Deschutes County

Group No.: G0037173
Plan Name: Medical Plan
Effective: January 1, 2024

With Third Party Administrative Services Provided By:

PacificSource
HEALTH PLANS

Introduction

Deschutes County has established the Deschutes County Group Health Plan (referred to as the or this "Plan") to provide health care coverage for Eligible Employees and their Dependents. This Plan is established effective January 1, 2024 (the "Effective Date"). Deschutes County is the Plan Sponsor.

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

Nature of the Plan

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

This Plan is "self-insured" which means benefits are paid from the Employer's general assets and/or trust funds and are not guaranteed by an insurance company. The Plan Sponsor, which is also the Plan Administrator, has contracted with the Third Party Administrator to perform certain administrative services related to this Plan, and to generally provide administrative services to the Plan. If anything is unclear to you, please contact the Plan Sponsor or the Third Party Administrator at the number or address available in this Introduction section.

PacificSource Health Plans ("PacificSource") is the Third Party Administrator and will process claims, manage the network of health care Providers, and answer medical benefit and claim questions.

Written Plan Document and SPD

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

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

Non-Grandfathered Health Plan

The consumer protections of the Patient Protection and Affordable Care Act (PPACA) apply to this Plan.
Questions regarding the Plan's status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272,

or visit www.dol.gov/ebsa/healthreform.

Retention of Fiduciary Duties

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

Governing Law

This Plan must comply with both state and federal law, including required changes occurring after the Plan's effective date. Therefore, coverage is subject to change as required by law.

Additional Information

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

Questions?

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

For enrollment or eligibility questions, please contact the Plan Sponsor.

PacificSource Customer Service

Phone 888-246-1370
Email cs@pacificsource.com

Para asistencia en español, por favor llame al número 866-281-1464.

PacificSource Headquarters

555 International Way, Springfield, OR 97477
PO Box 7068, Springfield, OR 97475-0068
Phone 541-686-1242 or 888-977-9299

PacificSource Website

PacificSource.com

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MEDICAL BENEFIT SUMMARY
Standard Plan

Group Name: Deschutes County
Group Number: G0037173
Provider Network: Navigator
Benefit Year: Calendar Year

Employee Eligibility Requirements

Minimum Hour Requirement: Twenty (20) hours per week

Waiting Period Requirement: First of the month following hire

- 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 (immediate benefits, either that day or back to the first of the month).
- If you are hired after the first business day of the month, your benefits will start on the first day of the following month.

- After satisfying the waiting period, elected officials* of the County and their eligible dependents are eligible for the Plan without regard to the number of hours worked by each such Official. Coverage will end at the end of the month in which they are no longer serving as an elected official of the County.

  *Elected Officials:

  - Three County Commissioners,
  - County Sheriff,
  - District Attorney,
  - County Assessor,
  - County Clerk,
  - Justice of the Peace,
  - County Treasurer.

Deductible Per Benefit Year	Deschutes County Onsite Clinic Providers	Navigator Providers and Out-of-network Providers	
Individual/Family	None / None	$500 / $1,500	
Out-of-Pocket Limit Per Benefit Year	**Deschutes County Onsite Clinic Providers**	**Navigator Providers**	**Out-of-network Providers**
Individual/Family	None / None	$2,000 / $6,000	$4,000 / $12,000

Note: Your actual costs for services provided out-of-network may exceed this Plan's out-of-pocket limit for out-of-network services. In addition, Out-of-network Providers may in certain circumstances bill you for the difference between the amount charged by the Provider and the amount allowed by this Plan (called Balance Billing). Balance Billing amounts are not counted toward the out-of-network out-of-pocket limit. For additional information about Balance Billing or Allowable Fee, please see the Definitions Section of the Plan Document.

The Member is responsible for any amounts shown above, in addition to the following amounts:

Service/Supply	Deschutes County Onsite Clinic Providers	Navigator Providers	Out-of-network Providers
Preventive Care			
Well baby/Well child care	Not available	No Deductible, 0%	No Deductible, 20%
Preventive physicals	No Deductible, 0%	No Deductible, 0%	No Deductible, 20%
Well woman visits	No Deductible, 0%	No Deductible, 0%	No Deductible, 20%
Preventive mammograms	Not available	No Deductible, 0%	No Deductible, 20%
Immunizations	No Deductible, 0%	No Deductible, 0%	No Deductible, 20%
Preventive and diagnostic colonoscopy	Not available	No Deductible, 0%	No Deductible, 20%
Prostate cancer screening	Not available	No Deductible, 0%	No Deductible, 20%
Preventive electron beam tomography (EBT)	Not available	No Deductible, 0%	No Deductible, 20%
Professional Services			
Office and home visits	No Deductible, 0%	First three visits, no Deductible, $5. Subsequent visits, no Deductible, $25*	No Deductible, $25 plus 20%
Naturopath office visits	No Deductible, 0%	No Deductible, $25	No Deductible, $25 plus 20%
Specialist office and home visits	No Deductible, 0%	No Deductible, $25	No Deductible, $25 plus 20%
Telehealth visits	No Deductible, 0%	First three visits, no Deductible, $5. Subsequent visits, no Deductible, $25*	No Deductible, $25 plus 20%
Office procedures and supplies	No Deductible, 0%	After Deductible, 20%	After Deductible, 40%
Skin lesion removal in the Provider's office	Not available	No Deductible, 20%	No Deductible, 40%
Nutritional counseling	No Deductible, 0%	No Deductible, 0%	No Deductible, 20%
Surgery	No Deductible, 0%	After Deductible, 20%	After Deductible, 40%
Outpatient Rehabilitation and Habilitation Services	Not available	After Deductible, $10	After Deductible, 40%
Hospital Services			
Inpatient room and board	Not available	After Deductible, $100 plus 20%	After Deductible, $100 plus 40%

Service/Supply	Deschutes County Onsite Clinic Providers	Navigator Providers	Out-of-network Providers
Inpatient Rehabilitation and Habilitation Services	Not available	After Deductible, 20%	After Deductible, 40%
Skilled nursing facility care	Not available	After Deductible, 20%	After Deductible, 40%
Outpatient Services			
Diagnostic and Supplemental Breast Examinations	Not available	No Deductible, 0%	No Deductible, 20%
Outpatient surgery/services	Not available	After Deductible, 20%	After Deductible, 40%
Diagnostic imaging – advanced	Not available	No Deductible, 20%	No Deductible, 40%
Diagnostic and therapeutic radiology/laboratory – non-advanced	No Deductible, 0%	No Deductible, 20%	No Deductible, 40%
Dialysis	Not available	No Deductible, 20%	No Deductible, 40%
Urgent and Emergency Services			
Urgent care center visits - professional	No Deductible, 0%	No Deductible, $25	No Deductible, $25 plus 20%
Urgent care center visits - facility	No Deductible, 0%	After Deductible, 20%	After Deductible, 20%
Emergency room visits – medical emergency	Not available	After Deductible, $100 plus 20%^	After Deductible, $100 plus 20%^
Emergency room visits – non-emergency	Not available	Not covered	Not covered
Ambulance, ground	Not available	After Deductible, 20%	After Deductible, 20%
Ambulance, air	Not available	After Deductible, 20%	After Deductible, 20%
Maternity Services**			
Physician/Provider services (Global Charge)	Not available	No Deductible, 12%	After Deductible, 40%
Hospital/Facility services	Not available	After Deductible, 20%	After Deductible, 40%
Mental Health and Substance Use Disorder Services			
Office visits	No Deductible, 0%	First three visits, no Deductible, $5. Subsequent visits, no Deductible, $25*	No Deductible, $25 plus 20%
Inpatient care	Not available	After Deductible, 20%	After Deductible, 40%

Service/Supply	Deschutes County Onsite Clinic Providers	Navigator Providers	Out-of-network Providers
Residential programs	Not available	After Deductible, 20%	After Deductible, 40%
Other Covered Services			
Allergy injections	No Deductible, 0%	No Deductible, $5	No Deductible, $5 plus 20%
Durable medical equipment	Not available	After Deductible, 20%	After Deductible, 40%
Pediatric hearing aids (ages 18 and younger or 19 to 25 if enrolled in secondary school or an accredited education institution)– limited to one hearing aid per ear every 24 months.	Not available	No Deductible, 20%	No Deductible, 40%
Adult hearing aids – limited to one hearing aid per ear up to a maximum of $2,500 every 24 months.	Not available	After Deductible, 50%	After Deductible, 50%
Home health services	Not available	After Deductible, 20%	After Deductible, 40%
Chiropractic manipulations/spinal manipulations (Limited to 24 visits per Benefit Year)* **	Not available	No Deductible, $25	No Deductible, $25
Acupuncture (Limited to 24 visits per Benefit Year)	Not available	No Deductible, $25	No Deductible, $25
Massage therapy (Limited to $1,200 per Benefit Year)	Not available	No Deductible, $25	No Deductible, $25
Transplants	Not available	After Deductible, 20%	After Deductible, 40%
Obesity services (Limited to 26 visits per Benefit Year)	Not available	No Deductible, 0%	No Deductible, 20%
Temporomandibular joint (TMJ) (Lifetime Maximum of $2,000)	Not available	After Deductible, 50%	After Deductible, 50%

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

^ Copay applies to ER physician and facility charges only. Copay waived if admitted into Hospital.

** Medically necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six weeks postpartum will not be subject to a Deductible, Copayment, or Coinsurance.
*** Physical Therapy services performed by a chiropractor will apply to the Outpatient Rehabilitation benefit and not apply under the alternative care benefit.
* First 3 visits per Benefit Year combined for Professional Services – Office and Home Visits, Telehealth Visits, and Mental Health and Substance Use Disorder Services – Office Visits.

Additional information

What is the Deductible?

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

In-network expense and out-of-network expense apply together toward your Deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for Covered Services during the Benefit Year. Once the out-of-pocket limit has been met, this Plan will pay 100 percent of allowed amounts for Covered Services for the rest of that Benefit Year. The individual out-of-pocket limit applies only if you enroll without Dependents. If you and one or more Dependents enroll, the individual out-of-pocket limit applies for each Member only until the family out-of-pocket limit has been met. Be sure to check the Plan Document, as there are some charges, such as non-Essential Health Benefits, penalties, and Balance Billed amounts that do not count toward the out-of-pocket limit.

In-network expense and out-of-network expense apply together toward your out-of-pocket limits. After the in-network out-of-pocket limit is met, out-of-network expense continues to apply to the out-of-network out-of-pocket limit until the out-of-network out-of-pocket limit is met.

Payments to Providers

Payment to Providers is based on the prevailing or Allowable Fee for Covered Services. In-network Providers accept the Allowable Fee as payment in full. Services of Out-of-network Providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior Authorization

Coverage of certain medical services and Surgical Procedures requires a Benefit Determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for in-network and Out-of-network Providers. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business)

Discrimination is against the law

Both the Plan Sponsor and PacificSource Health Plans comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan Sponsor and PacificSource do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MEDICAL BENEFIT SUMMARY
High Deductible Plan

Group Name: Deschutes County
Group Number: G0037173
Provider Network: Navigator
Benefit Year: Calendar Year

Employee Eligibility Requirements

Minimum Hour Requirement: Twenty (20) hours per week

Waiting Period Requirement: First of the month following hire

- 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(immediate benefits, either that day or back to the first of the month).
- If you are hired after the first business day of the month, your benefits will start on the first day of the following month.

- After satisfying the waiting period, elected officials* of the County and their eligible dependents are eligible for the Plan without regard to the number of hours worked by each such Official. Coverage will end at the end of the month in which they are no longer serving as an elected official of the County.

  *Elected Officials:

  - Three County Commissioners,
  - County Sheriff,
  - District Attorney,
  - County Assessor,
  - County Clerk,
  - Justice of the Peace,
  - County Treasurer.

Deductible Per Benefit Year	Deschutes County Onsite Clinic Providers	Navigator Providers and Out-of-network Providers	
Individual/Family	None / None	$2,500 / $5,000	
Out-of-Pocket Limit Per Benefit Year	**Deschutes County Onsite Clinic Providers**	**Navigator Providers**	**Out-of-network Providers**
Individual/Family	None / None	$5,000 / $10,000	$10,000 / $20,000

Note: Your actual costs for services provided out-of-network may exceed this Plan's out-of-pocket limit for out-of-network services. In addition, Out-of-network Providers may in certain circumstances bill you for the difference between the amount charged by the Provider and the amount allowed by this Plan (called Balance Billing). Balance Billing amounts are not counted toward the out-of-network out-of-pocket limit. For additional information about Balance Billing or Allowable Fee, please see the Definitions Section of the Plan Document.

The Member is responsible for any amounts shown above, in addition to the following amounts:

Service/Supply	Deschutes County Onsite Clinic Providers Member Pays	Navigator Providers Member Pays	Out-of-network Providers Member Pays
Preventive Care			
Well baby/Well child care	Not available	No Deductible, 0%	No Deductible, 20%
Preventive physicals	No Deductible, 0%	No Deductible, 0%	No Deductible, 20%
Well woman visits	No Deductible, 0%	No Deductible, 0%	No Deductible, 20%
Preventive mammograms	Not available	No Deductible, 0%	No Deductible, 20%
Immunizations	No Deductible, 0%	No Deductible, 0%	No Deductible, 20%
Preventive and diagnostic colonoscopy	Not available	No Deductible, 0%	No Deductible, 20%
Prostate cancer screening	Not available	No Deductible, 0%	No Deductible, 20%
Preventive electron beam tomography (EBT)	Not available	No Deductible, 0%	No Deductible, 20%
Professional Services			
Office and home visits	No Deductible, 0%	First three visits, no Deductible, $5. Subsequent visits, no Deductible, $25*	No Deductible, $25 plus 20%
Naturopath office visits	No Deductible, 0%	No Deductible, $25	No Deductible, $25 plus 20%
Specialist office and home visits	No Deductible, 0%	No Deductible, $25	No Deductible, $25 plus 20%
Telehealth visits	No Deductible, 0%	First three visits, no Deductible, $5. Subsequent visits, no Deductible, $25*	No Deductible, $25 plus 20%
Office procedures and supplies	No Deductible, 0%	After Deductible, 20%	After Deductible, 40%
Skin lesion removal in the Provider's office	Not available	No Deductible, 20%	No Deductible, 40%
Nutritional counseling	No Deductible, 0%	No Deductible, 0%	No Deductible, 20%
Surgery	No Deductible, 0%	After Deductible, 20%	After Deductible, 40%
Outpatient Rehabilitation and Habilitation Services	Not available	After Deductible, $10	After Deductible, 40%
Hospital Services			
Inpatient room and board	Not available	After Deductible, $100 plus 20%	After Deductible, $100 plus 40%

Service/Supply	Deschutes County Onsite Clinic Providers Member Pays	Navigator Providers Member Pays	Out-of-network Providers Member Pays
Inpatient Rehabilitation and Habilitation Services	Not available	After Deductible, 20%	After Deductible, 40%
Skilled nursing facility care	Not available	After Deductible, 20%	After Deductible, 40%
Outpatient Services			
Diagnostic and Supplemental Breast Examinations	Not available	No Deductible, 0%	No Deductible, 20%
Outpatient surgery/services	Not available	After Deductible, 20%	After Deductible, 40%
Diagnostic imaging – advanced	Not available	No Deductible, 20%	No Deductible, 40%
Diagnostic and therapeutic radiology/laboratory – non-advanced	No Deductible, 0%	No Deductible, 20%	No Deductible, 40%
Dialysis	Not available	No Deductible, 20%	No Deductible, 40%
Urgent and Emergency Services			
Urgent care center visits - professional	No Deductible, 0%	No Deductible, $25	No Deductible, $25 plus 20%
Urgent care center visits - facility	No Deductible, 0%	After Deductible, 20%	After Deductible, 40%
Emergency room visits – medical emergency	Not available	After Deductible, $100 plus 20%^	After Deductible, $100 plus 20%^
Emergency room visits – non-emergency	Not available	Not covered	Not covered
Ambulance, ground	Not available	After Deductible, 20%	After Deductible, 20%
Ambulance, air	Not available	After Deductible, 20%	After Deductible, 20%
Maternity Services**			
Physician/Provider services (Global Charge)	Not available	No Deductible, 12%	After Deductible, 40%
Hospital/Facility services	Not available	After Deductible, 20%	After Deductible, 40%
Mental Health and Substance Use Disorder Services			
Office visits	No Deductible, 0%	First three visits, no Deductible, $5. Subsequent visits, no Deductible, $25*	No Deductible, $25 plus 20%

Service/Supply	Deschutes County Onsite Clinic Providers Member Pays	Navigator Providers Member Pays	Out-of-network Providers Member Pays
Inpatient care	Not available	After Deductible, 20%	After Deductible, 40%
Residential programs	Not available	After Deductible, 20%	After Deductible, 40%
Other Covered Services			
Allergy injections	No Deductible, 0%	No Deductible, $5	No Deductible, $5 plus 20%
Durable medical equipment	Not available	After Deductible, 20%	After Deductible, 40%
Pediatric hearing aids (ages 18 and younger or 19 to 25 if enrolled in secondary school or an accredited education institution)– limited to one hearing aid per ear every 24 months.	Not available	No Deductible, 20%	No Deductible, 40%
Adult hearing aids – limited to one hearing aid per ear up to a maximum of $2,500 every 24 months.	Not available	After Deductible, 50%	After Deductible, 50%
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Massage therapy (Limited to $1,200 per Benefit Year)	Not available	No Deductible, $25	No Deductible, $25
Transplants	Not available	After Deductible, 20%	After Deductible, 40%
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In-network expense and out-of-network expense apply together toward your Deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for Covered Services during the Benefit Year. Once the out-of-pocket limit has been met, this Plan will pay 100 percent of allowed amounts for Covered Services for the rest of that Benefit Year. The individual out-of-pocket limit applies only if you enroll without Dependents. If you and one or more Dependents enroll, the individual out-of-pocket limit applies for each Member only until the family out-of-pocket limit has been met. Be sure to check the Plan Document, as there are some charges, such as non-Essential Health Benefits, penalties, and Balance Billed amounts that do not count toward the out-of-pocket limit.

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Payments to Providers

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Benefit Year: Calendar Year

The following shows the vision benefits available under this Plan for all covered vision exams, lenses, and frames when performed or prescribed by a licensed ophthalmologist or licensed optometrist. Copayment and/or Coinsurance for Covered Services apply to the medical out-of-pocket limit.

Member Responsibility

Service/Supply	Deschutes County Onsite Clinic Providers Member Pays	Navigator Providers and Out-of-network Providers Member Pays
Members Age 18 and Younger		
Eye exam	Not available	No Deductible, 0%
Vision hardware	Not available	No Deductible, 0% up to $250, After Deductible, 20%
Members Age 19 and Older		
Eye exam	Not available	No Deductible, $25
Vision hardware	Not available	No Deductible, 0% up to $250 maximum benefit, then Member responsibility

Benefit Limitations: Members age 18 and younger

- One vision exam every Benefit Year (includes contact lens fitting).
- Vision hardware includes glasses (lenses and frames) and/or contact lenses.
- Corrective eye surgery is covered up to a Lifetime Maximum of $250 per eye. This includes reversals, revision, surgical procedures, and any complications.

