Member Benefit Handbook

Graduate Teaching Fellows Federation

Group No.: G0021003

PREFERRED 90+100 VAR GF 0812

Effective: 9/16/2012

01/14/2013

2324990

PacificSource HEALTH PLANS

We're in it for the people.

Welcome to your PacificSource group health plan. Your employer offers this coverage to help you and your family members stay well, and to protect you in case of illness or injury. Your plan includes a wide range of benefits and services, and we hope you will take the time to become familiar with them.

Using this Handbook

This handbook will help you understand how your plan works and how to use it. Please read it carefully and thoroughly. Although it is only a summary, it is intended to answer most of your questions. If there is a conflict between this benefit handbook and the group health contract, this plan will pay benefits according to the contract language.

Within this handbook you'll find Member Benefit Summaries for your medical plan and any other health benefits provided under your employer's group health contract. The summaries work with this handbook to explain your plan benefits. The handbook explains the services covered by your plan; the benefit summaries tell you how much your plan pays toward expenses and how much you're responsible for.

If anything is unclear to you, the PacificSource Customer Service staff is available to answer your questions. Please give us a call, visit us on the Internet, or stop by our office. We look forward to serving you and your family.

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.

PacificSource Customer Service Department
Phone (541) 684-5582 or (888) 977-9299
Email cs@pacificsource.com

PacificSource Headquarters
PO Box 7068, Springfield, OR 97475-0068
Phone (541) 686-1242 or (800) 624-6052

Website
PacificSource.com

Para asistirle en español, por favor llame el numero (800) 624-6052, extensión 1009, de Lunes a Viernes, 7:00 a.m. hasta 5:00 p.m.

This benefit book is printed on environmentally friendly paper that uses minimal chemicals and 50% fewer trees than regular paper. PacificSource is proud to align business innovation with environmental responsibility.

CONTENTS

MEDICAL BENEFIT SUMMARY....A

VISION SUMMARY....C

ALTERNATIVE CARE SUMMARY....E

PHARMACY BENEFIT SUMMARY....G

DENTAL SUMMARY....K

GRANDFATHERED HEALTH PLAN....1

USING THE PROVIDER NETWORK....1

PARTICIPATING PROVIDERS....1

NON-PARTICIPATING PROVIDERS....2

NETWORK NOT AVAILABLE BENEFITS....3

COVERAGE WHILE TRAVELING....4

FINDING PARTICIPATING PROVIDER INFORMATION....4

TERMINATION OF PROVIDER CONTRACTS....5

BECOMING COVERED....5

ELIGIBILITY....5

ENROLLING DURING THE INITIAL ENROLLMENT PERIOD....6

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD....8

PLAN SELECTION PERIOD....9

TERMINATING COVERAGE....10

CONTINUATION OF INSURANCE....11

USERRA CONTINUATION....11

SURVIVING OR DIVORCED SPOUSES AND REGISTERED DOMESTIC PARTNERS....11

COBRA CONTINUATION....12

WORK STOPPAGE....13

INDIVIDUAL PORTABILITY POLICY....14

COVERED EXPENSES....14

PLAN BENEFITS....15

PREVENTIVE CARE SERVICES....15

PROFESSIONAL SERVICES....17

HOSPITAL AND SKILLED NURSING FACILITY SERVICES....18

OUTPATIENT SERVICES....19

EMERGENCY SERVICES....20

MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES....20

HOME HEALTH AND HOSPICE SERVICES....23

DURABLE MEDICAL EQUIPMENT....24

TRANSPLANT SERVICES....25
OTHER COVERED SERVICES, SUPPLIES, AND TREATMENTS....26
BENEFIT LIMITATIONS AND EXCLUSIONS....29
EXCLUDED SERVICES....30
EXCLUSION PERIODS....34
CREDIT FOR PRIOR COVERAGE....35
PREAUTHORIZATION....35
CASE MANAGEMENT....36
INDIVIDUAL BENEFITS MANAGEMENT....36
UTILIZATION REVIEW....37
HOW TO USE YOUR DENTAL PLAN....39
DENTAL PLAN BENEFITS....39
COVERED DENTAL SERVICES....39
CLASS I SERVICES - DIAGNOSTIC AND PREVENTIVE TREATMENT....40
CLASS II SERVICES - RESTORATIVE....40
CLASS II SERVICES - COMPLICATED....40
EXCLUSIONS....41
CLAIMS PAYMENT....45
COORDINATION OF BENEFITS....46
THIRD PARTY LIABILITY....48
COMPLAINTS, GRIEVANCES, AND APPEALS....49
GRIEVANCE AND APPEAL PROCEDURES....49
APPEAL PROCEDURES....49
HOW TO SUBMIT GRIEVANCES OR APPEALS....51
SOURCES FOR INFORMATION AND ASSISTANCE....51
FEEDBACK AND SUGGESTIONS....52
RIGHTS AND RESPONSIBILITIES....53
PRIVACY AND CONFIDENTIALITY....54
PLAN ADMINISTRATION....54
EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)....55
DEFINITIONS....56
ADDITIONAL MATERIAL....67
PRIVACY POLICY....67
VALUABLE PROGRAMS AND SERVICES....69
TRAVEL BENEFITS....73

ASSIST AMERICA.....75

MEDICAL BENEFIT SUMMARY

POLICY INFORMATION

Group Name:	Graduate Teaching Fellows Federation
Group Number:	G0021003
Plan Name:	PREFERRED 90+100 VAR GF 0812
Provider Network:	PSN

EMPLOYEE ELIGIBILITY REQUIREMENTS

Minimum Hour Requirement:	Per Employer Policy
Waiting Period for New Employees:	Per Employer Policy

SCHEDULE OF BENEFITS

Annual Deductible $100 per person / $300 per family

The deductible is an amount of covered medical expenses the member pays each contract year before the plan's benefits begin. The deductible applies to all services and supplies except those marked with an asterisk (*). Once a member has paid a total amount toward covered expenses during the contract year equal to the per person amount listed above, the deductible will be satisfied for that person for the rest of that contract year. Once any covered family members have paid a combined total toward covered expenses during the contract year equal to the per family amount listed above, the deductible will be satisfied for all covered family members for the rest of that contract year.

Annual Out-Of-Pocket Limit

Participating Providers	$1,000 per person
Non-participating Providers	$3,000 per person

Only participating provider expense applies to the participating provider out-of-pocket limit and only non-participating provider expense applies to the non-participating out-of-pocket limit. Once the participating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges (after the co-payment is deducted) for participating and network not available providers for the rest of that contract year. Once the non-participating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges (after the co-payment is deducted) for non-participating providers for the rest of that contract year. Co-payments, infertility services, non-participating transplant facility charges, ER co-payments and non-participating provider charges in excess of the allowable fee do not accumulate toward the out-of-pocket limit. Co-payments and non-participating provider charges in excess of the allowable fee will continue to be the member's responsibility even after the out-of-pocket limit is met.

After the annual deductible is met, the member is responsible for the following co-payments and co-insurance:

SERVICE:	PARTICIPATING PROVIDERS / NETWORK NOT AVAILABLE:	NON-PARTICIPATING PROVIDERS:
PREVENTIVE CARE		
Well Baby/Well Child Care	No charge*	30% co-insurance
Routine Physicals	No charge*	30% co-insurance
Well Woman Visits	No charge*	30% co-insurance
Immunizations	No charge*	30% co-insurance
Routine Colonoscopy, age 50-75	No charge*	30% co-insurance
PROFESSIONAL SERVICES		
Office and Home Visits	10% co-insurance	30% co-insurance
Office Procedures and Supplies	10% co-insurance	30% co-insurance
Surgery	10% co-insurance	30% co-insurance
Outpatient Rehabilitation Services	10% co-insurance	30% co-insurance
HOSPITAL SERVICES		
Inpatient Room and Board	10% co-insurance	30% co-insurance
Inpatient Rehabilitation Services	10% co-insurance	30% co-insurance
Skilled Nursing Facility Care	10% co-insurance	30% co-insurance
OUTPATIENT SERVICES		
Outpatient Surgery/Services	10% co-insurance	30% co-insurance
Advanced Diagnostic Imaging	10% co-insurance	30% co-insurance
Diagnostic and Therapeutic Radiology and Lab	10% co-insurance	30% co-insurance

SERVICE:	PARTICIPATING PROVIDERS / NETWORK NOT AVAILABLE:	NON-PARTICIPATING PROVIDERS:
URGENT AND EMERGENCY SERVICES		
Urgent Care Center Visits	10% co-insurance	30% co-insurance
Emergency Room Visits	$50 co-pay/visit plus 10% co-insurance^	$50 co-pay/visit plus 30% co-insurance^
Ambulance, Ground	20% co-insurance	20% co-insurance
Ambulance, Air	20% co-insurance	20% co-insurance
MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES		
Office Visits	10% co-insurance	30% co-insurance
Inpatient Care	10% co-insurance	30% co-insurance
Residential Programs	10% co-insurance	30% co-insurance
OTHER COVERED SERVICES		
Allergy Injections	10% co-insurance	30% co-insurance
Durable Medical Equipment	10% co-insurance	30% co-insurance
Home Health Care	10% co-insurance	30% co-insurance
Alternative & Chiro Care (10 visits per contract year)	10% co-insurance	30% co-insurance
Alternative & Chiro Care Lab & Xray ($250 contract year max)	10% co-insurance	30% co-insurance

✶ Not subject to annual deductible.

^ Co-pay waived if admitted into hospital. For emergency medical conditions, non-participating providers are paid at the participating provider level.

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. Although participating providers accept the fee allowance as payment in full, non-participating providers may not. Services of non-participating providers could result in out-of-pocket expense in addition to the percentage indicated. Network Not Available payment is allowed when PacificSource has not contracted with providers in the geographical area of the member's residence or work for a specific service or supply. Payment to providers for Network Not Available is based on the usual, customary, and reasonable charge (see 'allowable fee' in the Definitions section) for the geographical area in which the charge is incurred.

BENEFIT SUMMARY VISION

Your group health plan covers vision exams, eyeglasses, and contact lenses. The following shows the vision benefits available.

BENEFIT PERIOD

Eye Exam: Limited to a combined maximum amount of $200 in any contract year for all the services listed below.
Lenses: Limited to a combined maximum amount of $200 in any contract year for all the services listed below.
Frames: Limited to a combined maximum amount of $200 in any contract year for all the services listed below.
Contact Lenses: Limited to a combined maximum amount of $200 in any contract year for all the services listed below.

SERVICE/SUPPLY	PARTICIPATING PROVIDERS:	NON-PARTICIPATING PROVIDERS:
Eye Exam	No charge	60% co-insurance
Hardware		
Lenses (maximum per pair)		
Single Vision	No charge	60% co-insurance
Bifocal	No charge	60% co-insurance
Trifocal	No charge	60% co-insurance
Lenticular		
Progressive		
Frames	No charge	60% co-insurance
Contacts (in place of glasses)	No charge	60% co-insurance

The amounts listed above are the maximum benefits allowed for all vision exams, lenses, and frames furnished during any benefit period when prescribed by a licensed ophthalmologist or licensed optometrist. Participating providers discount hardware services.

Limitations and Exclusions

The out-of-pocket expense for vision services (copayments and service charges) does not apply to the medical plan's deductible or out-of-pocket limit. Also, the member continues to be responsible for the vision co-payments and service charges regardless of whether the medical plan's out-of-pocket limit is satisfied.

Covered expenses do not include, and no benefits are payable for:

- Special procedures such as orthoptics or vision training
- Special supplies such as sunglasses (plain or prescription) and subnormal vision aids
- Tint
- Plano contact lenses
- Anti-reflective coatings and scratch resistant coatings
- Separate charges for contact lens fitting
- Replacement of lost, stolen, or broken lenses or frames
- Duplication of spare eyeglasses or any lenses or frames
- Nonprescription lenses
- Visual analysis that does not include refraction
- Services or supplies not listed as covered expenses
- Eye exams required as a condition of employment, or required by a labor agreement or government body
- Expenses covered under any workers' compensation law
- Services or supplies received before this plan's coverage begins or after it ends
- Charges for services or supplies covered in whole or in part under any other medical or vision benefits provided by the employer
- Medical or surgical treatment of the eye

- Visual field charting
- Lenticular lenses
- Aniseikonic lenses
- More than the allowance for a standard lens when multi-focal hard resin lenses or no-line bifocals (blended) are chosen
- Charges for more than one exam, two lenses, and one frame per person in any contract year. Contact charges for more then the allowance for single vision lenses and frames.

Important information about your vision benefits

Your PacificSource group health plan includes coverage for vision services, including prescription eyeglasses and contact lenses. To make the most of those benefits, it's important to keep in mind the following:

- **Participating Providers**
  PacificSource is able to add value to your vision benefits by contracting with a network of vision providers. Those providers offer vision services at discounted rates, which are passed on to you in your benefits.
- **Paying for Services**
  Please remember to show your current PacificSource ID card whenever you use your plan's benefits. Our provider contracts require participating providers to bill us directly whenever you receive covered services and supplies. Providers normally call PacificSource to verify your vision benefits, then bill us directly. Participating providers should not ask you to pay the full cost in advance. They may only collect your share of the expense up front, such as copayments and amounts over your plan's allowances. If you are asked to pay the entire amount in advance, tell the provider you understand they have a contract with PacificSource and should bill PacificSource directly.
- **Sales and Special Promotions**
  Vision retailers often use coupons and promotions to bring in new business, such as free eye exams, two-for-one glasses, or free lenses with purchase of frames. Because participating providers already discount their services through their contract with PacificSource, your plan's participating provider benefits cannot be combined with any other discounts or coupons. You can use your plan's participating provider benefits, or you can use your plan's non-participating provider benefits to take advantage of a sale or coupon offer. If you do take advantage of a special offer, the participating provider may treat you as an uninsured customer and require full payment in advance. You can then send the claim to PacificSource yourself, and we will reimburse you according to your plan's non-participating provider benefits.

We hope this information helps clarify your vision benefits. If you or your provider have any questions about your benefits, please call PacificSource Customer Service at (541) 686-1242 from Eugene-Springfield or (888) 977-9299 from other areas.

Your plan's alternative care benefit allows you to receive treatment from the licensed alternative care providers listed below for medically necessary diagnosis and treatment of illness or injury. Refer to the Medical Benefit Summary for your co-payment and/or co-insurance information.

PacificSource contracts with a network of alternative care providers, so you can reduce your out-of-pocket expense by using one of the participating providers. For a listing of participating alternative care providers in your area, please refer to your plan's participating provider directory, visit our website, Pacificsource.com, or call our Customer Service Department.

Covered Services

- Services of a licensed naturopath and massage therapy for medically necessary diagnosis and treatment of illness or injury.

- Acupuncture services of a licensed acupuncturist (under ORS677.757 to ORS677.770) or physician when necessary for diagnosis and treatment of illness or injury.

- Services of a licensed chiropractor for medically necessary diagnosis and treatment of illness or injury.

The combined benefit for all treatments, services, and supplies provided or ordered by an alternative care provider is limited to 10 visits per person per contract year. That amount includes, but is not limited to, covered charges for any acupuncture, chiropractic manipulations and massage therapy. Laboratory services, x-rays, radiology, and durable medical equipment provided by or ordered by an alternative care provider are limited to $250 per person per contract year.

Excluded Services

- Any service or supply excluded or not otherwise covered by the policy.

- Drugs, homeopathic medicines, or homeopathic supplies furnished by an alternative care provider.

- Services of an alternative care provider for pregnancy or childbirth.

Your PacificSource health plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. Your prescription drug plan qualifies as creditable coverage for Medicare Part D.

MEMBER COST SHARE (other than for Specialty Drugs)
Each time a covered pharmaceutical is dispensed, you are responsible for the co-payment and/or co-insurance below:

From a participating retail pharmacy using the PacificSource Pharmacy Program (see below):	**Tier 1: Generic**	**Tier 2: Formulary**	**Tier 3: Non-formulary**
Up to a 30-day supply:	30%	30%	30%
From the University of Oregon Student Health Center:			
Up to a 30-day supply:	30%	30%	30%
From a participating mail order service (see below):			
From a participating retail pharmacy without using the PacificSource Pharmacy Program, or from a non-participating pharmacy (see below):		50%	

MEMBER COST SHARE FOR SPECIALTY DRUG
Each time a covered specialty drug is dispensed, you are responsible for the co-payment and/or co-insurance below:

From the participating specialty pharmacy:	
Up to a 30-day supply:	30% up to a $300 maximum
From a participating retail pharmacy, from a participating mail order service, or from a non-participating pharmacy or pharmaceutical service provider:	50%

WHAT HAPPENS WHEN A BRAND NAME DRUG IS SELECTED
Regardless of the reason or medical necessity, if you receive a brand name drug or if your physician prescribes a brand name drug when a generic is available, you will be responsible for the brand name drug's co-payment and/or co-insurance.

USING THE PACIFICSOURCE PHARMACY PROGRAM
Retail Pharmacy Network
To use the PacificSource pharmacy program, you must show the pharmacy plan number on the PacificSource ID card at the participating pharmacy to receive your plan's highest benefit level.
When obtaining prescription drugs at a participating retail pharmacy, the PacificSource pharmacy program can only be accessed through the pharmacy plan number printed on your PacificSource ID card. That plan number allows the pharmacy to collect the appropriate co-payment from you and bill PacificSource electronically for the balance.

