures (when Medically Necessary), will be considered the same as any other covered illness. These procedures are not considered under the Transplant Benefit, but will be considered per the regular medical benefits of the Plan, subject to any Plan provisions and applicable benefits limitations as stated in the Schedule of Benefits:

- Cornea transplantation
- Skin grafts
- Artery
- Vein
- Valve
- Transplantation of blood or blood derivatives (except for bone marrow or stem cells)

- (c1) **Orthotics.** The initial purchase, fitting, and repair of orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

Note: Foot orthotics or orthopedics *are not* a covered benefit under this Plan.

- (d1) **Outpatient Surgical Center.** Charges made by an Outpatient Surgical Center or a minor emergency medical clinic.

- (e1) **Pervasive Developmental Disorder.** Pervasive Developmental Disorder (PDD) is defined as a neurological condition, including Asperger's syndrome, autism, developmental delay, and developmental disability as defined in the more recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Benefits for Pervasive Developmental Disorder include but are not limited to:

- Evaluation and testing to confirm the PDD diagnosis
- Medical services
- Applied Behavior Analysis (ABA) therapy

Benefits are limited to treatment that is prescribed by a Physician and must be documented with a written plan of care.

The plan of care should include goals, specific treatment techniques and anticipated frequency and duration of treatment. The plan of care should be updated as the Covered Person's condition changes and treatment should demonstrate a reasonable explanation of improvements, in addition to documentation of continued progress to the goals.

Benefits for physical, occupational or speech therapy in conjunction with PDD will be payable per the normal plan provisions.

- (f1) **Parenteral Nutrition (intravenous feeding).** Charges for hyperalimentation or total parenteral nutrition (TPN) for persons recovering from or preparing for surgery.

- (g1) **Prenatal genetic testing.** Medically necessary prenatal genetic testing for covered women with increased risk factors.

- (h1) **Prescription Drugs (as defined).** Outpatient Prescription Drugs will be payable under the separate Prescription Drug Benefit section of this Plan.

- (i1) **Routine Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

Charges for Routine Well Care. Routine well care is care by a Physician that is not for an Injury or Sickness.

Charges for Women's Preventive Services as specifically stated in the Schedule of Benefits.

- (j1) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

This benefit includes coverage for maxillofacial prosthetic services considered necessary for adjunctive treatment. "Maxillofacial prosthetic services considered necessary for adjunctive treatment" means restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma or birth and developmental deformities when such restoration and management are performed for the purpose of:

- (i) Controlling or eliminating infection;
- (ii) Controlling or eliminating pain, or
- (iii) Restoring facial configuration of functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.

- (k1) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

- (i) Reconstruction of the breast on which a mastectomy has been performed,
- (i) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- (iii) Coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

- (l1) **Rehabilitation Services.** Charges for rehabilitation services up to the limits stated in the Schedule of Benefits. Services must be Medically Necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental Injury, Illness, or surgery.

Inpatient Care. Services must be furnished in a specialized rehabilitative unit of a Hospital and billed by the Hospital or be furnished and billed by a rehabilitation facility approved by the Plan. This benefit only covers care the Covered Person received within 24 months from the onset of the Injury or Illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physiatrist (a Physician specializing in rehabilitative medicine).

*Note: Pre-notification is required for all inpatient admissions. Please contact **CareLink** toll-free at (866) 894-1505 to satisfy pre-notification requirements.*

Outpatient Care. Coverage will be provided for outpatient occupational therapy, physical therapy, speech therapy, and vision therapy as noted below and will be payable subject to the (combined) limit as stated in the Schedule of Benefits.

Occupational therapy by a licensed occupational therapist. Therapy must occur as the result of an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

Physical therapy by a licensed physical therapist. The therapy must be for conditions which are subject to significant improvement through short-term therapy.

Speech therapy by a licensed speech therapist. The therapy must follow either:

- Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person;
- An Injury; or
- A Sickness.

Vision therapy/orthoptics, when provided by a Physician, are covered for diagnosis and treatment of an Illness or Injury.

- (m1) Medically Necessary removal of benign **skin lesions**, such as but not limited to, skin tags, benign seborrheic keratosis, sebaceous cysts, viral warts.
- (n1) **Sleep studies for sleep disorders.** Sleep studies for sleep disorders are payable as described in the Schedule of Benefits.
- (o1) **Sterilization** procedures for Employee and Dependent Spouse. Sterilization procedures for female Covered Persons will be payable as shown under the Preventive Care benefit as shown in the Schedule of Benefits.

The following charges will be payable per normal Plan provisions:

- Hysterectomies; and
 - Sterilization procedures for male Covered Persons.
- (p1) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
 - (q1) **Telemedicine.** Medically Necessary services delivered through a two-way video communication that allows a health professional to interact with a patient who is at an originating site (including services for the treatment of diabetes and services offered by an academic medical center). "Originating site" means the physical location of the patient receiving a telemedical health service.

The Plan will provide coverage of a telemedical health service if:

- The health service is Medically Necessary; and
- The health service does not duplicate or supplant a health service that is available to the patient in person.

An originating site for a telemedical health service includes but is not limited to a:

- Hospital;
- Rural health clinic;
- Federally qualified health center;
- Physician's office;
- Community mental health center;
- Skilled nursing facility;
- Renal dialysis center; or
- Site where public health services are provided.

- (r1) **Therapeutic Injection.** Injectable medication, chemotherapy, blood products or other substances intended for injection (but not those included with home health services, home infusion therapies, hospitalization, or the Prescription Drug benefit).
- (s1) **Tobacco cessation.** Treatment in connection with tobacco cessation. *Prescription Drugs and products for the treatment of tobacco cessation will be covered under the separate Prescription Drug Benefits section of this Plan.*
- (t1) Coverage of **Well Newborn Nursery/Physician Care.**

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care, including circumcision, for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Allowable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the Allowable Charges made by a Physician, including circumcision, for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

- (u1) **Diagnostic x-rays.**

CARE MANAGEMENT SERVICES

UTILIZATION MANAGEMENT

Utilization Management is a program designed to assist Covered Persons in understanding and becoming involved with their diagnosis and medical plan of care, and advocates patient involvement in choosing a medical plan of care. Utilization Management begins with the pre-notification process.

Pre-notification of certain services is required by the Plan. Pre-notification of other services is **strongly recommended**. Pre-notification provides information regarding coverage before the Covered Person receives treatment, services and/or supplies. A pre-notification of services by CareLink is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided. *A denial of a pre-notification request may be appealed under the Plan's Internal and External Claims Review Procedures.*

Pre-notification of services is required for the following services:

- Inpatient admissions to a Hospital, Skilled Nursing Facility, Hospice Facility, or any other inpatient facility stay
- Inpatient admissions to a free-standing chemical dependency, mental health, or rehabilitation facility

If there is an emergency admission to the Hospital, the Covered Person, Covered Person's family member, Hospital or attending Physician must notify CareLink within two (2) business days after the admission.

Failure to notify CareLink of an inpatient admission prior to the inpatient claims being received by the Claims Administrator will result in the benefit payment being reduced by a maximum of \$1,000. The maximum penalty, if needed, shall be adjusted so as not to reduce the benefit more than 50%. Any reduction of Covered Charges will not apply toward the medical maximum out-of-pocket amount.

Hospital Observation Room stays in excess of 23 hours are considered an admission for purposes of this program, therefore CareLink should be notified.

Pre-notification of other services is strongly recommended.

Pre-notification of services (other than inpatient admissions as described above), is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Covered Person receives treatment, services and/or supplies. *All Claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits, and is eligible for appeal under the procedures in this Care Management Services section.*

Examples of when the Physician and Covered Person should contact CareLink prior to treatment include:

- Organ Transplant evaluation.
- Cancer treatment plan of care, administered on an outpatient basis
- Outpatient surgeries relating to, but not limited to, hysterectomies, back surgery, or bariatric surgery (if applicable under this Plan); and
- Outpatient services as follows:
 - Dialysis
 - Genetic Testing
 - Injectables
 - Home Health Care
 - Hospice
 - Durable Medical Equipment (DME) over \$2,000

All Claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided.