Benefit Limitations: Members age 19 and older

- One vision exam every Benefit Year (includes contact lens fitting).
- Vision hardware includes glasses (lenses and frames), and/or contact lenses. Benefit maximum is per Benefit Year.
- Corrective eye surgery is covered up to a Lifetime Maximum of $250 per eye. This includes reversals, revision, surgical procedures, and any complications.
- Lens tint is covered.

Exclusions

- Anti-reflective coatings and scratch resistant coatings.
- Charges for services or supplies covered in whole or in part under any medical or vision benefits provided by an employer.

- Expenses covered under any workers' compensation law.
- Eye exams required as a condition of employment, required by a labor agreement or government body.
- Medical or surgical treatment of the eye (other than as specifically noted above).
- Non-prescription lenses.
- Plano contact lenses.
- Services or supplies not listed as Covered Services.
- Services or supplies received before this Plan's coverage begins or after it ends.
- Special procedures, such as orthoptics or vision training.
- Special supplies, such as plain sunglasses and subnormal vision aids.
- Visual analysis that does not include refraction.

Important information about your vision benefits

This Plan includes coverage for vision services. To make the most of those benefits, it's important to keep in mind the following:

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

Paying for Services: Provider contracts require In-network Providers to bill PacificSource directly whenever you receive Covered Services and supplies. Providers will verify your vision benefits.

In-network Providers should not ask you to pay the full cost in advance. They may only collect your share of the expense up front, such as Copayments and amounts over this Plan's maximum benefit. If you are asked to pay the entire amount in advance, tell the Provider you understand they have a contract with PacificSource and they should bill PacificSource directly.

Sales and Special Promotions: Vision retailers often use coupons and promotions to bring in new business, such as free eye exams, two-for-one glasses, or free lenses with purchase of frames. Because In-network Providers already discount their services through their contract with PacificSource, this Plan's in-network benefits cannot be combined with any other discounts or coupons. You can use this Plan's in-network benefits, or you can use this Plan's out-of-network benefits to take advantage of a sale or coupon offer.

If you do take advantage of a special offer, the In-network Provider may treat you as an uninsured customer and require full payment in advance. You can then send the claim to PacificSource yourself, and this Plan will reimburse you according to this Plan's out-of-network benefits.

Prescription Drug Benefit Maximum Out-of-Pocket amounts

Out-of-Pocket Limit	Per Person, Per Calendar Year	Per Family, Per Calendar Year
Standard Plan	$1,200	$3,600
High Deductible Plan	$1,200	$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 Prescriptions 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.

Note: If the covered member's physician prescribes a generic drug, but a brand name drug is purchased, the covered Member must pay the Copayment plus the difference in the generic and brand name cost. These differences may not apply to the out-of-pocket amounts; unless brand name is prescribed out of medical necessity.

ONSITE CLINIC – DESCHUTES COUNTY ONSITE CLINIC PHARMACY SERVICES (541) 385-1071

	Generic Drugs:	Formulary Drugs:	Non-Formulary and Compound Drugs:
Limited to a 30-day supply:			
Copayment	$2 Copayment	$20 Copayment	$40 Copayment
Limited to a 90-day supply:			
Copayment	$4 Copayment	$40 Copayment	$80 Copayment
Note: Prescriptions filled through the Deschutes Onsite Clinic Pharmacy are available for up to a 90-day supply. Mail order maintenance medications are excluded in certain locations. Specialty medications are limited to a 30 day supply. ***Prescriptions for female contraceptives, tobacco cessation drugs or products, and certain vaccines and immunizations are available at no cost to the Covered Person.*** ***Insulin Copayments will not exceed $85 for a 30 day supply or $255 for a 90 day supply***			

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

RETAIL – PRESCRYPTIVE HEALTH (206) 686-9016

30 Day Retail Pharmacy Option – Limited to a 34-day supply:

	Generic Drugs:	Formulary Drugs:	Non-Formulary and Compound Drugs:
Limited to a 34-day supply:			
Copayment	$20 Copayment	Greater of 20% Coinsurance or $50 Copayment up to a maximum of $100	Greater of 20% Coinsurance or $75 Copayment up to a maximum of $125
Note: Insulin Copayments will not exceed $85 for a 30 day supply			

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

	Generic Drugs:	Formulary Drugs:	Non-Formulary and Compound Drugs:
Limited to a 34-day supply:			
Copayment		No Charge	

Retail Expense Submitted by Employee:

	Generic Drugs:	Formulary Drugs:	Non-Formulary and Compound Drugs:
Limited to a 34-day supply:			
Coinsurance		50% Coinsurance	
Note: If a drug is purchased from an out-of-network pharmacy, or an in-network 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 Prescryptive Health for reimbursement less any applicable Copayment as shown above.			

90 DAY RETAIL (UP TO A 100 DAY SUPPLY) OR MAIL ORDER

MAIL ORDER – WALMART HOME DELIVERY (800) 273-3455

WWW.WALMART.COM/HOMEDELIVERY

90 DAY RETAIL OR MAIL ORDER PHARMACY OPTION – LIMITED TO A 100-DAY SUPPLY:

	Generic Drugs:	Formulary Drugs:	Non-Formulary and Compound Drugs:
Limited to a 100-day supply:			
Copayment	$40 Copayment	Greater of 20% Coinsurance or $100 Copayment up to a maximum of $200	Greater of 20% Coinsurance or $150 Copayment up to a maximum of $300

Note: Insulin Copayments will not exceed $255 for a 90 day supply

Mail Order Pharmacy Option – Diabetes management for covered Pregnant Women (i.e., diabetic medications and supplies):

	Generic Drugs:	Formulary Drugs:	Non-Formulary and Compound Drugs:
Limited to a 100-day supply:			
Copayment		No Charge	

The following will be covered at 100%, no Copayment required:

- 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).

- 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 covered female members with reproductive capacity.

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

- 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 an in-network 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 Prescryptive at (206) 686-9016 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 Drugs section of this Plan Document.

UNDERSTANDING HOW YOUR BENEFITS ARE PAID

This section of the Plan Document contains information to help you understand the benefits of this Plan and how certain aspects of this Plan work, including Deductibles, Copayments, Coinsurance, out-of-pocket limits, and benefit maximums. For more information, see the Benefit Summaries for Plan details.

BENEFIT YEAR

Calendar Year

Many benefits and provisions in this Plan are calculated on a calendar year basis. Each January 1, these provisions renew and may change, and you must satisfy the new or revised amounts for that year. Any benefit with a separate maximum benefit (for example, not on a calendar year basis) is identified in the Covered Services section of this Plan Document.

If this Plan renews or is modified mid-calendar year, the previously satisfied Deductibles and benefit maximums will be credited toward the renewed or modified Plan.

DEDUCTIBLE

This Plan may require you to satisfy a Deductible before this Plan will pay benefits. Except for certain services that do not require satisfaction of the Deductible, this Plan will only begin to pay benefits for Covered Services once a Member satisfies the Deductible by incurring a specific amount of expenses during the Benefit Year. The amount that accrues to the Deductible is the Allowable Fee.

Your expenses for the following do not count toward the Deductible and will be your responsibility:

- Charges over the Allowable Fee;
- Charges for non-Covered Services; and
- Charges for any Coinsurance or Copayments.

Covered Services used to satisfy the Deductible also accrue to the annual or Lifetime Maximums, if any apply.

COPAYMENT

This Plan may include a Copayment on certain services or supplies each time you receive a specified service or supply. Copayments are fixed dollar amounts. Any Copayment required will be the lesser of the fixed dollar amount or the Allowable Fee for the service or supply. The Provider will collect any Copayment.

COINSURANCE

After a Member has satisfied the individual Deductible or the family Deductible, if any applies, this Plan may include a Coinsurance payment on certain services or supplies each time you receive a specified service or supply until a Member meets any applicable out-of-pocket limit. Coinsurance is a percentage of the Allowable Fee. Any Coinsurance required will be based on the lesser of the billed charges or the Allowable Fee. The Provider will bill you and collect any Coinsurance payment.

OUT-OF-POCKET LIMIT

This Plan has an out-of-pocket limit provision. The Benefit Summaries show this Plan's annual out-of-pocket limits. If you incur Covered Services over those amounts, this Plan will pay 100 percent of the Allowable Fee for the remainder of the Benefit Year.

The allowed amounts Members pay for Covered Services will accrue toward the annual out-of-pocket limit except for the following, which will continue to be your responsibility:

- Charges for non-Covered Services.
- Incurred charges that exceed amounts allowed under this Plan.

ESSENTIAL HEALTH BENEFITS

Except for pediatric dental which is not included in this Plan, this Plan covers the Essential Health Benefits as defined by the Secretary of the U.S. Department of Health and Human Services. Annual and Lifetime Maximum dollar limits will not be applied for any service that is an Essential Health Benefit.

UNDERSTANDING MEDICAL NECESSITY

In order for a service or supply to be covered, it must be both a Covered Service *and* Medically Necessary.

Be careful – just because a treatment is prescribed or recommended by a Provider does not mean it is Medically Necessary under the terms of this Plan. This Plan provides coverage only when such care is necessary to treat an Illness or Injury or the service qualifies as preventive care. All treatment is subject to review for Medical Necessity. Review of treatment may involve prior authorization, concurrent review of the continuation of treatment, post-treatment review, or any combination of these. A second opinion (at no cost to you when requested by PacificSource or the Plan Sponsor) may be required for a Medical Necessity determination.

Some Medically Necessary services are not Covered Services. Medically Necessary services and supplies that are specifically excluded from coverage under this Plan can be found in the Benefit Exclusions section.

If you ever have a question about your benefits, contact the PacificSource Customer Service team.

UNDERSTANDING EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN SERVICES

This Plan does not cover services or treatments that are Experimental, Investigational, or Unproven.

To ensure you receive the highest quality care at the lowest possible cost, PacificSource, on behalf of the Plan Sponsor, reviews new and emerging technologies and medications on a regular basis. PacificSource's internal committees make decisions about coverage of these methods and medications based on literature reviews, standards of care and coverage, consultations, and review of Evidence-based Criteria. In addition, if you seek services from a Provider outside Idaho, Montana, Oregon, and Washington, PacificSource may delegate the development and use of Evidence-based Criteria to a third party for such services. You and your Provider may request information regarding the criteria for determining these services or treatments. The Plan Sponsor has sole and complete authority to determine what is and is not covered under the terms of the Plan.

ELIGIBLE PROVIDERS

This Plan provides benefits only for Covered Services and supplies rendered by an eligible Provider, Hospital, Specialized Treatment Facility, Durable Medical Equipment Supplier, or other licensed medical Providers. The services or supplies provided by individuals or companies that are not specified as eligible Providers are not eligible for reimbursement under the benefits of this Plan. To be eligible, the Providers must be practicing within the scope of their licenses.

COVERED SERVICES

This section of the Plan Document contains information about the benefits provided under this Plan. The following list of benefits is exhaustive. You are responsible for all charges for services that are not a Covered Service.

As described in the prior section, these services and supplies may require you to satisfy a Deductible, make a Copayment, and/or pay Coinsurance. They may be subject to additional limitations or maximum dollar amounts (maximum dollar amounts do not apply to Essential Health Benefits). For an expense to be eligible for payment, you must be a Member of this Plan on the date the expense is incurred and eligible Providers practicing within the scope of their licenses must render the services. A treatment or service may be Medically Necessary, yet not be a Covered Service. For information about exclusions, see the Benefit Exclusions section.

Subject to all the terms of this Plan, the following services and supplies are covered according to the Benefit Summaries.

PREVENTIVE CARE SERVICES

This Plan covers preventive care services in accordance with the age limits and frequency guidelines according to the recommendations of the United States Preventive Services Task Force (USPSTF) – the A and B list of preventive services, the Health Resources and Services Administration (HRSA), and by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

For a list of the services that fall within this benefit, please visit the USPSTF website, uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations or the HRSA website, hrsa.gov/womens-guidelines (note that these websites may change). If you do not have Internet access or have additional questions, please contact the PacificSource Customer Service team for a complete description of the preventive services lists. Below are some of the services that fall within this benefit. In addition to the Affordable Care Act (ACA) required benefits as explained above, the list also includes state mandated benefits.

Colorectal Cancer Screening

This Plan covers colorectal cancer screening as required under ACA. Screening coverage includes a follow up colonoscopy performed after a positive non-invasive stool based screening or direct visualization. For colorectal cancer screenings not required to be covered as preventive under ACA, see the Diagnostic and Therapeutic Radiology/Laboratory– (non-advanced) section. The benefit includes coverage for fecal immunochemical test (FIT) – DNA commonly called Cologard.

Electron Beam Tomography

Preventive Electron Beam Tomography (EBT) is covered.

Immunizations

This Plan covers age-appropriate childhood and adult immunizations for primary prevention of infectious diseases as recommended and adopted by the USPSTF, CDC, or similar standard-setting body. This benefit does not include immunizations that are determined to be elective or Experimental, Investigational, or Unproven.

Preventive Physicals

This Plan covers appropriate screening radiology and laboratory tests and other screening procedures. Screening exams and laboratory tests may include, but not limited to, depression screening for all adults including pregnant and postpartum women, blood pressure checks, weight checks, occult blood tests, urinalysis, complete blood count, prostate exams, cholesterol exams, stool guaiac screening, EKG screens, blood sugar tests, and tuberculosis skin tests. Only laboratory tests and other routine screening procedures related to the preventive physical are covered by this benefit. Diagnostic radiology and laboratory services outside the scope of the preventive physical will be subject to the standard cost sharing.

- Benefits are limited as follows: Age 22 and older once per Benefit Year

Prostate Cancer Screening

This Plan covers appropriate screening that includes, but not limited to, a digital rectal exam and a prostate-specific antigen test.

Tobacco Cessation Program Services

This Plan covers Tobacco Cessation Program services.

Weight Reduction or Control Services

This Plan covers intensive behavioral interventions for children ages six and older and adults who qualify as obese, as required under the USPSTF recommendations.

Well Baby/Well Child Care

This Plan covers well baby/well child examinations. Only laboratory tests and other routine screening procedures related to the well baby/well child exam are covered by this benefit. Diagnostic radiology and laboratory services outside the scope of the preventive physical will be subject to the standard cost sharing.

- Benefits are limited as follows:
  - At birth: One standard in-Hospital exam
  - Ages 0-2: 12 additional exams during the first 36 months of life
  - Ages 3-21: One exam per Benefit Year

Well Woman Care

This Plan covers ACA recommended Women's Healthcare Services. Services include, but not limited to, preventive mammograms including 3D, preventive gynecological exams, pelvic exams, pap

smears, and maternity related services to be covered as preventive under the ACA. For diagnostic mammograms, see the Diagnostic and Therapeutic Radiology/Laboratory– (non-advanced) section.

PROFESSIONAL SERVICES

Acupuncture

This Plan covers services for acupuncture.

- Benefits are limited as follows: Up to 24 visits per Benefit Year.

Audiological Tests

This Plan covers audiological (hearing) tests.

Biofeedback

This Plan covers biofeedback services to treat migraine headaches or urinary incontinence.

- Benefits are limited as follows: Lifetime Maximum of ten sessions.

Cardiac Rehabilitation

This Plan covers Cardiac Rehabilitation.

- Benefits are limited as follows:
  - Phase I (inpatient) services are covered under inpatient Hospital benefits.
  - Phase II (short term outpatient) services provided in connection with a Cardiac Rehabilitation exercise program that does not exceed a Lifetime Maximum of 36 visits.
  - Phase III (long-term outpatient) services are not covered.

Child Abuse Medical Assessments

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

Chiropractic Manipulation/Spinal Manipulation

This Plan covers services for chiropractic manipulation/spinal manipulation.

- Benefits are limited as follows: Up to 24 visits per Benefit Year.

Clinical Trials (Approved)

This Plan covers Routine Costs of Care associated with Approved Clinical Trials for qualified individuals. Expenses for services or supplies that are not considered Routine Costs of Care are not covered. A qualified individual is a Member who is eligible to participate in an Approved Clinical Trial

and either the referring Provider is an In-network Provider and has concluded that the trial would be appropriate for the Member, or the Member provides medical or scientific information establishing that the trial would be appropriate. If an In-network Provider is participating in an Approved Clinical Trial, the Member may be required to participate in the trial through that In-network Provider if the Provider will accept the Member as a participant.

Cosmetic or Reconstructive Surgery

This Plan provides cosmetic or reconstructive services in the following situations:

- When necessary to correct a functional disorder or Congenital Anomaly;
- When necessary because of an Accidental Injury or Illness, or to correct a scar or defect that resulted from treatment of an Accidental Injury or Illness;
- When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery; or
- When necessary for gender affirmation.

Cosmetic or reconstructive surgery is provided for one attempt and must take place within 18 months after the Injury, surgery, scar, or defect first occurred unless determined otherwise through Medical Necessity review.

Some cosmetic or reconstructive surgeries require prior authorization. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Craniofacial Anomalies

This Plan covers dental and orthodontic services for the treatment of craniofacial anomalies when Medically Necessary to restore function. Coverage includes, but not limited to, physical disorders identifiable at birth that affect the bony structure of the face or head, such as a cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome. Coverage is limited to the least costly clinically appropriate treatment. Cosmetic procedures and procedures to improve on the normal range of functions are not covered.

Dietary or Nutritional Counseling

This Plan covers services for prediabetes education via National Diabetes Prevention Programs, diabetic education, management of inborn errors of metabolism, and management of eating disorders if provided by a qualified Provider or as required under ACA for obesity screening and counseling. Counseling will also be provided for women 40 to 60 years of age with normal or overweight body mass to maintain weight or limit weight gain to prevent obesity.

Foot Care

This Plan covers routine foot care for Members with diabetes mellitus.

Gender Affirmation

When Medically Necessary to treat a mental health diagnosis, this Plan covers Medically Necessary gender affirming services and related procedures, and requires prior authorization.

Genetic Counseling

This Plan covers services of a board-certified or board-eligible genetic counselor for evaluation of genetic disease.

Inborn Errors of Metabolism

This Plan covers treatment for inborn errors of metabolism involving amino acid, carbohydrate, and fat metabolism for which widely accepted standards of care exist for diagnosis, treatment, and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage includes expenses for diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including, but not limited to, clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.

Injectable Drugs and Biologicals

This Plan covers injectable drugs and biologicals when administered by a Provider and Medically Necessary for diagnosis or treatment of an Illness or Injury. For information about drugs or biologicals that can be self-administered or are dispensed to a Member, see the Prescription Drugs section.

Injury of the Jaw or Natural Teeth

This Plan covers the services of a Provider to treat Injury of the jaw or natural teeth. Except for the initial examination, such services require prior authorization.

- Benefits are limited as follows: Services must be provided within 18 months of the Injury.

Massage Therapy Services

This Plan covers services for massage therapy by a Provider for treatment of myofascial, neuromusculoskeletal, or pain syndromes.

- Benefits are limited as follows: Up to $1,200 per Benefit Year.

Newborn Nurse Home Visiting Services

This Plan covers newborn nurse home visiting services for a newborn child up to the age of six months.

Office Visits and Urgent Care Visits

This Plan covers office visits and treatments, including associated supplies and services such as therapeutic injections and related supplies.