Mail Order Service

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

Specialty Drug Program

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

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

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

Diabetic Supplies

- Insulin, diabetic syringes, lancets, and test strips are available.
- Glucagon recovery kits are available for the plan's formulary co-payment.
- Glucostix and glucose monitoring devices are not covered under this pharmacy benefit, but are covered under the medical plan's durable medical equipment benefit.

Contraceptives

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

Tobacco Cessation

Program specific tobacco cessation medications are covered with active participation in a plan approved tobacco cessation program (see Preventive Care in the policy's Covered Expenses section).

Orally Administered Anticancer Medications

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

LIMITATIONS AND EXCLUSIONS

- This plan only covers drugs prescribed by a licensed physician (or other licensed practitioner eligible for reimbursement under your plan) prescribing within the scope of his or her professional license, except for:
  - Over-the-counter drugs or other drugs that federal law does not prohibit dispensing without a prescription (even if a prescription is required under state law).
  - Drugs for any condition excluded under the health plan. That includes drugs intended to promote fertility, treatments for obesity or weight loss, tobacco cessation drugs (except as specifically provided for under Other Covered Pharmaceuticals), experimental drugs, and drugs available without a prescription (even if a prescription is provided).
  - Some specialty drugs that are not self-administered are not covered by this pharmacy benefit, but are covered under the medical plan's office supply benefit.
  - Immunizations (although not covered by this pharmacy benefit, immunizations may be covered under the medical plan's preventive care benefit.)
  - Drugs and devices to treat erectile dysfunction.
  - Drugs used as a preventive measure against hazards of travel.
  - Vitamins, minerals, and dietary supplements, except for prescription prenatal vitamins and fluoride products.
- Certain drugs require preauthorization by PacificSource in order to be covered. An up-to-date list of drugs requiring preauthorization is available on our website, PacificSource.com.
- Certain drugs are subject to step therapy protocols. An up-to-date list of drugs subject to step therapy protocols is available on our website, PacificSource.com.
- PacificSource may limit the dispensing quantity through the consideration of medical necessity, generally accepted standards of medical practice, and review of medical literature and governmental approval status.
- Quantities for any drug filled or refilled are limited to no more than a 30-day supply.
- For drugs purchased at non-participating pharmacies or at participating pharmacies without using the PacificSource pharmacy program, reimbursement is limited to an allowable fee.
- The member cost share for prescription drugs (co-payments, co-insurance, and service charges) does not apply to the

medical deductible or out-of-pocket limit of the policy. You continue to be responsible for the prescription drug co-payments and service charges regardless of whether the policy's out-of-pocket limit is satisfied.

- Prescription drug benefits are subject to the plan's coordination of benefits provision. (See Coordination of Benefits in the policy's General Limitations section.)

GENERAL INFORMATION ABOUT PRESCRIPTION DRUGS

A ***drug formulary*** is a list of preferred medications used to treat various medical conditions. The drug formulary is used to help control rising healthcare costs while ensuring that you receive medications of the highest quality. It is a guide for your physician and pharmacist in selecting drug products that are safe, effective and cost efficient. The drug formulary is made up of both generic and brand name products. A complete list of medications covered under the drug formulary is available on the For Members area on our website, PacificSource.com. The drug formulary is developed by Caremark® in cooperation with PacificSource. Non-formulary drugs are covered brand name medications not on the formulary.

Generic drugs are equivalent to name brand medications. By law, they must have the same active ingredients as the brand name medication and are subject to the same standards of their brand name counterpart. Name brand medications lose their patent protection after a number of years. Any drug company can then produce the drug, and the manufacturer must pass the same strict FDA standards of quality and product safety as the original manufacturer. Generic drugs are less expensive than brand name drugs because there is more competition and there is no need to repeat costly research and development. Your pharmacist and physician are encouraged to use generic drugs whenever they are available.

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

J

DENTAL BENEFIT SUMMARY

POLICY INFORMATION

Group Name:	Graduate Teaching Fellows Federation
Group Number:	G0021003
Plan Name:	PREVENTIVE DENTAL, $25/$1000 VAR

EMPLOYEE ELIGIBILITY REQUIREMENTS

Minimum Hour Requirement:	Per Employer Policy
Waiting Period for New Employees:	Per Employer Policy

SCHEDULE OF BENEFITS

Subject to all the terms of this Group Dental Policy, PacificSource will pay a dental benefit for covered dental expenses incurred by a covered person. If a procedure is not shown in the schedule and is not excluded by any terms of the policy, PacificSource will determine which category of dental service the procedure falls under. The dental benefit is a percentage of the usual, customary, and reasonable charge for covered dental expenses incurred, subject to an annual maximum benefit, and an annual deductible, as follows:

Maximum Payment

The maximum amount payable by this policy for covered services received each contract year, or portion thereof, for each eligible patient is limited to $1,000.

Deductible

Covered dental services are subject to the following deductibles per contract year or portion thereof:

	Individual Deductible	**Family Maximum Deductible**
Class II Services:	$25	$75

The deductible is the amount the member pays before the plan starts paying benefits.

Contract Year	**September 16-September 15**

PLAN PAYMENT SCHEDULE

Class I Services-	Plan pays 100% of UCR toward covered Class I Services - Diagnostic and Preventive Treatment.
Class II Services -	Plan pays 80% of UCR after the deductible toward covered Class II Services - Basic Treatment.
Class III Services-	Not Covered.

L

GRANDFATHERED HEALTH PLAN

PacificSource believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your employer (the plan administrator), or you may contact PacificSource at:

PacificSource Health Plans
PO Box 7068
Springfield OR 97475-0068
Phone (541) 686-1242 or (800) 624-6052

If this plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If this plan is not subject to ERISA, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

USING THE PROVIDER NETWORK

This section explains how your plan’s benefits differ when you use participating and non-participating 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.

All healthcare providers are independent contractors. PacificSource cannot be held liable for any claim or damages for injuries you experience while receiving medical care.

PARTICIPATING PROVIDERS

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

PacificSource contracts directly and/or indirectly with participating providers throughout our Oregon, Idaho, and Montana service areas and in bordering communities in southwest Washington. We also have an agreement with a nationwide provider network, The First Health® Network, which includes more than 550,000 participating physicians and 5,000 participating hospitals. The First Health providers outside our service area are also considered PacificSource participating providers under your plan.

If you are a Graduate Teaching Fellow employed as such by the University of Oregon, you may also use the University of Oregon Student Health Center for covered services. Insured dependents are not eligible to receive services at the Student Health Center.

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

Risk-sharing Arrangements

A participating provider contracts with PacificSource to furnish medical services and supplies to members enrolled in PacificSource health benefit plans for a set fee. That fee is called the contracted reimbursement rate. By agreement, a participating provider may not bill a member for any amount in excess of the contracted reimbursement rate. However, the agreement does not prohibit the provider from collecting co-payments, deductibles, co-insurance, and non-covered services from the member. And, if PacificSource was to become insolvent, a participating provider agrees to continue to provide covered services to a member for the duration of the period for which premium was paid to PacificSource on behalf of the member. Again, the participating provider may only collect applicable co-payments, deductibles, co-insurance, and amounts for non-covered services from the member.

NON-PARTICIPATING PROVIDERS

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

Allowable Fee

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

PacificSource bases payment to non-participating providers on our 'allowable fee' for the same services or supplies. We use several sources to determine the allowable fee, depending on the service or supply and the geographical area where it is provided. The allowable fee may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), Viant Health Payment Solutions, other nationally recognized databases, or PacificSource.

In areas where our members have reasonable geographic access to a participating provider, the allowable fee for professional services is based on PacificSource's standard participating provider reimbursement rate or a contracted reimbursement rate. Outside the PacificSource service area and in areas where our members do not have reasonable access to a participating provider (see the Network Not Available Benefits section, below), the allowable fee is based on the usual, customary, and reasonable charge (UCR) at the 85th percentile. UCR is based on data collected for a geographic area. Provider charges for each type of service are collected and ranked from lowest to highest. Charges at the 85th position in the ranking are considered to be the 85th percentile.

To calculate our payment to non-participating providers, we determine the allowable fee, then subtract the non-participating provider co-insurance shown in the 'Non-participating Provider' column of your Medical Benefit Summary. Our allowable fee is often less than the non-participating provider's charge. In that case, the difference between our allowable fee and the provider's billed charge is also your responsibility. That amount does not count toward this plan's out-of-pocket maximum. It also does not apply toward any deductibles or co-payments required by the plan. In any case, after any co-payments or deductibles, the amount PacificSource pays to a non-participating provider will not be less than 50 percent of the allowable fee for a like service or supply.

To maximize your plan's benefits, please check with us before receiving care from a non-participating provider. Our Customer Service Department can help you locate a participating provider in your area. If

there is no participating provider for the service or supply you need, our staff will verify that your plan's Network Not Available benefits apply.

Example of Provider Payment

The following illustrates how payment could be made for a covered service billed at $120. In this example, the Medical Benefit Summary shows a participating providers co-insurance of 20 percent and a non-participating providers co-insurance of 30 percent. This is only an example; your plan's benefits may be different.

	Participating Provider	Non-participating Provider
Provider's usual charge	$120	$120
PacificSource's negotiated provider discount	$20	$0
PacificSource's allowable fee	$100	$100
Patient's co-insurance from Medical Benefit Summary	20%	30%
PacificSource's payment	$80	$70
Patient's amount of allowable fee	$20	$30
Charges above the allowable fee	$0	$20
Patient's total payment to provider	$20	$50
Percent of charge paid by PacificSource	80%	58%
Percent of charge paid by patient	20%	42%

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

NETWORK NOT AVAILABLE BENEFITS

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

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

- You seek treatment from a nearby non-participating provider of that service or supply.
- PacificSource determines the allowable fee for that service or supply (the term 'allowable fee' is explained above under Non-participating Providers).
- We apply the Network Not Available benefit level as stated in your Medical Benefit Summary to the allowable fee to calculate covered expenses.
- You are responsible for any co-payments, co-insurance, deductibles, and amounts over the allowable fee.

COVERAGE WHILE TRAVELING

Your PacificSource plan is powered by the PacificSource Network (PSN). The PSN Network covers Oregon, Idaho, Montana, southwest Washington, and eastern Washington. When you need medical services outside of the PSN Network, you can save out-of-pocket expense by using the participating providers available through The First Health® Network.

- At U of O: University of Oregon Student Health Center (GTF employee only)

Nonemergency Care While Traveling

To find a participating provider outside the regions covered by the PacificSource Network, call The First Health® Network at (800) 226-5116. (The phone number is also printed on your PacificSource ID card for convenience.) Representatives are available at any time to help you find a participating physician, hospital, or other outpatient provider. Nonemergency care outside of the United States is not covered, except as specified in the Covered Expenses - Other Covered Services, Supplies, and Treatments section for this handbook.

- If a participating provider is available in your area, your plan's participating provider benefits will apply if you use a participating provider.
- If a participating provider is not available in your area, your plan's Network Not Available benefits will apply.
- If a participating provider is available but you choose to use a non-participating provider, your plan's non-participating provider benefits will apply.

Emergency Services While Traveling

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

FINDING PARTICIPATING PROVIDER INFORMATION

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

- By asking your healthcare provider if he or she is a participating provider for PacificSource Preferred plans.
- On the PacificSource website, PacificSource.com. Simply click on 'Find a Provider' and you can easily look up participating providers or print your own customized directory.
- By contacting the PacificSource Customer Service Department. Our staff can answer your questions about specific providers. If you'd like a complete provider directory for your plan, just ask--we'll be glad to mail you a directory free of charge.
- By calling The First Health® Network at (800) 226-5116 if you live outside the area covered by the PacificSource Network.

TERMINATION OF PROVIDER CONTRACTS

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

- A provider terminates a contractual relationship with PacificSource in accordance with the terms and conditions of the 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.

For the purposes of continuity of care, PacificSource may require the provider to adhere to the medical services contract and accept the contractual reimbursement rate applicable at the time of contract termination.

BECOMING COVERED

ELIGIBILITY

Employees

You are eligible if you are any of the following:

A Graduate Teaching Fellow employed as such on a .20 FTE basis by the University of Oregon and an active member of the Graduate Teaching Fellows Federation, Local 3544 bargaining unit as defined in Article I of the collective bargaining agreement;

A Graduate Teaching Fellow on an approved leave of absence under the Family and Medical Leave Act of 1993;

A University of Oregon graduate student with funding through an Igert or K12 grant, commonly known as a Training Grant, and legally barred from being a Graduate Teaching Fellow employed by the University of Oregon;

An employee of the Graduate Teaching Fellows Federation, Local 3544; or

An employee of the Graduate Teaching Fellows Federation Health & Welfare Trust, insofar as his or her duties are principally connected with such trusteeship.

You must be enrolled in both medical and dental coverage to be eligible for this plan.

Family Members

While you are insured under this plan, the following family members are also eligible for coverage:

- Your legal spouse or registered or unregistered 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. A dependent child who is eligible to enroll in any other employer-sponsored group health plan as an employee or spouse is not eligible to enroll in this plan.
- Your, your spouse's, or your domestic partner's unmarried dependent children age 26 or over who are mentally or physically disabled. To qualify as dependents, they must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability. PacificSource requires documentation of the disability from the child's physician, and will review the case before determining eligibility for coverage.

- The term 'dependent children' may also include any siblings, nieces, nephews, or grandchildren under age 19 and expected to live in your household for at least a year, if you are the court appointed legal custodian or guardian. Newborn children born to a covered dependent, both of whom you are financially responsible for, are also covered.
- 'Dependent children' means any natural, step, and adopted children you or your domestic partner are legally obligated to support or contribute support for. It may also include any foster children you intend on adopting who are under age 19, unmarried and expected to live in your household for at least a year, if you are the court appointed legal custodian or guardian.

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

ENROLLING DURING THE INITIAL ENROLLMENT PERIOD

You must file an application for yourself and any dependents you want insured no later than 31-days after the date you receive your graduate teaching appointment. A new application must be submitted if you have a lapse in coverage.

Coverage will begin on the first day of the term for which you have received the appointment as follows:

- Fall Term: Coverage will be effective on September 16
- Winter Term: Coverage will be effective on December 16
- Spring Term: Coverage will be effective on March 16
- Summer Term: Coverage will be effective on June 16

When you become eligible to enroll in this plan, you and your eligible family members must enroll within the initial enrollment period and premium for dependents must be paid at the time the application is submitted. If you miss your initial enrollment period, your dependents may be subject to a waiting period. (For more information, see 'Special Enrollment Periods' and 'Late Enrollment' under the Enrolling After the Initial Enrollment Period section.) To enroll, you must complete and sign an enrollment application, which is available from your employer. The application must include complete information on yourself and your enrolling family members.

Applications must be submitted to:

Graduate Teaching Fellows Federation Office
870 E 13th Ave
Eugene, OR 97401

If you are enrolling an unregistered domestic partner, a notarized Affidavit of Domestic Partnership must be attached to the application.

Newborns

Your, your spouse's, or your domestic partner's natural born baby is eligible for enrollment under this plan during the 31-day initial enrollment period after birth. PacificSource cannot enroll the child and pay benefits until we receive an enrollment application listing the child as your dependent. A claim for maternity care is not considered notification for the purpose of enrolling a newborn child. Anytime there is a delay in providing enrollment information, PacificSource may ask for legal documentation to confirm validity.

Adopted Children

When a child is placed in your home for adoption, the child is eligible for enrollment under this plan during the 31-day initial enrollment period after placement. 'Placement' means you, your spouse, or your domestic partner have assumed financial responsibility for the support and care of the child in

anticipation of adoption. To add the child to your coverage, you must complete and submit an enrollment application listing the child as your dependent.

If additional premium is required, then the natural born or adopted child's eligibility for enrollment will end 31-days after placement if PacificSource has not received an enrollment application and premium. Premium is charged from the date of placement and prorated for the first month.

If no additional premium is required, then the natural born or adopted child's eligibility continues as long as you are covered. However, PacificSource cannot enroll the child and pay benefits until we receive an enrollment application listing the child as your dependent.

Family Members Acquired by Marriage

If you marry, you may add your new spouse and any newly eligible dependent children to your coverage during the 31-day initial enrollment period after the marriage. PacificSource must receive your enrollment application and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the 16th day of the month after the marriage.

Family Members Acquired by Domestic Partnership

If you and your domestic partner have been issued a Certificate of Registered Domestic Partnership, your domestic partner and your partner's dependent children are eligible for coverage during the 31-day initial enrollment period after the registration of the domestic partnership. PacificSource must receive your enrollment application and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the month after the registration of the domestic partnership. You may be required to submit a copy of your Certificate of Registered Domestic Partnership to complete enrollment. The enrollment application and affidavit (if applicable) must be submitted within 31 days of the employee's initial eligibility period or within 31 days of the registration of the domestic partnership or within 14 days of the domestic partner first becoming eligible according to the criteria set forth on the Affidavit of Domestic Partnership supplied by your employer.

Opposite-gender and unregistered same-gender domestic partners and their children may also become eligible for enrollment. If you and your unregistered domestic partner meet the criteria on the Affidavit of Domestic Partnership supplied by your employer, your domestic partner and your partner's dependent children are eligible for coverage during the 31-day initial enrollment period after the requirements of the Affidavit of Domestic Partnership are satisfied. PacificSource must receive your enrollment application, a notarized copy of your Affidavit of Domestic Partnership, and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the month after the Affidavit of Domestic Partnership is notarized.

Family Members Placed in Your Guardianship

If a court appoints you custodian or guardian of an eligible foster child, sibling, niece, nephew, or grandchild, you may add that family member to your coverage. To be eligible for coverage, the family member must be:

- Unmarried:
- Not in a domestic partnership, registered or otherwise;
- under age 19; and
- Expected to live in your household for at least a year.