The Physician or Covered Person should notify CareLink at least seven (7) days before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Employee identification number and address of the Covered Person
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Hospital, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The plan of care, treatment protocol and/or informed consent, if applicable

Contact the Care Management administrator at:

**CareLink (406) 245-3575 or (866) 894-1505
Monday through Friday, 6:00 a.m. to 7:00 p.m. (Mountain Time)**

PRE-ADMISSION AND POST DISCHARGE CARE CALLS

A CareLink nurse will contact the Covered Person to provide health education, pre-surgical counseling, inpatient care coordination, facilitation of discharge plan and post-discharge follow-up.

PRE-NOTIFICATION DETERMINATION AND REVIEW PROCESS - *(Applicable to services for which pre-notification is strongly recommended, but not required)*

The Plan Administrator or its designee, on the Plan's behalf, will review the submitted information and make a determination on a pre-notification request within fifteen (15) days of receipt of the pre-notification request and all supporting documentation. If additional records are necessary to process the pre-notification request, the Plan Administrator or its designee will notify the Covered Person or the Physician. The time for making a determination on the request will be deferred from the date that the additional information is requested until the date that the information is received.

The Physician and Covered Person will be provided notice of the Plan's determination. If the pre-notification request is denied, written notice will provide the reason for the adverse pre-notification determination.

The Plan offers a one-level review procedure for adverse pre-notification determinations. The request for reconsideration must be submitted in writing within thirty (30) days of the receipt of the adverse pre-notification determination and include a statement as to why the Covered Person disagrees with the adverse pre-notification determination. The Covered Person may include any additional documentation, medical records, and/or letters from the Covered Person's treating Physician(s). The request for reconsideration should be addressed to:

CareLink
Attn: Appeals
7400 West Campus Rd.
New Albany, OH 43054

The Plan Administrator or its designee will perform the reconsideration review. The Plan Administrator or its designee will review the information initially received and any additional information provided by the Covered Person, and determine if the pre-notification determination was appropriate. If the adverse pre-notification

determination was based upon the medical necessity, the Experimental/ Investigational nature of the treatment, service or supply or an equivalent exclusion, the Plan may consult with a health care professional who has the appropriate training and experience in the applicable field of medicine. Written or electronic notice of the determination upon reconsideration will be provided within thirty (30) days of the receipt of the request for reconsideration.

CASE MANAGEMENT

Upon the occurrence of a catastrophic condition, including but not limited to, a spinal cord Injury, cancer, or a premature birth, where a person may require long-term, perhaps lifetime care, a Case Manager will monitor these certain patients and assess, plan, evaluate, discuss, and coordinate appropriate Medically Necessary care. The Case Manager will consult with the patient, the family, and the attending Physician in order to assist in coordinating the plan of care approved by the patient's attending Physician and the patient.

This plan of care may include some or all of the following:

- Individualized support to the patient;
- Contacting the family to offer assistance for coordination of medical care needs;
- Monitoring response to treatment;
- Evaluating outcomes; and
- Assisting in obtaining any necessary equipment and services.

Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

MATERNITY MANAGEMENT PROGRAM

The Maternity Management Program is an educational and empowerment program for eligible female Employees and Dependents.

This program provides a means to positively affect a Pregnancy and the health of the baby. A CareLink nurse will set up a confidential, personal telephone interview to identify medical history and lifestyles that could have an impact on the outcome of the Pregnancy.

A CareLink nurse is available to assist and coordinate high risk aspects of maternity care. This includes providing information such as access to educational programs and community resources designed to meet the needs identified by the patient or Physician.

Certification Notification: The Covered Person needs to notify CareLink during the first trimester of their Pregnancy.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time or part-time basis.

Acupuncture means acupuncture, including but not limited to, electro-acupuncture, cupping, moxibustion, extravasation and Gua Sha/Tui Na/Shiatsu that are provided by a Physician or licensed acupuncturist.

Allowable Charge means the charge for a treatment, service, or supply that is the lesser of: 1) the charge made by the provider that furnished the care, service, or supply; 2) the negotiated amount established by a provider network arrangement or other discounting or negotiated arrangement; 3) the reasonable and customary charge for the same treatment, service, or supply furnished in the same geographic area by a provider of like service as further described below; or 4) an amount equivalent to the following:

1. For specialty drugs, the lesser of the average wholesale price (AWP) minus 10% or the amount set by the Plan's Prescription Drug service vendor;
2. For inpatient or outpatient facility claims, an amount equivalent to 200% of the Medicare equivalent allowable.

The reasonable and customary charge shall mean an amount equivalent to the 90th percentile of a commercially available database, or such other cost or quality-based reimbursement methodologies as may be available and adopted by the Plan. If there are insufficient charges submitted for a given procedure, the Plan will determine an Allowable Charge based upon charges made for similar services. Determination of the reasonable and customary charge will consider the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience, and the cost and quality data for that provider.

For Covered Charges rendered by a Physician, Hospital or Ancillary Provider in a geographic area where applicable law dictates the maximum amount that can be billed by the rendering provider, the Allowable Charge shall mean the amount established by applicable law for that Covered Charge.

The Plan Administrator or its designee has the ultimate discretionary authority to determine an Allowable Charge, including establishing the negotiated terms of a provider arrangement (including a PPO agreement, if applicable) as the Allowable Charge even if such negotiated terms do not satisfy the lesser of test described above.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Complications of Pregnancy are determined as follows:

These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy related conditions will be covered that are as medically severe as those listed.

These conditions **are not** considered a Complication of Pregnancy: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning sickness; or like conditions that are not medically termed as Complications of Pregnancy.

Cosmetic Dentistry means dentally unnecessary procedures.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee, Retiree or Dependent who is covered under this Plan.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Domestic Partner shall mean a person of the same sex meeting the following criteria: are not married or legally separated from anyone else; are not acting under fraud or duress; are both at least 18 years old and competent to enter into a contract; are not related by blood closer than permitted under marriage laws of the State of Oregon; reside together and have shared the same principle residence for the last 12 consecutive months and intend to do so indefinitely; are jointly responsible for each other's basic living expenses and agree that anyone who is owed for these expenses can collect from either person; have no other Domestic Partner nor had a different Domestic Partner in the last 12 consecutive months; and each declares in writing, under penalty of perjury, that she or he is the other's Domestic Partner.

Domestic Partnership shall mean the committed, long-term relationship of two same-sex Domestic Partners residing together.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Deschutes County.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the

claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) Except as provided under the Clinical Trials benefit in the Medical Benefits section of the Covered Charges section, If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolite, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician that is reviewed at least every 30 days; it must state the diagnosis; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution that is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and that fully meets these tests: it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it has received accreditation from CARF (Commission of Accreditation of Rehabilitation Facilities) or JCAHO (Joint Commission of Accreditation of Hospital Organizations) or if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special lifesaving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the Lifetime of the Covered Person.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically or Dentally Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services or is listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center, or the patient's home.

Outpatient Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is made for room and board.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Naturopathic Medicine (N.D.) Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, a Nurse Practitioner, Physician's Assistant, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Deschutes County Employee Benefit Plan, which is a benefits plan for certain Employees of Deschutes County and is described in this document.

Plan Participant is any Employee, Retiree or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on August 1 and ending on July 31.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Retired Employee. A Retired Employee of Deschutes County, who meets all of the following criteria:

- (1) The Employee has been enrolled in the Plan (or a prior plan sponsored by the employer) for at least 24 consecutive months immediately prior to retirement, unless otherwise indicated by a management/labor agreement;
- (2) The Employee will be receiving benefits from PERS (Public Employee Retirement System) or from a similar retirement plan offered by the Employer.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Urgent Care Services means care and treatment for an Illness, Injury or condition, serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

PLAN EXCLUSIONS

Note: All exclusions related to the Deschutes Onsite Clinic Benefits are shown in the Deschutes Onsite Clinic section of this Plan.

Note: All exclusions related to Dental Benefits are shown in the Dental Benefits section of this Plan.

Note: Refer the Vision Care Benefits section of this Plan for additional limitations on Vision Care.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

- (1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.
- (2) **Adoption** expenses or any expenses related to surrogate parenting.
- (3) **Biofeedback.**
- (4) **Coding Guidelines.** Charges for inappropriate coding in accordance with the industry standard guidelines in effect at the time services were received.
- (5) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.
- (6) **Counseling.** Care and treatment for marital or pre-marital counseling.