This Plan covers Urgent Care visits, including facility costs and supplies at the Urgent Care Treatment Facility. This benefit includes a visit requested by the Member for the purpose of obtaining a second opinion regarding a covered medical diagnosis or treatment plan.

All professional services performed in the office that are billed separately from the office visit or are not related to the actual visit (for example, separate laboratory services billed in conjunction with the office visit) are not considered part of the office visit and are subject to the applicable benefit for such service.

Obesity Services (Interventions)

This Plan covers obesity services (interventions) when Plan Sponsor criteria is met. Covered Services include Provider-directed intensive, multicomponent behavioral interventions for weight management for Members age 18 and older with a body mass index (BMI) of 30 kg/m2 or higher. Prior to seeking services for this benefit, contact the PacificSource Customer Service team for eligibility.

- Benefits are limited as follows: Limited to 26 visits per Benefit Year. Bariatric surgery and other gastric restrictive procedures, or the revision of these procedures, and related services are not covered. Medications for weight reduction control and all categories of obesity are not covered.

Orthognathic (Jaw) Surgery

This Plan covers services of a Provider for orthognathic (jaw) surgery.

- Benefits are limited as follows:
  - When Medically Necessary to repair an Accidental Injury. Services must be provided within 120 days after the Accident; or
  - For removal of a malignancy, including reconstruction of the jaw within 120 days after that surgery.

Pediatric Dental Care Requiring General Anesthesia

This Plan covers facility charges of a Hospital or Ambulatory Surgical Center.

- Benefits are limited as follows: One visit per Benefit Year and is subject to prior authorization.

Skin Lesion Removal

This Plan covers the Medically Necessary removal of benign skin lesions, including but not limited to, skin tags, benign seborrheic keratosis, sebaceous, and viral warts, when removal is performed in a Provider's office.

Sleep Studies

This Plan covers sleep studies when ordered by a pulmonologist, neurologist, otolaryngologist, internist, family practitioner, or certified sleep medicine specialist.

Surgery

This Plan covers surgery and other outpatient services performed in a Providers office or an Ambulatory Surgical Center. Some surgeries require prior authorization. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Telehealth

This Plan covers Medically Necessary Telehealth services when provided by a Provider.

Traumatic Brain Injury

This Plan covers Medically Necessary therapy and services for the treatment of traumatic brain Injury.

AMBULANCE SERVICES

This Plan covers services of a state certified ground or air ambulance to the nearest facility capable of treating the condition, when other forms of transportation will endanger your health. There is no coverage for services that are for personal or convenience purposes. Air ambulance service is only covered when ground transportation is medically or physically inappropriate. Non-emergency ground or air ambulance between facilities requires prior authorization.

BLOOD TRANSFUSIONS

This Plan covers blood, blood products, and blood storage, including services and supplies of a blood bank.

BREAST PROSTHESES

This Plan covers removal, repair, and/or replacement of breast prostheses due to a contracture or rupture, but only when the original prosthesis was for a Medically Necessary Mastectomy. Prior authorization by PacificSource is required, and eligibility for benefits is subject to the following criteria:

- The contracture or rupture must be clinically evident by a Provider's physical examination, imaging studies, or findings at surgery;
- Removal, repair, and/or replacement of the prosthesis is not covered when recommended due to an autoimmune disease, connective tissue disease, arthritis, allergenic syndrome, psychiatric syndrome, fatigue, or other systemic signs or symptoms.

COCHLEAR IMPLANTS

This Plan covers single or bilateral cochlear implants when Medically Necessary, including programming and reprogramming. The cost of repair and replacement parts are covered if the repair or replacement parts are not under warranty. Some services may require prior authorization. You can search for procedures and services that require prior authorization on the PacificSource website, Authgrid.PacificSource.com (select Commercial for the line of business). For more information, see the Durable Medical Equipment section.

CONTRACEPTIVES AND CONTRACEPTIVE DEVICES/FAMILY PLANNING

This Plan covers IUD, diaphragm, and cervical cap contraceptives and contraceptive devices along with their insertion or removal, as well as hormonal contraceptives including injections, formulary oral, patches, and rings prescribed by your Provider. Contraceptive drugs, devices, and other products approved by the Food and Drug Administration (FDA) and on the formulary are covered by this Plan when prescribed.

Over-the-counter contraceptive drugs approved by the FDA, purchased without a prescription, are reimbursable by this Plan.

This Plan covers tubal ligation, vasectomy, and abortion (termination of pregnancy) procedures.

DIABETIC EQUIPMENT, SUPPLIES, AND TRAINING

This Plan covers certain diabetic equipment, supplies, and training, as follows:

- Medications and diabetic supplies will be payable under the separate Prescription Drug Benefits section under this Plan.
- Outpatient and self-management training and education for the treatment of diabetes and National Diabetes Prevention Programs. The training must be provided by a Provider with expertise in diabetes.

- Medically Necessary Telehealth, via two-way electronic communication, provided in connection with the treatment of diabetes.

DIAGNOSTIC AND THERAPEUTIC RADIOLOGY/LABORATORY– (NON-ADVANCED)

This Plan covers diagnostic and therapeutic radiology/laboratory services provided in a Hospital or outpatient setting when ordered by a Provider. These services may be performed or provided by laboratories, radiology facilities, Hospitals, and Providers, including services in conjunction with office visits.

A colonoscopy that is not required to be covered as preventive under ACA, or is performed for the evaluation or treatment of a known medical condition, is paid at no cost share when provided by an In-network Provider. Non-preventive colonoscopies performed by an Out-of-network Provider will be covered under the diagnostic benefit and is subject to cost sharing.

A mammogram, MRI, and ultrasound for a Diagnostic Breast Examination or Supplemental Breast Examination are paid at no cost share when provided by an In-network Provider. See Diagnostic and Supplemental Breast Examinations in the Medical Benefit Summary for out-of-network cost sharing.

This Plan covers therapeutic radiology services and Chemotherapy provided or ordered by a Provider. Covered Services include a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells.

See the Medical Benefit Summary for cost sharing information on benefits (other than colonoscopy which is at no cost share for In-network Providers) that fall under this category.

DIALYSIS

This Plan covers dialysis. Absent an Allowable Fee amount based on the Medicare allowable, benefits for Members who are receiving renal dialysis are limited to 125 percent of the current Medicare allowable amount for In-network and Out-of-network Providers. In all situations and settings, benefits are subject to the Deductibles, Copayments, and/or Coinsurance stated in the Medical Benefit Summary for Outpatient Services – Dialysis.

If a Member obtains a Medicare Part B Supplement Policy upon qualifying for Medicare coverage due to end-stage renal disease (ESRD), the Plan will reimburse the Member for the cost of the applicable Medicare Part B Supplement Policy. Requests for reimbursement must be submitted to the Plan per the Plan policies and procedures.

In order to ensure the correct coordination of claims payments between the Plan and Medicare, Members are required to provide the Plan Administrator with the effective date of Medicare coverage.

DIAGNOSTIC IMAGING – ADVANCED

This Plan covers Medically Necessary advanced diagnostic imaging for the diagnosis of Illness or Injury. For the purposes of this benefit, advanced diagnostic imaging includes CT scans, MRIs, PET scans, CATH labs, and nuclear cardiology studies. Some diagnostic imaging requires prior authorization. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business).

DURABLE MEDICAL EQUIPMENT

This Plan covers services and applicable sales tax for Durable Medical Equipment. Durable Medical Equipment must be prescribed.

This Plan covers Prosthetic Devices and Orthotic Devices to restore or maintain the ability to complete activities of daily living or essential job-related activities and are not for comfort or convenience. Repair or replacement of a Prosthetic Device and Orthotic Device is covered when needed due to normal use. This Plan covers maxillofacial prostheses to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing.

- Benefits are limited as follows:
  - Some Durable Medical Equipment requires a prior authorization. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business). Benefits will be paid toward either the purchase or the rental of the equipment for the period needed, whichever is less. Repair or replacement of equipment is also covered when necessary, subject to all conditions and limitations of this Plan.
  - Only expenses for Durable Medical Equipment, or Prosthetic and Orthotic Devices that are provided by a PacificSource contracted Provider or a Provider that satisfies the criteria of the Medicare fee schedule for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Other Items and Services are eligible for reimbursement.
  - Medically Necessary treatment for sleep apnea and other sleeping disorders is covered. Prior authorization is required. Coverage of oral devices includes charges for consultation, fitting, adjustment, follow-up care, and the appliance. The appliance must be prescribed by a Provider specializing in evaluation and treatment of sleep disorders.
  - Hearing Aids: Hearing Aids, Hearing Assistive Technology Systems, and ear molds are provided in accordance with state and federal law. Contact the PacificSource Customer Service team for specific coverage requirements. Benefits are as follows:
    - For Members age 18 and younger, or age 19 to 25 when enrolled in a secondary school or an accredited educational institution, coverage is limited to a maximum benefit of one Hearing Aid per ear every 24 months.
    - For Members age 19 and older, or age 19 to 25 not enrolled in a secondary school or an accredited educational institution, coverage is limited to a maximum benefit of one Hearing Aid per ear up to a maximum of $2,500 every 24 months.
  - Wheelchairs: Purchase, rental, repair, lease, or replacement of a power-assisted wheelchair (including batteries and other accessories) requires prior authorization and is payable only in lieu of benefits for a manual wheelchair.

- Lenses: Only lenses to correct a specific vision defect resulting from a severe medical or surgical problem are covered subject to the following limitations:
    - The medical or surgical problem must cause visual impairment or disability due to loss of binocular vision or visual field defects (not merely a refractive error or astigmatism) that requires lenses to restore some normalcy to vision.
    - The maximum allowance for glasses (lenses and frames), or contact lenses in lieu of glasses, is limited to one pair per Benefit Year when surgery or treatment is performed on either eye. Other Plan limitations, such as exclusions for extra lenses, other hardware, tinting of lenses, eye exercises, or vision therapy, also apply.
    - Benefits for subsequent Medically Necessary vision corrections to either eye (including an eye not previously treated) are limited to the cost of lenses only.
    - Reimbursement is subject to the Deductible, Copayment, and/or Coinsurance stated in the Medical Benefit Summary for Durable Medical Equipment and is in lieu of, and not in addition to any other vision benefit payable.
- Breast Pumps: Manual and electric breast pumps are covered at no cost share when provided by an In-network Provider, or purchased from a retail outlet, and are limited to once per pregnancy. Hospital-grade breast pumps are not covered.
- Wigs: Wigs following Chemotherapy or Radiation Therapy are covered up to a maximum benefit of $150 per Benefit Year.

Maxillofacial Prosthetic Services

This Plan covers maxillofacial prosthetic services when prescribed by a Provider as necessary to restore and manage head and facial structures. Coverage is provided only when head and facial structures cannot be replaced with living tissue, and are defective because of disease, trauma, or birth and developmental deformities. To be covered, treatment must be necessary to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing.

- Benefits are limited as follows: Coverage is limited to the least costly clinically appropriate treatment, as determined by the Provider. Cosmetic procedures and procedures to improve on the normal range of functions are not covered.

ELEMENTAL ENTERAL FORMULA

This Plan covers Medically Necessary non-prescription elemental enteral formula ordered by a Provider for home use to treat severe intestinal malabsorption disorder when the formula comprises a predominant or essential source of nutrition.

EMERGENCY ROOM – PROVIDER AND FACILITY

This Plan covers an Emergency Medical Screening Exam and Emergency Services to evaluate and treat an Emergency Medical Condition. Any referred services or treatment after discharge from the emergency room will be covered under the applicable benefit for such services and treatment. For Emergency Medical Conditions, Out-of-network Providers are paid at the In-network Provider level. If you are admitted to an out-of-network Hospital, PacificSource will coordinate your transfer to an in-network facility if necessary.

Emergency Medical Screening Exams and Emergency Services, including any diagnostic tests necessary for emergency care (including radiology, laboratory work, CT scans and MRIs) are subject to the Deductibles, Copayment, and/or Coinsurance stated in your Medical Benefit Summary for either Diagnostic and therapeutic radiology/laboratory– (non-advanced) or Diagnostic imaging - advanced, depending on the specific service provided.

Non-emergent services received in the emergency room are not covered.

If you need immediate assistance for a medical emergency, call 911, or go to the nearest emergency room or appropriate facility.

HEALTH EDUCATION BENEFITS

This Plan covers health education benefits. Health education topics usually include matters such as maternity, fitness and education, newborn care and parenting skills, nutrition and healthy heart exercises or CPR skills. Covered services include health-related classes and printed materials required for the class.

- Benefits are limited as follows: Up to $150 per Benefit Year.

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

HOME HEALTHCARE SERVICES

This Plan covers Home Healthcare services, including home infusion services that cannot be self-administered, when provided by a licensed home health agency.

- Benefits are limited as follows: Up to 180 visits per Benefit Year. Covered Services are limited to no more than two visits per day. Private duty nursing is not covered.

HOSPICE CARE SERVICES

This Plan covers Hospice Care services intended to meet the physical, emotional, and spiritual needs of the Member and family during the final stages of Illness and dying, while maintaining the Member in the home setting. Services are to supplement the efforts of an unpaid caregiver and include pastoral care and bereavement services.

This Plan covers respite care provided in a nursing facility to provide relief for the primary caregiver.

- Benefits are limited as follows:
  - Hospice Care: This Plan does not cover services of a primary caregiver such as a relative, friend, or private duty nurse. Care is provided for a terminally ill Member when determined Medically Necessary.
  - Respite care: Care is subject to a maximum of five consecutive days and to a Lifetime Maximum benefit of 30 days. The Member must be enrolled in a hospice program to be eligible for respite care benefits.

INPATIENT SERVICES

Hospital Services

This Plan covers Hospital inpatient services up to the Hospital's semi-private room rate, except when a private room is determined to be necessary.

This Plan covers hospitalization for dental procedures under limited circumstances and requires prior authorization. For more information, see Pediatric Dental Care Requiring General Anesthesia in the Professional Services section.

Inpatient Habilitation

This Plan covers inpatient Habilitation Services when Medically Necessary to help a person keep, learn, or improve skills and functioning for daily living. These services must be consistent with the condition being treated, and must be part of a written treatment program prescribed by a Provider and are subject to concurrent review by PacificSource. Recreation therapy is only covered as part of an inpatient admission.

- Benefits are limited as follows: Up to a combined maximum of 30 days per Benefit Year with extensions subject to Medical Necessity review. Additional treatment may be considered when criteria for individual/supplemental benefits are met.

Inpatient Rehabilitation

This Plan covers inpatient Rehabilitation Services when Medically Necessary to keep, restore or improve skills and function for daily living that have been lost or impaired due to Illness, Injury or disability. Recreation therapy is only covered as part of an inpatient admission.

- Benefits are limited as follows: Up to a combined maximum of 30 days per Benefit Year with extensions subject to Medical Necessity review. Additional treatment may be considered when criteria for individual/supplemental benefits are met.

Mental Health and Substance Use Disorder Services – Inpatient

This Plan complies with all federal laws and regulations related to the Mental Health Parity and Addiction Equity Act of 2008. Treatment of Substance Use Disorder and related disorders is subject to placement criteria established by the American Society of Addiction Medicine, Third Edition.

This Plan covers crisis intervention, diagnosis, and treatment of Behavioral Health Conditions and Substance Use Disorders including withdrawal management by a Mental Health and/or Substance Use Disorder Healthcare Provider or Mental Health and/or Substance Use Disorder Healthcare Program or Mental Health and/or Substance Use Disorder Healthcare Facility, except as otherwise excluded in this Plan. Services are also covered when provided by a qualified Provider for covered diagnoses when the Member is in a Skilled Nursing Facility.

Skilled Nursing Facilities and Convalescent Homes

This Plan covers Skilled Nursing Facilities and Convalescent Homes and are subject to admission notification and concurrent review.

- Benefits are limited as follows: Confinement for Custodial Care is not covered. Benefit is limited to semiprivate room rates.

MATERNITY SERVICES

This Plan covers services of Providers practicing within the scope of their license, for prenatal and postnatal (provided within six weeks of delivery) maternity, childbirth, and complications of pregnancy. A Hospital stay of at least 48 hours (vaginal) or 96 hours (cesarean) is covered.

Medically Necessary services, medication, and supplies to manage diabetes during pregnancy, from conception through six weeks postpartum, will not be subjected to a Deductible, Copayment, or Coinsurance.

This Plan covers routine nursery care of a newborn child born to a Member while the mother is hospitalized and eligible for pregnancy-related benefits under this Plan if the newborn is also eligible and enrolled in this Plan.

This Plan covers labor and delivery services at an out-of-network facility when a Member is unable to be treated by an in-network facility during a declared public health emergency. These services will be paid at the in-network cost sharing amount.

Please contact the PacificSource Customer Service team as soon as you learn of your pregnancy. Their team will explain this Plan's maternity benefits and help you enroll in a prenatal care program.

OUTPATIENT SERVICES

Autism Spectrum Disorder Services and Applied Behavioral Analysis (ABA) Therapy

This Plan covers ABA according to this Plan's guidelines for Medical Necessity. Prior authorization and a treatment plan are required.

Mental Health and Substance Use Disorder Services – Outpatient

This Plan complies with all federal laws and regulations related to the Mental Health Parity and Addiction Equity Act of 2008. Treatment of Substance Use Disorder and related disorders is subject to placement criteria established by the American Society of Addiction Medicine, Third Edition.

This Plan covers crisis intervention, diagnosis, and treatment of Behavioral Health Conditions and Substance Use Disorders including withdrawal management by a Mental Health and/or Substance Use Disorder Healthcare Provider or Mental Health and/or Substance Use Disorder Healthcare Program, except as otherwise excluded in this Plan.

Outpatient Habilitation

This Plan covers Physical/Occupational Therapy, speech therapy, and vision therapy services to help a person keep, learn, or improve skills and functioning for daily living. These services must be part of a written treatment program that includes site, modality, duration, and frequency of treatment.

- Benefits are limited as follows: Up to a combined maximum of 30 visits per Benefit Year with extensions subject to Medical Necessity review. Additional treatment may be considered when criteria for individual/supplemental benefits are met. Treatment of neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which Habilitation Services would be appropriate are covered up to 30 additional visits will be allowed for head and spinal Injury, cardiovascular accident, stroke or major Injury.

Outpatient Rehabilitation

This Plan covers outpatient Rehabilitation Services to help a person keep, restore, or improve skills and function for daily living that have been lost or impaired due to Illness, Injury, or disability and do not include maintenance services. Services must be part of a written treatment program that includes site, modality, duration, and frequency of treatment.

- Benefits are limited as follows: Up to a combined maximum of 30 visits per Benefit Year with extensions subject to Medical Necessity review. Additional treatment may be considered when criteria for individual/supplemental benefits are met. Treatment of neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which Rehabilitation Services would be appropriate are covered up to 30 additional visits will be allowed for head and spinal Injury, cardiovascular accident, stroke or major Injury.

Outpatient pulmonary rehabilitation programs are covered for Members with severe chronic lung disease that interferes with normal daily activities despite optimal medication management.

PRESCRIPTION DRUGS

This Plan includes Prescription Drug benefits through Prescryptive Health Inc In-network Pharmacies including the Walmart Home Delivery 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 the 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.