PacificSource must receive your enrollment application and additional premium during the 31-day initial enrollment period beginning on the date of the court appointment. Coverage for grandchildren will then begin on the first of the month following the date the court appoints you as legal guardian. In all other instances coverage will begin on the 16th day of the month following the date of the court order.

Qualified Medical Child Support Orders

This health plan complies with qualified medical child support orders (QMCSO) issued by a state court or state child support agency. A QMCSO is a judgment, decree, or order, including approval of a settlement agreement, that provides for health benefit coverage for the child of a plan member.

If a court or state agency orders coverage for your spouse or child, they may enroll in this plan within a 31-day initial enrollment period beginning on the date of the order. Coverage will become effective on the 16th day of the month after PacificSource receives the enrollment application.

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD

Returning to Work after a Layoff

If you are laid off and then rehired by your employer within three months, you will not have to satisfy another probationary waiting period.

Your health coverage will resume the first of the month following your return to work and again meet your employer's minimum hour requirement. If your family members were covered before your layoff, they can resume coverage at that time as well. You must submit the enrollment application within the 31-day initial enrollment period following your return to work.

Returning to Work after a Leave of Absence

If you return to work after an employer-approved leave of absence of three months or less, you will not have to satisfy another probationary waiting period. Your health coverage will resume once you return to work and again meet your employer's minimum hour requirement. If your family members were covered before your leave of absence, they can resume coverage at that time as well. You must submit the enrollment application within the 31-day initial enrollment period following your return to work.

Returning to Work after Family Medical Leave

If you work for a company that employs 50 or more people, your employer is probably subject to the Family Medical Leave Act (FMLA). To find out if you have rights under FMLA, ask your health plan administrator. Under FMLA, if you return to work after a qualifying FMLA medical leave, you will not have to satisfy another probationary waiting period or any previously satisfied exclusion period under this plan. Your health coverage will resume the day you return to work and meet your employer's minimum hour requirement. If your family members were covered before your leave, they can also resume coverage at the time if you re-enroll them within the 31-day initial enrollment period following your return.

Special Enrollment Periods

Some employers have agreements with PacificSource allowing employees with other health coverage to waive this plan's coverage. In that case, both you and your family members may decline coverage during your initial enrollment period. If you are eligible to decline coverage and you wish to do so, you must submit a written waiver of coverage to PacificSource through your employer. You and your family members may enroll in this plan later if you qualify under Rule #1, Rule #2, or Rule #3 below.

If the agreement between PacificSource and your employer requires all eligible employees to participate in this plan, you must enroll during your initial enrollment period. However, your family members may decline coverage, and they may enroll in the plan later if they qualify under Rule #1, Rule #2, or Rule #3 below.

To find out if your employer's plan allows employees to decline coverage, ask your health plan administrator.

- Special Enrollment Rule #1

  If you declined enrollment for yourself or your family members because of other health insurance coverage, you or your family members may enroll in the plan later if the other coverage ends involuntarily. 'Involuntarily' means coverage ended because continuation coverage was exhausted, employment terminated, work hours were reduced below the employer's minimum requirement, the other insurance plan was discontinued or the maximum lifetime benefit of the other plan is exhausted, the employer's premium contributions toward the other insurance plan ended, or because of death of a spouse, divorce, or legal separation. To do so, you must request enrollment within 31 days after the other health insurance coverage ends (or within 60 days after the other health insurance coverage ends if the other coverage is through Medicaid or a State Children's Health Insurance Program). Coverage will begin on the 16th day of the month after the other coverage ends.

- Special Enrollment Rule #2

  If you acquire new dependents because of marriage, domestic partnership, birth, or placement for adoption, you may be able to enroll yourself and/or your newly acquired dependents at that time. To do so, you must request enrollment within 31 days after the marriage, registration of domestic partnership, birth, or placement for adoption. In the case of marriage, and domestic partnership, coverage begins on the 16th day of the month after the marriage or registration of the domestic partnership. In the case of birth or placement for adoption, coverage begins on the date of birth or placement.

- Special Enrollment Rule #3

  If you or your dependents become eligible for a premium assistance subsidy under Medicare or 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 16th day of the month after becoming eligible for such assistance.

Late Enrollment

If you did not enroll during your initial enrollment period and you do not qualify for a special enrollment period, your enrollment will be delayed until the plan's anniversary date.

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

- Did not enroll during the 31-day initial enrollment period; or
- Enrolled during the initial enrollment period but discontinued coverage later.

If you do not enroll within the timeframe allowed, you (but not your dependents) may still enroll effective the 16th of the month following the date of initial eligibility. Enrollment can be processed retroactively to the first day of the most current academic term. Retroactive enrollment will not be allowed for prior academic terms. All prior premium must be paid.

You may enroll your dependent as a 'late enrollee' by submitting an enrollment application to your employer during one of the following open enrollment periods designated by your employer:

- For applications received August 16-September 15, enrollment becomes effective September 16
- For applications received February 16-March 15, enrollment becomes effective March 16

PLAN SELECTION PERIOD

If your employer offers more than one benefit plan option, you may choose another plan option only upon your plan's anniversary date. You may select a different plan option by completing a selection form or application form. Coverage under the new plan option becomes effective on your plan's anniversary date.

TERMINATING COVERAGE

You may terminate your insurance, or insurance for any insured dependent, by giving us written notice through the group. Insurance will end on the 15th of the month through which premiums are paid. If you terminate your own insurance, insurance for your dependents also ends.

If you leave your job for any reason or your work hours are reduced below your employer's minimum requirement, coverage for you and your enrolled family members will end. Coverage ends on the 15th of the month in which termination or ineligibility occurred. You may, however, be eligible to continue coverage for a limited time; please see the Continuation section of this handbook for more information.

You can voluntarily discontinue coverage for your enrolled family members at any time by completing a Termination of Dependent Coverage form and submitting it to your employer. Keep in mind that once coverage is discontinued, your family members may be subject to the late enrollment waiting period if they wish to re-enroll later.

If you lose eligibility for coverage at the end of spring term, you may elect to continue coverage under the plan during the summer term for those three months by self-payment. This three month continuation period is in addition to the continuation coverage described in the Continuation section of this handbook.

Divorced Spouses

If you divorce, coverage for your spouse will end on the 15th day of the month in which the divorce decree or legal separation is final. You must notify your employer of the divorce or separation, and continuation coverage may be available for your spouse. If there are special child custody circumstances, please contact the PacificSource Membership Services Department. Please see the Continuation section for more information.

Dependent Children

When your enrolled child no longer qualifies as a dependent, coverage will end on the 15th day of that month. Please see the Eligibility section of this handbook for information on when your dependent child is eligible beyond age 22. The Continuation and Individual Portability Policy sections include information on other coverage options for those who no longer qualify for coverage.

Dissolution of Domestic Partnership

If you dissolve your domestic partnership, coverage for your domestic partner and their children not related to you by birth or adoption will end on the day in which the dissolution of the domestic partnership is final. You must notify your employer of the dissolution of the domestic partnership. Except as provided for under the COBRA Continuation provisions, a registered domestic partner and their covered children may continue this policy's coverage under the same circumstances and to the same extent afforded an enrolled spouse and their enrolled children in the Continuation of Insurance section.

Certificates of Creditable Coverage

A certificate of creditable coverage is used to verify the dates of your prior health plan coverage when you apply for coverage under a new policy. These certificates are issued by health insurers whenever a plan participant's coverage ends. After your or your dependent's coverage under this plan ends, you will receive a certificate of creditable coverage by mail. We have an automated process that generates and mails these certificates whenever coverage ends. We will send a separate certificate for any dependents with an effective or termination date that differs from yours. For questions or requests

regarding certificates of creditable coverage, you are welcome to contact our Membership Services Department at (541) 684-5583 or (866) 999-5583.

CONTINUATION OF INSURANCE

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

- Your employment ends or you have a reduction in hours
- You take a leave of absence for military service
- You divorce
- You die
- You become eligible for Medicare benefits if it causes a loss of coverage for your dependents
- Your children no longer qualify as dependents

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

USERRA CONTINUATION

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

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

The following requirements apply to USERRA continuation:

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

SURVIVING OR DIVORCED SPOUSES AND REGISTERED DOMESTIC PARTNERS

If your group has 20 or more employees, or your group health plan has 20 or more subscribers, and you die, divorce, or dissolve your registered 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 eligible for Medicare or other coverage. Dependent children are subject to the group policy's age and other eligibility requirements. Some restrictions and guidelines apply; please see your employer for specific details.

COBRA CONTINUATION

If you work for an employer that has 20 or more employees, your employer is probably subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended. To find out if you have continuation rights under COBRA, ask your health plan administrator.

COBRA Eligibility

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

Qualifying Event	Continuation Period
Employee's termination of employment or reduction in hours	Employee, spouse, and children may continue for up to 18 months[1]
Employee's divorce	Spouse and children may continue for up to 36 months[2]
Employee's eligibility for Medicare benefits if it causes a loss of coverage	Spouse and children may continue for up to 36 months
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 covered dependent is determined disabled by the Social Security Administration within the first 60 days of COBRA coverage, all qualified beneficiaries may continue coverage for up to 29 months.

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

If your 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, including the late enrollment waiting period.

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

Domestic partners and their covered children may not continue this policy's coverage under COBRA independent of the employee.

When Continuation Coverage Ends

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

- Your continuation premium is not paid on time.
- You become covered under another group health plan that does not exclude or limit treatment for your pre-existing conditions.
- You become entitled to Medicare benefits.
- Your employer discontinues its health plan and no longer offers a group health plan to any of its employees.
- Your continuation period was extended from 18 to 29 months due to disability, and you are no longer considered disabled.

When COBRA continuation coverage ends, you may be eligible to purchase an individual portability policy. Please see the Individual Portability Policy section for more information.

Type of Coverage

Under COBRA, you may continue any coverage you had before the qualifying event. If your employer provides both medical and dental coverage and you were enrolled in both, you may continue both medical and dental. If your employer 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 your employer's current benefits. Your employer has the right to change the benefits of its health plan or eliminate the plan entirely. If that happens, any changes to the group health plan will also apply to everyone enrolled in continuation coverage.

Your Responsibilities and Deadlines

You must notify your employer within 60 days if you divorce, or if your child no longer qualifies as a dependent. That will allow your employer to notify you or your dependents of your continuation rights.

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

If you or your employer do not provide these notifications within the time frames required by COBRA, PacificSource's responsibility to provide coverage under the group policy will end.

Continuation Premium

You or your family members are responsible for the full cost of continuation coverage. The monthly premium must be paid to your employer; PacificSource cannot accept continuation premium directly from you. You may make your first premium payment any time within 45 days after you return your Continuation Election Form to your employer. After the first premium payment, each monthly payment must reach your employer within 30 days of your employer's premium due date. If your employer 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. Premium rates are established annually and may be adjusted if the plan's benefits or costs change.

WORK STOPPAGE

Labor Unions

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

EXTENSION OF BENEFITS

If you are on a employer-approved non-FMLA leave of absence, you may continue coverage under active status for up to three months. Premiums must be paid through the employer in order to maintain coverage during a leave of absence. A leave of absence is a period off work granted by your employer at your request during which you are still considered to be employed and are carried on the employment records of the group. A leave can be granted for any reason acceptable to the group. Absenses extending beyond three months will be subject to the Continuation of Insurance provisions of this plan.

INDIVIDUAL PORTABILITY POLICY

When coverage under this policy ends, you may be able to purchase a PacificSource individual portability policy. If you are eligible, you may purchase the policy when you lose coverage under this policy, or during your continuation coverage, or as soon as continuation coverage ends. In order to be eligible for the portability policy:

- You must live in Oregon.
- You must have been covered by this plan for at least six months (or by a combination of this plan and another Oregon group health benefit plan with no break in coverage).
- You must apply for the portability policy within 63 days after coverage under this plan or your continuation coverage ends.
- You must pay the premium to PacificSource on time each month.

You are not eligible to purchase a portability policy if you are eligible for this or any other plan provided by your employer, or are covered under another health plan, or are eligible for Medicare. For information on PacificSource individual portability policies, contact our Individual Sales Department at (541) 684-5585 or (866) 695-8684.

COVERED EXPENSES

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

Some medically necessary services and supplies may be excluded from coverage under this plan. Be sure you read and understand the Benefit Limitations and Exclusions section of this book, including the section on Preauthorization. If you ever have a question about your plan benefits, contact the PacificSource Customer Service Department.

Medical Necessity

Except for specified Preventive Care services, the benefits of this group policy are paid only toward the covered expense of medically necessary diagnosis of treatment of illness or injury. This is true even though the service or supply is not specifically excluded. All treatment is subject to review for medical necessity. Review of treatment may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. For additional information, see ‘medically necessary’ in the Definitions section of this handbook.

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

Healthcare Providers

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

Your Annual Out-of-Pocket Limit

This plan has an out-of-pocket limit provision to protect you from excessive medical expenses. The Medical Benefit Summary shows your plan's annual out-of-pocket limits for participating and/or non-participating providers. If you incur covered expenses over those amounts, this plan will pay 100 percent of eligible charges, subject to the allowable fee.

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

- Emergency room co-payments
- Transplants performed at non-contracting facilities
- Prescription drugs
- Charges over the allowable fee for services of non-participating providers
- Incurred charges that exceed amounts allowed under this plan
- Infertility services

Charges over the allowable fee for services of non-participating providers, and incurred charges that exceed amounts allowed under this plan, and co-payments will continue to be your responsibility even after the out-of-pocket or stop-loss limit is reached.

Prescription drug benefits are not affected by the out-of-pocket or stoploss limit. You will still be responsible for that co-payment or co-insurance payment even after the out-of-pocket or stoploss limit is reached.

PLAN BENEFITS

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

PREVENTIVE CARE SERVICES

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

- **Routine physicals** for members age 22 and older according to the following schedule:
  - Ages 22-39: One exam every five years
  - Ages 40-59: One exam every two years
  - Ages 60 and over: One exam every year

  Only laboratory work tests and other diagnostic testing procedures related to the routine physical exam are covered by this benefit. Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a routine physical examination are not covered by this preventative care benefit. Please see Outpatient Services in this section.
- **Well woman visits**, including the following:
  - One **routine gynecological exam** each contract year for women 18 and over. Exams may include Pap smear, pelvic exam, breast exam, blood pressure check, and weight check. Covered lab services are limited to occult blood, urinalysis, and complete blood count.
  - **Routine preventive mammograms** for women as recommended.

    - The deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for 'Preventive Care - Well Woman Visits' applies to mammograms that are considered 'routine' according to the guidelines of the U.S. Preventive Services Task Force.
    - The deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for 'Outpatient Services - Diagnostic and Therapeutic Radiology and Lab' applies to diagnostic mammograms related to the ongoing evaluation or treatment of a medical condition.
  - **Pelvic exams and Pap smear exams** at any time upon referral of a women's healthcare provider; and pelvic exams and Pap smear exams annually for women 18 to 64 years of age with or without a referral from a women's healthcare provider.
  - **Breast exams** annually for women 18 years of age or older or at any time when recommended by a women's healthcare provider for the purpose of checking for lumps and other changes for early detection and prevention of breast cancer.
- **Colorectal cancer screening** exams and lab work including the following:
  - A fecal occult blood test
  - A flexible sigmoidoscopy
  - A colonoscopy
    - The deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for 'Preventive Care - Routine Colonoscopy' applies to colonoscopies that are considered 'routine' according to the guidelines of the U.S. Preventive Services Task Force.
    - The deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for 'Professional Services - Surgery' and for 'Outpatient Services - Outpatient Surgery/Services' apply to colonoscopies related to ongoing evaluation or treatment of a medical condition.)
  - A double contrast barium enema
- **Prostate cancer screening,** including digital rectal examination and a prostate-specific antigen test.
- **Well baby/child care exams**,Well baby/child care exams, for members age 21 and younger according to the following schedule:
  - Infants: Well-baby exam during first year of life as recommended by provider
  - Ages 1-2: One exam every three months
  - Ages 3-11: One exam per year
  - Ages 12-17: One exam every three years
  - Ages 18-21: One exam every five years

  Only laboratory tests and other diagnostic testing procedures related to a well baby/child care exam are covered by this benefit. Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a well baby/child care exam are not covered by this preventative care benefit. Please see Outpatient Services in this section.
- Standard age-appropriate childhood and adult **immunizations** for primary prevention of infectious diseases as recommended by and adopted by the Centers for Disease Control and Prevention, American Academy of Pediatrics, American Academy of Family Physicians, or similar standard-setting body. Benefits do not include immunizations for more elective, investigative, unproven, or discretionary reasons (e.g. travel). Covered immunizations include, but may not be limited to the following:

  - Diphtheria, pertussis, and tetanus (DPT) vaccines, given separately or together
  - Hemophilus influenza B vaccine
  - Hepatitis A vaccine
  - Hepatitis B vaccine
  - Human papillomavirus (HPV) vaccine
  - Influenza vaccine
  - Measles, mumps, and rubella (MMR) vaccines, given separately or together
  - Meningococcal (meningitis) vaccine
  - Pneumococcal vaccine
  - Polio vaccine
  - Varicella (chicken pox) vaccine
- **Tobacco use cessation program services** are covered only when provided by a PacificSource approved program. Approved programs are covered at 100% of the cost up to a maximum lifetime benefit of two quit attempts. Approved programs are limited to members age 15 or older. Specific nicotine replacement therapy will only be covered according to the program's description. If this policy includes benefits for prescription drugs, tobacco use cessation program will be covered to the same extent this policy covers other prescription medications.