Note: Counseling for these and other services is available through the Employee Assistance Program (EAP), which provides Employees and their families with confidential assistance when needing help dealing with problems and managing change.

Please contact your Plan Administrator for additional information.

- (7) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care, except as specifically stated as a benefit of this Plan.
- (8) **Drugs, medicines, or supplies** which do not require a Physician's prescription; anorexiant (weight-loss drugs); fertility drugs; vitamins and nutritional supplements that do not require a Physician's prescription; drugs to promote hair growth; impotence treatments; and drugs prescribed for cosmetic purposes (e.g., Retin-A for any diagnosis except acne).
- (9) **Duplication of benefits** provided by any other program sponsored by Deschutes County.
- (10) **Educational or vocational testing.** Services for educational or vocational testing or training, except as specifically stated as a benefit of this Plan.
- (11) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.
- (12) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (13) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental / Investigational or not Medically Necessary.
- (14) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. However, refer to the Schedule of Benefits for Vision Care Benefits and coverage under the Vision Care Benefits section

of this Plan. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

- (15) **Faith healing services**, even if a covered provider performs services.
- (16) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the primary purpose of obtaining medical services.
- (17) **Genetic counseling or testing** for any condition, unless stated otherwise in the Plan.
- (18) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid, hospitals or mental health and developmental disability programs owned or operated by the State of Oregon, or when otherwise prohibited by law.
- (19) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
- (20) **Home birth and related expenses.**
- (21) **Homeopathic** treatment, except as stated as a specific benefit of this Plan.
- (22) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (23) **Hospitalization** ordered solely due to the patient's age, apprehension, or emotional state; or for the convenience of the patient, family, or Physician.
- (24) **Hypnosis or hypnotherapy.**
- (25) **Illegal Acts.** Charges for services received as a result of an Illness or Injury occurring directly, or indirectly as a result of a serious criminal act, or a riot or public disturbance, or regardless of causation, if such Illness or Injury occurs in connection with, or while engaged in, or attempting to engage in, a serious criminal act, or a riot or public disturbance. For the purposes of this exclusion, the term "serious criminal act" shall mean any act or series of acts by the Plan participant, or by the Plan participant in concert with another or others, for which, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. For this exclusion to apply, it is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (26) **Impotence.** Treatment of sexual disorders and /or dysfunction including, but not limited to, impotence, frigidity, and penile implants. This exclusion includes all Physician examinations and diagnostic x-ray or laboratory studies and related expenses.
- (27) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization.
- (28) **Mailing or Sales Tax.** Charges for mailing, shipping, handling, conveyance, postage and sales tax.
- (29) **Massage, massage therapy, rolfing** except as stated as a specific benefit of this Plan.
- (30) **Mental examinations or psychological testing and evaluations not provided as an adjunct to treatment or diagnosis of a mental disorder**, including, but not limited to: mental examinations for the purpose of adjudication of legal rights, administrative awards or benefits, or corrections or social service placement; or for any use except as a diagnostic tool for the provision of mental health or chemical dependency treatment as provided by the Plan.

- (31) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (32) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (33) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (34) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (35) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (36) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness, except as specifically stated as a benefit of this Plan. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals.
- (37) **Occupational Injury.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit and for which the Plan Participant is eligible to receive benefits under any Worker's Compensation or occupational disease law. However, this exclusion will also apply in the event the Plan Participant was eligible to receive such Worker's Compensation benefits and failed to properly file a claim for such benefits or to comply with any other provision of the law to obtain such benefits.

Charges for care or treatment related to an occupational injury for which a Workers Compensation claim has been filed but not yet granted or denied, to the applicable **State of Oregon** workers compensation carrier, *will be considered eligible* subject to this Plan's Third Party Recovery rights. This *exception* will not apply in the event the Plan Participant was eligible to receive such Worker's Compensation benefits but failed to properly file a claim for such benefits or to comply with any other provision of the law to obtain such benefits.

- (38) **Personal comfort items.** Personal comfort items, patient convenience or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-Prescription Drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (39) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
- (40) **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse.
- (41) **Reflexology.**
- (42) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (43) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (44) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or

treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, except as stated as a specific benefit of this Plan or otherwise mandated by law.

- (45) **Routine foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails unless needed in treatment of a metabolic or peripheral-vascular disease, or as otherwise deemed Medically Necessary.
- (46) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. *This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.*
- (47) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (48) **Sterilization** for Dependent children. Sterilization procedures for female Covered Persons will be payable as shown under the Preventive Care benefit as shown in the Schedule of Benefits.
- (49) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (50) **Tobacco Cessation products or medications.** *Tobacco cessation products or medications, when prescribed by a Physician, will be covered under the Prescription Drug Benefit section of this Plan.*
- (51) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as stated as a benefit of this Plan.
- (52) **War.** Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

The Prescription Drug Plan includes **Northwest Pharmacy Services** Participating Pharmacies, and the **WellPartner** Mail-Order Program.

This Plan will not exclude coverage of a particular drug for a particular indication based solely on the grounds that the indication has not been approved by the FDA. Coverage for such drug(s) is available if the State of Oregon Health Resources Commission has determined that the drug is recognized as effective for the treatment of that indication in publications that the Commission determines to be the equivalent to:

- (1) The American Hospital Formulary Services drug information;
- (2) "Drug Facts and Comparisons" (Lippincott-Raven Publishers);
- (3) The United States Pharmacopoeia drug information;
- (4) Other publications that have been identified by the United States Secretary of Health and Human Services as authoritative;
- (5) In the majority of relevant peer-reviewed medical literature; or
- (6) By the United States Secretary of Health and Human Services.

Coverage of Prescription Drugs shall include coverage for Medically Necessary services associated with the administration of that drug.

Nothing in this section requires coverage for any Prescription Drug if the United States Food and Drug Administration has determined use of the drug to be contraindicated.

Nothing in this section requires coverage for experimental drugs not approved for any indication by the United States Food and Drug Administration, except Covered Charges as related to the Plan's Clinical Trials benefit as indicated within the Covered Charges section of this Plan.

CONTACT INFORMATION

Northwest Pharmacy Services
(800) 998-2611
www.nwpsrx.com

WellPartner Inc., Mail-Order Program
(877) 935-5797
www.wellpartner.com

WHERE TO SUBMIT PHARMACY CLAIMS

Northwest Pharmacy Services is the Retail Pharmacy Claims Administrator. Claims for retail pharmacy expenses should be submitted to the Retail Claims Administrator at the address below:

Northwest Pharmacy Services
929 East Main Street, Suite 310
Puyallup, WA 98372-3124

WellPartner, Inc., is the Mail-Order program Claims Administrator. Claims for mail-order pharmacy expenses should be submitted to the Mail-Order Claims Administrator at the address below:

WellPartner, Inc
Customer Service
P.O. Box 5909
Portland, OR 97228-5909

Generic Substitution

Over 400 commonly prescribed drug products are now available in a generic form at an average cost of 50% less than the brand name products. This Plan encourages the use of generic Prescription Drugs. By law, generic drugs must meet the same standards of safety, purity, strength and effectiveness as brand name drugs. Since brand name drugs are often two to three times more expensive than generic drugs, use of generics with this benefit will save money, and the Covered Person is encouraged to ask his or her Physician to prescribe a generic whenever possible.

If a generic drug is prescribed but the Covered Person purchases a brand name drug through the WellPartner Mail-Order Program, the Covered Person will be required to pay both the copayment, plus the difference in cost between the generic and the brand name drug. If a generic drug is prescribed but the Covered Person purchases a brand name drug through a Northwest Pharmacy Services pharmacy, the Covered Person will be required to pay a higher copayment.

Step Therapy

Step Therapy requires the Covered Person to try two “first step” medications first before moving to a “second step” medication.

What happens when a medication is Medically Necessary but it is part of a Step Therapy protocol? If it is Medically Necessary for the Covered Person to receive a “second step” medication before any “first step” medications have been tried, the Covered Person’s Physician may contact Northwest Pharmacy Services toll-free at 1 (800) 998-2611 to request coverage of the medication as a medical exception.

Payment Schedule

The Covered Person must pay a copayment for each prescription filled, as shown in the Prescription Drug Benefits section of the Schedule of Benefits.