Contact Information

Prescryptive Health Inc.
206-686-9016

www.prescryptive.com

Walmart Pharmacy
(800) 273-3455
e-Prescribe: Walmart Pharmacy 2625

Amber Specialty Pharmacy
(206) 413-9371

Where to Submit Pharmacy Claims

Pharmacy claims that qualify for member reimbursement can be submitted by going to Prescryptive.com/member-resources and navigating to Member Reimbursement Form.

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 though the Walmart Home Delivery 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 Member purchases a brand name drug, the Member will be required to pay a higher Copayment.

Prior Authorization

Prior Authorization is required for medication that requires review to be approved for coverage. Medication may require Prior Authorization because of the utilization or the expense. Prior Authorization Request Form is available at Prescryptive.com/Member-Resources

What happens when a medication is Medically Necessary but requires Prior Authorization? If it is Medically Necessary to the covered person to receive the medication, the covered person's physician must fill out the Prior Authorization form and submit it to the Prescryptive secure fax machine at (855) 708-4808 or by mail:
Prescryptive Health
Pharmacy Prior Authorization
PO Box 403
Redmond, WA 98073

For any questions about the form or to inquire about the request under review, please call (206) 686-9016.

Payment Schedule

The covered person must pay a Copayment for each prescription filled, as shown in the Prescription Drug Benefit Summary.

Prescriptions Purchased Without the Prescryptive Health Benefit

If a prescription is purchased at a Pharmacy but the participant does not utilize his or her Prescryptive Health benefit at the time of the prescription purchase, , the Member must file a claim with Prescryptive Health using their claim form; a 50% Copayment will be taken.

Mail-Order Information

For an existing prescription, provide Walmart Home Delivery with the information requested on the initial order form and a Walmart pharmacist will transfer the existing prescription to the Walmart Home Delivery Pharmacy. The prescriber can also telephone in refill prescriptions to save time. Refills can be ordered over the telephone with a credit card by calling (800) 273-3455. The prescriber can also telephone or fax new prescriptions to Walmart Home Delivery Pharmacy if the participant has previously provided credit card payment information. Walmart pharmacists automatically contact the prescriber for refills when the prescriptions expire.

Walmart Pharmacists are available for counseling Monday through Friday from 7:00 am to 5:00pm, Pacific Time, at (800) 273-3455.

Walmart Home Delivery 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 two to three 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 any retail pharmacy in the Prescryptive Health network. 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 a 90 day prescription which can be obtained either with the Walmart Home Delivery program or at any retail pharmacy. The covered person should call both their local retail pharmacist and Walmart Home Delivery Pharmacy to verify which pharmacy will be more cost effective.

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. Drugs used to treat attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD).

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 Benefit Summary.

5. Fluoride products.

6. Oral dental rinses requiring a prescription.

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 oral isotretinoin (i.e; Claravis).
10. Antibiotics.
11. Vitamins and minerals requiring a prescription.
12. Hematinics (iron preparations) requiring a 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 prescription.
20. Compound medications which include at least one legend drug. (considered non-formulary or non-formulary tier)
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 and 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 regarding additional coverage for intrauterine devices (IUD), 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 an in-network pharmacy.

   Please note, the USPSTF grades A and B recommendations are subject to change as new medications become available and other recommendations change. Coverage of new

recommended mediations 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 *Prescryptive Health 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 the Prescription Drug 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 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. Anorexiants.
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 member 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 excluded by this Plan.

TEMPOROMANDIBULAR JOINT SERVICES

This Plan covers treatment of temporomandibular joint syndrome (TMJ) for medical reasons only. All TMJ-related services, including but not limited to, diagnostic and Surgical Procedures, must be provided by Providers practicing within the scope of their licenses and, if necessary, prior authorized. Services are only covered when Medically Necessary due to a history of advanced pathologic process (arthritic degeneration) or in the case of severe acute trauma.

- Benefits are limited as follows: Up to a Lifetime Maximum benefit of $2,000.

TRANSPLANT SERVICES

- This Plan covers the following Medically Necessary organ and tissue transplants including supplies, treatment, preparation, and facility fees for both donors and recipients: stem cell transplants and high-dose Chemotherapy; corneal transplants; heart; heart – lungs; intestine; kidney; kidney – pancreas; liver; lungs; and whole organ pancreas transplantation. Expenses for the acquisition of organs or tissues for transplantation are only covered when the transplantation itself is covered under this Plan, and is limited to selection, removal of the organ, storage, and transportation of the organ or tissue.

- Benefits are limited as follows:

  - Except for corneal transplants which do not require prior authorization, transplant supplies, treatments, services and evaluations, including pre-transplant evaluations, require prior authorization.

  - Only transplants of human body organs and tissues are covered. Transplants of animal, artificial, or other non-human organs and tissues are not covered.

  - Testing of related or unrelated donors for a potential living related organ donation is payable at the same percentage that would apply to the same testing of a covered recipient.

  - Expense for acquisition of cadaver organs is covered, payable at the same percentage and subject to the same limitations, if any, as the transplant itself.

  - Medical services required for the removal and transportation of organs or tissues from living donors are covered. Coverage of the organ or tissue donation is payable at the same percentage as the transplant itself if the recipient is a Plan Member.

  - If the donor is not covered by this Plan, only those complications of the donation that occur during the initial hospitalization are covered, and such complications are only covered to the extent that they are not covered by another health plan or government program. Coverage is payable at the same percentage as the transplant itself.

  - If the donor is a Plan Member, complications of the donation are covered as any other Illness would be covered.

  - Transplant related services, including human leukocyte antigen (HLA) typing, sibling tissue typing, and evaluation costs, are considered transplant expenses and accumulate toward any transplant benefit limitations and are subject to PacificSource's Provider contractual agreements. For more information, see Payment of Transplant Benefits.

If the transplant is performed at an in-network transplant facility or a Center of Excellence facility and the Member resides 50 miles or more from the transplant facility, this Plan will pay for the following services incurred during the transplant benefit period. Travel and housing benefits are covered for the Member, one caregiver, and the living donor. However, if the Member is a Dependent minor child, the coverage will be for the Dependent minor child, the living donor, and two parents/legal guardians, or they may have one adult caregiver. Travel benefits are as follows:

- Limited to $200 per day, up to a maximum of $10,000 per transplant.

- Travel includes reasonable food, lodging (private residences are not covered), and transportation (limited to commercial transportation, coach class only).

Travel and housing expenses are not covered when transplant is received from out-of-network providers.

Payment of Transplant Benefits

If a transplant is performed at an in-network Center of Excellence transplantation facility, covered charges of the facility are subject to this Plan's in-network transplant benefit. If the contract with the facility includes the services of the medical professionals performing the transplant, those charges are also subject to this Plan's in-network transplant benefit. If the professional fees are not included in the contract with the facility, then those benefits are provided according to the Medical Benefit Summary.

Transplant services that are not received at an in-network Center of Excellence and/or services of out-of-network medical professionals are paid at the out-of-network percentages stated in the Medical Benefit Summary. The maximum benefit payment for transplant services of Out-of-network Providers is 125 percent of the Medicare allowance.

VISION SERVICES

This Plan covers vision exams, lenses, and frames when performed or prescribed by a Provider practicing within the scope of their licenses.

If charges for a service or supply are less than the Allowable Fee, the benefit will be equal to the actual charge. If services are provided out-of-network and the Provider's billed charges are greater than the Allowable Fee, Balance Billing will apply.

This Plan covers vision hardware including glasses (lenses and frames) and/or contacts (lenses and fitting).

See the Vision Benefit Summary for cost share information.

WOMEN'S HEALTH AND CANCER RIGHTS

Breast Reconstruction

This Plan covers breast reconstruction in connection with a Medically Necessary Mastectomy, as required by the Women's Health and Cancer Rights Act of 1998. Coverage is provided in a manner determined in consultation with the attending Provider and for:

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

Benefits for breast reconstruction are subject to all terms and provisions of this Plan, including Deductibles, Copayments, and/or Coinsurance.

Post-Mastectomy Care

This Plan covers post-Mastectomy care for a period of time as determined by the attending Provider and, in consultation with the Member, determined to be Medically Necessary following a Mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

WEIGHT WATCHERS

This Plan covers Weight Watchers benefits. You must be enrolled in this Plan at the time of your first and last Weight Watchers meeting to qualify for reimbursement. You must complete a minimum of ten weeks during a consecutive four month period during the Benefit Year. Participation verification is required. To be eligible for reimbursement, the Reimbursement Request Form must be submitted within two months of the last Weight Watchers class attended. You may obtain the Reimbursement Request Form from the Plan Sponsor, or PacificSource's Customer Service team.

- Benefits are limited as follows: Up to $100 per Benefit Year.

BENEFIT EXCLUSIONS

This Plan does not cover the following:

- Abdominoplasty for any indication.
- Academic skills training. This exclusion does not apply if the program, training, or therapy is part of a treatment plan for a pervasive developmental disorder.
- Aversion therapy.
- Biofeedback (other than as specifically noted under the Covered Services section).
- Charges for missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims unless otherwise contracted.
- Charges that are the responsibility of a third party who may have caused the Illness or Injury, or other insurers covering the incident (such as workers' compensation insurers and automobile insurers, and general liability insurers).
- Chelation therapy including associated infusions of vitamins and/or minerals, except as Medically Necessary for the treatment of selected medical conditions and medically significant heavy metal toxicities.
- Computer or electronic equipment for monitoring asthmatic, similar medical conditions, or related data.
- Cosmetic/reconstructive services and supplies - Services and supplies, including drugs, rendered primarily for cosmetic/reconstructive purposes (does not apply to Emergency Services). Cosmetic/reconstructive services and supplies are those performed primarily to improve the body's appearance and not primarily to restore impaired function of the body, unless the area needing treatment is a result of a Congenital Anomaly or gender dysphoria.
- Court-ordered sex offender treatment programs.
- Day care or Custodial Care, including non-skilled care and helping with activities of daily living, except as specified above in conjunction with Home Healthcare or Hospice Care.
- Dental examinations and treatment to prevent, diagnose, or treat diseases or conditions of the teeth and supporting tissues or structures, including treatment that restores the function of teeth.
- Educational or correctional services or sheltered living provided by a school or halfway house, except outpatient services received while temporarily living in a shelter.

- Equine/animal therapy.
- Equipment commonly used for non-medical purposes and/or marketed to the general public.
- Equipment used primarily in athletic or recreational activities. This includes exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal problems.
- Experimental, Investigational, or Unproven – This Plan does not cover services, supplies, protocols, procedures, devices, Chemotherapy, drugs or medicines, or the use thereof that are Experimental, Investigational, or Unproven for the diagnosis and treatment of the Member. This limitation also excludes treatment that, when and for the purpose rendered: has not yet received recognized compendia support (for example, UpToDate, Lexicomp, FDA) for other than Experimental, Investigational, or Unproven, or clinical testing; is not of generally accepted medical practice in this Plan's state of issuance or as determined by medical advisors, medical associations, and/or technology resources; is not approved for reimbursement by the Centers for Medicare and Medicaid Services; is furnished in connection with medical or other research; or is considered by any governmental agency or subdivision to be Experimental, Investigational, or Unproven, not reasonable and necessary, or any similar finding.

  If you or your Provider have any concerns about whether a course of treatment will be covered, we encourage you to contact the PacificSource Customer Service team. They will arrange for medical review of your case against the criteria established by the Plan Sponsor, and notify you of whether or not the proposed treatment will be covered.
- Eye exercises and eye refraction, therapy, and procedures – Orthoptics, vision therapy, and procedures intended to correct refractive errors.
- Fitness or exercise programs and health or fitness club memberships.
- Foot orthotics.
- Foot care (routine) – Services and supplies for corns and calluses of the feet, conditions of the toenails other than infection, hypertrophy, or hyperplasia of the skin of the feet, and other routine foot care, except in the case of Members being treated for diabetes mellitus.
- Growth hormone injections or treatments, except to treat documented growth hormone deficiencies.
- Homeopathic medicines or homeopathic supplies.
- Hypnotherapy.
- Immunizations when recommended for, or in anticipation of, exposure through travel or work.
- Infertility – This Plan does not cover Infertility diagnostic or treatment services.
- Instructional or educational programs, except National Diabetes Prevention Programs, diabetes self-management programs when Medically Necessary.
- Jaw – Services or supplies for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants, improving placement of dentures and artificial larynx.
- Maintenance supplies and equipment not unique to medical care.
- Mattresses and mattress pads unless Medically Necessary to heal pressure sores.

- Mental health treatment related to the following are excluded: court-mandated psychological evaluations for child custody determinations; voluntary mutual support groups; mental examinations for the purpose of adjudication of legal rights; psychological testing and evaluations not provided as an adjunct to treatment or diagnosis of a Behavioral Health Condition; stress management, parenting skills, or family education; and assertiveness training.
- Modifications to vehicles or structures to prevent, treat, or accommodate a medical condition.
- Motion analysis, including videotaping and 3-D kinematics, dynamic surface and fine wire electromyography, including Provider review.
- Myeloablative high dose Chemotherapy, except when the related transplant is specifically covered under the transplantation provisions of this Plan.
- Naturopathic supplies.
- Nicotine related disorder treatment, other than those covered through Tobacco Cessation Program services.
- Obesity or weight reduction control – Surgery or other related services or supplies provided for weight reduction control or obesity (including all categories of obesity), whether or not there are other medical conditions related to or caused by obesity. Obesity screening and counseling are covered for Members age 18 and older; see the Obesity Services (Interventions) section under Other Covered Services.
- Oral/facial motor therapy for strengthening and coordination of speech-producing musculature and structures, except as Medically Necessary in the restoration or improvement of speech following a traumatic brain Injury or for Members diagnosed with a pervasive developmental disorder.
- Orthodontics/orthodontia, other than as specifically noted under the Covered Services section.
- Orthognathic surgery – Services and supplies to augment or reduce the upper or lower jaw, except to repair an Accidental Injury or for removal of a malignancy, including reconstruction of the jaw.
- Orthopedic shoes, diabetic shoes, and shoe modifications.
- Over-the-counter non-Prescription Drugs. Does not apply to tobacco cessation medications covered under USPSTF guidelines.
- Panniculectomy (removal of panniculus, or excess skin, from lower abdomen) for any indication.
- Personal items such as telephones, televisions, and guest meals during a stay at a Hospital or other inpatient facility.
- Physical or eye examinations required for administrative purposes such as participation in athletics, admission to school, or by an employer.
- Private nursing service.
- Programs that teach a person to use medical equipment, care for family members, or self-administer drugs or nutrition, except for diabetic education benefit.
- Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present.

- Recreation therapy – outpatient.
- Rehabilitation – Functional capacity evaluations, work hardening programs, vocational rehabilitation, community reintegration services, and driving evaluations and driving training programs, except as Medically Necessary in the restoration or improvement of speech following a traumatic brain Injury or for Members diagnosed with a pervasive developmental disorder.
- Replacement costs for worn or damaged Durable Medical Equipment that would otherwise be replaceable without charges under warranty or other agreement.
- Scheduled and/or non-emergent care outside of the United States.
- Screening tests – Services and supplies, including imaging and screening exams performed for the sole purpose of screening and not associated with specific diagnoses and/or signs and symptoms of disease or of abnormalities on prior testing (including, but not limited to, total body CT imaging, CT colonography, and bone density testing). This does not include preventive care screenings listed in the Preventive Care Services section.
- Self-help health or instruction or training programs.
- Sensory integration training. This exclusion does not apply if the program, training, or therapy is part of a treatment plan for a pervasive developmental disorder.
- Services or supplies covered under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law.
- Services or supplies not listed as a Covered Service, unless required under federal or state law.
- Services or supplies with no charge, or for which your Employer or the Plan Sponsor has paid, or for which the Member is not legally required to pay, or for which a Provider or facility is not licensed to provide even though the service or supply may otherwise be eligible. This exclusion includes any service provided by the Member, or any licensed professional that is directly related to the Member by blood or marriage.
- Services required by state law as a condition of maintaining a valid driver license or commercial driver license.
- Services, supplies, and equipment not involved in diagnosis or treatment but provided primarily for the comfort, convenience, alteration of the physical environment, or education of a Member. This includes appliances like adjustable power beds sold as furniture, air conditioners, air purifiers, room humidifiers, heating and cooling pads, home blood pressure monitoring equipment, light boxes, conveyances other than conventional wheelchairs, whirlpool baths, spas, saunas, heat lamps, tanning lights, and pillows.
- Sexual disorders – Services or supplies for the treatment of erectile or sexual dysfunction, unless defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.
- Snoring – Services or supplies for the diagnosis or treatment of snoring, except when attributed to the diagnosis of sleep apnea.
- Social skills training. This exclusion does not apply if the program, training, or therapy is part of a treatment plan for a pervasive developmental disorder.
- Sterilization of Dependent Children.

- Support groups.
- Transplants – Any services, treatments, or supplies for the transplantation of stem cells or any human body organ or tissue, except as expressly provided under the provisions of this Plan for covered transplantation expenses.
- Treatment after coverage ends – Services or supplies a Member receives after the Member's coverage under this Plan ends.
- Treatment not Medically Necessary – Services or supplies that are not Medically Necessary for the diagnosis or treatment of an Illness or Injury.
- Treatment of any Illness or Injury resulting from an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement other than with the local supervisory authority while pending disposition of charges.
- Treatment of any work-related Illness or Injury except as described in the On-the-Job Illness or Injury and Workers' Compensation section.
- Treatment prior to enrollment.
- Unwilling to release information – Charges for services or supplies for which a Member is unwilling to release medical or eligibility information necessary to determine the benefits covered under this Plan.
- War-related conditions – The treatment of any condition caused by or arising out of an act of war, armed invasion, or while in the service of the armed forces unless not covered by the Member's military or veterans coverage.

UTILIZATION REVIEW

PacificSource has a utilization review program based on criteria adopted by the Plan Sponsor to determine coverage. This program is administered by the PacificSource Health Services team for prior authorization, concurrent reviews, and post-service reviews. PacificSource may delegate certain utilization review functions to third parties, including utilization review for services rendered by Providers outside of Idaho, Montana, Oregon, and Washington. Questions regarding Medical Necessity, possible Experimental, Investigational, or Unproven services, appropriate setting, and appropriate treatment are forwarded to the PacificSource Medical Director for review and Benefit Determination based on the criteria established by the Plan Sponsor, where applicable.

If you would like information on how PacificSource reached a particular utilization review Benefit Determination, please contact the PacificSource Health Services team by phone at 888-691-8209, or by email at healthservices@pacificsource.com.

PRIOR AUTHORIZATION

Coverage of certain services requires a Benefit Determination by PacificSource, on behalf of the Plan Sponsor, before the services are performed. This process is called prior authorization. PacificSource will utilize the criteria adopted by the Plan Sponsor and, where necessary, will coordinate review with the Plan Sponsor, to render a determination based on the Plan.

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

Your Provider can request prior authorization from the PacificSource Health Services team. If your Provider will not request prior authorization for you, you may contact PacificSource yourself. In some cases, they may ask for more information or require a second opinion before authorizing coverage. You and/or your Provider are responsible for providing PacificSource with all information necessary to make a Benefit Determination.