PROFESSIONAL SERVICES

This plan covers the following professional services when medically necessary:

- Services of a **physician** (M.D. or D.O.) for diagnosis or treatment of illness or injury
- Services of a licensed **physician assistant** under the supervision of a physician
- Services of a certified **surgical assistant, surgical technician, or registered nurse** (R.N.) when providing medically necessary services as a surgical first assistant during a covered surgery
- Services of a **nurse practitioner**, including certified registered nurse anesthetist (C.R.N.A.) and certified nurse midwife (C.N.M.), for medically necessary diagnosis or treatment of illness or injury
- **Urgent care services** provided by a physician. 'Urgent care' means services for an unforeseen illness or injury that requires treatment within 24 hours to prevent serious deterioration of a patient's health. Urgent conditions are normally less severe than medical emergencies. Examples of conditions that could need urgent care are sprains and strains, vomiting, cuts, and severe headaches.
- **Outpatient rehabilitative services** provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide physical, occupational, or speech therapy. Services must be prescribed in writing by a licensed physician, dentist, podiatrist, nurse practitioner, or physician assistant. The prescription must include site, modality, duration, and frequency of treatment. Total covered expenses for outpatient rehabilitative services is limited to a combined maximum of 30 visits per contract year subject to preauthorization and concurrent review by PacificSource for medical necessity. Only treatment of neurologic conditions (e.g. stroke, spinal cord injury, head injury, pediatric neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which rehabilitative services would be appropriate for children under 18 years of age) may be considered for additional benefits, not to exceed 30 visits per condition, when criteria for supplemental services are met.

  Services for speech therapy will only be allowed when needed to correct stuttering, hearing loss, peripheral speech mechanism problems, and deficits due to neurological disease or injury. Speech and/or cognitive therapy for acute illnesses and injuries are covered up to one year post injury

when the services do not duplicate those provided by other eligible providers, including occupational therapists or neuropsychologists.

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

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

- Services of a physician or a licensed certified nurse midwife for **pregnancy**. Services are subject to the same payment amounts, conditions, and limitations that apply to similar expenses for illness, except that pregnancy is not considered a pre-existing condition.

Please contact the PacificSource Customer Service Department as soon as you learn of your pregnancy. Our staff will explain your plan's maternity benefits and help you enroll in our free prenatal care program.

- **Routine nursery care** of a newborn while the mother is hospitalized and eligible for pregnancy-related benefits under this plan if the newborn is also eligible and enrolled in this plan.
- Services of a licensed audiologist for medically necessary **audiological (hearing) tests**.
- Services of a dentist or physician to treat **injury of the jaw or natural teeth**. Services must be provided within 12 months of the injury. Except for the initial examination, services for treatment of an injury to the jaw or natural teeth require preauthorization to be covered.
- Services of a dentist or physician for **orthognathic (jaw) surgery** as follows:
  - When medically necessary to repair an accidental injury. Services must be provided within one year after the accident
  - For removal of a malignancy, including reconstruction of the jaw within one year after that surgery
- Services of a board-certified or board-eligible **genetic counselor** when referred by a physician or nurse practitioner for evaluation of genetic disease.
- Medically necessary **telemedical health services** for health services covered by this plan when provided in person by a healthcare professional when the telemedical health service does not duplicate or supplant a health service that is available to the patient in person. The location of the patient receiving telemedical health services may include, but is not limited to: hospital; rural health clinic; federally qualified health center; physician's office; community mental health center; skilled nursing facility; renal dialysis center; or site where public health services are provided. Coverage of telemedical health services are subject to the same deductible, co-payment, or co-insurance requirements that apply to comparable health services provided in person.

HOSPITAL AND SKILLED NURSING FACILITY SERVICES

This plan covers medically necessary **hospital inpatient services**. Charges for a hospital room are covered up to the hospital's semi-private room rate (or private room rate, if the hospital does not offer semi-private rooms). Charges for a private room are covered if the attending physician orders hospitalization in an intensive care unit, coronary care unit, or private room for medically necessary isolation.

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

- Cardiac care unit
- Operating room

- Anesthesia and post-anesthesia recovery
- Respiratory care
- Inpatient medications
- Lab and radiology services
- Dressings, equipment, and other necessary supplies

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

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

Services of a **skilled nursing facility and convalescent homes** are covered for up to 14 days per stay. If care is necessary beyond 14 days, Pacificsource may authorize up to 100 additional days. For skilled nursing benefits to renew after each stay, you or your insured dependent must be discharged and at least 90 consecutive days must pass before re-admission. Services mst be medically necessary. Confinement for custodial care is not covered.

Inpatient rehabilitative services Inpatient rehabilitative services medically necessary to restore and improve lost body functions after illness or injury. The service must be consistent with the condition being treated, and must be part of a formal written treatment program prescribed by a physician. Recreation therapy is only covered as part of an inpatient rehabilitation admission.

OUTPATIENT SERVICES

This plan covers the following outpatient care services:

- **Advanced diagnostic imaging procedures** that are medically necessary for the diagnosis of illness or injury. For purposes of this benefit, advanced diagnostic imaging procedures include CT scans, MRIs, PET scans, CATH labs and nuclear cardiology studies. When services are provided as part of a covered emergency room visit, your plan's emergency room benefit applies. In all other situations and settings, benefits are subject to the deductibles, co-payments, and/or co-insurance stated in your Medical Benefit Summary for Outpatient Services - Advanced Diagnostic Imaging.
- Diagnostic **radiology and laboratory procedures** provided or ordered by a physician, nurse practitioner, alternative care practitioner, or physician assistant. These services may be performed or provided by laboratories, radiology facilities, hospitals, and physicians, including services in conjunction with office visits.
- **Emergency room services**. The emergency room co-payment stated in your Medical Benefit Summary covers medical screening and any diagnostic tests needed for emergency care, such as radiology, laboratory work, CT scans, and MRIs. The co-payment does not cover further treatment provided on referral from the emergency room.

  In true medical emergencies, non-participating providers are paid at the participating provider level.

  Emergency room charges for services, supplies, or conditions excluded from coverage under this plan are not eligible for payment. That includes conditions subject to the plan's exclusion periods for pre-existing and other conditions. Please see the Benefit Limitations and Exclusions section of this handbook.

- **Surgery** and other outpatient services. Benefits are based on the setting where services are performed.
  - For surgeries or outpatient services performed in a physician's office, the benefit stated in your Medical Benefit Summary for Professional Services - Office Procedures and Supplies applies.
  - For surgeries or outpatient services performed in an ambulatory surgical center or outpatient hospital setting, both the benefits stated in your Medical Benefit Summary for Professional Services - Surgery and the Outpatient Services - Outpatient Surgery/Services apply.
- Therapeutic **radiology services, chemotherapy, and renal dialysis** provided or ordered by a physician. Covered services include a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Other medically necessary **diagnostic services** provided in a hospital or outpatient setting, including testing or observation to diagnose the extent of a medical condition.

EMERGENCY SERVICES

In a true medical emergency, this plan covers services and supplies necessary to determine the nature and extent of the emergency condition and to stabilize the patient.

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

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

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

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

MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

This plan covers medically necessary crisis intervention, diagnosis, and treatment of mental health conditions and chemical dependency. Refer to the Benefit Limitations and Exclusions section of this handbook for more information on services not covered by your plan.

Providers Eligible for Reimbursement

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

- The mental and/or chemical healthcare provider is approved by the Oregon Department of Human Services;
- The mental and/or chemical healthcare provider is accredited for the particular level of care for which reimbursement is being requested by the Oregon Joint Commission on Accreditation of Hospitals or the Oregon Commission on Accreditation of Rehabilitation Facilities; or
- The patient is staying overnight at the mental and/or chemical healthcare facility (see Definitions section of this handbook) and is involved in a structured program at least eight hours per day, five days per week; or
- The mental and/or chemical healthcare provider is providing a covered benefit under this policy; and
- The mental and/or chemical healthcare provider has met the credentialing requirements of PacificSource.

Eligible mental and/or chemical healthcare providers are:

- A program licensed, approved, established, maintained, contracted with, or operated by the Addictions and Mental Health Division of the Oregon Health Authority;
- A medical or osteopathic physician licensed by the State Board of Medical Examiners;
- A psychologist (Ph.D.) licensed by the State Board of Psychologists' Examiners;
- A nurse practitioner registered by the State Board of Nursing;
- A clinical social worker (L.C.S.W.) licensed by the State Board of Clinical Social Workers;
- A Licensed Professional Counselor (L.P.C) licensed by the State Board of Licensed Professional Counselors and Therapists;
- A Licensed Marriage and Family Therapist (L.M.F.T) licensed by the State Board of Licensed Professional Counselors and Therapists; and
- A hospital or other healthcare facility licensed for inpatient or residential care and treatment of mental health conditions and/or chemical dependency.

Medical Necessity and Appropriateness of Treatment

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

Mental Health Parity and Addiction Equity Act of 2008

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

HOME HEALTH AND HOSPICE SERVICES

- This plan covers **home health services** when preauthorized by PacificSource. Covered services include skilled nursing by a R.N. or L.P.N.; physical, occupational, and speech therapy; and medical social work services provided by a licensed home health agency. Private duty nursing is not covered.
- **Home infusion services** are covered when preauthorized by PacificSource. This benefit covers parenteral nutrition, medications, and biologicals (other than immunizations) that cannot be self-administered. Benefits are paid at the percentage stated in your Medical Benefit Summary for home health care.
- This plan covers **hospice services** when preauthorized by PacificSource. Hospice services are intended to meet the physical, emotional, and spiritual needs of the patient and family during the final stages of illness and dying, while maintaining the patient in the home setting. Services are intended to supplement the efforts of an unpaid caregiver. Hospice benefits do not cover services of a primary caregiver such as a relative or friend, or private duty nursing. Hospice benefits are limited to a lifetime maximum of $8,000 per member. PacificSource uses the following criteria to determine eligibility for hospice benefits:
  - The member's physician must certify that the member is terminally ill with a life expectancy of less than six months;
  - The member must be living at home;
  - A nonsalaried primary caregiver must be available and willing to provide custodial care to the member on a daily basis; and
  - The member must not be undergoing treatment of the terminal illness other than for direct control of adverse symptoms.

Only the following hospice services are covered:

- Home nursing visits;
- Home health aides when necessary to assist in personal care;
- Home visits by a medical social worker;
- Home visits by the hospice physician;
- Prescription medications for the relief of symptoms manifested by the terminal illness.
- Medically necessary physical, occupational, and speech therapy provided in the home.
- Home infusion therapy.
- Durable medical equipment, oxygen, and medical supplies.
- Respite care provided in nursing facility to provide relief for the primary caregiver, subject to a maximum of five consecutive days and to a lifetime maximum benefit of 30 days. A member must be enrolled in a hospice program to be eligible for respite care benefits.
- Inpatient hospice care when provided by a Medicare-certified or state-certified program when admission to an acute care hospital would otherwise be medically necessary, up to 12 days during the period of covered hospice care.
- Pastoral care and bereavement services.

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

DURABLE MEDICAL EQUIPMENT

- This plan covers **prosthetic and orthotic devices** that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. Benefits include coverage of all services and supplies medically necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device. Benefits also include coverage for any repair or replacement of a prosthetic or orthotic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.
- This plan covers **durable medical equipment** prescribed exclusively to treat medical conditions. Covered equipment includes crutches, wheelchairs, orthopedic braces, home glucose meters, equipment for administering oxygen, and non-power assisted prosthetic limbs and eyes. Durable medical equipment must be prescribed by a licensed M.D., D.O., N.P., P.A., D.D.S., D.M.D., or D.P.M. to be covered. This plan does not cover equipment commonly used for nonmedical purposes, for physical or occupational therapy, or prescribed primarily for comfort. Please see 'Excluded Services - Equipment and Devices' in the Benefit Limitations and Exclusions section for information on items not covered. The following limitations apply to durable medical equipment:
  - This benefit covers the cost of either purchase or rental of the equipment for the period needed, whichever is less. Repair or replacement of equipment is also covered when necessary, subject to all conditions and limitations of the plan. If the cost of the purchase, rental, repair, or replacement is over $800, preauthorization by PacificSource is required.
  - Only expenses for durable medical equipment, or prosthetic and orthotic devices that are provided by a PacificSource contracted provider or a provider that satisfies the criteria in the Medicare Quality Standards for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Other Items and Services handbook are eligible for reimbursement. Mail order or Internet/Web based providers are not eligible providers.
  - Purchase, rental, repair, lease, or replacement of a power-assisted wheelchair (including batteries and other accessories) requires preauthorization by PacificSource and is payable only in lieu of benefits for a manual wheelchair. For members age 19 or older, this benefit is limited to one power-assisted wheelchair in a lifetime.
  - The durable medical equipment benefit also covers lenses to correct a specific vision defect resulting from a severe medical or surgical problem, such as stroke, neurological disease, trauma, or eye surgery other than refraction procedures. Coverage is subject to the following limitations.
    - The medical or surgical problem must cause visual impairment or disability due to loss of binocular vision or visual field defects (not merely a refractive error or astigmatism) that requires lenses to restore some normalcy to vision.
    - The maximum allowance for glasses (lenses and frames), or contact lenses in lieu of glasses, is limited to $200 per 'initial case' is defined as the first time surgery or treatment is performed on either eye. Other policy limitations, such as exclusions for extra lenses, other hardware, tinting of lenses, eye exercises, or vision therapy, also apply.
    - Benefits for subsequent medically necessary vision corrections to either eye (including an eye not previously treated) are limited to the cost of lenses only.
    - Reimbursement is subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment and is in lieu of, and not in addition to benefits payable under any vision endorsement that may be added to this plan.

- The durable medical equipment benefit also covers hearing aids for members 18 years of age and younger, or 19 to 25 years of age who are enrolled in an accredited educational institution. Coverage is limited to a maximum benefit of $4,000 every 48 months. The benefit amount shall be adjusted on January 1 of each year to reflect the U.S City Average Consumer Price Index.
- Medically necessary treatment for sleep apnea and other sleeping disorders is covered when preauthorized by PacificSource. Coverage of oral devices includes charges for consultation, fitting, adjustment, follow-up care, and the appliance. The appliance must be prescribed by a physician specializing in evaluation and treatment of obstructive sleep apnea, and the condition must meet criteria for obstructive sleep apnea.
- Wigs following chemotherapy or radiation therapy are covered up to a maximum benefit of $150 per calendar year.

TRANSPLANT SERVICES

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

All pretransplant evaluations, services, treatments, and supplies for transplant procedures require preauthorization by PacificSource.

You must have been covered under this plan for at least 24 consecutive months or since birth to be eligible for transplant benefits, including benefits for transplantation evaluation. See Exclusion Periods - Transplants in the Benefit Limitations and Exclusions section of this handbook for details.

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

- Kidney
- Kidney - Pancreas
- Pancreas whole organ transplantation (under certain criteria)
- Heart
- Heart - Lung
- Lung
- Liver (under certain criteria)
- Bone marrow and peripheral blood stem cell
- Pediatric bowel

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

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

- Testing of related or unrelated donors for a potential living related organ donation is payable at the same percentage that would apply to the same testing of an insured recipient.
- Expense for acquisition of cadaver organs is covered, payable at the same percentage and subject to the same maximum dollar limitation, 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 at the same percentage payable for the transplant itself up to $8,000 if the recipient is a PacificSource member, and applies to the maximum dollar limitation for the transplant, if any.

- If the donor is not a PacificSource member, only those complications of the donation that occur during the initial hospitalization are covered, and such complications are covered only to the extent that they are not covered by another health plan or government program. Coverage is at the same percentage payable for the transplant itself, and also applies to the maximum dollar limitation, if any, for the transplant.
- If the donor is a PacificSource member, complications of the donation are covered as any other illness would be covered.

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

Travel and housing expenses for the recipient are limited to $5,000 per transplant. Travel and living expenses are not covered for the donor.

Payment of Transplant Benefits

If a transplant is performed at a participating Center of Excellence transplantation facility, covered charges of the facility are paid in full. If our contract with the facility includes the services of the medical professionals performing the transplant (such as physicians, nurses, and anesthesiologists), those charges are also paid in full. If the professional fees are not included in our contract with the facility, then those benefits are provided according to your Medical Benefit Summary.

If transplant services are available through a contracted transplantation facility but are not performed at a contracted facility, you are responsible for satisfying any deductibles or co-payments shown on your Medical Benefit Summary. This plan then pays 70 percent of the amount that would have been paid to a participating facility. Services of non-participating medical professionals are paid at the non-participating provider percentages shown on the Medical Benefit Summary and do not accumulate towards the plan's out-of-pocket maximum.

OTHER COVERED SERVICES, SUPPLIES, AND TREATMENTS

- This plan covers services of a state certified ground or air **ambulance** when private transportation is medically inappropriate because the acute medical condition requires paramedic support. Benefits are provided for emergency ambulance service and/or transport to the nearest facility capable of treating the condition. Air ambulance service is covered only when ground transportation is medically or physically inappropriate. Reimbursement to non-participating air ambulance services are based on Medicare allowance. In some cases Medicare allowance may be significantly lower than the provider's billed amount. The provider may hold you responsible for the amount they bill in excess of the Medicare allowance, as well as applicable deductibles and co-insurance.
- This plan covers **biofeedback** to treat migraine headaches or urinary incontinence when provided by an otherwise eligible practitioner. Benefits are limited to a lifetime maximum of ten sessions.
- This plan covers **blood transfusions**, including the cost of blood or blood plasma.
- This plan covers removal, repair, or replacement of an internal **breast prosthesis** due to a contracture or rupture, but only when the original prosthesis was for a medically necessary mastectomy. Preauthorization by PacificSource is required, and eligibility for benefits is subject to the following criteria:
  - The contracture or rupture must be clinically evident by a physician's physical examination, imaging studies, or findings at surgery.
  - This plan covers removal, repair, and/or replacement of the prosthesis; a new reconstruction is not covered.