Prescriptions Purchased Without the Northwest Pharmacy Services Benefit

If a prescription is purchased at a Northwest Pharmacy Services Participating Pharmacy but the participant does not utilize his or her Northwest Pharmacy Services benefit at the time of the prescription purchase, or if a prescription is purchased at a non-participating pharmacy, the Employee must file a claim with Northwest Pharmacy Services using their claim form; a 50% copayment will be taken.

Mail-Order Information

For an existing prescription, provide WellPartner Inc., with the information requested on the initial order form and a WellPartner pharmacist will transfer the existing prescription to the WellPartner Inc., Mail-Order pharmacy. The Physician can also telephone in refill prescriptions to save time. Refills can be ordered over the telephone with a credit card by calling (877) 935-5797. The Physician can also telephone or fax new prescriptions to WellPartner if the participant has previously provided credit card payment information. WellPartner Inc., pharmacists automatically call the Physician for refills when the prescriptions expire.

Pharmacists are available for counseling Monday through Friday from 7:00 a.m. to 5:00 p.m., Pacific Time, at **(877) 935-5797**.

WellPartner Inc., maintains a quick turnaround time. Orders which do not require a conversation with either the participant or the Physician prior to dispensing will be filled and mailed within one or two days. Prescriptions that require communication with either the participant or the Physician will not be filled until all questions have been answered.

Summary

In order to best use the prescription benefits, continue to have non-maintenance prescriptions (prescribed for an urgent illness or injury) filled at a Northwest Pharmacy Services Participating Pharmacy. When ordering maintenance medications (those taken on a regular or long-term basis such as heart, allergy, diabetes or blood

pressure medications), it may be more cost effective to use the WellPartner Mail-Order Program. The covered person should call both their local retail pharmacist and WellPartner to verify which copayment will be less for medications, since mail-order benefits are applied differently than retail pharmacy benefits.

Covered Prescription Drugs

- (1) Legend drugs, (those drugs which cannot be purchased without a prescription written by a Physician or dentist)
- (2) Allergy extracts or other injectable drugs intended for use in a Physician's office or settings other than home use
- (3) Ritalin
- (4) Insulin and diabetic supplies

Note: Diabetic medications, including insulin, and other diabetic supplies (and when prescribed by a Physician) in connection with **diabetes management for covered Pregnant women** will be payable subject to first dollar coverage (i.e., no deductible or copayment will apply) as shown in the Prescription Drug Schedule of Benefits.

- (5) Fluoride products
- (6) Peridex
- (7) Migraine therapy
- (8) Injectable medications, including Imitrex, bee sting kits, Glucagon, growth hormones, Lupron, and interferons
- (9) Acne treatments, including Retin-A, through age 24, and Accutane
- (10) Antibiotics
- (11) Vitamins and minerals requiring a Physician's prescription
- (12) Hematinics (iron preparations) requiring a Physician's prescription
- (13) Anabolic steroids
- (14) Psychotherapeutic drugs
- (15) Alcoholism and chemical dependency medications
- (16) AIDS treatments
- (17) Immunosuppressant agents
- (18) Chemotherapy agents
- (19) Laxatives requiring a Physician's prescription
- (20) Compound medications which include at least one legend drug
- (21) Syringes and needles
- (22) Orally administered anti-cancer medications

The following will be covered at 100%, no copayment required.

- (1) Physician-prescribed tobacco cessation products or medications. Limited to a 168-day supply per Calendar Year of nicotine replacement products (such as nicotine patch, gum, lozenges) and a 168-day

supply per Calendar Year of Physician-prescribed medications (such as Zyban, Chantix).

- (2) Physician-prescribed contraceptive methods (Food and Drug Administration (FDA) approved) including but not limited to oral contraceptive medications, transdermals, devices (diaphragms, cervical caps), vaginal contraceptives, and injectables. This also includes physician-prescribed over-the-counter (OTC) contraceptives (such as female condoms, spermicides, and sponges); for all female Covered Persons with reproductive capacity.

Refer to the Medical Benefits section of this Plan regarding additional coverage for intrauterine devices (IUDs), and implantables.

- (3) Additional Physician-prescribed medications as recommended by the U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations will be covered at 100%, no prescription copayment, coinsurance or deductible will be required, and will only be available when utilizing a participating pharmacy.

Please note, the USPSTF grades A and B recommendations are subject to change as new medications become available and other recommendations may change. Coverage of new recommended medications will be available following the one (1) year anniversary date of the adoption of the USPSTF grade A and B recommendation.

Refer to the following link for more information regarding USPSTF grade A and B recommendations or contact *Northwest Pharmacy Services* for more information regarding which medications are available. *Note: Age and/or quantity limitations may apply.*

<http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations>

Limits To This Benefit

The Prescription Drug Plan will cover the amount normally prescribed by a Physician, not to exceed a 34-day supply for prescriptions purchased at the pharmacy, or up to a 100-day supply for prescriptions purchased through the Mail-Order Program.

Expenses Not Covered

- (1) No prescription. A drug or medicine that can legally be bought without a written prescription. This does not apply to insulin or to over-the-counter drugs prescribed by a Physician and as specifically stated as a covered benefit of this Plan.
- (2) Anorexiant.
- (3) Fertility drugs.
- (4) Cosmetic indications.
- (5) Viagra and other medications for impotence.
- (6) Ostomy supplies.
- (7) Drugs with no proven therapeutic indication.
- (8) Administration or injection of drugs.
- (9) Immunization agents, biological sera, blood, or blood plasma.
- (10) Vitamins and fluoride (except those which by law require a prescription order).
- (11) Drugs prescribed for weight loss or treatment of obesity (including, but not limited to amphetamines).

- (12)** Drugs dispensed in a facility (drugs dispensed to the Employee or covered Dependent while a patient in a Hospital, Skilled Nursing Facility, nursing home, or other health care institution).
- (13)** Medical exclusions. A charge associated with treatment or services included in the Plan Exclusions section of this Plan.

VISION CARE BENEFITS

Vision care benefits apply when vision care charges are incurred by a Covered Person for services that are recommended and approved by a Physician or Optometrist.

BENEFIT PAYMENT

Benefit payment for a Covered Person will be made as described in the Schedule of Benefits.

VISION CARE CHARGES

Vision care charges are the Allowable Charges for the vision care services and supplies shown in the Schedule of Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Benefits for each vision care service or supply.

LIMITS

No benefits will be payable for the following:

- (1) **Before covered.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.
- (2) Charges for vision care services for which benefits are **provided under any other portion of the Plan**, or under any other medical or vision care expense benefit plan carried or sponsored by Deschutes County, whether benefits are payable as to all or only part of the expenses.
- (3) Charges for any eye examination **required by an employer as a condition of employment**, or which an employer is required to provide under a labor agreement, or which any law or government requires.
- (4) Charges for **tinted lenses**.
- (5) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.
- (6) **Health plan.** Any charges that are covered under a health plan that reimburses a greater amount than this Plan.
- (7) **No prescription.** Charges for lenses ordered without a prescription.
- (8) **Orthoptics.** Charges for orthoptics (eye muscle exercises).
- (9) **Training.** Charges for vision training or subnormal vision aids.
- (10) **Sunglasses.** Charges for non-prescription safety goggles or sunglasses
- (11) Charges for vision care services for which benefits are provided under any **Workers' Compensation** law or any other law of similar purpose, whether benefits are payable as to all or only part of the expenses.

Charges for care or treatment related to an occupational injury for which a Workers Compensation claim has been filed but not yet granted or denied, to the applicable **State of Oregon** workers compensation carrier, *will be considered eligible* subject to this Plan's Third Party Recovery rights. This *exception* will not apply in the event the Plan Participant was eligible to receive such Worker's Compensation benefits but failed to properly file a claim for such benefits or to comply with any other provision of the law to obtain such benefits.

DENTAL BENEFITS

Participation in the Dental Benefits of this Plan requires a separate enrollment election and a separate premium amount.

This benefit applies when covered dental charges are incurred by a person while covered under this Plan. If care is transferred from one dentist to another during a course of treatment, the Plan will only pay benefits up to the amount it would have paid had only one dentist rendered service.

Individuals who do not enroll in Dental Benefits when they initially qualify will be required to wait until the Plan's next Open Enrollment period to enroll, unless there is a qualifying Special Enrollment event.