Because of the changing nature of care, PacificSource, on behalf of the Plan Sponsor, continually reviews new technologies and standards. Therefore, procedures and services requiring prior authorization is subject to change. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business). The prior authorization search tool is not intended to suggest that all items listed are covered by the benefits in this Plan.

When services are received from an In-network Provider, the Provider is responsible for contacting PacificSource to obtain prior authorization.

If your treatment does not receive prior authorization, you can still seek treatment, but your Post-Service Claim will be subjected to retrospective authorization. If a treatment requires prior authorization but was not received, the Post-service Claim must be submitted within 60 days of the date of service. If the claim is not submitted within 60 days or if the review determines the expenses were either not covered by this Plan or were not Medically Necessary, you will be held responsible for the expense. Remember, any time you are unsure if an expense will be covered, contact the PacificSource Customer Service team.

Notification of the Benefit Determination will be communicated by letter, fax, or electronic transmission to the Hospital, the Provider, and you. If time is a factor, notification will be made by telephone and followed up in writing. For more information regarding the timelines for review of Pre-service Review and Post-service Claims, see Benefit and Claim Determinations in the Benefit Determinations and Claims Payment section.

In a medical emergency, services and supplies necessary to determine the nature and extent of an Emergency Medical Condition and to Stabilize the Member are covered without prior authorization requirements. A Hospital or other healthcare facility must notify PacificSource of an emergency admission within two business days.

PacificSource reserves the right to contract with a third party to perform prior authorization procedures on its behalf and such third parties may impose independently developed, Evidence-based Criteria for making prior authorization determinations. If you have questions about any third party criteria, please contact the PacificSource Customer Service team.

If your Provider's prior authorization request is denied as not Medically Necessary or as Experimental, Investigational, or Unproven, your Provider may Appeal the Benefit Determination. You retain the right to Appeal the Benefit Determination independent from your Provider.

CASE MANAGEMENT

Case management is a service provided by Registered Nurses who are Certified Case Managers and Licensed Behavioral Health Clinicians with specialized skills to respond to the complexity of a Member's healthcare needs. Case management services may be initiated by PacificSource when there is a high utilization of health services or multiple Providers, or for health problems such as, but not limited to, transplantation, high risk obstetric or neonatal care, spinal cord Injury, trauma or traumatic Injury, or any acute or chronic condition that may necessitate specialized treatment or care coordination.

Case managers are experienced licensed healthcare professionals with specialized skills to respond to the complexity of a Member's healthcare needs. When case management services are implemented, a case manager will work in collaboration with a Member's Provider and the PacificSource Medical Director and, where necessary, the Plan Sponsor, to enhance the quality of care, maximize available benefits, and propose individual supplemental benefits. PacificSource reserves the right to employ a third party to assist with or perform the function of case management.

INDIVIDUAL/SUPPLEMENTAL BENEFITS

An individual/supplemental benefit may be available if the Plan approves coverage for services or supplies that are not a Covered Service under this Plan (for example, continuation of home health Physical Therapy beyond the benefit limit, if Medical Necessity determines that continuation would result in both improved health of Member and overall reduction in costs). This Plan may cover these supplemental benefits through case management if it is determined that supplemental benefits are Medically Necessary and will result in an overall reduction in covered costs and improved quality of care. The decision to allow supplemental benefits will be made by the Plan on a case-by-case basis. The Plan and your attending Provider must concur in the request for supplemental benefits in lieu of specified Covered Services before supplemental benefits will be covered. The Plan's determination to cover and pay for supplemental benefits does not set a precedent for coverage of continued or additional supplemental benefits. No substitution will be made without your consent.

USING THE PROVIDER NETWORK

This section explains how this Plan's benefits differ when you use Tier One and/or Tier Two In-network and Out-of-network Providers. This information is not meant to prevent you from seeking treatment from any Provider if you are willing to take increased financial responsibility for the charges incurred. Your network name is listed at the beginning of the Medical Benefit Summary.

All Providers are independent contractors. Neither the Plan Sponsor nor PacificSource can be held liable for any claim for damages or injuries you experience while receiving care. Members have the right to choose their Providers.

Under this Plan, you are free to seek care, including Women's Healthcare Services, from any Provider without a referral. You may, however, be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan.

Nothing in this Plan is designed to restrict Members from contracting to obtain any healthcare services outside the Plan on any terms Members choose.

IN-NETWORK PROVIDERS

In-network Providers contract with PacificSource to provide services and supplies for an Allowable Fee. In-network Providers bill PacificSource directly, and are paid directly by this Plan. When you receive Covered Services or supplies from an In-network Provider, you are only responsible for any applicable Deductibles, Copayments, and/or Coinsurance amounts. To ensure the highest level of benefits, access care from an In-network Provider including specialists and Hospitals.

PacificSource contracts directly and/or indirectly with In-network Providers throughout our networks' Service Area. They also have agreements with nationwide Provider networks. These Providers outside Idaho, Montana, Oregon, and Washington are also considered In-network Providers under your Plan.

It is not safe to assume that when you are treated at an in-network facility that all services are performed by In-network Providers. Whenever possible, you should arrange for professional services, such as surgery and anesthesiology, to be provided by an In-network Provider. Doing so may help you maximize your benefits and limit your out-of-pocket expenses.

Risk-sharing Arrangements

By agreement, an In-network Provider may not bill you for any amount in excess of the Allowable Fee. However, the agreement does not prohibit the Provider from collecting Deductibles, Copayments, Coinsurance, and amounts for non-Covered Services.

YOUR PRIMARY CARE PROVIDER

Some In-network Providers for this Plan are designated as primary care Providers (PCPs). PCPs are family practitioners, physician assistants, pediatricians, internists, nurse practitioners, and Women's Healthcare Providers. PCPs are noted in your Plan's Provider directory.

When enrolling in this Plan, Members are highly encouraged to select a PCP from the Provider directory. You have the right to designate any PCP who participates in the network and who is available to accept Members. You do not need prior authorization from your PCP in order to obtain access to obstetrical or preventive gynecological care from a Provider in the network who specializes in obstetrics or gynecology. The Provider may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan or procedures for making referrals. The PCP assumes primary responsibility for medical care and maintains your medical records. Your PCP will assist in coordinating your medical care, including specialist services, Hospital services, and urgent medical needs.

Once you have chosen a PCP, if you are not an existing patient, you may want to phone the Provider's office and introduce yourself as a new patient. When you call, you may arrange for your medical records to be transferred and find out how to contact your PCP after hours.

Changing PCPs

You may change your PCP by contacting the PacificSource Customer Service team.

The PCP change will be effective on the first of the month after PacificSource receives your request.

SHARED DECISION MAKING

Shared decision making (SDM) is a collaborative process that allows Members and their Providers to make healthcare decisions together, taking into account the best scientific evidence available, as well as the Member's values and preferences. SDM honors both the Provider's expert knowledge and the your right to be fully informed of all care options and the potential harms and benefits. This process provides you with the support you need to make the best decisions about your care, while allowing Providers to feel confident in the care they prescribe. For certain procedures, you may be required to complete SDM tools for review with your Providers in order to receive the highest level of benefits.

Under this Plan, you are free to seek care from Providers other than your PCP without a referral.

In addition to the In-network Providers for this Plan, PacificSource has agreements with a number of medical centers and specialized treatment programs. If you need services for which PacificSource has Provider contracts, you will be required to use the contracted Providers for your treatment to be covered at the Plan's highest benefit level.

FINDING AN IN-NETWORK PROVIDER

You can find up-to-date In-network Provider information:

- On the PacificSource website, PacificSource.com, go to Find a Doctor to easily look up In-network Providers, specialists, behavioral health Providers, and Hospitals. You can also print your own customized directory.
- Contact the PacificSource Customer Service team. They can answer your questions about specific Providers.

OUT-OF-NETWORK PROVIDERS

When you receive services or supplies from an Out-of-network Provider, your out-of-pocket expense is likely to be higher than if you had used an In-network Provider. If the same services or supplies are available from an In-network Provider, you may be responsible for more than the applicable Deductibles, Copayments, and/or Coinsurance amounts.

Allowable Fee for Out-of-network Providers

PacificSource, as your Third Party Administrator, bases payment to Out-of-network Providers on the Allowable Fee, which may be derived from several sources, depending on the service or supply and the Service Area where it is provided. To calculate the payment to Out-of-network Providers, PacificSource determines the Allowable Fee, then subtract the Out-of-network Provider benefits.

Your Rights and Protections Against Surprise Medical Bills and Balance Billing

When you get emergency care or get treated by an Out-of-network Provider at an in-network Hospital or Ambulatory Surgical Center, you are protected from Balance Billing. In these cases, you shouldn't be charged more than this Plan's Copayments, Coinsurance, and/or Deductible.

What is Balance Billing (sometimes called 'surprise billing')?

When you see a doctor or other healthcare Provider, you may owe certain out-of-pocket costs, like a Copayment, Coinsurance, or Deductible. You may have additional costs or have to pay the entire bill if you see a Provider or visit a healthcare facility that isn't in this Plan's network.

Out-of-network means Providers and facilities that haven't signed a contract with this Plan to provide services. Out-of-network Providers may be allowed to bill you for the difference between what this Plan pays and the full amount charged for a service. This is called 'Balance Billing'. This amount is likely more than in-network costs for the same service and might not count toward this Plan's Deductible or annual out-of-pocket limit.

'Surprise billing' is an unexpected Balance Bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an Out-of-network Provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are Protected from Balance Billing for:

- **Emergency Services:**

  If you have an Emergency Medical Condition and get Emergency Services from an Out-of-network Provider or facility, the most they can bill you is this Plan's in-network cost-sharing amount (such

as Copayments, Coinsurance, and Deductibles). You can't be Balance Billed for these Emergency Services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be Balance Billed for these post-stabilization services.

- **Certain Services at an in-network Hospital or Ambulatory Surgical Center:**

  When you get services from an in-network Hospital or Ambulatory Surgical Center, certain Providers there may be out-of-network. In these cases, the most these Providers may bill you is this Plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeons, hospitalists, or intensivist services. These Providers can't Balance Bill you and may not ask you to give up your protections not to be Balance Billed.

  If you get other services at these in-network facilities, Out-of-network Providers can't Balance Bill you, unless you give written consent and give up your protections.

  You're never required to give up your protections from Balance Billing. You also aren't required to get out-of-network care. You can choose a Provider or facility in this Plan's network.

When Balance Billing Isn't Allowed, You also have the Following Protections:

You are only responsible for paying your share of the cost (like the Copayments, Coinsurance, and Deductibles) that you would pay if the Provider or facility was in-network. This Plan will pay any additional costs to Out-of-network Providers and facilities directly.

Generally, this Plan must:

- Cover Emergency Services without requiring you to get approval for services in advance (also known as 'prior authorization');
- Cover Emergency Services by Out-of-network Providers;
- Base what you owe the Provider or facility (cost-sharing) on what it would pay an In-network Provider or facility and show that amount in your explanation of benefits; and
- Count any amount you pay for Emergency Services or out-of-network services toward your in-network Deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact Oregon Division of Financial Regulation at dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx or by calling **503-947-7984** or **888-877-4894**; and/or file a Complaint with the federal government at cms.gov/nosurprises/consumers or by calling **800-985-3059**.

Visit cms.gov/nosurprises/consumers for more information about your rights under federal law.

Example of Provider Payment

The following provides an example of how a payment could be made for In-network or Out-of-network Providers. This is only an example; this Plan's benefits may be different.

PacificSource will pay 80 percent of the Allowable Fee for In-network Providers and 60 percent of the Allowable Fee for Out-of-network Providers. The benefits would appear as follows:

In-network Provider	Out-of-network Provider
Payment: After Deductible, Member pays 20% of the Allowable Fee.	Payment: After Deductible, Member pays 40% of the Allowable Fee and the balance of billed charges (see Your Rights and Protections Against Surprise Medical Bills and Balance Billing).

In this example, the Provider's charge for a service is $5,000 and the Allowable Fee for an In-network Provider is $4,000. This example assumes that a Member has met the Deductible during the Benefit Year, but has not yet met the out-of-pocket limit for the Benefit Year:

In-network Provider:

This Plan would pay 80 percent of the Allowable Fee and the Member would pay 20 percent of the Allowable Fee, as follows:

Amount the In-Network Provider must discount (Allowable Fee):	$1,000
Amount this Plan pays (80% of the $4,000 Allowable Fee):	$3,200
Amount the Member pays (20% of the $4,000 Allowable Fee):	**$800**
Total:	$5,000

Out-of-network Provider:

This Plan would pay 60 percent of the Allowable Fee. (For this example, $4,000 is also the charge upon which the Out-of-Network Provider's Allowable Fee is established.) Because the Out-of-Network Provider does not accept the Allowable Fee and may charge more, the Member would pay 40 percent of the Allowable Fee, plus the $1,000 difference between the Out-of-Network Provider's billed charges and the Allowable Fee, as follows:

Amount this Plan pays (60% of the $4,000 Allowable Fee):	$2,400
Amount the Member pays (40% of the $4,000 Allowable Fee and the $1,000 difference between the billed charges and the Allowable Fee):	**$2,600**
Total:	$5,000

This Plan's actual benefits may vary, so please review the Benefit Summaries and Covered Services section to determine how your benefits are paid. Please remember that the Allowable Fee may vary for a Covered Service depending upon the selected Provider.

COVERAGE WHILE TRAVELING

Finding an In-network Provider

If you are away from home but *within* the Service Area, you may find an In-network Provider by using the PacificSource directory, providerdirectory.PacificSource.com/Commercial or by contacting the PacificSource Customer Service team.

If you are *outside* of the Service Area, go to the link above and follow the instructions to find In-network Providers outside the Service Area. The listed Providers are part of nationwide Provider

networks with whom we have agreements. Providers on these networks are considered in-network when *and only when* you are outside your Service Area.

Out-of-network Provider for Non-Emergency Services

If you use an Out-of-network Provider for non-emergency Covered Services, this Plan's Out-of-network Provider benefits will apply. For more information, see the Out-of-network Providers section.

Non-emergency care outside of the United States is not covered.

Out-of-network Provider for Emergency Services

If you use an Out-of-network Provider for emergency Covered Services, this Plan will pay benefits at the In-network Provider level.

If you are admitted to an out-of-network Hospital and require additional services to further Stabilize your Emergency Medical Condition, your Provider or Hospital should contact the PacificSource Health Services team at 888-691-8209 as soon as possible. PacificSource, on behalf of the Plan Sponsor, may coordinate your transfer to an in-network facility.

Emergency care outside of the United States is covered. You will need to pay for these services upfront and submit a claim for reimbursement. Your claim for reimbursement must include a detailed invoice from the treating facility.

EPIDEMIC

PacificSource will work in conjunction with local authorities and health systems to coordinate in the communication of health services to assist you with accessing care in the event of an epidemic. Critical care and Emergency Services are given the highest priority.]

DEPENDENT CHILDREN RESIDING OUTSIDE THE SERVICE AREA

If a Dependent Child under age 26 does not live with the Subscriber and lives outside of the Service Area, they are not required to use the services of a PCP to receive benefits from this Plan. These Dependent Children may access the highest level of benefits by using the services of an In-network Provider for Tier one benefits or a nationwide Provider for Tier two benefits. For more information, see the Finding an In-network Provider section.

TERMINATION OF PROVIDER CONTRACTS

PacificSource, on behalf of the Plan Sponsor, will attempt to notify you within 30 days of learning about the termination of a Provider contractual relationship if you have received services in the previous six months from such a Provider when:

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

You are entitled to continue care with an individual Provider or facility, whose contract was terminated without cause, for a limited period of time at the in-network cost share. Continuation of care will not be available if you are no longer covered under this Plan, the Provider will not accept the Allowable Fee under the terms of their terminated agreement, the Provider no longer holds an active license, or the Provider is otherwise unavailable to continue the care. Contact the PacificSource Customer Service team for additional information.

If you do not qualify for continuation of care, the Provider becomes an Out-of-network Provider on the date the contract with PacificSource terminates. Any services you receive from them will be paid at the percentage shown in the out-of-network column of the Benefit Summaries. To avoid unexpected costs, be sure to verify each time you see your Provider that they are still in-network.

Active Course of Treatment

If the contract of a Provider who is providing to you an active course of treatment, is terminated without cause, you may be able to continue to receive services from the Provider at the in-network benefit level for a limited period of time. The services may be paid at in-network cost sharing until the earliest of the following:

- Treatment is complete; or
- 90 days after you were notified that the contract ended.

BENEFIT DETERMINATIONS AND CLAIMS PAYMENT

How to File a Claim

When an In-network Provider treats you, your claims are automatically sent to PacificSource and processed. All you need to do is show your PacificSource Member ID card to the Provider.

If you receive care from an Out-of-network Provider, the Provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to them for processing. Your claim must include a copy of your Provider's itemized bill, including the Provider name and address, the Provider tax identification number and National Provider Identifier (NPI), procedure codes, and diagnosis codes. It must also include your name, PacificSource Member ID number, group name, group number, and the Member's name. If you were treated for an Accidental Injury, please include the date, time, place, and circumstances of the Accident.

All claims for benefits should be turned in to PacificSource within 90 days of the date of service. If you are unable to submit a claim within 90 days, present the claim with an explanation for consideration for coverage. This Plan will never pay a claim that was submitted more than a year after the date of service.

Claims Payment Practices

Unless additional information is needed to process your claim, PacificSource, on behalf of the Plan Sponsor, will make every effort to pay or deny your claim within 30 days of receipt. If a claim cannot be paid within 30 days of receipt because additional information is needed, PacificSource will acknowledge receipt of the claim and explain why payment is delayed.

Benefit and Claim Determinations

Benefit Determination – PacificSource will make a Benefit Determination for healthcare services, including those subject to prior authorizations, within the time period noted in the chart below for the specific type of review. This does not apply to Emergency Services or Urgent Care services. No extension is permitted for Urgent Care Reviews.

Benefit Determination	Pre-service Review	Concurrent Care Review	Urgent Care Review
Initial determination by PacificSource	2 business days	24 hours	72 hours
If PacificSource requires additional information, PacificSource will make request within	2 business days	24 hours	24 hours
Provider or Member must provide requested additional information within	15 business days	24 hours	48 hours
Once PacificSource receives the information, decision will be made and written notice sent within	2 business days	24 hours	48 hours

Claim Determination – PacificSource, on behalf of the Plan Sponsor, will make a claim determination within the time period noted in the chart below, unless additional information is necessary to process the claim. In that event, PacificSource will send you notice that the claim was received and explain what additional information is necessary to process the claim. If PacificSource does not receive the necessary information within 15 days of the delay notice, they will either deny the claim or notify you every 45 days while the claim remains under investigation.

Claim Determination	Post-service Claim
Initial determination by PacificSource	30 calendar days
If PacificSource requires additional information, PacificSource will make request within	30 calendar days
Provider or Member must provide requested additional information within	15 calendar days
Once PacificSource receives the information, decision will be made and written notice sent within	30 calendar days

Adverse Benefit Determinations – PacificSource will notify you in writing of a decision to deny, modify, reduce, or terminate payment, coverage authorization or provision of services or benefits.

Review of Adverse Benefit Determinations – An Adverse Benefit Determination applied for on a pre-service, post-service, or concurrent care basis may be Appealed in accordance with this Plan's Appeals procedures. For more information, see the Complaints, Grievances, and Appeals section.