— 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.

— PacificSource may require a signed loan receipt/subrogation agreement before providing coverage for this benefit.

- This plan covers **breast reconstruction** in connection with a medically necessary mastectomy. Coverage is provided in a manner determined in consultation with the attending physician and patient for:
  - All stages of reconstruction of the breast on which the mastectomy was performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - Prostheses; and
  - Treatment of physical complications of the mastectomy, including lymphedema

  Benefits for breast reconstruction are subject to all terms and provisions of the plan, including deductibles, co-payments and/or co-insurance stated in your Medical Benefit Summary.
- This plan covers **cardiac rehabilitation** as follows:
  - Phase I (inpatient) services are covered under inpatient hospital benefits.
  - Phase II (short-term outpatient) services are covered subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for outpatient hospital benefits. Benefits are limited to services provided in connection with a cardiac rehabilitation exercise program that does not exceed 36 sessions and that are considered reasonable and necessary.
  - Phase III (long-term outpatient) services are not covered.
- This plan covers IUD, diaphragm, and cervical cap **contraceptive devices** along with their insertion or removal. Contraceptive devices that can be obtained over the counter or without a prescription, such as condoms are not covered.
- This plan covers **corneal transplants**. Preauthorization is not required.
- In the following situations, this plan covers one attempt at **cosmetic or reconstructive surgery:**
  - When necessary to correct a functional disorder; or
  - When necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury; or
  - When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery

  Cosmetic or reconstructive surgery must take place within 18 months after the injury, surgery, scar, or defect first occurred. Preauthorization by PacificSource is required for all cosmetic and reconstructive surgeries covered by this plan. For information on breast reconstruction, see ’breast prosthesis’ and ’breast reconstruction’ in this section.
- This plan provides coverage for certain **diabetic supplies and training** as follows:
  - Diabetic supplies other than insulin and syringes (such as lancets, test strips, and glucostix) are covered subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment. You may purchase those supplies from any retail outlet and send your receipts to PacificSource, along with your name, group number, and member ID number. We will process the claim and mail you a reimbursement check.
  - Diabetic insulin and syringes are covered under your prescription drug benefit, if your plan includes prescription coverage. Lancets and test strips are also available under that prescription benefit in lieu of those covered supplies under the medical plan.

  - This plan covers one diabetes self-management education program at the time of diagnosis, and up to three hours of education per year if there is a significant change in your condition or its treatment. To be covered, the training must be provided by an accredited diabetes education program, or by a physician, registered nurse, nurse practitioner, certified diabetes educator, or licensed dietitian with expertise in diabetes.
  - This plan covers medically necessary telemedical health services provided in connection with the treatment of diabetes (see Professional Services in this section).

- This plan covers **dietary or nutritional counseling** provided by a registered dietitian under certain circumstances. It is covered under the diabetic education benefit, or for management of inborn errors of metabolism (excluding obesity), or for management of anorexia nervosa or bulimia nervosa (to a lifetime maximum of five visits).
- This plan covers nonprescription **elemental enteral formula** ordered by a physician for home use. Formula is covered when medically necessary to treat severe intestinal malabsorption and the formula comprises a predominant or essential source of nutrition. Coverage is subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment.
- This plan covers routine **foot care** for patients with diabetes mellitus.
- **Hospitalization for dental procedures** is covered when the patient has another serious medical condition that may complicate the dental procedure, such as serious blood disease, unstable diabetes, or severe cardiovascular disease, or the patient is physically or developmentally disabled with a dental condition that cannot be safely and effectively treated in a dental office. Coverage requires preauthorization by PacificSource, and only charges for the facility, anesthesiologist, and assistant physician are covered. Hospitalization because of the patient's apprehension or convenience is not covered.
- This plan covers treatment for **inborn errors of metabolism** involving amino acid, carbohydrate, and fat metabolism for which widely accepted standards of care exist for diagnosis, treatment, and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage includes expenses for diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. Nutritional supplies are covered subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment.
- **Injectable drugs and biologicals** administered by a physician are covered when medically necessary for diagnosis or treatment of illness or injury. This benefit does not include immunizations (see Preventive Care Services in this section) or drugs or biologicals that can be self-administered or are dispensed to a patient.
- This plan covers **maxillofacial prosthetic services** when prescribed by a physician as necessary to restore and manage head and facial structures. Coverage is provided only when head and facial structures cannot be replaced with living tissue, and are defective because of disease, trauma, or birth and developmental deformities. To be covered, treatment must be necessary to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing. Coverage is limited to the least costly clinically appropriate treatment, as determined by the physician. Cosmetic procedures and procedures to improve on the normal range of functions are not covered. Dentures, prosthetic devices for treatment of TMJ conditions, and artificial larynx are also not covered.
- For **pediatric dental care** requiring general anesthesia, this plan covers the facility charges of a hospital or ambulatory surgery center. Benefits are limited to a lifetime maximum of $2,000, and preauthorization by PacificSource is required.

- The **routine costs of care associated with qualifying clinical trials** are covered. Benefits are only provided for routine costs of care associated with qualifying clinical trials. Expenses for services or supplies that are not considered routine costs of care are not covered. PacificSource is not, based on the coverage provided, liable for any adverse effects of a clinical trial. For more information, see 'routine costs of care' in the Definitions section of this handbook.
- **Scheduled and/or non-emergent medical care outside of the United States.**is covered for covered employees residing outside the United States for three or more months as part of their job requirements, and for full-time students attending college outside the United States for three or more months.
- **Sleep studies** are covered when ordered by a pulmonologist, neurologist, otolaryngologist, or certified sleep medicine specialist, and when performed at a certified sleep laboratory.
- This plan covers medically necessary therapy and services for the treatment of **traumatic brain injury.**
- This plan covers **tubal ligation and vasectomy** procedures once the exclusion period has been satisfied (see Exclusion Periods in the following section).
- **Gender identity disorder (GID)**, including hormone therapy and sex reassignment surgery, is covered for members ages 18 and older when preauthorized and meets PacificSource criteria. Prior to seeking services for this benefit, contact PacificSource for preauthorization and eligibility.
- **Infertility services** Infertility services are covered when medically necessary subject to a 50% co-payment. In-vitro fertilization and procedures we determine to be experimental or investigational in nature are not covered (see Excluded Services section). Infertility services do not accumulate toward the medical out-of-pocket maximum.
- **Circumcision** is covered regardless of age or medical necessity. This benefit is limited to one circumcision per member per lifetime.

MEDICAL EVACUATION AND REPATRIATION BENEFITS

If you are outside your home country to attend the University of Oregon or participate in a program related to your degree, your plan provides medical evacuation and repatriation benefits as follows.

Medical Evacuation

For medical evacuation to your home country, your plan's deductible will be waived and the plan will pay 100% of charges, up to a maximum of $10,000.

Repatriation of Remains

For repatriation of your remains to your home country, your plan's deductible will be waived and the plan will pay 100% of charges, up to a maximum of $7,500.

BENEFIT LIMITATIONS AND EXCLUSIONS

Least Costly Setting for Services

Covered services must be performed in the least costly setting where they can be provided safely. If a procedure can be done safely in an outpatient setting but is performed in a hospital inpatient setting, this plan will only pay what it would have paid for the procedure on an outpatient basis. If services are performed in an inappropriate setting, your benefits can be reduced by up to 30 percent or $2,500, whichever is less.

EXCLUDED SERVICES

A Note About Optional Benefits

If your employer provides coverage for optional benefits such as prescription drugs, vision services, chiropractic care, or alternative care, you'll find those Member Benefit Summaries in this handbook.

Types of Treatment - This plan does not cover the following:

- Chelation therapy, unless preauthorized by PacificSource for certain medical conditions or heavy metal toxicities
- Day care or custodial care, including help with daily activities such as walking, getting in or out of bed, bathing, dressing, eating, and preparing meals
- Dental examinations and treatment, which means any services or supplies to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures except as specifically provided with a separate PacificSource Dental Plan (See the Dental Benefit Plan section of this handbook).
- Fitness or exercise programs and health or fitness club memberships
- Foot care (routine), unless you are being treated for diabetes mellitus. Routine foot care includes services and supplies for corns and calluses, toenail conditions other than infection, and hypertrophy or hyperplasia of the skin of the feet
- Genetic (DNA) testing, except for tests identified as medically necessary for the diagnosis and standard treatment of specific diseases
- Homeopathic treatment
- Infertility - Services or supplies to diagnose, prevent, or treat sterility, infertility, erectile dysfunction, frigidity, or sexual dysfunction
- Instructional or educational programs, except diabetes self-management programs
- Jaw - Services or supplies for developmental or degenerative abnormalities of the head and face that can be replaced with living tissue; services that do not control or eliminate pain or infection or that do not restore functions such as speech, swallowing or chewing; cosmetic procedures and procedures to improve on the normal range of functions; and dentures, prosthetic devices for treatment of TMJ conditions and artificial larynx.
- Massage, massage therapy, or neuromuscular re-education, even as part of a physical therapy program
- Motion analysis, including physician review
- Myeloablative high dose chemotherapy, except when the related transplant is covered
- Obesity (including all categories) or weight control treatment or surgery, even if there are other medical reasons for you to control your weight. Food supplementation programs, behavior modification and self-help programs, and other services and supplies for weight loss are also excluded from coverage.
- Osteopathic manipulation, except for treatment of disorders of the musculoskeletal system
- Physical or eye exams required for administrative purposes, such as participation in athletics, admission to school, or employment
- Private nursing service
- Programs that teach a person to use medical equipment, care for family members, or self-administer drugs or nutrition (except for the diabetic education benefit)
- Screening tests, imaging, and exams solely for screening, and not associated with a specific diagnosis, sign of disease, or abnormality on prior testing (including but not limited to total body CT imaging, CT colonography, and bone density testing), except as allowed under the preventive care benefit

- Self-help or training programs
- Snoring - Services or supplies for the diagnosis or treatment of snoring or upper airway resistance disorders, including somnoplasty
- Speech therapy - Oral/facial motor therapy for strengthening and coordination of speech-producing muscles and structures, except as medically necessary in the restoration or improvement of speech following a traumatic brain injury or for a child 17 years of age or younger diagnosed with a pervasive developmental disorder
- Temporomandibular joint (TMJ)-related services, or treatment for associated myofascial pain, including physical or oromyofacial therapy
- Vocational rehabilitation, functional capacity evaluations, work hardening programs, community reintegration services, and driving evaluations and training programs, except as medically necessary in the restoration or improvement of speech following a traumatic brain injury or for a child 17 years of age or younger diagnosed with a pervasive developmental disorder

Surgeries and Procedures - This plan does not cover the following:

- Abdominoplasty
- Artificial insemination, in vitro fertilization, or GIFT procedures
- Cosmetic or reconstructive services, except as specified in the Covered Expenses - Other Covered Services, Supplies, and Treatments section
- Electronic Beam Tomography (EBT)
- Eye refraction procedures, orthoptics, vision therapy, or other services to correct refractive error
- Jaw surgery - Treatment for abnormalities of the jaw, malocclusion, or improving the placement of dentures and dental implants
- Orthognathic surgery - Treatment to augment or reduce the upper or lower jaw, except for reconstruction due to an injury (see the Covered Expenses - Professional Services section)
- Panniculectomy
- Sex transformations – Excluded procedures include, but are not limited to: staged gender reassignment surgery, including breast augmentation, facial bone reconstruction, blepharoplasty, liposuction, thyroid chondroplasty, laryngoplasty or shortening of the vocal cords, and/or hair removal to assist the appearance or other characteristics of gender reassignment, and complications resulting from gender reassignment procedures.
- Surgery to reverse voluntary sterilization
- Transplants, except as specified in the Covered Expenses - Transplants section

Mental Health Services - This plan does not cover the following services, whether provided by a mental health or chemical dependency specialist or by any other provider:

Treatment for the following diagnosis:

- Mental retardation
- Paraphilias
- Learning disorders
- Urinary incontinence
- Diagnostic codes V 15.81 through V71.09 (DSM-IV-TR, Fourth Edition) except V61.20, V61.21, and V62.82 when used with children five years of age or younger
- Food dependencies
- Nicotine-related disorders

Treatment programs, training, or therapy as follows:

- Educational or correctional services or sheltered living provided by a school or halfway house
- Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present
- Court-ordered sex offender treatment programs
- Court-ordered screening interviews or drug or alcohol treatment programs
- Marital/partner counseling
- Support groups
- Sensory integration training
- Biofeedback (other than as specifically noted under the Covered Expenses - Other Covered Services, Supplies, and Treatments section)
- Hypnotherapy
- Academic skills training
- Equine/animal therapy
- Narcosynthesis
- Aversion therapy
- Social skill training
- Recreational therapy outside an inpatient or residential treatment setting

Drugs and Medications - This plan does not cover the following:

- Drugs and biologicals that can be self-administered (including injectables), other than those provided in a hospital, emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered
- Growth hormone injections or treatments, except to treat documented growth hormone deficiencies
- Immunizations or other medications or supplies for protection while traveling or at work
- Over-the-counter medications or nonprescription drugs

Equipment and Devices - This plan does not cover the following:

- Computer or electronic equipment for monitoring asthmatic, diabetic, or similar medical conditions or related data
- Equipment commonly used for nonmedical purposes, or marketed to the general public, or intended to alter the physical environment. 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. It also includes orthopedic shoes and shoe modifications. Mattresses and mattress pads are only covered when medically necessary to heal pressure sores.
- Equipment used primarily in athletic or recreational activities. This includes exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal problems.
- Modifications to vehicles or structures to prevent, treat, or accommodate a medical condition
- Replacement costs for worn or damaged durable medical equipment that would otherwise be replaceable without charge under warranty or other agreement
- Personal items such as telephones, televisions, and guest meals during a stay at a hospital or other inpatient facility

Experimental or Investigational Treatment

Your PacificSource plan does not cover experimental or investigational treatment. By that, we mean services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines or the use thereof that are experimental or investigational for the diagnosis and treatment of the patient. It includes treatment that, when and for the purpose rendered:

- Has not yet received full U.S. government agency approval (e.g. FDA) for other than experimental, investigational, or clinical testing;
- Is not of generally accepted medical practice in Oregon or as determined by PacificSource in consultation with medical advisors, medical associations, and/or technology resources;
- Is not approved for reimbursement by the Centers for Medicare and Medicaid Services;
- Is furnished in connection with medical or other research; or
- Is considered by any governmental agency or subdivision to be experimental or investigational, not reasonable and necessary, or any similar finding.

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

When making benefit determinations about whether treatments are investigational or experimental, we rely on the above resources as well as:

- Expert opinions of specialists and other medical authorities;
- Published articles in peer-reviewed medical literature;
- External agencies whose role is the evaluation of new technologies and drugs; and
- External review by an independent review organization.

The following will be considered in making the determination whether the service is in an experimental and/or investigational status :

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

If you or your provider have any concerns about whether a course of treatment will be covered, we encourage you to contact our Customer Service Department. We will arrange for medical review of your case against our criteria, and notify you of whether the proposed treatment will be covered.

Other Items - This plan does not cover the following:

- Services or supplies that are not medically necessary
- Charges for inpatient stays that began before you were covered by this plan
- Services or supplies received before this plan's coverage began
- Services or supplies received after enrollment in this plan ends. (The only exception is that if this policy is replaced by another group health policy while you are hospitalized, PacificSource will continue paying covered hospital expenses until you are released or your benefits are exhausted, whichever occurs first.)
- Care and related services designed essentially to assist a person in maintaining activities of daily living, e.g. services to assist with walking, getting in/out of bed, bathing, dressing, feeding,

preparation of meals, homemaker services, special diets, rest cures, day care, and diapers. Custodial care is only covered in conjunction with respite care allowed under this policy's hospice benefit (see Covered Expenses - Hospital, Skilled Nursing Facility, Home Health, and Hospice Services).

- 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 authority
- Services or supplies available to you from another source, including those available through a government agency
- Services or supplies with no charge, or which your employer would have paid for if you had applied, or which you are not legally required to pay for. This includes services provided by yourself or an immediate family member.
- 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, automobile insurers, and general liability insurers)
- Services or supplies for which you are not willing to release the medical or eligibility information PacificSource needs to determine the benefits payable under this plan
- Treatment of any condition caused by a war, armed invasion, or act of aggression, or while serving in the armed forces
- Treatment of any work-related illness or injury, unless you are the owner, partner, or principal of the employer group insured by PacificSource, injured in the course of employment of the employer group insured by PacificSource, and are otherwise exempt from, and not covered by, state or federal workers' compensation insurance. This includes illness or injury caused by any for-profit activity, whether through employment or self-employment.
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims
- Any amounts in excess of the allowable fee for a given service or supply
- Services of providers who are not eligible for reimbursement under this plan. An individual, organization, facility, or program is not eligible for reimbursement for services or supplies, regardless of whether this plan includes benefits for such services or supplies, unless the individual, organization, facility, or program is licensed by the state in which services are provided as an independent practitioner, hospital, ambulatory surgical center, skilled nursing facility, durable medical equipment supplier, or mental and/or chemical healthcare facility. And, to the extent PacificSource maintains credentialing requirements the practitioner or facility must satisfy those requirements in order to be considered an eligible provider.
- Scheduled and/or non-emergent medical care outside of the United States, except as specified in the Covered Expenses - Other Covered Services, Supplies, and Treatments section for this handbook
- Any services or supplies not specifically listed as covered benefits under this plan

EXCLUSION PERIODS

Transplants

Except for corneal transplants, organ and tissue transplants are not covered until you have been enrolled in this plan for 24 months. If you were covered under another health insurance plan before enrolling in this plan, you can receive credit for your prior coverage. See the Credit for Prior Coverage section, below.