COPAYMENT

Copayments are dollar amounts that the Covered Person must pay before the Plan pays. See the Schedule of Benefits for details.

BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount if applicable. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the Allowable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class A Services: Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

- (1) Diagnostic oral exams.
- (2) Prophylaxis (or cleaning) of the teeth.
- (3) Topical application of fluoride.
- (4) Bitewing x-rays.
- (5) Full-mouth (or panorex) x-ray.
- (6) Space maintainers for children, when used to maintain space for eruption of permanent teeth. Space maintainers used in conjunction with orthodontia treatment are covered only under the Orthodontia Services benefit.

- (7) Application of pit and fissure sealants.
- (8) Initial orthodontic exam.
- (9) Examination for a Statement Certifying Oral Health. Oregon State law requires this certificate before most care furnished by a dentist.

**Class B Services:
Basic Dental Procedures**

- (1) Tooth fillings necessary to restore the structure of teeth broken down by decay or injury. *(The charge for gold restorations will be reduced to the amalgam allowance for the same procedure.)*
- (2) Root canal therapy and other endodontic treatment
- (3) Palliative treatment (emergency treatment primarily for relief, not cure).
- (4) Periodontal procedures, including scaling and root-planing, gingival curettage, periodontal maintenance procedures, gingivectomy, gingivoplasty, osseous surgery, mucogingival surgery.
- (5) General anesthesia (including nitrous oxide) and its administration in connection with complex oral surgery, major periodontics procedures, fractures or dislocations, or due to a concurrent medical condition.
- (6) Oral surgery, extraction of teeth, surgical extraction of impacted molars.
- (7) Dental x-rays not included in Preventive Services.
- (8) Antibiotics administered by a dentist or Physician

Class C Services: Major Dental Procedures

- (1) Crowns, inlays and onlays necessary to restore the structure of teeth broken down by decay or injury when the tooth cannot be restored with filling materials such as amalgam, silicate or plastic. Crowns, inlays or onlays on the same tooth are covered once in a five-year period.
- (2) Initial installation of fixed and removable bridgework (including wing attachments, inlays and crowns as abutments).
- (3) Replacement of existing fixed and removable bridgework. Replacement of existing bridgework is covered only once every five years and only then if it is unserviceable and cannot be made serviceable. No benefits will be provided for lost or stolen prosthetic devices.
- (4) Initial installation of full or partial dentures. Charges for adjustments of prosthetic devices made within six months of installation are not covered.
- (5) Replacement of existing full or partial dentures. Replacement of an existing prosthetic device is covered only once every five years and only then if it is unserviceable and cannot be made serviceable. No benefits will be provided for lost or stolen prosthetic devices. Charges for adjustments of prosthetic devices made within six months of installation are not covered.
- (6) Installation of precision attachments for removable dentures.
- (7) Addition of clasp or rest to existing partial removable denture.
- (8) Rebasing or relining a denture.
- (9) Repair and re-cementing of crowns, inlays, bridgework and dentures.

- (10) Prosthetic services provided by a denturist must be accompanied by a Statement Certifying Oral Health from a Dentist or Physician, except when services are to repair a denture or to replace a denture that was placed within 12 months prior.
- (11) Bruxism splints and night guards.
- (12) Periodontal splints.
- (13) Dental Implants, including associated procedures and appliances. This benefit does not apply to dental implants for cosmetic purposes.

Class D Services: Orthodontic Treatment and Appliances

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

These services include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance. The initial orthodontic exam is covered under Preventive Services. Payments for comprehensive full-banded orthodontic treatments are made in installments.

PREDETERMINATION OF BENEFITS

Before starting a dental treatment for which the charge is expected to be **\$300** or more, a predetermination of benefits form may be submitted to the Claims Administrator by the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Administrator at this address:

Employee Benefits Management Services, Inc.
 P.O. Box 21367
 Billings, Montana 59104
 (406) 245-3575 or (800) 777-3575

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

EXCLUSIONS

A charge for the following is not covered:

- (1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.
- (2) **Appliances or restorations** to correct vertical dimension or occlusion or to break habits, except as stated as a benefit of this Plan.
- (3) **Broken appointments.** Charges for broken or missed dental appointments; completion of charts or forms; or patient management.
- (4) **Cosmetic.** Services or supplies that are primarily cosmetic in nature.

- (5) **Cosmetic implants.** Implants for cosmetic purposes, including any appliances and/or crowns and the surgical insertion or removal of implants.
- (6) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
- (7) **Duplicate bridge or denture** or any other duplicate dental appliance, unless the existing denture is an immediate temporary denture and replacement by a permanent denture is completed within 12 months from the date of the initial installation of the temporary denture. Permanent appliances that replace temporary appliances are limited to the maximum UCR allowance for the permanent appliance.
- (8) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.
- (9) **Gnathological recordings** (recording of jaw movement and positions).
- (10) **Gold,** when billed separately.
- (11) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.
- (12) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.
- (13) **Myofunctional therapy.**
- (14) **No listing.** Services which are not included in the list of covered dental services.
- (15) **Orthognathic surgery.** Surgery to correct malposition in the bones of the jaw, except as specifically stated as a benefit under this Plan.
- (16) **Periodontal probing or charting,** when billed separately.
- (17) **Personalization.** Personalization of dentures.
- (18) **Precision or semi-precision attachments,** except as stated as a benefit of this for in the Plan.
- (19) **Prescription Drugs** are payable only under the medical benefits when Medically Necessary for the treatment of infection or pain, except as listed in the Dental Benefits section.
- (20) **Replacement.** Replacement of lost or stolen appliances.
- (21) **Services for cosmetic or aesthetic reasons** including, but not limited to laminates; restorations due to misalignment or discoloration of teeth; and bleaching.
- (22) Services or supplies for which payment could be obtained in whole or in part if the Covered Person had applied for payment under any **city, county, state or federal law** except Medicaid.
- (23) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic, except as stated as a benefit under this plan.
- (24) **Study models.**
- (25) **TMJ.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.

COORDINATION OF BENEFITS

Coordination of the benefit plans. The Plan's Coordination of Benefits provision sets forth rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. The Plan has adopted the order of benefits as set forth in the National Association of Insurance Commissioners (NAIC) Model COB Regulations, as amended. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan, or the couple's Covered children are covered under two or more plans the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or nongroup insurance contracts and subscriber contracts;
- (2) Uninsured arrangements of group or group-type coverage;
- (3) Group and nongroup coverage through closed panel plans;
- (4) Group-type contracts;
- (5) The medical components of long-term care contracts, such as skilled nursing care;
- (6) Medicare or other government benefits, as permitted by law. This does not include Medicaid, or a government plan that by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan;
- (7) The medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts;
- (8) Any third-party source, including but not limited to, automobile or homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured or self-insured basis.

The term benefit plan does not include hospital indemnity, accident only, specified disease, school accident or non-medical long-term care coverage.

Allowable Charge(s). For a charge to be allowable it must be a usual, customary, and reasonable charge and at least part of it must be covered under this Plan. (See "Allowable Charge" in the Defined Terms section.)

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When any medical benefits coverage is available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

- (A) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (B) Plans with a coordination provision will pay their benefits up to the Allowable Charge. The first rule that describes which plan is primary is the rule that applies:
 - (1) The benefits of the plan which covers the person directly (that is, as a Member/Employee, Retiree, or subscriber) (“Plan A”) are determined before those of the plan which covers the person as a Dependent (“Plan B”). For Qualified Beneficiaries, coordination is determined based on the person’s status prior to the Qualifying Event.

Special rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay first.

- (2) Unless there is a court decree stating otherwise for a Dependent child up to age 19, when a child is covered as a Dependent by more than one plan the order of benefits is determined as follows:

When a child is covered as a Dependent and the parents are married or living together, these rules will apply:

- The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
- If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

When a child’s parents are divorced, legally separated or not living together, whether or not they have ever been married, these rules will apply:

- A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the financially responsible parent has no health care coverage for the Dependent child, but that parent’s spouse does, the plan of that parent’s spouse is the primary plan. This rule applies beginning the first of the month after the plan is given notice of the court decree.
- A court decree may state both parents will be responsible for the Dependent child’s health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);
- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are married or living together.