Payment of Claims

PacificSource, on behalf of the Plan Sponsor, may pay benefits to the Member, the Provider, or both jointly. Neither the benefits of this Plan nor a claim for payment of benefits under the Plan are assignable in whole or in part to any person or entity.

Questions about Benefit Determinations and Claims

If you have questions about the status of a Benefit Determination or claim, you are welcome to contact the PacificSource Customer Service team or go online to view the information via the PacificSource website.

Benefits Paid in Error

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

In the same manner, if the Plan applies expenses to the Deductible that would not otherwise be reimbursable under the terms of this Plan, it may deduct a like amount from the accumulated Deductible amounts and/or recover payment of expenses that would have otherwise been applied to the Deductible.

Legal Procedures

You may not take legal action against the Plan Sponsor or PacificSource to enforce any provision of this Plan until 60 days after your claim is submitted. Also, you must exhaust this Plan's claims procedures before filing benefits litigation. No such action shall be brought against the Plan Sponsor or PacificSource more than three years after the deadline for claim submission has expired.

You must exhaust this Plan's Appeal procedures, including but not limited to, seeking an External Review before filing benefits litigation under this Plan.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has healthcare coverage under more than one plan. Plan is defined below.

The order of Benefit Determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its plan terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100 percent of the total allowable expense.

Definitions

For the purpose of this section only, the following definitions apply:

A **plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

- Plan includes: group and non-group health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

- Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; Accident

only coverage; specified disease or specified Accident coverage; school Accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage described above is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This plan means, in a COB provision, the part of the contract providing the healthcare benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing healthcare benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rules. The rules that determine whether this plan is a primary plan or secondary plan when the person has healthcare coverage under more than one plan.

- When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits.

- When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100 percent of the total allowable expense.

Allowable Expense. A healthcare expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

- The difference between the cost of a semi-private Hospital room and a private Hospital room is not an allowable expense, unless one of the plans provides coverage for private Hospital room expenses.

- If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

- If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

- If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the Provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

- The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred Provider arrangements.

Closed Panel Plan. A plan that provides healthcare benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial Parent. The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plans.

Except as provided below, a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.

- Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

Each plan determines its order of benefits using the first of the following rules that apply:

Non-Dependent or Dependent. The plan that covers the person other than as a Dependent, for example as an Employee, member, policyholder, Subscriber, or retiree is the primary plan and the plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person as other than a Dependent (for example, a retired Employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an Employee, member, policyholder, Subscriber, or retiree is the secondary plan and the other plan is the primary plan.

Dependent Children. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one plan the order of benefits is determined as follows. The following is known as the birthday rule:

- For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:

- The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
- If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

- For a Dependent Child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
  - If a court decree states that one of the parents is responsible for the Dependent Child's healthcare expenses or healthcare coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
  - If a court decree states that both parents are responsible for the Dependent Child's healthcare expenses or healthcare coverage, the provisions above shall determine the order of benefits;
  - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the Dependent Child, the provisions above shall determine the order of benefits; or
  - If there is no court decree allocating responsibility for the Dependent Child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
    - The plan covering the custodial parent;
    - The plan covering the Spouse of the custodial parent;
    - The plan covering the non-custodial parent; and then
    - The plan covering the Spouse of the non-custodial parent.
- For a Dependent Child covered under more than one plan of individuals who are not the parents of the child, the provisions above shall determine the order of benefits as if those individuals were the parents of the child.

Active Employee or Retired or Laid-off Employee. The plan that covers a person as an active Employee, that is, an Employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off Employee is the secondary plan. The same would hold true if a person is a Dependent of an active Employee and that same person is a Dependent of a retired or laid-off Employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the non-Dependent or Dependent rule above can determine the order of benefits.

COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an Employee, member, Subscriber, or retiree or covering the person as a Dependent of an Employee, member, Subscriber, or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the non-Dependent or Dependent rule above can determine the order of benefits.

Longer or Shorter Length of Coverage. The plan that covered the person as an Employee, member, policyholder, Subscriber, or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of this Plan

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other healthcare coverage.

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. PacificSource may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. PacificSource need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give PacificSource any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, PacificSource may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. PacificSource will not have to pay that amount again. The term payment made includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by PacificSource is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The amount of the payments made includes the reasonable cash value of the benefits provided in the form of services.

Coordination with Medicare

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

- *Employers with 19 or fewer Employees:* If you are Medicare entitled due to age, and are enrolled in Medicare Parts A and B, this Plan only pays the portion of covered charges that would not be paid by Medicare Parts A and B. In other words, this Plan pays secondary for anyone eligible for and enrolled in Medicare Parts A and B.

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

THIRD PARTY LIABILITY

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

Third party liability means claims that are the responsibility of someone other than the Plan Sponsor. The liable party may be a person, firm, or corporation. Auto Accidents, slip-and-fall property Accidents, and medical malpractice claims are examples of common third party liability cases.

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

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

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

- If this Plan pays any claim that you claim is, or that is alleged to be, the responsibility of another party, you will hold the right of recovery against the other party in trust for the Plan Sponsor.

- The Plan Sponsor is entitled to reimbursement for any paid claims out of the recovery from a third party if there is a settlement, judgment, or recovery from any source. This is regardless of whether the other party or insurer admits liability or fault, or otherwise disputes the relatedness of the claims paid by this Plan to the Injury caused by the third party. The Plan Sponsor shall have the first right of reimbursement in advance of all other parties, including the Member, and a priority to any money recovered from third parties (with the exception of claims arising from motor vehicle Accidents).

- The Plan Sponsor may subtract a proportionate share of the reasonable attorney's fees you incurred from the money you are to pay back to the Plan Sponsor.

- The Plan Sponsor may ask you to take action to recover expenses they have paid from the responsible party. The Plan Sponsor may also assign a representative to do so on your behalf. If there is a recovery, the Plan Sponsor will be reimbursed for any expenses or attorney's fees out of

that recovery, as allowed by state law.

- If you receive a third party settlement, that money must be used to pay your related expenses incurred both before and after the settlement. If you have ongoing expenses after the settlement, PacificSource, on behalf of the Plan Sponsor, may deny your related claims until the full settlement (less reasonable attorney's fees) has been used to pay those expenses (with the exception of claims arising from motor vehicle Accidents).
- You and/or your agent or attorney must agree to keep segregated in its own account any recovery or payment of any kind to you or on your behalf that relates directly or indirectly to an Injury or Illness giving rise to the Plan Sponsor's right of reimbursement or subrogation, until that right is satisfied or released.
- If any of these conditions are not met, then PacificSource, on behalf of the Plan Sponsor, may recover any such benefits paid or advanced for any Illness or Injury through legal action, as well as reasonable attorney fees incurred by the Plan Sponsor.
- Unless Federal Law is found to apply.
- Unless expressly prohibited by state law, the Plan Sponsor's right to reimbursement overrides the made whole doctrine and this Plan disclaims the application of the made whole doctrine to the fullest extent permitted by law.

Right of Recovery – Time Limit for Reimbursements

PacificSource regularly engages in activities to identify and recover claims payments which should not have been paid or applied to Deductible amounts (for example, claims which are duplicate claims, errors, or fraudulent claims). If PacificSource, on behalf of the Plan Sponsor, makes a payment to you that you are not entitled to, or pays a person who is not eligible for payment, they may recover the payment. They must request reimbursement within 12 months of the claim payment except under the following circumstance:

- In the case where PacificSource and/or the Plan Sponsor becomes aware of an incorrect payment that was made due to an error, misstatement, misrepresentation, omission, or concealment other than insurance fraud by the Provider or another person, the 12 month time limit begins on the date PacificSource and/or the Plan Sponsor has actual knowledge of the invalid claim, claim overpayment, or other incorrect payment. Regardless of the date upon which PacificSource and/or the Plan Sponsor obtains actual knowledge of an invalid claim, claim overpayment, or other incorrect payment, PacificSource, on behalf of the Plan Sponsor, may not request reimbursement more than 24 months after the payment.

Motor Vehicle and Other Accidents

In accordance with state law, and notwithstanding the information above, you must provide PacificSource notice, by personal service or by registered or certified mail, if you make a claim or bring legal action for damages for injuries against any other person arising from a motor vehicle Accident. If PacificSource, on behalf of the Plan Sponsor, elects to seek reimbursement out of any recovery from such a claim or legal action, PacificSource will provide you with written notice to that effect by personal service or by registered or certified mail within 30 days of receipt of notice from you of such claim or legal action. Further, in such situations, PacificSource, on behalf of the Plan Sponsor, will take no action to reduce payments or subrogate until you receive full compensation for your injuries and the reimbursement or subrogation is paid only from the total amount of the recovery in excess of the amount that fully compensates you for your injuries.

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

This Plan may pay your medical claims from the Accident if an insurance claim has been filed with the other insurance company and that insurance has not yet paid.

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

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

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

- You are the owner, partner, or principal of the Plan Sponsor, are injured in the course of employment, and are otherwise exempt from the applicable state or federal workers' compensation insurance program;
- The appropriate state or federal workers' compensation insurance program has determined that coverage is not available for your Injury; or
- You are employed by an Oregon based group, and have timely filed an application for coverage with the State Accident Insurance Fund or other Workers' Compensation carrier and are waiting for determination of coverage from that entity.

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

If you are not the owner, partner, or principal of the Plan Sponsor, then this Plan may pay your claims if a workers' compensation claim has been denied on the basis that the Illness or Injury is not work related, and the denial is under Appeal.

Continuation of Benefits After Injury or Illness Covered by Workers' Compensation Insurance

Coverage under this Plan shall be available to eligible Employees who are not actively working and are receiving workers' compensation insurance payments. 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 extension provision and with any state or federal continuation requirements. If an Employee incurs an Injury or Illness for which a workers' compensation claim is filed, the Eligible Employee may maintain such coverage until the earlier or:

- The Employee takes full-time employment with another Employer; or
- Twelve months from the date the Employee first makes payment of contribution 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.

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

Surrogacy Health Services

A Member who enters into a surrogacy agreement and receives compensation under such surrogacy agreement, must reimburse this Plan for claims paid for Covered Services related to conception, fertility treatments, pregnancy, delivery, or postpartum care that are received in connection with the surrogacy agreement. This Plan is entitled to reimbursement for any paid claims out of the compensation a Member receives or is entitled to receive under a surrogacy agreement. A Member who enters into a surrogacy agreement must inform PacificSource of that agreement within 30 days of entering that agreement or becoming a Member of this Plan and provide a copy of the agreement to PacificSource.

COMPLAINTS, GRIEVANCES, AND APPEALS

QUESTIONS, CONCERNS, OR COMPLAINTS

If you have a question, concern, or Complaint about your coverage, please contact the PacificSource Customer Service team. Many times, their Customer Service team can answer your question or resolve an issue to your satisfaction right away. If you feel your issues have not been addressed, you have the right to submit a Grievance and/or Appeal in accordance with this section.

Members who do not speak English, have literacy difficulties, or have physical or mental disabilities that impede their ability to file an Appeal may contact the PacificSource Customer Service team for assistance. They can usually arrange for a multilingual staff member or interpreter to speak with them in their native language.

GRIEVANCE PROCEDURES

If you or your Authorized Representative are dissatisfied with the availability, delivery, or the quality of healthcare services; or claims payment, handling, or reimbursement for healthcare services; you may file a Grievance in writing. Grievances are not Adverse Benefit Determinations and do not establish a right to internal or External Review for a resolution to a Grievance.

PacificSource, on behalf of the Plan Sponsor, will attempt to address your Grievance, generally within 30 days of receipt. For more information, see the How to Submit Grievances or Appeals section.

APPEAL PROCEDURES

First Internal Appeal: If you believe this Plan has improperly reduced or terminated a healthcare item or service, or failed or refused to provide or make a payment in whole or in part for a healthcare item or service that is based on any of the reasons listed below, you or your Authorized Representative may Appeal the decision. The request for Appeal must be made in writing and within 180 days of your receipt of the Adverse Benefit Determination. For more information, see the How to Submit Grievances or Appeals section. You may Appeal if there is an Adverse Benefit Determination based on a:

- Denial of eligibility for or termination of enrollment in a plan;
- Rescission or cancellation of your coverage, whether or not the Rescission has an adverse effect on any particular benefit at the time;
- Imposition of a third party liability, network exclusion, annual benefit limit, or other limitation on otherwise Covered Services or items;

- Determination that a healthcare item or service is Experimental, Investigational, or Unproven, not Medically Necessary, effective, or appropriate; or
- Determination that a course or plan of treatment you are undergoing is an active course of treatment for the purpose of continuity of care.

Any staff involved in the initial Adverse Benefit Determination will not be involved in the Internal Appeal.

You or your Authorized Representative may submit additional comments, documents, records, and other materials relating to the Adverse Benefit Determination that is the subject of the Appeal. If an Authorized Representative is filing on your behalf, PacificSource will not consider your Appeal to be filed until such time as they have received the Authorization to Use or Disclose PHI and the Designation of Authorized Representative forms.

If you request review of an Adverse Benefit Determination, this Plan will continue to provide coverage for the disputed benefit, pending outcome of the review, if you are currently receiving services or supplies under the disputed benefit. If this Plan prevails in the Appeal, you may be responsible for the cost of coverage received during the review period. The decision at the External Review level is binding unless other remedies are available under state or federal law.

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

Any staff involved in the first Internal Appeal will not be involved in the second Internal Appeal.

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

External Independent Review: If your dispute with the Plan relates to an Adverse Benefit Determination that a course or plan of treatment is not a Medical Necessity; is Experimental, Investigational, or Unproven; is not an active course of treatment for purposes of continuity of care; or is not delivered in an appropriate healthcare setting and with the appropriate level of care, you or your Authorized Representative may request an External Review by an independent review organization. PacificSource must receive a signed Authorization To Use/Disclose Protected Health Information form within five business days of your external independent review request. This form must be signed to grant the review organization access to health records relevant to the decision. This form is located on the website, PacificSource.com/resources/documents-and-forms. For more information, see the How to Submit Grievances or Appeals section.

Your request for an independent review must be made within 180 days of the date of the second Internal Appeal response. External independent review is available at no cost to you, but is generally only available when coverage has been denied for the reasons stated above and only after all Internal Appeal levels are exhausted. You are provided five days to submit additional written information to the independent review organization for consideration during the review.

PacificSource, on behalf of the Plan Sponsor may, at its discretion and with your consent, waive the requirements of compliance with the Internal Appeals process and have a dispute referred directly to External Review. You shall be deemed to have exhausted the Internal Appeals if the Plan Sponsor fails to strictly comply with its Appeals process and with state and federal requirements for Internal Appeals.

If the independent review organization reverses the decision, this Plan will apply their decision quickly. However, if the independent review organization stands by the decision, there is no further Appeal available to you.

If the Plan Sponsor fails to comply with the decision of the independent review organization assigned under Oregon law, you have a private right of action against the Plan Sponsor for damages arising from an Adverse Benefit Determination subject to the External Review.

If you have questions regarding Oregon's External Review process, you may contact:

Division of Financial Regulation
Call 503-947-7984 or 888-877-4894

Timelines for Responding to Appeals

You will be afforded two levels of Internal Appeal and, if applicable to your case, an External Review. PacificSource will acknowledge receipt of an Appeal no later than seven days after receipt. A written decision in response to the Appeal will be made within 30 days after receiving your request to Appeal.

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

Information Available with Regard to an Adverse Benefit Determination

The final Adverse Benefit Determination will include:

- A reference to the specific internal rule or guideline used in the Adverse Benefit Determination; and
- An explanation of the scientific or clinical judgment for the Adverse Benefit Determination, if the Adverse Benefit Determination is based on Medical Necessity, Experimental, Investigational, or Unproven treatment, or a similar exclusion.

Upon request, this Plan will provide you with any additional documents, records, or information that is relevant to the Adverse Benefit Determination.

HOW TO SUBMIT GRIEVANCES OR APPEALS

Grievances and Appeals can be submitted in writing by you or your Authorized Representative. Before submitting a Grievance or Appeal, we suggest you contact the PacificSource Customer Service team with your concerns. Issues can often be resolved at this level. Otherwise, you may file a Grievance or Appeal by contacting:

PacificSource Health Plans
Attn: Grievance and Appeals
PO Box 7068
Springfield, OR 97475-0068

Email cs@pacificsource.com, with Grievance or Appeal as the subject

Fax 541-225-3628

Assistance Outside PacificSource

You have the right to file a Complaint or seek other assistance from the Division of Financial Regulation. Assistance is available by contacting:

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

Call 503-947-7984 or 888-877-4894

Email dfr.insurancehelp@dcbs.oregon.gov

Website dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx

BECOMING COVERED

Who Pays for Your Benefits

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 Sponsor. The Plan Sponsor reserves the right to change the level of Employee contributions.

In addition, the Deductibles, Copayment amounts, and/or Coinsurance may also change periodically. You will be notified by your Plan Sponsor of any changes in the cost this Plan's coverage before they take effect.

ELIGIBILITY

Employees

Your status as an Employee is determined by the employment records maintained by the Plan Sponsor. Workers classified by the Plan Sponsor as independent contractors are not eligible for coverage under this Plan under any circumstances. You become eligible to enroll in coverage on this Plan when you have met the Plan Sponsor's eligibility requirements, which may include a Waiting Period or require you to work a certain minimum number of hours.

Elected Officials

The Plan Sponsor provides coverage for elected officials and their families. Please see the Medical Benefit Summary for the Plan Sponsor's eligibility requirements, including the length of the Waiting Period. The following elected officials are eligible for coverage:

- Three County Commissioners,
- County Sheriff,
- District Attorney,
- County Assessor,
- County Clerk,
- Justice of the Peace,
- County Treasurer.

Dependents

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

- Your legal Spouse or your Domestic Partner.
- Your, your Spouse's, or your Domestic Partner's Dependent Children under age 26 regardless of the child's place of residence, marital status, or financial dependence on you.
- Your, your Spouse's, or your Domestic Partner's unmarried Dependent Children age 26 or older who are mentally or physically disabled. To qualify as Dependents, they must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability. The Plan Sponsor requires documentation of the disability from the Dependent Child's Provider, and will review the case before determining eligibility for coverage.

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

No person can be covered both as an Employee and as a Dependent, or as a Dependent of more than one Employee. Separate enrollments for Employees that are married or are in a domestic partnership will not be allowed. The Employee who is employed the longest with Deschutes County must enroll his or her Spouse, Domestic Partner and any other eligible Dependents.

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.

To be eligible, the family or household member must permanently reside within the United States.

Special Rules for Eligibility

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

ENROLLING DURING THE INITIAL ENROLLMENT PERIOD

Once you satisfy the Plan Sponsor's Waiting Period, and meet the hours required for eligibility, you and your eligible Dependents become eligible for this Plan. Starting on the date you become eligible, you and your Dependents have 31 days to enroll, called the Initial Enrollment Period. To enroll, you must submit the enrollment information to the Plan Sponsor. The Plan Sponsor will send the information to PacificSource.

If you miss your Initial Enrollment Period, you will not be able to enroll in this Plan later in the year, unless you qualify for a special enrollment period. For more information, see the Enrolling After the Initial Enrollment Period section.