CREDIT FOR PRIOR COVERAGE

You can receive credit toward this plan's exclusion periods if you had qualifying healthcare coverage before enrolling in this plan. To qualify for this credit, there may not have been more than a 63-day gap between your last day of coverage under the previous health plan and your first day of coverage (or the first day of your employer's probationary waiting period) under this plan.

Your prior coverage must have been a group health plan, COBRA or state continuation coverage, individual health policy (including student plans), Medicare, Medicaid, TRICARE, State Children's Health Insurance Program, and coverage through high risk pools and the Peace Corps. If you were covered as a dependent under a plan that meets these qualifications, you will qualify for credit. Many people elect the COBRA or state continuation coverage available under a prior plan to make sure they won't have more than a 63-day gap in coverage.

It is your responsibility to show you had creditable coverage. If you qualify for credit, PacificSource will count every day of coverage under your prior plan toward this plan's exclusion periods for pre-existing conditions, other specified conditions, and transplants (explained above).

Evidence of Prior Creditable Coverage

You can show evidence of creditable coverage by sending PacificSource a Certificate of Creditable Coverage from your previous health plan. All health plans, insurance companies, and HMOs are required by law to provide these certificates on request. Most insurers issue these certificates automatically whenever someone's coverage ends. The certificate shows how long you were covered under your previous plan and when your coverage ended.

If you do not have a certificate of prior coverage, contact your previous insurance company or plan sponsor (such as your former employer, if you had a group health plan). You have the right to request a certificate from any prior plan, insurer, HMO, or other entity through which you had creditable coverage. If you are unable to obtain a certificate, contact our Membership Services Department and we will assist you.

PREAUTHORIZATION

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called 'preauthorization'.

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

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

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

Because of the changing nature of medicine, PacificSource continually reviews new technologies and standards of medical practice. The list of procedures and services requiring preauthorization is therefore subject to revision and update. ***The list is not intended to suggest that all the items***

included are necessarily covered by the benefits of this policy. You'll find the most current preauthorization list on our website, PacificSource.com.

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

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

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

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

CASE MANAGEMENT

Case management is a service provided by Registered Nurses with specialized skills to respond to the complexity of a member's healthcare needs. Case management services may be initiated by PacificSource when there is a high utilization of health services or multiple providers, or for health problems such as, but not limited to, transplantation, high risk obstetric or neonatal care, open heart surgery, neuromuscular disease, spinal cord injury, or any acute or chronic condition that may necessitate specialized treatment or care coordination. When case management services are implemented, the nurse care manager will work in collaboration with the patient's primary care provider and the PacificSource Chief Medical Officer to enhance the quality of care and maximize available health plan benefits. A case manager may authorize benefits for supplemental services not otherwise covered by this policy (See Individual Benefits Management in this section).

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

INDIVIDUAL BENEFITS MANAGEMENT

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

UTILIZATION REVIEW

PacificSource has a utilization review program to determine coverage of hospital admissions. This program is administered by our Health Services Department. All hospital admissions are reviewed by PacificSource Nurse Case Managers, who are all registered nurses and certified case managers. Questions regarding medical necessity, possible experimental or investigational services, appropriate setting, and appropriate treatment are forwarded to the PacificSource Chief Medical Officer, an M.D., for review and benefit determination.

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

Authorization of Hospital Admissions

When a PacificSource member is admitted to a hospital within the area covered by PacificSource's provider networks (see the Using the Provider Network - Coverage While Traveling section), the hospital's admitting clerk calls PacificSource to verify the patient's eligibility and benefits. The clerk gives us information about the patient's diagnosis, procedure, and attending physician. We use that information to create a daily report of all PacificSource members currently admitted to hospitals within our service area. The authorization status with regards to available benefits for each admission is documented in the report.

As part of the utilization review process, PacificSource evaluates how long each patient is expected to remain hospitalized. This is called the 'target length of stay.' We use the target length of stay to monitor the patient's progress and plan for any necessary follow-up care after the patient is discharged.

The PacificSource Health Services Department assigns the target length of stay based on the patient's diagnosis and/or procedure. For standard hospitalizations, we use written procedures that were developed based on the following guidelines:

- Milliman & Robertson Optimal Recovery Guidelines
- HCIA Length of Stay by Diagnosis & Operation, Western Region, 50th percentile
- Standard of practice in the state of Oregon

If we are unable to assign a length of stay based on those guidelines, our Nurse Case Manager contacts the hospital's utilization review coordinator for more specific information about the case. We then use that information to assign an expected length of stay for the patient.

Extension of Hospital Stays

If a patient's hospital stay extends beyond the assigned length of stay, a Nurse Case Manager contacts the hospital's utilization review coordinator. We obtain current information about the patient's medical progress and assign a new length of stay or begin planning for the patient's discharge. The PacificSource Chief Medical Officer may review the case to determine if extended hospitalization meets coverage criteria.

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

Timeliness for Responding to Coverage Request

When PacificSource receives a request for coverage of an admission or extension of a hospital stay, we are generally able to provide an answer that same day. If we do not have enough information to make a benefit determination, we request further information and attempt to provide a determination on the day we receive that information. If a member is discharged before we receive the information we need, the case is reviewed retrospectively by the Nurse Case Manager and the Chief Medical Officer for a determination regarding coverage.

Questions About Specific Utilization Review Decisions

If you would like information on how we reached a particular utilization review benefit determination, please contact our Health Services Department by phone at (541) 684-5584 or (888) 691-8209, or by email at healthservices@pacificsource.com. We will provide you with a written summary of information we may consider in utilization review of the particular condition, if we in fact maintain such criteria.

HOW TO USE YOUR DENTAL PLAN

When you need dental care, you may visit any dentist. Most dental offices will bill PacificSource directly. If your dentist has any questions regarding billing procedures, he or she can call PacificSource at (541) 225-1981, or (866) 373-7053 from outside the Eugene-Springfield area.

When you first visit your dentist after becoming covered under this plan, let the office staff know you have dental benefits through PacificSource. You will need to show your PacificSource ID card, which contains your group number and benefit information. Your dentist may submit claims and treatment programs on a standard American Dental Association form.

For extensive dental work, we recommend that your dentist submit a pre-treatment estimate to PacificSource. We then determine how much your plan will pay toward the proposed treatment and review the estimate with your dentist prior to treatment. If your covered family members require extensive dental work, be sure your member ID number and group number are included on their pre-treatment form for identification purposes.

DENTAL PLAN BENEFITS

When this plan pays for dental services, it actually pays the stated percentage of charges based on reasonable and customary charges. A charge is reasonable and customary when it falls within a general range of charges being made by most dental providers in your service area for similar treatment of similar dental conditions. If the charge for a treatment or service is more than the reasonable and customary charge in your service area, you may be required to pay the difference. The reasonable and customary charge for dental expense is the 'covered charge' referred to in this booklet.

If you or your covered family member selects a more expensive treatment than is customarily provided, this plan will pay the applicable percentage of the lesser fee. You will be responsible for the balance of the provider's charges.

With the Advantage Network, participating dentists agree to write off any charges over and above the negotiated, contracted fees for most services. When you use a participating dentist in the Advantage Network, you will not be responsible for any excess charges and will pay only your plan's deductible and/or co-insurance amount. If you choose not to use a participating Advantage Network dentist, or don't have access to them, reimbursement will continue to be based on usual, customary, and reasonable (UCR) charges. If that non-participating dentist's fees exceed the UCR charges, the excess charges are also your responsibility.

COVERED DENTAL SERVICES

This dental plan covers the following services when performed by an eligible provider and when determined to be necessary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury, including masticatory function. Covered services may also be provided by a dental hygienist or denturist to the extent that he or she is operating within the scope of his or her license as required under law in the State of Oregon.

Covered dental services are organized into three classes, starting with preventive care and advancing into specialized dental procedures.

CLASS I SERVICES - DIAGNOSTIC AND PREVENTIVE TREATMENT

- **Examinations** (routine or other diagnostic exams) are covered twice per person per contract year. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
- **Full mouth x-rays and/or panorex** are covered to one complete mouth series and/or panorex in any five-year period and limited to four bite-wing films in a six-month period. When an accumulative charge for x-rays in a one-year period matches that of a complete mouth series, no further benefits for mouth x-rays or panorex are available for the remainder of the year.
- **Dental cleanings (prophylaxis and periodontal maintenance)** are covered to a combined total of two procedures per person contract year. The limitation for dental cleaning applies to any combination of prophylaxis and/or periodontal maintenance (a Class II procedure) in the contract year. A separate charge for periodontal charting is not a covered benefit. Periodontal maintenance is not covered when performed within three months of periodontal scaling and root planing and/or curettage.
- **Topical applications of fluoride** are covered to two applications per contract year and only for individuals through the age of 16.

CLASS II RESTORATIVE SERVICES - BASIC AND RESTORATIVE TREATMENT

- **Composite, resin , or similar restoration** in a posterior (back) tooth is covered to the amount that would be paid for a corresponding amalgam restoration. A separate charge for anesthesia when used during restorative procedures is not a covered benefit.
- **Simple and Surgical extractions of teeth** and other minor oral surgery procedures are covered. General anesthesia used in conjunction with these extractions administered by a dentist in a dental office is also covered. A separate charge for alveolectomy performed in conjunction with removal of teeth is not a covered benefit.
- **Space maintainers** to preserve the space between teeth caused by the premature loss of a primary tooth.
- Benefits for **full mouth debridement** are limited to once every 24 months. This procedure is only covered if the teeth have not received a prophylaxis in the prior 24 months and if an evaluation cannot be performed due to the obstruction by plaque and calculus on the teeth. This procedure is not covered if performed on the same date as the prophylaxis.

CLASS II COMPLICATED SERVICES - COMPLICATED TREATMENT

- **Pulp capping** is covered only when there is an exposure to the pulp. These are direct pulp caps. Indirect pulp caps are not covered.
- **Pulpotomy** is covered only for deciduous teeth.
- **Root canal therapy** is covered on the same tooth only for one charge in a three-year period.
- **Repair of dentures and bridges** is covered. Replacement of dentures and bridges is excluded.
- **Application of sealants** is covered to one application in a five-year period to permanent molars and only for children up to age 16.

EXCLUDED DENTAL SERVICES

This plan does not provide benefits in any of the following circumstances or for any of the following conditions:

- **Aesthetic dental procedures** - Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.
- **Antimicrobial agents** - Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.
- **Benefits not stated** - Any services and supplies not specifically described as covered benefits under this plan.
- **Biopsies or histopathologic exams** - or histopathologic exams
- **Bone replacement grafts** to prepare sockets for implants after tooth extraction.
- Charges for **broken appointments.**
- **Collection of cultures and specimens.**
- **Connector bar or stress breaker.**
- **Core build-ups** are not covered unless used to restore a tooth that has been treated endodontically (root canal).
- **Cosmetic/reconstructive services and supplies** - Procedures, appliances, restorations, or other services that are primarily for cosmetic purposes. This includes services or supplies rendered primarily to correct congenital or developmental malformations, including but not limited to, peg laterals, cleft palate, maxillary and mandibular (upper and lower jaw) malformation, enamel hypoplasia, and fluorosis (discoloration of teeth). However, the replacement of congenitally missing teeth is covered.
- **Crowns** and other cast or laboratory-processed restorations.
- **Dentures**, including cast partial denture, full, immediate, or overdenture.
- **Denture replacement** made necessary by loss, theft, or breakage.
- **Diagnostic casts** - Diagnostic casts (study models), gnathological recordings, occlusal appliances, occlusal equilibration procedures, or similar procedures.
- **Drugs and medications** that are prescribed drugs, premedication drugs. analgesics (e.g., nitrous oxide or non-intravenous sedation), any other euphoric drugs, or any take-home medicine or supplies distributed by a provider.
- **Educational programs** - Instructions and/or training in plaque control and oral hygiene.
- **Experimental or investigational procedures** - Services, supplies, protocols, procedures, devices, drugs or medicines, or the use thereof that are experimental or investigational for the diagnosis and treatment of the patient. An experimental or investigational service is not made eligible for benefits by the fact that other treatment is considered by the member's dental care provider to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.
- **Fixed bridges or removable cast partials.**
- **Fractures of the mandible -** Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible
- **General anesthesia** except when administered by a dentist in connection with oral surgery in his/her office

- **Gingivetomcy, gingivoplasty or crown lengthening** in conjunction with crown preparation or fixed bridge services done on the same date of service.
- **Hospital charges** or additional fees charged by the dentist for hospital treatment
- **Hypnosis**
- **Implants** - Surgical preparation, surgical placement, or removal of implants
- **Infection control** - A separate charge for infection control or sterilization.
- **Intra and extra coronal splinting** - Devices and procedures for intra and extra coronal splinting to stabilize mobile teeth.
- **Oral surgery treating any fractured jaw.**
- **Orthodontic services** - Treatment of malalignment of teeth and/or jaws, or any ancillary services expressly performed because of orthodontic treatment, are excluded.
- **Orthognathic surgery** - Surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship to the facial bones.
- **Periodontal probing, charting, and re-evaluations.**
- **Photographic images.**
- **Pin retention** in addition to restoration.
- **Precision attachments.**
- **Pulpotomies on permanent teeth.**
- **Removal of clinically serviceable amalgam restorations** to be replaced by other materials free of mercury, except with proof of allergy to mercury.
- **Replacement of an existing prosthetic device.**
- **Services covered by the member's medical plan.**
- **Services for rebuilding or maintaining chewing surfaces** due to teeth out of alignment or occlusion, or for stabilizing the teeth.
- **Services otherwise available** - These include but are not limited to:
  - Services or supplies for which payment could be obtained in whole or in part if the member applied for payment under any city, county, state, or federal law (except Medicaid); and
  - Services or supplies the member could have received in a hospital or program operated by a federal government agency or authority. Covered expenses for services or supplies furnished to a member by the Veterans' Administration of the United States that are not service-related are eligible for payment according to the terms of this policy.
  - Services or supplies for which payment would be made by Medicare
- **Services or supplies for which no charge is made,** which you are not legally required to pay, or which a provider or facility is not licensed to provide even though the service or supply may otherwise be eligible. This includes services provided by you or an immediate family member.
- **Sinus lift grafts** to prepare sinus site for implants.
- **Temporomandibular joint (TMJ)** - Any services or supplies for treatment of any disturbance of the temporomandibular joint.
- **Third party liability, motor vehicle liability, motor vehicle insurance coverage, workers' compensation** - Any services or supplies for illness or injury for which a third party is responsible

or which are payable by such third party or which are payable pursuant to applicable workers' compensation laws, motor vehicle liability, uninsured motorist, underinsured motorist, and personal injury protection insurance and any other liability and voluntary medical payment insurance to the extent of any recovery received from or on behalf of such sources.

- **Tooth transplantation** - Services and supplies provided in connection with tooth transplantation, including re-implantation from one site to another and splinting and/or stabilization. This exclusion does not relate to the re-implantation of a tooth into its original socket after it has been avulsed.
- **Treatment after insurance ends** - Services or supplies provided after enrollment in this plan ends.
- **Treatment not dentally necessary** according to acceptable dental practice or treatment not likely to have a reasonably favorable prognosis
- **Treatment prior to enrollment** - Dental services begun before you or your family member became eligible for those services under this plan
- **Treatment while incarcerated** - Services or supplies received while in the custody of any state or federal law enforcement authorities or while in jail or prison
- **Unwilling to release information** - Charges for services or supplies for which you are unwilling to release medical information necessary to determine eligibility for payment under this policy
- **War-related conditions** - The treatment of any condition caused by or arising out of an act of war, armed invasion, or aggression, or while in the service of the armed forces.
- **Work-related conditions** - Services or supplies for treatment of illness or injury arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense for the service or supply is paid under workers' compensation.
- **Gnathologic recordings** or similar procedures
- **Periodontal Services - Diagnosis and treatment of diseases of the connective tissues around and supporting the teeth. Root planning and scaling. A separate charge for periodontal charting.**
- **Periodontal surgery**
- **Prosthetic Services** other than repair of dentures or bridges. Restoration of decayed or missing teeth with crowns, jackets, gold cast restoratives, inlays, or onlays. Fixed or removable bridges, full or partial dentures, denture replacement, and denture adjustment and reliness.
- **Splints, night guards, or appliances used to increase vertical dimensions,** restore the occulsion, or correct habits such as tongue thrust and grinding teeth. Periodontal splinting including crowns and bridgework used in conjuction with periodontal splinting.

CLAIMS PAYMENT

How to File a Claim

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

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

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

All claims should be sent to:

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

Claim Handling Procedures

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

Pre-service claims--Your plan subjects the receipt of benefits for some services or supplies to a preauthorization review. Although a preauthorization review is generally done on a pre-service basis, it may in some case be conducted on a post-service basis. Unless a response is needed sooner due to the urgency of the situation, a pre-service preauthorization review will be completed and notification made to you and your medical provider as soon as possible, generally within two working days, but no later than 15 days within receipt of the request.