If there is no court decree allocating responsibility for the Dependent child’s health care expenses, the order of benefits are as follows:

- 1st The plan covering the custodial parent,
- 2nd The plan covering the spouse of the custodial parent,
- 3rd The plan covering the non-custodial parent, and
- 4th The plan covering the spouse of the non-custodial parent.

When a child is covered as a Dependent under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined as if those individuals were parents of the child.

Unless specifically stated otherwise, court order and custody provisions apply up to age 19 for any Dependent child.

For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, Rule (5) applies. If the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the birthday rule shall apply to the Dependent child's parents and the Dependent child's spouse.

- (3) The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or as a Dependent of a Member/Employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid-off or Retired Member/Employee. This rule does not apply if Rule (1) can be used to determine the order of benefits. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - (4) The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or a Dependent of a Member/Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if Rule (1) can be used to determine the order of benefits.
 - (5) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (C) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts; except in the case of kidney dialysis and End Stage Renal Disease (ESRD) care and treatment. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.
 - (D) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
 - (E) The Plan will pay primary to Tricare to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year or Plan Year basis, as shown in the Schedule of Benefits section. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines

it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

HOW TO SUBMIT MEDICAL CLAIMS

When you receive services from a health care provider, show your EBMS/Deschutes County Identification card to the provider. Most providers should submit claims on your behalf.

If it is necessary for you to submit a claim yourself, please request an itemized bill **which includes procedure (CPT) and diagnostic (ICD) codes** from your health care provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill
- Group name and number (Deschutes County, Group #0000917)
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Amount billed

Note: Plan participants can obtain a claim form from the Plan Administrator or the Claims Administrator. Claim forms are also available at <http://www.ebms.com>.

WHERE TO SUBMIT CLAIMS

Employee Benefit Management Services, Inc., is the Claims Administrator. Claims for expenses should be submitted to the Claims Administrator at the address below:

Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within *one year* from the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURES

A **Claim** means a request for a Plan benefit, made by a Plan Participant or by an authorized representative of a Plan Participant that complies with the Plan's reasonable procedures for filing benefit Claims. A Claim does not include an inquiry on a Plan Participant's eligibility for benefits.

A Plan Participant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. A healthcare provider is not an authorized representative simply by virtue of an assignment of benefits. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives.

There are four types of claims.

Pre-Service Claim

A **Pre-Service Claim** is a Claim for medical care, treatment, or services that a Plan Participant had not yet received, that resulted in a reduction in benefits for certain Covered Services because the Plan Participant did not obtain the required Plan approval before receiving the treatment. This Plan does require prior approval for certain covered services or treatments as a condition to receiving benefits under the Plan. The review program is known as pre-notification. See the “Schedule of Benefits” and the “Care Management Services” section for more information.

Urgent Care Claim

An **Urgent Care Claim** is any Pre-Service Claim where application of the time periods for review and determination of the Pre-Service Claim could seriously jeopardize the life or health of the Plan Participant or the Plan Participant’s ability to regain maximum function, or – in the opinion of the Plan Participant’s treating physician, would subject the Plan Participant to severe pain that cannot be managed without the proposed treatment

Concurrent Care Determination

A **Concurrent Care Determination** is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. *If Case Management is appropriate for a Plan participant, Case Management is not considered a Concurrent Care Determination. Please refer to the Care Management Services section.*

Post-Service Claim

A **Post-Service Claim** is a Claim for medical care, treatment, or services that a Plan Participant has already received.

All questions regarding Claims should be directed to the Claims Administrator. All claims will be considered for payment according to the Plan’s terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims involving specialized medical knowledge or judgment. The Plan Administrator shall have full responsibility to adjudicate all claims and to provide a full and fair review.

A Claim will not be deemed submitted until it is received by the Claims Administrator.

Initial Benefit Determination

The initial benefit determination will be made as follows:

Pre-Service Claims for Urgent Care

If the Pre-Service Claim is determined by the Claims Administrator to be a claim involving Urgent Care, notice of the Plan’s decision will be provided to the Plan Participant within 72 hours of receipt of the Pre-Service Claim by the Claims Administrator.

The exception is if the Plan Participant does not provide sufficient information to decide the Pre-Service Claim. In that case, notice requesting specific additional information will be provided to the Plan Participant within 24 hours of receipt of the Pre-Service Claim. The Plan’s decision regarding the Pre-Service Claim will be made within 48 hours of receipt of the requested information by the Claims Administrator.

Pre-Service Claims for non-Urgent Care

If the Pre-Service Claim is not an Urgent Care claim, written notice of the Plan’s decision will generally be provided to the Plan Participant within 2 business days of receipt of the Pre-Service Claim by the Claims Administrator.

If matters beyond the control of the Claims Administrator so require, one 2-business day extension of time for processing the Pre-Service Claim may be taken. Written notice of the extension will be furnished to the Plan Participant before the end of the initial 2-business day period. If an extension is required because the Plan Participant did not provide the information necessary, the notice of extension will specifically describe the required information.

The time-period for processing the Pre-Service Claim will be tolled beginning on the date this extension notice is sent to the Plan Participant and ending on the earlier of:

- The date the Claims Administrator receives the additional information, or
- The date set by the Plan for the Plan Participant's response (at least 45 days).

Concurrent Care Claims

Notice of the Plan's decision will generally be provided to the Plan Participant or treating physician within 2 business days of receipt of the Concurrent Care Claim by the Claims Administrator.

The exception is if the Plan Participant does not provide sufficient information to decide the Concurrent Care Claim. In that case, notice requesting specific additional information will be provided to the Plan Participant or treating physician within 24 hours of receipt of the Concurrent Care Claim. The Plan's decision regarding the Concurrent Care Claim will be tolled until the date the Claims Administrator receives the requested information.

Post-Service Claims

The initial benefit determination on a Post-Service Claim will be made within 30 days of the Claim Administrator's receipt of the Post-Service Claim. If additional information is necessary to process the Post-Service Claim, the Claims Administrator will request the additional information from the Plan Participant or treating physician within this initial 30-day period. The Plan Participant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. **Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits.** A benefit determination on the Post-Service Claim will be made within 15 days of the Plan's receipt of the additional information.

Notice of Adverse Benefit Determination

The Plan shall provide written or electronic notice of the determination on a Claim in a manner meant to be understood by the Plan Participant. If a Claim is denied in whole or in part, notice will include the following:

- (1) Information to identify the claim involved.
- (2) Specific reason(s) for the denial, including the denial code and its meaning.
- (3) Reference to the specific Plan provisions on which the denial was based.
- (4) Description of any additional information necessary for the Plan participant to perfect the Claim and an explanation of why such information is necessary.
- (5) Description of the Plan's Grievance and Grievance Appeal procedures and the applicable time limits.
- (6) Statement that the Plan participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

If applicable:

- (7) Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim.
- (8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim.

- (9) Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Plan Participant does not understand the reason for the denial or reduction in benefits, the Plan Participant can contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, or is a retroactive cancellation or discontinuance because of the Plan participant's failure to timely pay required premiums.

COMPLAINTS AND GRIEVANCES

A Plan Participant has the right to ask questions and voice complaints or file Grievances. Our goal is to listen, resolve your problems, and improve our service to you. To provide you an opportunity to resolve problems that may occur, please follow the following procedures. While the Plan is not a Group Health Plan subject to the provisions the Employee Retirement Income Security Act of 1974 (ERISA), these procedures will nonetheless fulfill in all respects the requirements concerning internal claims and appeals found in Section 2719 of the Public Health Service Act, as added by Section 1001 of the Affordable Care Act (PHS Act Section 2719), implementing guidance concerning PHS Act Section 2719 as provided by the Department of Treasury (26 CFR §54.9815-2719T), the Department of Health and Human Services (45 CFR §147.136), and the Department of Labor (29 CFR §2590.715-2719), and relevant Oregon regulatory requirements.

The Complaint Procedure

A complaint is an expression of dissatisfaction that is about a specific problem encountered by a Plan Participant, or about a decision by the Plan, and that includes a request for action to resolve the problem or change the decision.

When the Plan Participant has a complaint, he or she should call the Claims Administrator. The Claims Administrator will send the Plan Participant a letter to acknowledge receipt of the complaint within seven (7) days of its receipt.