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, as defined by the ACA. Employees will be credited for time previously satisfied toward the employment Waiting Period.

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD

ENROLLING NEW DEPENDENTS

To enroll new Dependents that become eligible for coverage after your effective date, complete and submit an enrollment change to the Plan Sponsor. Requests for enrollment of a new Dependent due to a qualifying event must be received by the Plan Sponsor within 31 days of the qualifying event. The Plan Sponsor may ask for legal documentation to confirm the status of the Dependent.

A newborn child is eligible from the moment of birth and will be automatically enrolled from the date of birth for 31 days. A claim for maternity care is not considered notification for the purpose of enrolling a newborn child. A grandchild of a Subscriber is not eligible unless court-ordered or legally adopted by a Subscriber.

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

Any contributions due must be paid as directed by the Plan Sponsor.

Qualifying Events

Coverage for newly eligible Dependents due to the following events will begin on the date of the event:

- Birth of a newborn Dependent Child; or
- Placement of an adopted or foster child.

Coverage for newly eligible Dependents due to the following events will begin on the first day of the month after the event:

- Marriage (if the enrollment change is received prior to the date of marriage, coverage for your new Dependents will begin on the date of marriage) or domestic partnership;
- Guardianship; or
- Qualified medical child support order (QMCSO).

This Plan complies with a QMCSO issued by a state court or state child support agency. A QMCSO is a judgment, decree, or order, including approval of a settlement agreement, which provides for benefit coverage for the child of a Member.

Open Enrollment Periods

If Eligible Employees and/or eligible Dependents are not enrolled during the Initial Enrollment Period, they must wait until the next open enrollment period to enroll unless they qualify for a special enrollment period as described below.

Special Enrollment Periods

You and/or your Dependents may decline coverage during your Initial Enrollment Period. To find out if this Plan allows Employees to decline coverage, ask the Plan Sponsor. If you wish to do so, you must submit a waiver of coverage to the Plan Sponsor.

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

You and/or your Dependents may enroll in this Plan later if you qualify under the special enrollment rules below. Employees are allowed to waive medical coverage and enroll in dental only if the employee has an eligible waiver.

All special enrollment provisions assume that the Employee has satisfied any Waiting Periods required and each individual is eligible as stated in the Plan.

- Special Enrollment Rule #1

  If you declined enrollment for yourself or your Dependents because of other coverage or there was a change in contribution, you or your Dependents may enroll in the Plan later if the other coverage ends. To do so, you must submit a completed enrollment application to the Plan Sponsor within 31 days after the other health coverage ends. If the other coverage was through Medicaid or a State Children's' Health Insurance Program, you and/or your Dependents will have 60 days to submit an enrollment change. Coverage will begin on the first day of the month following the receipt of the completed enrollment application.

- Special Enrollment Rule #2

- If you acquire new Dependents due to a qualifying event, you may be able to enroll yourself and/or your eligible Dependents at that time. Special Enrollment Rule #3

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

Late Enrollment

If you did not enroll during your Initial Enrollment Period or enrolled and later discontinued coverage, and you do not qualify for a special enrollment period, your enrollment will be delayed until the Plan's next designated open enrollment period.

The annual open enrollment period is every November, during a two-week period to be determined annually. Employees and their Dependents who are otherwise eligible for coverage under the Plan will be able to enroll in the Plan. Benefit choices made during the open enrollment period will become effective January 1st. Plan participants will receive detailed information regarding open enrollment from their employer.

Returning to Work after a Layoff or Termination

If you are laid off or terminated, and then rehired by the Plan Sponsor within six months, you will not have to satisfy another Waiting Period.

Your coverage will resume the first day of the month after you return to work and again meet the Plan Sponsor's minimum hour requirement. If your Dependents were covered before your layoff, they can resume coverage at that time as well. You must re-enroll yourself and/or your Dependents by submitting an enrollment change within the 31 day enrollment period following your return to work.

Returning to Work after a Leave of Absence

If you return to work after a Plan Sponsor-approved Leave of Absence of six months or less, you will not have to satisfy another Waiting Period.

Your coverage will resume the first day of the month after you return to work and again meet the Plan Sponsor's minimum hour requirement. If your Dependents were covered before your leave, they can resume coverage at that time as well. You must re-enroll yourself and/or your Dependents by submitting an enrollment change within the 31 day enrollment period following your return to work.

Returning to Work after Family Medical Leave

If the Plan Sponsor employs 50 or more people, it is probably subject to the Family Medical Leave Act (FMLA). To find out if you have rights under FMLA, ask the Plan Sponsor. Under FMLA, if you return to work after a qualifying FMLA medical leave, you will not have to satisfy another Waiting Period.

Your coverage will resume the day you return to work and again meet the Plan Sponsor's minimum hour requirement. If your Dependents were covered before your leave, they can resume coverage at that time as well. You must re-enroll yourself and/or your Dependents by submitting an enrollment change within the 31-day enrollment period following your return to work.

Status Change

Part-time to full-time conversion

Part-time Employees who have waived coverage and then become a full-time Employee or have a significant increase in work hours (minimum of 25%) may elect to enroll in the Standard Plan at that time. You may enroll by submitting an enrollment change to the Plan Sponsor within the 31 days following the change in your employment status. Coverage is effective the first of the month following the receipt of the 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. You may enroll by submitting an enrollment change to the Plan Sponsor within the 31 days following the change in your employment status. 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.

If a part-time Employee's hours are reduced by a Deschutes County approved temporary reduction in hours, coverage will continue without termination.

Full-time to part-time conversion

Full-time Employees who have been 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. You may enroll by submitting an enrollment change to the Plan Sponsor within the 31 days following the change in your employment status. 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. You may enroll by submitting an enrollment change to the Plan Sponsor within the 31 days following the change in your employment status. 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. Starting with the fourth calendar month, the Employee's eligibility will be determined on a month-to-month basis for the remainder of the stability period.

Employment transfer between COIC and Deschutes County

Employees who were employed by COIC and transfer their employment to Deschutes County or vice versa, will not have to re-serve the waiting period.

PLAN SELECTION PERIOD

If the Plan Sponsor offers more than one Plan option, you may only change to a different Plan option upon this Plan's anniversary date. You may select a different Plan option, if available, by submitting an enrollment change. Coverage under the new Plan option becomes effective on this Plan's anniversary date.

WHEN COVERAGE ENDS

If you leave your job for any reason or your work hours are reduced below the Plan Sponsor's minimum requirement, coverage for Members will end. Coverage ends on the last day of the month in which you worked the required minimum hours for coverage. Coverage for elected officials ends on the last day of the month in which they are no longer serving as an elected official of the County. They may be eligible to continue coverage for a limited time. For more information, see the Continuation of Coverage section.

Dependent Children

When your enrolled child no longer qualifies as a Dependent, their coverage will end on the last day of that month.

If two Employees are covered under the Plan and the Employee who is covering the Dependent Children terminates coverage, the Dependent Child may be continued by the other covered Employee with no waiting period as long as coverage has been continuous.

Dissolution of Domestic Partnership

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

Divorced Spouses

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

CONTINUATION OF COVERAGE

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

Continuation Due to Plan Sponsor Approved Paid Administrative Leave of Absence, Disability, or Leave of Absence

A Member may remain eligible for coverage 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, coverage eligibility will remain in effect until the end of the three-calendar month period that next follows the month in which the Member last worked as an active Employee.

For paid administrative leave, coverage eligibility will remain in effect until the date the Employer, in its sole discretion, ends such eligibility.

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 Members.

If you return to work after a Plan Sponsor-approved paid administrative leave of absence, you will not have to satisfy another Waiting Period.

USERRA CONTINUATION

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

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

The following requirements apply to USERRA continuation:

- Only Dependents who were enrolled in the Plan can take continuation. The only exceptions are newborn babies and newly acquired eligible Dependents not covered by another group health plan.
- To apply for continuation, you must submit a completed Continuation Election form to the Plan Sponsor within 60 days after the last day of coverage under the Plan.
- You must pay continuation premium to the Plan Sponsor by the first of each month. PacificSource cannot accept the premium directly from you.
- The Plan Sponsor must still be self-insured. If the Plan Sponsor discontinues this Plan, you will no longer qualify for continuation.

COBRA CONTINUATION

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

If COBRA is available to you and certain circumstances (a qualifying event) occur that cause you to lose coverage, you may have the right to continue coverage for a period of time.

COBRA Eligibility and Length of Continuation

When the following qualifying events cause you to lose coverage, you may continue coverage for the lengths of time shown in the table:

Qualifying Event	Continuation Period
Employee's termination of employment or reduction in hours	Employee, Spouse, and children may continue for up to 18 months[1]
Employee's divorce or legal separation	Spouse and children may continue for up to 36 months[2]
Employee's entitlement to Medicare benefits if it causes a loss of coverage	Spouse and children may continue for up to 36 months[2]
Employee's death	Spouse and children may continue for up to 36 months[2]
Child no longer qualifies as a Dependent	Child may continue for up to 36 months[2]

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

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

If your Dependents were not covered prior to your qualifying event, they may enroll in the continuation coverage while you are on continuation. They will be subject to the same rules that apply to active Employees.

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

Domestic Partners and their Dependent Children may not continue this Plan's coverage under COBRA independent of the Employee.

When Continuation Coverage Ends

COBRA coverage will end earlier than the maximum period outlined in the table above if:

- Premiums are not paid timely;
- Member becomes covered under another group plan or Medicare after electing COBRA. Coverage already in effect under another plan at the time of COBRA election will not make COBRA unavailable and COBRA coverage may continue for up to 36 months from the date the Member became entitled to Medicare;
- The Plan Sponsor discontinues this Plan and no longer offers a group health plan to any of its Employees;
- Member who qualified for a disability extension is determined by the Social Security Administration to no longer be disabled;
- Member is terminated for cause (for example, submission of fraudulent claims).

Type of Coverage

Under COBRA, you may continue any coverage you had before the qualifying event. If the Plan Sponsor provides both medical and dental coverage and you were enrolled in both, you may continue both medical and dental. If the Plan Sponsor provides only one type of coverage, or if you were enrolled in only one type of coverage, you may continue only that coverage.

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

Your Responsibilities and Deadlines

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

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

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

Continuation Premium

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

SURVIVING OR DIVORCED SPOUSES AND DOMESTIC PARTNERS

If your group has 20 or more Employees, or this Plan has 20 or more Subscribers, and you die, divorce, or dissolve your domestic partnership, and your Spouse or Domestic Partner is 55 years or older, your Spouse or Domestic Partner may be able to continue coverage until entitled to Medicare or other coverage. Dependent Children are subject to this Plan's age and other eligibility requirements. Some restrictions and guidelines apply; contact the Plan Sponsor for specific details.

CONTINUATION WHEN YOU RETIRE

Continuation upon retirement is based on meeting all the retirement requirements set forth in the terms and conditions of your employment agreed to with your Plan Sponsor

- You must be receiving benefits from PERS (Public Employee Retirement System) or from a similar retirement Plan offered by your Plan Sponsor;
- You must have been continuously covered under the group's Plan for at least 24 consecutive months prior to the retirement, unless otherwise indicated by a management/labor agreement.

Retired Employees must elect Retiree coverage within 30 days of the date of their retirement or loss of other Deschutes County coverage to be eligible for this coverage.

Only those Dependents who are enrolled under this Plan at the time the Employee retired are eligible to continue coverage under this 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/her retirement date.

If you become eligible for PERS while enrolled in COBRA due to a medical determination that you are not able to work because of disability, you can elect to re-enroll as a retired Employee only under this Plan. You must request re-enrollment within 6 months of PERS eligibility.

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

When a retired Employee's coverage terminates. Retired Employee coverage will terminate on the earliest of these dates:

- The date the Plan is terminated;
- The date the covered retired Employee's eligible class is eliminated;

- The first day of the calendar month the covered retired Employee becomes entitled to Medicare;
- 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
- As otherwise specified in the Eligibility section of the Plan.

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

When Dependent Coverage of a Retired Employee 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 Sponsor must be notified that the 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:

- The last day of the calendar month the Plan or Dependent coverage under the Plan is terminated;
- 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 Continuation of Coverage section.);
- The first day of the month the covered Dependent Spouse or Domestic Partner becomes entitled to Medicare;
- On the last day of the calendar month that a Dependent Child ceases to be a Dependent as defined by the Plan (See the Continuation of Coverage section.);
- 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
- As otherwise specified in the Eligibility section of the Plan.

WORK STOPPAGE

Labor Unions

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 contribution, 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 contributions 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.

RESOURCES FOR INFORMATION AND ASSISTANCE

Assistance

Members who do not speak English, have literacy difficulties, or have physical or mental disabilities may contact the PacificSource Customer Service team for assistance.

Information Available from PacificSource

PacificSource makes the following disclosure information available to you free of charge. You may contact the PacificSource Customer Service team to request a copy (by mail or electronically) or by visiting the website, PacificSource.com. Available disclosure information includes, but not limited to, the following:

- A directory of Providers under this Plan;
- Information about our Drug List (also known as a formulary);
- A description (consistent with risk-sharing information required by the Centers for Medicare and Medicaid Services) of any risk-sharing arrangements the Plan or PacificSource has with Providers;
- A description of the Plan Sponsor's and/or PacificSource's efforts to monitor and improve the quality of health services;
- Information about how PacificSource checks the credentials of network Providers and how you can obtain the names and qualifications of your Providers;
- Information about prior authorization and utilization review procedures; and
- Information about any plan offered by PacificSource.

Information Available from the Division of Financial Regulation about PacificSource

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

- The results of all publicly available accreditation surveys;
- A summary of PacificSource's health promotion and disease prevention activities;
- Samples of the written summaries delivered to PacificSource policyholders;
- An annual summary of Grievances and Appeals against PacificSource;
- An annual summary of PacificSource's utilization review policies;
- An annual summary of PacificSource's quality assessment activities; and
- An annual summary of the scope of PacificSource's Provider network and accessibility of services.

You can request this information by contacting:

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

Call 503-947-7984 or 888-877-4894

Email dfr.insurancehelp@dcbs.oregon.gov

Website dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx

RIGHTS AND RESPONSIBILITIES

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

Your Rights as a Member

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

Your Responsibilities as a Member

- You are responsible for reading this Plan Document and all other communications from the Plan Sponsor and PacificSource, and for understanding this Plan's benefits. You are responsible for contacting the Plan Sponsor or PacificSource's Customer Service team if anything is unclear to you.
- You are responsible for making sure your Provider obtains prior authorization for any services that require it before you are treated.
- You are responsible for providing the Plan Sponsor and PacificSource with all the information required to provide benefits under this Plan.

- You are responsible for giving your Provider complete information to help accurately diagnose and treat you.
- You are responsible for telling your Providers you are covered by this Plan and showing your PacificSource Member ID card when you receive care.
- You are responsible for being on time for appointments, and contacting your Provider ahead of time if you need to cancel.
- You are responsible for any fees the Provider charges for late cancellations or no shows.
- You are responsible for contacting the Plan Sponsor or PacificSource if you believe you are not receiving adequate care.
- You are responsible for supplying information to the extent possible that the Plan Sponsor or PacificSource needs in order to administer your benefits or your Providers need in order to provide care.
- You are responsible for following plans and instructions for care that you have agreed to with your Providers.
- You are responsible for understanding your health problems and participating in developing mutually agreed upon goals, to the degree possible.

PRIVACY AND CONFIDENTIALITY

The Plan Sponsor and PacificSource have strict policies in place to protect the confidentiality of your personal information, including medical records. Detailed information is available at PacificSource.com/privacy-policy.

Your personal information is only available to staff members who need that information to do their jobs. Disclosure outside the Plan Sponsor and PacificSource is allowed only when necessary to provide your coverage, or when otherwise allowed by law. Except when certain statutory exceptions apply, the law requires written authorization from you (or your Authorized Representative) before disclosing your personal information outside the Plan Sponsor or PacificSource. An example of one exception is that we do not need written authorization to disclose information to a designee performing utilization management, quality assurance, or peer review on our behalf.

PLAN ADMINISTRATION

Name of Plan:

The Deschutes County Group Health Plan (the “Plan”).

Name and Address of the Plan Sponsor:

Deschutes County
PO Box 6005
Bend, OR 97708-6005
Phone: (541) 385-3215
Fax: (541) 330-4626

Plan Sponsor's Employer Identification / Tax Identification Number:

93-6002292

Plan Identification Number:

502

Contract Year:

January 1st to December 31st

Type of Plan:

Group Health Plan (self-insured)

Type of Administration:

The Plan is administered by Employees of the Plan Sponsor and under an administrative services agreement with a Third Party Administrator.

Name and Address of Third Party Administrator:

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

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

Deschutes County
Attn: Nick Lelack, County Administrator
PO Box 6005
Bend, OR 97708-6005
Phone: (541) 385-3215
Fax: (541) 330-4626

Funding Method and Contributions:

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

Plan Changes

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

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

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

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

DEFINITIONS

Wherever used in this Plan, the following definitions apply to the masculine and feminine, and singular and plural forms of the terms. Other terms are defined where they are first used in the text.

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

Adverse Benefit Determination means this Plan's denial, reduction, or termination of, or this Plan's failure to provide or make a payment in whole or in part, for a benefit that is based on this Plan's:

- Denial of eligibility for or termination of enrollment in this Plan;
- Rescission or cancellation of your coverage;
- Imposition of a third party liability, network exclusion, annual benefit limit, or other limitation on otherwise Covered Services or items;
- Determination that a healthcare item or service is Experimental, Investigational, or Unproven, not Medically Necessary, effective, or appropriate; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Allowable Fee is the maximum amount this Plan will reimburse Providers. In-network Providers are paid the Contracted Allowable Fee and Out-of-network Providers are paid the Out-of-network Allowable Fee.

- **Contracted Allowable Fee** is an amount this Plan agrees to pay an In-network Provider for a given service or supply through direct or indirect contract.
- **Out-of-network Allowable Fee** is the dollar amount established for reimbursement of charges for specific services or supplies provided by Out-of-network Providers. PacificSource, on behalf of the Plan Sponsor, uses several sources to determine the Out-of-network Allowable Fee. Depending on the service or supply and the Service Area in which it is provided, the Out-of-network Allowable Fee may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), contracted vendors, other nationally recognized databases, or PacificSource, as documented in PacificSource's payment policy and adopted by the Plan Sponsor.

An Out-of-network Provider may charge more than the limits established by the Out-of-network Allowable Fee. Charges that are eligible for reimbursement, but exceed the Out-of-network Allowable Fee, are the Member's responsibility. For more information, see the Out-of-network Providers section.

Ambulatory Surgical Center means a facility licensed by the appropriate state or federal agency to perform Surgical Procedures on an outpatient basis.

Appeal means a written or verbal request from a Member or, if authorized by the Member, the Member's Authorized Representative, to change a previous decision made under this Plan concerning:

- Access to healthcare benefits, including an Adverse Benefit Determination made pursuant to utilization management;
- Claims payment, handling, or reimbursement for healthcare services;
- Rescission of the Member's benefit coverage by the Plan Sponsor; and
- Other matters as specifically required by law.