Urgent care claims--If the time period for making a non-urgent care determination could seriously jeopardize your life, health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is proposed, a preauthorization review will be completed as soon as possible, generally within 24 hours, but no later than 72 hours of receipt of the request.

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

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

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

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

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

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

Questions About Claims

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

Benefits Paid in Error

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

In the same manner, if PacificSource applies medical expense to the plan deductible that would not otherwise be reimbursable under the terms of this policy; we may deduct a like amount from the accumulated deductible amount and/or recover payment of medical expense that would have otherwise been applied to the deductible. Examples of amounts recoverable under this provision include, but are not limited to benefits provided for incurred expense for the treatment of an excluded pre-existing medical condition (see Pre-existing condition in Definitions section). The fact that a medical expense was applied to the plan's deductible or a drug was provided under the plan's prescription drug program does not in itself create an eligible expense or infer that benefits will continue to be provided for an otherwise excluded condition.

COORDINATION OF BENEFITS

If you, or your enrolled dependents, are covered by more than one group insurance plan, PacificSource will work with your other insurance carriers to pay up to 100 percent of your covered expenses. This is called 'coordination of benefits.' We do this so you receive the maximum benefits available from all sources for the cost of your care.

When benefits are coordinated, one plan pays benefits first (the 'primary coverage') and the other pays based on the remaining balance (the 'secondary coverage'). If your primary and/or secondary coverage include a deductible, you will be required to satisfy each of those deductibles concurrently before benefits are available. The secondary plan shall credit to its deductible any amounts it would have credited to its deductible in the absence of the primary plan. This plan's rules for coordination of benefits are consistent with the requirements of coordination of benefits provision in Oregon Insurance regulations.

Here is how this plan's benefits are coordinated with your other group coverage:

- If the other plan does not include 'coordination of benefits,' that plan is primary and this plan is secondary.
- If you are covered as an employee on one plan and a dependent on another, your employer's plan is primary.
- When a child is covered under both parents' policies and the parents are either married or are living together (regardless of whether or not they have ever been married):
  - The parent whose birthday falls first in a calendar year has the primary plan; or
  - If both parents have the same birthday, the parent who has been covered the longest has the primary plan.

EXAMPLE *If your birthday is March 1 and your spouse's birthday is October 15, your plan is primary for your children.*

- When a child is covered under both parents' policies and the parents are divorced, separated, or not living together (regardless of whether or not they have ever been married):
  - If a court order specifies that one parent is responsible for the child's healthcare expenses, the mandated parent's coverage is primary regardless of custody.
  - If a court order specifies that both parents are responsible for the child's healthcare expenses, the parent whose birthday falls first in a calendar year has the primary plan. If both parents have the same birthday, the parent who has been covered the longest has the primary plan.
  - If a court order specifies that both parents have joint custody without specifying that one parent has responsibility for the child's healthcare expenses, the parent whose birthday falls first in a calendar year has the primary plan. If both parents have the same birthday, the parent who has been covered the longest has the primary plan.
  - If there is no court order, the order of benefits for the child are as follows:
    - The custodial parent's coverage is primary;
    - The spouse of the custodial parent's coverage pays second;
    - The natural parent without custody's coverage pays third; and
    - The spouse of the natural parent without custody's coverage pays fourth.
- If a plan covers you as an active employee or a dependent of an active employee, that plan is primary. Another plan covering you as inactive, laid off, or retired is secondary.
- If none of these rules apply, the coverage that has been in place longest is primary.

Most insurance companies send you an explanation of benefits, or EOB, when they pay a claim. If your other plan's coverage is primary, send PacificSource the other plan's EOB with your original bill and we will process your claim. If this plan is primary, send your PacificSource EOB and the original bill to your other insurance company. In most cases that is all the insurer needs to process your claim.

If you receive more than you should when your benefits are coordinated, you will be expected to repay any over-payment.

Coordination with Medicare

- *Medicare eligibility due to age:* If you are Medicare eligible due to age, this plan is usually the primary payer and Medicare is secondary. This rule applies to you and your enrolled dependents only if you are an active employee.

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

THIRD PARTY LIABILITY

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

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

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

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

Motor Vehicle and Other Accidents

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

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

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

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

This plan does not cover any work-related illness or injury, including those arising from self-employment. The only exception is if you are an owner, partner, or principal of the employer group insured by PacificSource, injured in the course of employment of the employer group insured by PacificSource, and are otherwise exempt from, and not covered by, state or federal workers' compensation insurance.

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

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

COMPLAINTS, GRIEVANCES, AND APPEALS

Questions, Concerns, or Complaints

PacificSource understands that you may have questions or concerns about your benefits, eligibility, the quality of care you receive, or how we reached a claim determination or handled a claim. We try to answer your questions promptly and give you clear, accurate answers.

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

GRIEVANCE PROCEDURES

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

APPEAL PROCEDURES

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

- Denial of eligibility for or termination of enrollment in a healthcare plan;
- Rescission or cancellation of your policy;
- Imposition of a pre-existing condition exclusion, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered services or items;
- Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate; or

- Determination that a course or plan of treatment you are undergoing is an active course of treatment for the purpose of continuity of care.

PacificSource 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.

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

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

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

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

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

PacificSource may, at its discretion and with your consent, waive the requirements of compliance with the internal appeals process and have a dispute referred directly to external review. You shall be deemed to have exhausted internal appeals if PacificSource fails to strictly comply with its appeals process and with state and federal requirements for internal appeals. If PacificSource fails to comply with the decision of the independent review organization assigned under Oregon law, you have a private right of action (sue) against PacificSource for damages arising from an adverse benefit determination subject to the external review.

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

Timelines for Responding to Appeals

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

Upon request, PacificSource will provide you with access to the following information at no charge:

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

HOW TO SUBMIT GRIEVANCES OR APPEALS

Before submitting a grievance or appeal, we suggest you contact our Customer Service Department with your concerns. You can reach us by phone at (541) 684-5582 or toll-free at (888) 977-9299, or by email at cs@pacificsource.com. Issues can often be resolved at this level. Otherwise, you may file a grievance or appeal by:

- **Writing to:**

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

- **Emailing** a message to lc@pacificsource.com, with 'Grievance' as the subject
- **Faxing** your message to (541) 225-3628

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

Assistance Outside PacificSource

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

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

  The Oregon Insurance Division
  Consumer Advocacy Unit
  PO Box 14489
  Salem, OR 97309-0405

- Through the Internet at http://insurance.oregon.gov/consumer/consumer.html
- Or by email at cp.ins@state.or.us

SOURCES FOR INFORMATION AND ASSISTANCE

Assistance in Other Languages

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

Information Available from PacificSource

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

- A directory of participating healthcare providers under your plan
- Information about our drug formulary, if your plan benefits include coverage for prescription drugs
- A copy of our annual report on complaints and appeals
- A description (consistent with risk-sharing information required by the Centers for Medicare and Medicaid Services, formerly known as Health Care Financing Administration) of any risk-sharing arrangements we have with providers
- A description of our efforts to monitor and improve the quality of health services
- Information about how we check the credentials of our network providers and how you can obtain the names and qualifications of your healthcare providers
- Information about our preauthorization and utilization review procedures

Information Available from the Oregon Insurance Division

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

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

You can request this information by contacting the Oregon Insurance Division by writing to the Oregon Insurance Division, Consumer Advocacy Unit, PO Box 14489, Salem, OR 97309-0405 or by phone at (503) 947-7984, or the toll-free message line at (888) 877-4894, on the Internet at http://insurance.oregon.gov/consumeer/consumer.html, or by email at cp.ins@state.or.us.

FEEDBACK AND SUGGESTIONS

As a PacificSource member, you are encouraged to help shape our corporate policies and practices. We welcome any suggestions you have for improving your plan or our services.

You may send comments or feedback using the 'Contact Us' form on our website, PacificSource.com. You may also write to us at:

PacificSource Health Plans
Attn: Executive Vice President and Chief Operating Officer
PO Box 7068
Springfield OR 97475-0068

RIGHTS AND RESPONSIBILITIES

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

Your Responsibilities as a Member:

- You are responsible for reading this benefit handbook and all other communications from PacificSource, and for understanding your plan's benefits. You are responsible for contacting PacificSource Customer Service if anything is unclear to you.
- You are responsible for making sure your provider obtains preauthorization for any services that require it before you are treated.
- You are responsible for providing PacificSource with all the information required to provide benefits under your plan.
- You are responsible for giving your healthcare provider complete health information to help accurately diagnose and treat you.
- You are responsible for telling your providers you are covered by PacificSource and showing your ID card when you receive care.
- You are responsible for being on time for appointments, and calling your provider ahead of time if you need to cancel. You are responsible for any fees the provider charges for late cancellations or 'no shows.'

- You are responsible for following the treatment plans or instructions agreed on by you and your healthcare provider.
- You are responsible for contacting PacificSource if you believe you are not receiving adequate care.

PRIVACY AND CONFIDENTIALITY

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

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

Group Insurance Contract

This plan is fully insured. Benefits are provided under a group insurance contract between your employer and PacificSource Health Plans. Your employer--the policyholder--has a copy of the group insurance contract, which contains specific information regarding eligibility and benefits. Under the insurance contract, PacificSource--not the policyholder--is responsible for paying claims. However, the policyholder and PacificSource share responsibility for administering the plan's eligibility and enrollment requirements. The policyholder has given PacificSource discretionary authority to determine eligibility for benefits under the plan and to interpret the terms of the plan.

If there are any conflicts between this benefit book and the group health contract, the group health contract will govern.

Our address is:

PacificSource Health Plans
PO Box 7068
Springfield OR 97475-0068

Plan Funding

Insurance premiums for employees are paid in whole or in part by the plan sponsor (your employer) out of its general assets. Any portion not paid by the plan sponsor is paid by employee payroll deductions.

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 policyholder's board of directors or other governing body
- The owner or partners of the business
- Anyone authorized by the above people to take such action

The plan administrator is authorized to apply for and accept policy changes on behalf of the policyholder.

If changes occur, PacificSource will provide your plan administrator with information to notify you of changes to your plan. Your plan administrator will then communicate any benefit changes to you.

If your group policy terminates and your employer does not replace the coverage with another group policy, your employer is required by law to advise you in writing of the termination. When this policy terminates, PacificSource will notify your employer about any continuation or portability coverage available to you.

Legal Procedures

You may not take legal action against PacificSource to enforce any provision of the group contract until 60 days after your claim is submitted to us. Also, you must exhaust this plan's claims procedures before filing benefits litigation. You may not take legal action against PacificSource more than three years after the deadline for claim submission has expired.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Generally, health benefit plans subject to ERISA include employer-sponsored plans, but do not include governmental and church plans or any other statute-exempt plan. If the plan under which you are covered is an ERISA plan, you have the right to bring civil action under ERISA section 502 to enforce your current or future rights under the terms of the plan or to recover benefits due you. Although PacificSource offers you the opportunity of a second level appeal and an independent review, ERISA permits civil action after you have received our decision at the first level appeal as described under the Complaints, Grievances, and Appeals - Grievance and Appeal Procedures section.

Your rights under ERISA

As a participant in an ERISA plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). The policyholder (your employer) is the 'plan administrator' as defined in ERISA. The plan administrator is an agent of those individually enrolled under the group policy, and is not the agent of PacificSource. ERISA states that all plan participants are entitled to:

Receive information about your plan and benefits.

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report (Form 5500 Series). The plan administrator is required by law to furnish each participant with a copy of this summary annual report only in a year in which the plan has to file an annual report.

Continue group health plan coverage.

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a

certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for six months (12 months for late enrollees) after your enrollment date in your coverage.

Prudent actions by plan fiduciaries.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called 'fiduciaries' of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising any rights under ERISA.

Enforce your rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see the Complaints, Grievances, and Appeals - Appeal Procedures section).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. (A claimant will need to exhaust the plan's claims procedure before filing benefits litigation; see the Complaints, Grievances, and Appeals - Appeal Procedures section and the first paragraph of this section.) In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance with your questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of Employee Benefits Security Administration., U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration., U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEFINITIONS

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

Abutment is a tooth used to support a prosthetic device (bridges, partials or overdentures). With an implant, an abutment is a device placed on the implant that supports the implant crown.

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

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

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

- Denial of eligibility for or termination of enrollment in a health benefit plan;
- Rescission or cancellation of a policy or coverage;
- Imposition of a pre-existing condition exclusion, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;
- Determination that a healthcare item or service is experimental, investigational, or not medically necessary, effective, or appropriate; or
- Determination that a course or plan of treatment that a member is undergoing it an active course of treatment for purposes of continuity of care under ORS 743.854.

Allowable fee is the dollar amount established by PacificSource for reimbursement of charges for specific services or supplies provided by non-participating providers. PacificSource uses several sources to determine the allowable fee. Depending on the service or supply and the geographical area in which it is provided, the allowable fee may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), Viant Health Payment Solutions, PacificSource Health Plans, or other nationally recognized databases.

Where the provider network is deemed adequate, the allowable fee for professional services is based on PacificSource's standard participating provider reimbursement rate or a contracted reimbursement rate. Outside the PacificSource service area and in areas where the participating provider network is not deemed adequate, the allowable fee is based on the usual, customary, and reasonable charge (UCR) at the 85th percentile. UCR is based on data collected for a geographic area. Provider charges for each type of service are collected and ranked from lowest to highest. Charges at the 85th position in the ranking are considered to be the 85th percentile.

Alveolectomy is the removal of bone from the socket of a tooth.

Amalgam is a silver-colored material used in restoring teeth.

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

Authorized representative is an individual who by law or by the contest of a person may act on behalf of the person.

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

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

Calendar year means the 12-month period beginning on each January 1 and ending on the next December 31.

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.

Cast restoration includes crowns, inlays, onlays, and other restorations made to fit a patient's tooth that are made at a laboratory and cemented onto the tooth.

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

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

Composite resin is a tooth-colored material used in restoring teeth.

Contract year means a 12-month period beginning on the date the insurance contract is issued or the anniversary of the date the insurance contract was issued. If changes are made to the insurance contract on a date other than the anniversary of issuance, a new contract year may start on the date the changes become effective if so agreed by PacificSource and the policyholder. A contract year may or may not coincide with a calendar year.

Contracted reimbursement rate is an amount PacificSource agrees to pay a participating provider for a given service or supply through direct or indirect contract.

Co-payment or co-insurance is the out-of-pocket amount a member is required to pay to a provider.

Creditable coverage means a member's prior health coverage that meets the following criteria:

- There was no more than a 63-day break between the last day of coverage under the previous policy and the first day of coverage under this policy. The 63-day limit excludes the employer's eligibility waiting period.
- The prior coverage was one of the following types of insurance: group coverage (including Federal Employee Health Benefit Plans and Peace Corps), individual coverage (including student health plans), Medicaid, Medicare, TRICARE, Indian Health Service or tribal organization coverage, state high-risk pool coverage, and public health plans.

Curettage is the scraping and cleaning of the walls of a real or potential space, such as a gingival pocket or bone, to remove pathological material.

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

Dental emergency means the sudden and unexpected onset of a condition, or exacerbation of an existing condition, requiring necessary care to control pain, swelling or bleeding in or around the teeth and gums. Such emergency care must be provided within 48 hours following the onset of the emergency and includes treatment for acute infection, pain, swelling, bleeding, or injury to natural teeth and oral structures. The emergency care does not include follow-up care such as, but not limited to, crowns, root canal therapy, or prosthetic benefits.

Dentist means a licensed doctor of dental surgery (D.D.S.) or a licensed doctor of medical dentistry (D.M.D.).

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

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

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

Eligible employee means an employee who works on a regularly scheduled basis, with a normal workweek of 17.5 or more hours. Eligible employee does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed for fewer than 90 days are not eligible employees unless the employer and PacificSource so agree. Eligible employees may be covered under the group health policy only if they meet the eligibility requirements according to the terms of the policy (see Administrative Provisions - Eligibility).

Eligible dental provider means a physician, dentist, oral surgeon, endodontist, orthodontist, periodontist, or pedodontist. Eligible provider may also include a denturist, or dental hygienist to the extent that he/she operates within the scope of their license.

Emergency medical condition means a medical condition:

- That manifests itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:
  - Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;
  - Result in serious impairment to bodily functions; or
  - Result in serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.

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

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

- An emergency medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to stabilize the patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.

Employee means any individual employed by an employer.

Endorsement is a written attachment that alters and supersedes any of the terms or conditions set forth in this contract.

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

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;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Exclusion period means a period during which specified conditions, treatments or services are excluded from coverage.

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

- Experimental or investigational services and supplies include, but are not limited to, services, supplies, procedures, devices, chemotherapy, drugs or medicines, or the use thereof, which at the time they are rendered and for the purpose and in the manner they are being used:
  - Have not yet received full U.S. government agency required approval (e.g., FDA) for other than experimental, investigational, or clinical testing;
  - Are not of generally accepted medical practice in the state of Oregon or as determined by PacificSource in consultation with medical advisors, medical associations, and/or technology resources;
  - Are not approved for reimbursement by the Centers for Medicare and Medicaid Services;
  - Are furnished in connection with medical or other research; or
  - Are considered by any governmental agency or subdivision to be experimental or investigational, not considered reasonable and necessary, or any similar finding.
- When making decisions about whether treatments are investigational or experimental, PacificSource relies on the above resources as well as:
  - Expert opinions of specialists and other medical authorities;
  - Published articles in peer-reviewed medical literature;
  - External agencies whose role is the evaluation of new technologies and drugs; and
  - External review by an independent review organization.
- The following will be considered in making the determination whether the service is in an experimental and/or investigational status:

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

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

Grievance means:

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

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

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

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

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

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

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

Initial enrollment period means a period of 31 days following the date an individual is first eligible to enroll.