A Plan Participant has the right to voice complaints about:

- Availability, delivery or quality of health care services, including a claim for benefits before or after services are rendered;
- Claims payment, handling, or reimbursement for health care services (Please also refer to the Notice of Adverse Benefit Determination section set forth above.); or
- Matters pertaining to the Plan.

If the Plan Participant's complaint cannot be resolved at the time of your call, the Plan will: Gather more information or records when necessary;

- Conduct a review; and
- Notify the Plan Participant of the outcome and the reasons for the decision.

If the Plan Participant has questions regarding the complaint procedure, please contact the Claims Administrator for assistance in filing a complaint. If the Plan Participant is not satisfied with the Plan's decisions, the Plan Participant may seek assistance from the Department of Consumer and Business Services at any time.

If the Plan Participant has questions regarding the complaint procedure, please contact the Claims Administrator for assistance in filing a complaint. If the Plan Participant is not satisfied with the Plan's decisions, the Plan Participant may seek assistance from the Department of Consumer and Business Services at any time.

Other assistance may be available from the Oregon Insurance Division:

By Calling: (503) 947-7984

By Writing: Director of the Department of Consumer and Business Services Consumer Protection Unit, 350 Winter Street, N.E., Room 440-2, Salem, OR 97310

On the Internet at: <http://www.cbs.state.or.us/external/ins>

The Grievance Procedure

If the Plan Participant's complaint is not satisfactorily resolved, the Plan Participant may submit a Grievance. A Grievance means a written complaint submitted by or on behalf of a Plan Participant regarding: 1) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review, 2) claims payment, handling or reimbursement for health care services, or 3) matters pertaining to the Plan. The Plan Participant may include additional supporting information, even if not initially submitted with the Claim. The Claims Administrator must receive your Grievance within:

- If regarding a Post-Service Claim, 180 days of the date the Plan Participant is notified of the outcome of the compliant review (or the Initial Benefit Determination if the Plan Participant did not file a complaint);
- If regarding a Pre-Service Claim, 30 days of the date the Plan Participant is notified of the outcome of the compliant review (or the Initial Benefit Determination if the Plan Participant did not file a complaint);
- If regarding a Concurrent Care Claim, 15 days of the date the Plan Participant is notified of the outcome of the compliant review (or the Initial Benefit Determination if the Plan Participant did not file a complaint.
- If the Plan Participant has questions regarding the Grievance procedure, please contact the Claims Administrator who can provide assistance in filing a Grievance.
- If the Plan Participant is not satisfied with the Plan's decisions, the Plan Participant may seek assistance from the Department of Consumer and Business Services at any time.

Should the Claims Administrator (for a Level I Review) or the Plan Administrator (for a Level II review), elect to have an independent external review performed or if a Level III Review is requested by a Plan Participant, such review will be assigned to an independent review organization (IRO) that is chosen by Claims Administrator on a random basis.

Send all Grievances to:

Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, MT 59104

The Grievance procedure has three levels of review:

LEVEL I:

The Claims Administrator will evaluate all the information and make a decision. The Claims Administrator will advise the Plan Participant in writing of its decision and the reasons for it. Some Grievances may take longer if there are delays beyond the Plan's control. In those cases, an additional 15 days may be needed to resolve the Plan Participant's Grievance. The Claims Administrator will give the Plan Participant or the authorized representative a notice of delay that includes a specific reason for the delay.

Written or electronic notice of the Claims Administrator's decision will be provided to the Plan Participant within:

- 30 days of receipt of a Grievance for a Post-Service Claim;
- 15 days of receipt of a Grievance for a Pre-Service Claim or a Concurrent Care Claim; or
- 72 hours of receipt of a Grievance for an Urgent Care Claim.

Except for Grievances concerning Urgent Care Claims, if the Plan Participant is not satisfied with the outcome at Level I, the Plan Participant may request a review at Level II:

- If regarding a Post-Service Claim, 180 days of the date the Plan Participant is notified of the outcome of the Level I review;
- If regarding a Pre-Service Claim, 30 days of the date the Plan Participant is notified of the outcome of the Level I review; or
- If regarding a Concurrent Care Claim, 15 days of the date the Plan Participant is notified of the outcome of the Level I review.

If regarding an Urgent Care Claim, the Plan Participant must file a Grievance at Level III. Urgent Care Claims shall not be grieved at Level II.

LEVEL II:

The Grievance will be reviewed by the Plan Administrator. The Plan Administrator may elect to delegate this review to the Claims Administrator or an independent external review organization chosen by the Plan Administrator. The Plan Participant should provide the Plan Administrator with any additional information not previously reviewed to support the Grievance. Such additional information should be provided with the Grievance or as soon after the Grievance is submitted as possible, but in no event later than 20 days after submission of the Grievance.

A Plan Participant may also provide a written statement to the Plan Administrator explaining why the Grievance should be resolved as requested by the Plan Participant. The written statement must be provided no later than 20 days after submission of the Grievance at Level II. Any written statement provided by the Plan Participant will be reviewed and considered by the Plan Administrator in deciding the Grievance.

If the Plan Administrator has elected to delegate review of the Grievance to an independent review organization, the written statement will be provided to the independent review organization for review and consideration. In the event a Plan Participant fails to timely provide additional information or a written statement in support of the Grievance, the additional information or written statement will not be considered. The Plan Administrator's decision regarding the Grievance shall be based on (1) the findings and conclusions of a delegated external review, if any, and (2) the express terms and conditions of the Plan Document. Written or electronic notice of the Plan Administrator's decision will be provided to the Plan Participant within:

- 30 days of receipt of a Grievance for a Post Service Claim;
- 15 days of receipt of a Grievance for a Pre-Service Claim or a Concurrent Care Claim; or

If the Plan Participant is not satisfied with the outcome of the Level II review, he or she may request a third and final external review through Level III.

LEVEL III:

A Plan Participant may, by written application to the Plan, obtain an external review by an independent review organization for a Level III Grievance on an Adverse Benefit Determination that involves one or more of the following:

- Whether a course or plan of treatment is Medically Necessary.
- Whether a course or plan of treatment is Experimental or Investigational.
- A rescission of coverage.

A Plan Participant shall apply in writing for external review of an adverse decision by the Plan not later than 180 days after receipt of the Plan's final written decision following Steps I and II of this Grievance procedure. A Plan Participant is eligible for external review only if the following requirements have been met:

- The Plan Participant must have signed a waiver granting the independent review organization access to the medical records of the Plan Participant.
- The Plan Participant must have exhausted all review rights through Level I and Level II of the Plan's Grievance procedure before submitting a request for a Level III external review. The Plan may waive the requirement of compliance with the internal Grievance procedure and have a dispute referred directly to external review upon the Plan Participant's written consent.
- The Plan Participant must provide accurate and complete information to the independent review organization in a timely manner.

The Plan agrees to be bound by the results of the Level III external review.

THIRD PARTY RECOVERY

Defined Terms

"Covered Person" means anyone covered under the Plan, including but not limited to minor Dependents and deceased Covered Persons. Covered Person shall also include the parents, trustees, guardians, heirs, personal representatives or other representatives of a Covered Person, regardless of applicable law and whether or not such representative has access or control of the Recovery.

"Recover," "Recovered," "Recovery" means all monies recovered by way of judgment, settlement, reimbursement, or otherwise to compensate for any loss related to any Injury, Sickness, condition, and/or accident where a Third Party is or may be responsible. "Recovery" includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, wages and/or any other recovery of any form of damages or compensation whatsoever.

"Subrogation" means the Plan's right to pursue a Covered Person's claims for medical or dental charges against a Third Party after the Plan has paid benefits or agreed to pay benefits to the Covered Person based on these charges.

"Third Party" means any third party including but not limited to another person, any business entity, or any insurance company or other business entity acting pursuant to its obligations under an insurance policy or any other policy or plan, including but not limited to uninsured or underinsured coverage, self-insured coverage, no-fault coverage, automobile coverage, premises liability (homeowners or business), umbrella policy, or workers compensation coverage.

Right to Reimbursement

This provision applies when the Covered Person has incurred medical or dental expenses due to an Injury, Sickness, condition, and/or accident which may be caused by the act or omission of a Third Party or where a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against a Third Party for payment of such expenses. To the extent that the Plan paid benefits on the Covered Person's behalf, the Covered Person agrees that the Plan has a lien on any Recovery ("Equitable Lien") whether or not such Recovery is designated as payment for such expenses. This Equitable Lien shall remain in effect until the Plan is repaid in full.