Approved Clinical Trials are Phase I, II, III, or IV clinical trials for the prevention, detection, or treatment of cancer or another life threatening condition or disease. Life threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The trial must be:

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

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

Balance Billing means the difference between the Allowable Fee and the Provider's billed charge. Out-of-network Providers may bill the Member this amount, unless the service qualifies for protection rights under federal law. For more information, see the Your Rights and Protections Against Surprise Medical Bills and Balance Billing section.

Behavioral Health Assessment means an evaluation by a behavioral health clinician, in person or using Telehealth, to determine a Member's need for immediate crisis stabilization.

Behavioral Health Condition means any mental or Substance Use Disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), the International Classification of Diseases, 10th Revision (ICD-10), or the International Classification of Diseases, 11th Revision (ICD-11).

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

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

- Eligibility and coverage determinations (including coordination of benefits), and adjudication or subrogation of claims;
- Review of healthcare services with respect to Medical Necessity (including underlying criteria), coverage under this Plan, appropriateness of care, Experimental, Investigational, or Unproven treatment, justification of charges; and
- Utilization review activities, including precertification and prior authorization of services and concurrent and post-service review of services.

Benefit Year refers to the period of time during which benefits accumulate toward Plan maximums and is on a calendar year basis, beginning January 1 through December 31 of the same year.

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

Chemotherapy means the use of drugs approved for use in humans by the FDA and ordered by the Provider for the treatment of disease.

Coinsurance means a defined percentage of the Allowable Fee for certain Covered Services and supplies the Member receives. It is the percentage the Member is responsible for, not including Copayments and Deductibles.

Complaint means an expression of dissatisfaction directly to the Plan Sponsor or PacificSource that is about a specific problem encountered by a Member, or about a Benefit Determination by the Plan Sponsor, or about an agent acting on behalf of the Plan Sponsor, including PacificSource. It includes a request for action to resolve the problem or change the Benefit Determination. The Complaint does not include an Inquiry.

Concurrent Care Review means a request for an extension of healthcare services already approved. The review is conducted during a Member's stay or course of treatment in a facility, the office of a Provider, or other inpatient or outpatient healthcare setting.

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

Copayment (also referred to as Copay) is a fixed, up-front dollar amount the Member is required to pay for certain Covered Services.

Covered Service means a service or supply for which benefits are payable under this Plan subject to applicable Deductibles, Copayments, Coinsurance, out-of-pocket limit, or other specific limitations.

Custodial Care means care that is for the purpose of watching and protecting a Member. Custodial Care includes care that helps the Member conduct activities of daily living that can be provided by a person without medical or paramedical skills and/or is primarily for the purpose of separating the Member from others or preventing self-harm.

Deductible means the portion of the expense for a Covered Service that must be paid by the Member before the benefits of this Plan are applied. A Plan may include more than one Deductible.

Dependent means the Employee's legal Spouse, Domestic Partner, and Dependent Children who qualify for coverage under the Employee's Plan. For more information, see the Eligibility section.

Dependent Children means the following:

- Biological children;
- Step children;
- Adopted children; a child will be considered a Dependent upon assumption of a legal obligation for total or partial support in anticipation of adoption; and
- Foster children or children for whom you or your Spouse/Domestic Partner are under a current court order to act as legal custodian or guardian.

Diagnostic Breast Examination means a Medically Necessary and clinically appropriate examination of the breast that is used to evaluate an abnormality seen or suspected from a screening examination for breast cancer or detected by another means of examination.

Domestic Partner means an individual that meets the following definition:

- **Registered Domestic Partner** means an individual, age 18 or older, who is joined in a domestic partnership as provided in ORS 106.310(1), or as similarly provided under the corresponding law of the state where the same gender domestic partnership was created and registered.

Durable Medical Equipment means equipment that can withstand repeated use; is primarily and customarily used to serve a medical purpose rather than convenience or comfort; is generally not useful to a Member in the absence of an Illness or Injury; is appropriate for use in the home; and is prescribed by a Provider. Examples include, but not limited to, Hospital beds, wheelchairs, crutches, canes, walkers, nebulizers, commodes, suction machines, traction equipment, respirators, and TENS units.

Durable Medical Equipment Supplier means a PacificSource In-network Provider or a Provider that satisfies the criteria in the Medicare Quality Standards for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and other items and services.

Eligible Employee means an Employee or former Employee who is eligible for coverage under this Plan. Eligible Employees may be covered under this Plan only if they meet the eligibility requirements according to the terms of this Plan.

Emergency Medical Condition means a medical, Mental Health, or Substance Use Disorder condition:

- Manifesting itself by acute symptoms of sufficient severity, including severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition:
  - Placing the health of the Member, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to affect a safe transfer to another Hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.
- That is a Behavioral Health Crisis.

Emergency Medical Screening Exam means the medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

Emergency Services means:

- An Emergency Medical Screening Exam or Behavioral Health Assessment that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Further medical examination and treatment as are required under 42 U.S.C. 1395dd to Stabilize the patient to the extent the examination and treatment are within the capability of the staff and facilities available at a Hospital.

Employee means any individual employed by the Plan Sponsor.

Employer generally means the Plan Sponsor unless otherwise noted.

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

- Ambulatory patient services;
- Emergency Services;
- Hospitalization;

- Laboratory services;
- Maternity and newborn care;
- Mental health and Substance Use Disorder services, including behavioral health treatment;
- Pediatric services, including oral and vision care;
- Prescription Drugs;
- Preventive and wellness services and chronic disease management; and
- Rehabilitation and Habilitation Services and Devices.

Evidence-based Criteria are coverage criteria or policies that integrates unbiased, medically appropriate, best-available research evidence, national consensus guidelines, or other compendia supported evidence and data.

Experimental, Investigational, or Unproven means services, supplies, protocols, procedures, devices, drugs or medicines, or the use thereof, that are Experimental, Investigational, or Unproven for the diagnosis and treatment of Illness or Injury.

- Experimental, Investigational, or Unproven services and supplies include, but not limited to, services, supplies, procedures, devices, Chemotherapy, drugs or medicines, or the use thereof, which at the time they are rendered and for the purpose and in the manner they are being used:
  - Have not yet received full U.S. government agency required approval (for example, FDA) for other than Experimental, Investigational, or Unproven, or clinical testing;
  - Are not of generally accepted medical practice in this Plan's state of issue or as determined by medical advisors, medical associations, and/or technology resources;
  - Are not approved for reimbursement by the Centers for Medicare and Medicaid Services;
  - Are furnished in connection with medical or other research; or
  - Are considered by any governmental agency or subdivision to be Experimental, Investigational, or Unproven, not considered reasonable and necessary, or any similar finding.
- Chemotherapy is considered Experimental, Investigational, or Unproven when its use is not recommended by National Comprehensive Cancer Network with at least a 2A level of evidence.
- When making decisions about whether treatments are Experimental, Investigational, or Unproven, the Plan Sponsor relies on the above resources as well as:
  - Expert opinions of specialists and other medical authorities;
  - Published articles in peer-reviewed medical literature;
  - External agencies whose role is the evaluation of new technologies and drugs; and
  - External Review by an independent review organization.
- The following will be considered in making the determination whether the service is in an Experimental, Investigational, or Unproven status:

- Whether there is sufficient evidence to permit conclusions concerning the effect of the services on health outcomes;
- Whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;
- Whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects; and
- Whether any improved health outcomes from the services are attainable outside an investigational setting.

PacificSource may delegate the determination whether a service is Experimental, Investigational, or Unproven to a third party for services received outside Idaho, Montana, Oregon, and Washington. Such determinations shall be based upon Evidence-based Criteria and may vary from PacificSource's determinations within Idaho, Montana, Oregon, and Washington.

External Review means the request by an appellant for a determination by an independent review organization at the conclusion of an Internal Appeal.

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

Grievance means a written Complaint submitted by or on behalf of a Member regarding service delivery issues other than denial of payment for healthcare services or non-provision of healthcare services, including dissatisfaction with health care, waiting time for services, Provider or staff attitude or demeanor, or dissatisfaction with service provided by the carrier.

Habilitation Services and Devices are healthcare services and devices that help a person keep, learn, or improve skills and functioning for daily living. These services and devices may include Physical/Occupational Therapy, speech-language pathology, and other services and devices for people with disabilities in a variety of inpatient and/or outpatient settings.

Hearing Aid means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments, or accessory for the instrument or device, except batteries and cords.

Hearing Assistive Technology Systems means devices used with or without Hearing Aids or cochlear implants to improve the ability of a user with hearing loss to hear in various listening situations, such as being located a distance from a speaker, in an environment with competing background noise or in a room with poor acoustics or reverberation.

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

- Home health aide services;
- Hospice therapy;
- Medical Supplies and equipment suitable for use in the home;
- Medically Necessary personal hygiene, grooming and dietary assistance;

- Nursing;
- Occupational therapy;
- Physical therapy; and
- Speech therapy.

Hospice Care means care designed to give supportive care to a Member in the final phase of a terminal Illness and focuses on comfort and quality of life, rather than curing a disease. A Member's Provider must certify that the Member is terminally ill with a life expectancy of less than six months, and the Member must not be undergoing treatment of the terminal Illness other than for direct control of adverse symptoms.

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

Illness means a sickness, disease, ailment, bodily disorder, and pregnancy.

In-network Provider means a Provider that directly or indirectly holds a Provider contract or agreement with PacificSource.

Infertility means disease of the male or female reproductive system defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse.

Initial Enrollment Period means a period of days set by the Plan Sponsor that determines when an Employee is first eligible to enroll.

Injury means bodily trauma or damage that is independent of disease or infirmity. The damage must be caused through external and Accidental means.

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

Internal Appeal means a review of an Adverse Benefit Determination.

Leave of Absence is a period of time off work granted to an Employee by the Plan Sponsor at the Employee's request and during which the Employee is still considered to be employed and is carried on the employment records of the Plan Sponsor. A leave can be granted for any reason acceptable to the Plan Sponsor, including disability and pregnancy.

Lifetime Maximum means the maximum benefit that will be provided toward the expenses incurred by any one Member while the Member is covered by this Plan or any other Plan offered by the Plan Sponsor. If any Covered Service is deemed to be an Essential Health Benefit as determined by the Secretary of the U.S. Department of Health and Human Services, Lifetime Maximum dollar limits will not apply to that Covered Service in accordance with the standards established by the Secretary.

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

Medical Supplies means items of a disposable nature that may be essential to effectively carry out the care a Provider has ordered for the treatment or diagnosis of an Illness or Injury. Examples of Medical Supplies include, but not limited to, syringes and needles, splints and slings, ostomy supplies, sterile dressings, elastic stockings, enteral foods, drugs or biologicals that must be put

directly into the equipment in order to achieve the therapeutic benefit of the Durable Medical Equipment or to assure the proper functioning of this equipment.

Medically Necessary or Medical Necessity means those services and supplies that are required for diagnosis or treatment of Illness or Injury and that are:

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

PacificSource may delegate determinations of Medical Necessity to third parties for services outside Idaho, Montana, Oregon, and Washington, and such third parties may utilize Evidence-based Criteria for determining Medical Necessity consistent with the above. Services and supplies intended to diagnose or screen for a medical condition in the absence of signs or symptoms, or of abnormalities on prior testing, including exposure to infectious or toxic materials or family history of genetic disease, are not considered Medically Necessary under this definition. For more information, see screening tests in the Benefit Exclusions section.

Member means a person covered by this Plan.

Mental Health and/or Substance Use Disorder Healthcare Facility means a corporate or governmental entity or other Provider of services for the care and treatment of Substance Use Disorders and/or Behavioral Health Conditions which is licensed by the state and accredited by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities for the level of care which the facility provides.

Mental Health and/or Substance Use Disorder Healthcare Program means a particular type or level of service that is organizationally distinct within a Mental Health and/or Substance Use Disorder Healthcare Facility.

Mental Health and/or Substance Use Disorder Healthcare Provider means a person that has met the applicable credentialing requirements, is otherwise eligible to receive reimbursement under this Plan and is:

- A Mental Health and/or Substance Use Disorder Healthcare Facility;
- A residential Mental Health and/or Substance Use Disorder Healthcare Program or Facility;
- A day or partial hospitalization program;
- An outpatient service;

- An individual behavioral health or medical professional duly licensed and authorized for reimbursement under state law; or

- Adolescent wilderness treatment programs, duly licensed and authorized for reimbursement as a Mental Health and/or Substance Use Disorder Healthcare Program or Facility under state law, when prior authorized for medical necessity.

Mental Health Condition means all disorders defined in the current edition of Diagnostic and Statistical Manual of Mental Disorders.

Orthotic Devices means rigid or semi rigid devices supporting a weak or deformed leg, foot, arm, hand, back, or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back, or neck. It includes orthopedic appliances or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. Orthotic Devices are usually customized for an individual's use and are not appropriate for anyone else. Examples of Orthotic Devices include, but not limited to, Ankle Foot Orthosis (AFO), Knee Ankle Foot Orthosis (KAFO), Lumbosacral Orthosis (LSO), and foot orthotics.

Out-of-network Provider means a Provider that does not directly or indirectly hold a Provider contract or agreement with PacificSource.

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

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

Post-service Claim means a request for benefits that involves services you have already received.

Pre-service Claim means a request for benefits that requires approval by PacificSource, on behalf of the Plan Sponsor, in advance (prior authorization) in order for a benefit to be paid.

Prescription Drugs are drugs that, under federal law, require a prescription by Providers practicing within the scope of their licenses.

Prosthetic Devices (excluding dental) means artificial limb devices or appliances designed to replace, in whole or in part, an arm or a leg. It includes devices that replace all or part of an internal or external body organ, or replace all or part of the function of a permanently inoperative or malfunctioning internal or external organ. Examples of Prosthetic Devices include, but not limited to, artificial limbs, cardiac pacemakers, prosthetic lenses, breast prosthesis (including Mastectomy bras), and maxillofacial devices.

Provider means a healthcare professional, Hospital/other institution or medical supplier that is state licensed or state certified to provide a Covered Service or supply. Healthcare professionals eligible to provide care include, but not limited to: chiropractors, dental Providers, massage therapists, mental health counselors, nurses, nurse midwives, nurse practitioners, pharmacists, physical therapists, physicians, podiatrists and psychologists.

Radiation Therapy is the treatment of disease using x-rays or similar forms of radiation.

Rehabilitation Services are those Medically Necessary services and devices that help a person keep, restore, or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt, or disabled.

Rescission means to retroactively cancel or discontinue coverage under this Plan for reasons other than failure to timely pay required premiums or required contributions. This Plan may not rescind coverage unless the Member or person seeking coverage on behalf of the Member, performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, as prohibited by the terms of the Plan or coverage and a 30 day prior written notice is provided.

Routine Costs of Care mean costs for Medically Necessary services or supplies covered by this Plan in the absence of a clinical trial. Routine Costs of Care do not include:

- The drug, device, or service being tested in the clinical trial unless the drug, device, or service would be covered for that indication by the Plan if provided outside of a clinical trial;
- Items or services required for the provisions of the drug, device, or service being tested in the clinical trial;
- Items or services required for the clinically appropriate monitoring of the drug, device, or service being tested in the clinical trial;
- Items or services required 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 to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Member;
- Items or services provided by a clinical trial sponsor free of charge to a Member participating in the clinical trial; or
- Items or services that are not covered by this Plan if provided outside of the clinical trial.

Service Area is Oregon, Idaho, Montana, and Washington.

Skilled Nursing Facility or Convalescent Home means an institution that provides skilled nursing care under the supervision of a Provider, provides 24 hour nursing service by or under the supervision of a registered nurse (RN), and maintains a daily record of each patient. Skilled Nursing Facilities must be licensed by an appropriate state agency and approved for payment of Medicare benefits to be eligible for reimbursement.

Specialized Treatment Facility means a facility that provides specialized short-term or long-term care. The term Specialized Treatment Facility includes Ambulatory Surgical Centers, birthing centers, hospice facilities, inpatient rehabilitation facilities, Mental Health and/or Substance Use Disorder Healthcare Facilities, organ transplant facilities, psychiatric day treatment facilities, residential treatment facilities, Skilled Nursing Facilities, Substance Use Disorder day treatment facilities, Substance Use Disorder Treatment Facilities, and Urgent Care Treatment Facilities.

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

Specialty Pharmacies specialize in the distribution of Specialty Drugs and providing pharmacy care management services designed to assist Members in effectively managing their condition.

Spouse means any individual who is legally married under current state law.

Stabilize means to provide medical treatment as necessary to ensure that, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during or to result from the transfer of the Member from a facility; and with respect to a pregnant woman who is in active labor, to perform the delivery, including the delivery of the placenta.

Step Therapy means a program that requires the Member to try lower-cost alternative medications (Step 1 drugs) before using more expensive medications (Step 2 or 3 drugs). The program will not cover a brand name, or second-line medication, until less expensive, first-line/generic medications have been tried first.

Subscriber means an Employee or former Employee covered under this Plan. When a family that does not include an Employee or former Employee is covered under this Plan, the oldest Dependent is referred to as the Subscriber.

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

Substance Use Disorder Treatment Facility means a treatment facility that provides a program for the treatment of Substance Use Disorders pursuant to a written treatment plan approved and monitored by a Provider or addiction counselor licensed by the state; is licensed or approved as a treatment center by the department of public health and human services, and is licensed by the state where the facility is located.

Supplemental Breast Examination means a Medically Necessary and appropriate examination of the breast that is used to screen for breast cancer when there is no abnormality seen or suspected and is based on personal or family medical history or other factors that may increase a person's risk of breast cancer.

Surgical Procedure means any of the following listed operative procedures:

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

Telehealth means the use of audio, video, or other telecommunications technology or media, including audio-only communication, that is used by a Provider or facility to deliver services, and delivered over a secure connection that complies with state and federal privacy laws.

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

Tobacco Cessation Program means a program recommended by a Provider that follows the United States Public Health Services guidelines for tobacco cessation. Tobacco Cessation Program includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products.

Tobacco Use means use of tobacco on average four or more times per week within the past six months. This includes all tobacco products. Tobacco Use does not include religious or ceremonial use of tobacco by American Indians and/or Alaska Natives.

Urgent Care means services for an unforeseen Illness or Injury that requires treatment within 24 hours to prevent serious deterioration of a Member's health. Urgent conditions are normally less severe than medical emergencies. Examples of conditions that could need Urgent Care are sprains and strains, vomiting, cuts, and headaches.

Urgent Care Claim means a request for medical care or treatment with respect to which the time periods for making a non-urgent determination could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

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

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

Women's Healthcare Provider means an obstetrician, gynecologist, physician assistant, naturopathic physician, nurse practitioner specializing in women's health, physician, or other Provider practicing within the scope of their license.

Women's Healthcare Services means organized services to provide healthcare to women, inclusive of the women's preventive services required by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The services include, but not limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. Women's Healthcare Services also include any appropriate healthcare service for other health problems, discovered and treated during the course of a visit to a Women's Healthcare Provider for a Women's Healthcare Service, which is within the Provider's scope of practice. For purposes of determining a woman's right to directly access health services covered by this Plan, maternity care, reproductive health, and preventive services include: Contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breastfeeding, and complications of pregnancy.

SIGNATURE PAGE

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

The effective date of the Plan is January 1, 2024.

Dated this 8 (Date) day of November (Month), 2023 (Year)

By Nick Lelack

Title County Administrator