The Covered Person, and/or anyone asking on his or her behalf, agrees to hold in trust for the benefit of the Plan, that portion of any Recovery received or that may be received from a Third Party in an amount equal to the benefits paid by the Plan or that the Plan has agreed pay on the Covered Person's behalf. The Covered Person shall promptly reimburse the Plan out of such Recovery, in first priority for the full amount of the Plan's Equitable Lien. The Covered Person will reimburse the Plan first, even if the Covered Person has not been fully compensated or "made whole" and/or the Recovery is called something other than a Recovery for healthcare, medical and/or dental expenses.

The Plan will only be responsible for those attorney fees and/or costs of recovery associated with a Covered Person pursuing a claim against a Third Party that the Plan agrees to in writing, is subject to the terms of a court order, or as is otherwise required by law.

Right to Subrogation

This provision applies when the Covered Person incurs medical or dental expenses due to an Injury, Sickness, condition, and/or accident which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against a Third Party for payment of such expenses.

The Covered Person agrees that the Plan is subrogated to any and all claims, causes of action or rights that the Covered Person may have now or in the future against a Third Party who has, or may have, caused, contributed aggravated, or who may otherwise be responsible for the Covered Person's Injury, Sickness, Condition, and/or accident to the extent the Plan has paid benefits or has agreed to pay benefits. The Covered Person further agrees that the Plan is subrogated to any and all claims or rights that the Covered Person may have against any Recovery,

including the Covered Person's rights under the Plan to bring an action to clarify his rights under the Plan. The Plan may assert this Right of Subrogation independently of the Covered Person. The Plan is not obligated to pursue this right independently or on behalf of the Covered Person, but may choose to exercise this right, in its sole discretion.

Provisions Applicable to Both the Right to Reimbursement and Right to Subrogation

The Covered Person automatically assigns to the Plan any and all rights he or she has or may have against any Third Party to the full extent of the Plan's Equitable Lien. The Covered Person agrees to:

- (a) Cooperate fully with the Plan and its agents, regarding the Plan's rights under this section;
- (b) Advise the Plan of any right or potential right to reimbursement and/or subrogation on the Plan's behalf;
- (c) Provide to the Plan in a timely manner any and all facts, documents, papers, information or other data reasonably related to the Covered Person's Injury, Sickness, condition, and/or accident, including any efforts by another individual to Recover on the Covered Person's behalf;
- (d) Execute all instruments and papers that the Plan or its agents may reasonably request to protect the Plan's rights under this section;
- (e) Hold in trust that portion of any Recovery received by the Covered Person or on the Covered Person's behalf equal to the Plan's Equitable Lien;
- (f) Agree not to impair, impede or prejudice in any way, the rights of the Plan under this section; and
- (g) Do whatever else the Plan deems reasonably necessary to secure the Plan's rights under this section.

The Plan may take one or more of the following actions to enforce its rights under this section:

- (a) The Plan may require the Covered Person as a condition of paying benefits for the Covered Person's Injury, Sickness, condition, or accident, to execute documentation acknowledging the Plan's rights under this section;
- (b) The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Reimbursement against any Recovery received, or that will be received, by or on behalf of Covered Person; or
- (c) The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Subrogation directly against a Third Party who is or may be responsible.

The Plan Administrator is vested with full discretionary authority to interpret and apply the provisions of this section. In addition, the Plan Administrator is vested with the discretionary authority to waive or compromise any of the Plan's rights under this section. Any decision of the Plan Administrator made in good faith will be final and binding. The Plan Administrator is authorized to adopt such procedures as deemed necessary and appropriate to administrate the Plan's rights under this section.

COBRA CONTINUATION COVERAGE

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What is COBRA Continuation Coverage?

“COBRA Continuation Coverage” is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a “Qualifying Event.” After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a “Qualified Beneficiary.” You, your Spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer’s plan) are not considered for continuation under COBRA.

Domestic Partners and Dependent children of a covered Employee’s Domestic Partner, who otherwise satisfy the Eligibility requirements set forth in the Eligibility provision and are covered under this Plan, will also be offered the opportunity to make an independent election to receive COBRA Continuation Coverage. All references to Spouse will also be applicable to a Domestic Partner, unless otherwise indicated

If you are a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse’s hours of employment are reduced;
- Your Spouse’s employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent-covered Employee dies;
- The parent-covered Employee’s hours of employment are reduced;
- The parent-covered Employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the plan as a “Dependent child.”

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, reduction of hours of employment, death of the covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

Plan Administrator
Deschutes County
1300 NW Wall, Suite 201
Bend, Oregon 97701
541-385-3215

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their Dependent children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

Medicare extension of COBRA Continuation Coverage

If you (as the covered Employee) become entitled to Medicare benefits, your Spouse and Dependent children may be entitled to an extension of the 18-month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination or employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA Continuation Coverage for your Spouse and Dependent children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18 month period.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator as set forth herein, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
Deschutes County
1300 NW Wall, Suite 201
Bend, Oregon 97701
541-385-3215

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
Deschutes County
1300 NW Wall, Suite 201
Bend, Oregon 97701
541-385-3215

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.healthcare.gov.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or the COBRA Administrator:

Plan Administrator
Deschutes County
1300 NW Wall, Suite 201
Bend, Oregon 97701
(541) 385-3215

COBRA Administrator
Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, MT 59104
(406) 245-3575 or (800) 777-3575

For more information about your rights under the Public Health Services Act, COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Deschutes County Employee Benefit Plan is the benefit plan of Deschutes County, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by Deschutes County to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Deschutes County shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan.

DUTIES OF THE PLAN ADMINISTRATOR.

- To administer the Plan in accordance with its terms.
- To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- To decide disputes which may arise relative to a Plan Participant's rights.
- To prescribe procedures for filing a claim for benefits and to review claim denials.
- To keep and maintain the Plan documents and all other records pertaining to the Plan.
- To appoint a Claims Administrator to pay claims.
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA). Under the Women's Health and Cancer Rights Act of 1998, the Plan is required to notify you, as a Plan participant or beneficiary, of your rights related to benefits provided through the Plan in connection with a mastectomy. As a Plan participant or beneficiary, you are entitled to have coverage provided in a manner determined in consultation with your attending Physician for:

- All stages of reconstruction of a breast on which a mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of a mastectomy, including lymphedema.

FUNDING THE PLAN AND PAYMENT OF BENEFITS. The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or

withheld from the Employee's pay through payroll deduction. Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT. The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

**STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE
"PRIVACY STANDARDS") ISSUES PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND
ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)**

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes

"Protected Health Information" (PHI) means individually identifiable health information, created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- (1) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
- (2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- (3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- (4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

- (5) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
- (6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
- (7) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- (8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);
- (9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- (10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - (a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Benefits Coordinator
Finance Officer
Accounting Manager
Human Resources Director
Human Resource Analyst
Internal Auditor
Personnel Specialist
Personnel Assistant
County Administrator
Deputy County Administrator
Legal Counsel
Assistant Legal Counsel

- (b) The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
- (c) In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE “PRIVACY STANDARDS”) ISSUES PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

- (a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- (b) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;
- (c) Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and
- (d) Report to the Plan any security incident of which it becomes aware.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Deschutes County Employee Benefit Plan

PLAN NUMBER: 502

TAX ID NUMBER: 93-6002292

PLAN EFFECTIVE DATE: August 1, 2000

PLAN YEAR ENDS: July 31

EMPLOYER INFORMATION

Deschutes County
1300 NW Wall, Suite 201
Bend, Oregon 97701
(541) 385-3215

PLAN ADMINISTRATOR

Deschutes County
1300 NW Wall, Suite 201
Bend, Oregon 97701
(541) 385-3215

CLAIMS ADMINISTRATOR

Employee Benefits Management Services, Inc.
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

Plan Name: Deschutes County Employee Benefit Plan

Effective: August 1, 2000

Restated: August 1, 2016

I, Tom Anderson, certify that I am the County Administrator
Name Title

of the Plan Sponsor/Administrator for the above named Health Plan, and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the above referenced Plan Document and am hereby authorizing its implementation as of the effective date stated above.

Signature: 

Print Name: Tom Anderson

Date: 11-2-16