Injury means bodily trauma or damage that is independent of disease or infirmity. The damage must be caused solely by external and accidental means and does not include muscular strain sustained while performing a physical activity.

Inquiry means a written request for information or clarification about any subject matter related to the member's health benefit plan.

Internal appeal means a review by PacificSource of an adverse benefit determination made by PacificSource.

Leave of absence is a period of time off work granted to an employee by the employer 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 employer. A leave can be granted for any reason acceptable to the employer, including disability and pregnancy.

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

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

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

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

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

Member means an individual insured under a PacificSource health policy.

Mental and/or chemical healthcare facility means a corporate or governmental entity or other licensed provider of services for the care and treatment of chemical dependency and/or mental or nervous conditions.

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

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

- A healthcare facility;
- A residential program or facility;
- A day or partial hospitalization program;
- An outpatient service; or
- An individual behavioral health or medical professional authorized for reimbursement under Oregon law.

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

- Mental Retardation (diagnostic codes 317, 318.0, 318.1, 318.2, 319);
- Learning Disorders (diagnostic codes 315.00, 315.1, 315.2, 315.9);
- Paraphilias (diagnostic codes 302.4, 302.81, 302.89, 302.2, 302.83, 302.84, 302.82, 302.9);
- Gender Identity Disorders in Adults (diagnostic codes 302.85, 302.6, 302.9 – this exception does not extend to children and adolescents 18 years of age or younger);
- 'V' codes (diagnostic codes V15.81 through V71.09 - this exception does not extend to children five years of age or younger for diagnostic codes V61.20, V61.21, and V62.82).

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

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

Non-formulary drugs are covered brand name medications not on the Open Formulary.

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

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

Periapical x-ray is an x-ray of the area encompassing or surrounding the tip of the root of a tooth.

Periodontal maintenance is a periodontal procedure for patients who have previously been treated for periodontal disease. In addition to cleaning the visible surfaces of the teeth (as in prophylaxis) surfaces below the gum-line are also cleaned. This is a more comprehensive service than a regular cleaning (prophylaxis).

Periodontal scaling and root planing means the removal of plaque and calculus deposits from the root surface under the gum line.

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

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

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

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

Pre-existing condition means a condition (physical or mental) for which medical advice, diagnosis, care, or treatment was recommended by or received from a licensed provider within the six-month period ending on the enrollment date. For the purpose of this definition, the enrollment date of a member is the earlier of the effective date of coverage or the first day of any required group eligibility waiting period, and the enrollment date of a late enrollee is the effective date of coverage. Pregnancy does not constitute a pre-existing condition, nor does genetic information without a diagnosis of a condition related to such information.

Formulary is a list of approved medications used to treat various medical conditions. The Open Formulary is developed by the pharmacy benefits management company and PacificSource.

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

Prophylaxis is a cleaning and polishing of all teeth.

Prosthetic devices (excluding dental) means artificial limb devices or appliances designed to replace in whole or in part an arm or a leg. Benefits for prosthetic devices include coverage of devices that replace all or part of an internal or external body organ, or replace all or part of the function of a permanently inoperative or malfunctioning internal or external organ, and are furnished on a physician's order. Examples of prosthetic devices include but are not limited to artificial limbs, cardiac pacemakers, prosthetic lenses, breast prosthesis (including mastectomy bras), and maxillofacial devices.

Pulpotomy is the removal of a portion of the pulp, including the diseased aspect, with the intent of maintaining the vitality of the remaining pulpal tissue by means of a therapeutic dressing.

Registered domestic partner means a same gender individual, age 18 or older, who is joined in a domestic partnership, and whose domestic partnership is registered with the state of Oregon.

Restoration is the treatment that repairs a broken or decayed tooth. Restorations include, but are not limited to, fillings and crowns.

Routine costs of care means medically necessary conventional care, items, or services covered by the health benefit plan if typically provided absent 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 policy if provided outside of a clinical trial;

- Items or services required solely for the provisions of the drug, device, or service being tested in the clinical trial;
- Items or services required solely for the clinically appropriate monitoring of the drug, device, or service being tested in the clinical trial;
- Items of services required solely for the prevention, diagnosis, or treatment of complications arising from the provision of the drug, device, or service being tested in the clinical trial;
- Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- Items or services customarily provided by a clinical trial sponsor free of charge to any participant in the clinical trial; or
- Items or services that are not covered by the policy if provided outside of the clinical trial.

Seasonal employee is an employee who is hired with the agreement that their employment will end after a predetermined period of time.

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

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

Small employer means an employer that employed an average of at least two but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within the state of Oregon, and that employs at least two eligible employees on the date on which coverage takes effect under a health benefit plan offered by the employer.

Any person that is treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. The determination of whether an employer that was not in existence throughout the preceding calendar year is a small employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

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

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

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

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

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

Surgical procedure means any of the following 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
- Destruction of tissue by thermal, chemical, electrical, laser, or ultrasound means

Telemedical means medical services delivered through a two-way video communication that allows a provider to interact with a patient who is at a different physical location than the provider.

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

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.

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

Our Privacy Policy

PacificSource HEALTH PLANS

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Our Commitment to Ensure Your Privacy

The privacy of your medical information is important to PacificSource. Although we are required by law to maintain the privacy of your protected health information and provide you with this notice, we are sincere in our pledge to ensure the confidentiality of your nonpublic personal information, including your medical records. This information pertains to you and any covered dependents, so please be sure to share it with any family members covered under your plan.

How We May Use and Disclose Medical Information About You

We may share a member's personal information for the purpose of claims processing and payment. By signing an application for enrollment, the member acknowledges that personal information can be shared for that express purpose.

We may use and disclose medical information as follows:

Treatment

We may share your information with doctors or hospitals to help them provide medical care to you. For example, we might create a treatment plan with your doctor to help improve your health.

Payment

We may use and disclose medical information to process your medical claims or coordinate your benefits with other health plans. For example, we may need to disclose medical information to determine your eligibility for benefits, or to examine medical necessity.

Healthcare Operations

We may use and disclose medical information for regular health plan operations. For example, we may disclose medical information to underwrite your policies, ensure proper billing, engage in case coordination or case management, protect you against fraud, and provide you with excellent customer service. Please note that we are prohibited from using or disclosing protected health information that is genetic information about you for underwriting purposes.

Business Associates

Business associates provide necessary services to our organization through contracts. Some examples of business associates are prescription drug benefit administrators, utilization management organizations, and entities that perform quality assurance or peer review on our behalf. We may disclose the minimum necessary medical information to our business associates so they can perform the job we have asked them to do. To protect your medical information, we require our business associates to appropriately safeguard your information. We will not share your information with these outside groups unless there is a business need to do so and they agree to keep it protected. We require our business partners to treat your private information with the same high degree of confidentiality that we do.

Plan Administration

We may share enrollment information with your employer to verify your coverage and your family's coverage for benefits. We may share summary data that cannot be individually identified. We do not share any other information with employers unless we have your written authorization.

Marketing

We will never sell information about you to any third party for marketing or any other purpose not described in this notice. Further, we do not use personal information for investigative consumer research or reporting.

Individuals Involved in Your Care or Payment for Your Care

We may disclose your medical information to a family member, friend, or other person who you indicate is involved in your care or payment for your care. This only pertains to your medical information that is directly relevant to their involvement. We will only make this disclosure if you agree or when required or authorized by law. In the event of your incapacity or in an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

As Required By Law and For Law Enforcement

We may use or disclose your medical information when required or permitted by federal, state, or local law, or by a court order.

Public Health and Safety

We may disclose medical information about you to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others.

State and Federal Agencies

We may be required to report information to state and federal agencies that regulate us, such as the United States Department of Health and Human Services.

Lawsuits and Disputes

If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We will only make such disclosures if efforts have been made to tell you about the request.

Continued on reverse

Military and National Security
Under certain circumstances, we may disclose to military authorities the medical information of armed forces personnel. To authorized federal officials, we may disclose medical information required for lawful intelligence, counterintelligence, and other national security activities.

Workers' Compensation
We may disclose medical information to coordinate benefits with workers' compensation insurance carriers.

Information About Health-Related Benefits
We, or our Business Associate, may communicate to you about other services or health-related benefits that may be of interest to you.

Other Uses and Disclosures
If we use or disclose your information for any reason other than those listed above, we will first obtain your written authorization. State laws may prohibit us from disclosing the following types of sensitive personal information without your authorization: chemical dependency, mental health, psychotherapy, genetic, or HIV/AIDS records. If you give us written authorization, you may revoke it at any time. This will not affect information that has already been shared.

Your Rights Regarding Your Medical Information
You have these rights regarding protected health information we maintain about you:

Right to Inspect and Copy
You have the right to inspect and obtain a copy of most information we maintain about you. To do so, request and complete a form we will provide. You may be charged a fee for the cost of copying your records.

Right to Request a Correction
If you believe that medical information we have about you is incorrect or incomplete, you have the right to ask us to change or amend the information. To do so, request and complete a correction form available from us.

Right to an Accounting of Disclosures
You have the right to request a list of disclosures we have made of your medical information for purposes other than treatment, payment, healthcare operations, and other limited activities. To do so, request and complete a form available from us. Your request may not be for a record of more than six years and may not include dates before April 14, 2003.

Right to Request Restrictions
You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or healthcare operations. You also have the right to ask us to restrict information we may give to those involved in your care, such as a family member or friend. You must make this request using a form we will provide. While we may honor your request for restrictions, we are not required to agree to these restrictions. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment or comply with a legal requirement.

Right to Request Confidential Communications
You have the right to ask that we communicate with you about health matters in a certain way or at a certain location. We will attempt to accommodate all reasonable requests and may require that you make your request in writing.

Right to Receive a Paper Copy of This Notice
You have the right to ask for a paper copy of this notice at any time, and it will always be available on our Web site at PacificSource.com/privacy.aspx.

If you wish to exercise any of these rights, please contact PacificSource. You will find our contact information below

How to Report a Problem or File a Complaint
You may contact any of the people listed below to report a problem or file a complaint. You must do so in writing. Your benefits will not be affected by any complaints you make. We will not take any action against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe is unlawful.

Changes to this Notice of Privacy Practices
This Notice of Privacy Practices takes effect on April 14, 2003, and will remain in effect until we update or replace it. In the future, we may change our Notice of Privacy Practices. Any changes will apply to medical information we already have about you as well as any information we receive in the future. Before we make a significant change to our privacy practices, we will change this notice and supply a copy to you within 60 days.

You may request that this notice be mailed to you at any time, and it will always be available on our Web site at PacificSource.com/privacy.aspx.

Contact Information
If you have any questions about this notice or want more information, you're welcome to contact us.

PacificSource Health Plans

Contact:	Customer Service Department, PacificSource Health Plans
Office Hours:	Monday through Friday, 8:00 A.M. to 5:00 P.M.
Address:	PO Box 7068 Springfield, OR 97475
Telephone:	(541) 684-5582 or toll-free (888) 977-9299
Fax:	(541) 684-5264
E-mail:	cs@pacificsource.com
Web site:	PacificSource.com

Health and Human Services

Contact:	Office for Civil Rights, U.S. DHHS
Address:	2201 Sixth Ave - Mail Stop RX-11 Seattle, WA 98121
Telephone:	(206) 615-2290
TDD:	(206) 615-2296
Fax:	(206) 615-2297
E-mail:	ocrcomplaint@hhs.gov

Value Added

Programs and Services

PacificSource Extras: Valuable Programs and Services That Enhance Your Coverage

We hope you take advantage of the no-cost "extras" that are part of your PacificSource coverage.

Wellness Programs

Tobacco Cessation
Our Quit For Life™ program offers one-on-one treatment sessions with a professional Quit Coach to help tobacco users kick the habit. As a participant, you may also receive gum or patches as nicotine replacement therapy. When prescribed by your doctor, certain prescription medications to help you quit tobacco are available. These medications are subject to your pharmacy copayment. See our website or our Quit For Life Program flier for more information. Or call (866) QUIT-4-LIFE (784-8454).

Health and Wellness Education
You can receive a reimbursement for hospital-based health and wellness education classes in your area. The program will reimburse you for up to $50 per eligible class or class series, up to $150 per member per plan year. See our website or our Hospital-Based Health Education Classes flier for more information.

Prenatal Care
Our Prenatal Care Program helps expectant mothers learn more about their pregnancy and the development of their child. Participants receive educational materials and toll-free telephone access to a nurse consultant. High-risk members receive additional nurse support. See our website or our Prenatal Program flier for more information.

In addition, pregnant members with pharmacy coverage are eligible to receive nine months of prenatal vitamins at no cost. For details, see our website or contact our Pharmacy Services Department.

continued on next page

If you have questions, you are welcome to contact our Customer Service Department at 888.977.9299 or email cs@pacificsource.com.

PacificSource HEALTH PLANS

Our Caremark® Prescription Discount Program, helps you save money on any prescription drugs not covered by your health plan. See our website PacificSource.com or our Prescription Discount Program flier for more information.

Save on Popular Weight Management Programs

As a part of your PacificSource medical coverage:

- Participate in a **Weight Watchers®** program and receive an annual reimbursement of $100 ($40 if an online Weight Watchers participant) for your Weight Watchers membership. Complete a minimum of ten weeks during a consecutive four-month period to be eligible.
- Receive **Jenny Craig®** program discounts: Free 30-Day Trial Program, 25% off a Premium Program.

For full details and eligibility requirements, visit the For Our Members>Health and Wellness area of PacificSource.com.

Wellness for Kids

Six- and nine-year-olds currently covered by a PacificSource medical plan are invited by mail to join HealthKicks!, a children's program that promotes healthy behaviors.

Children enrolling in HealthKicks! will receive a total of four age-appropriate, educational activity books in the mail—one about every three months.

Travel Emergency Assistance Program

Assist America® Global Emergency Services

If you experience a medical emergency while traveling 100 or more miles from home or abroad, you can access services provided by Assist America at no cost. Services include medical consultation and evaluation, medical referrals, foreign hospital admission guarantee, critical care monitoring, and when medically necessary, evacuation to a facility that can provide treatment. For more information, see our website or our Global Emergency Services Provided by Assist America flier.

Pharmacy

Prescription Discount Program

Our Caremark prescription discount program helps you save money on any prescription drugs not covered by your health plan. Simply present your PacificSource member ID card at any Caremark network pharmacy to receive a discount on the cash price of any drugs that aren't covered by your plan or costing less than your copay or coinsurance.

Mail Order Service

We partner with both CVS Caremark and Wellpartner Pharmacy for mail order services. If your plan includes prescription drug coverage, mail order is a convenient and cost-saving option.

CVS Caremark
Caremark.com
(866) 329-3051

CVS Caremark
PO Box 659541
San Antonio, TX 78265-9541

Wellpartner
Wellpartner.com
(877) 568-6460

Wellpartner, Inc.
PO Box 5909
Portland, OR 97228-5909

Care Management

Condition Support Programs

One-on-one support and care coordination are available to members with certain chronic or rare conditions. Members are invited to participate in a condition support program based on their pharmacy and medical claims, which would indicate that a member might have a chronic condition, or through referrals from a case manager or physician. These programs can help ensure optimal care, decrease complications, and improve health outcomes.

AccordantCare

Our AccordantCare® Rare Disease Program provides ongoing one-on-one support and care coordination to people with certain chronic, rare conditions. The program helps ensure optimal care, decrease complications, and improve health outcomes. See our website or our AccordantCare Rare Disease Program flier for more information.

Caremark Specialty Pharmacy

Members with conditions that require injectable medications and biotech drugs have access to our specialty pharmacy program through Caremark® Specialty Pharmacy Services. A pharmacist-led CareTeam provides individual follow-up care and support. See our website or contact PacificSource Customer Service for more information.

Case Management Services

If you have an ongoing medical need, our Nurse Case Managers can help. PacificSource Case Managers, all of whom are registered nurses with extensive experience, work with you and your healthcare providers to ensure continuity of care and prevent breaks in necessary medical services. Should you need help managing specific healthcare needs in the future, our Case Managers will become involved, helping improve your health, financial outcomes, and quality of life. Examples include:

- Special-needs children
- Transplants
- Chronic pain
- Extended hospital care
- Skilled nursing care
- Coordination of home health or equipment.

For more information on case management services, contact PacificSource Customer Service.

Online Tools and Resources

Our website, PacificSource.com, offers you a wealth of tools, information, and resources to help you make the most of your PacificSource benefits.

InTouch: Access Coverage and Benefit Information

By logging into InTouch, you can easily and conveniently manage your insurance coverage and health 24/7. InTouch lets you:

- Look up coverage information and review benefit summaries in your Member Handbook.
- Check the status of a claim and access your claim history.
- View Explanation of Benefits for paid claims.
- Review your family enrollment history.
- Change your address.
- Take a health risk assessment.
- Calculate expenses accumulated towards your plan's deductible.
- Order new ID cards.

With InTouch for Members, you have secure online access to your coverage information and a variety of health and wellness resources.

continued on next page

If you have questions, you are welcome to contact our Customer Service Department at 888.977.9299 or email cs@pacificsource.com.

- Take advantage of smoking cessation or other wellness programs through Health Manager.

For more information, visit PacificSource.com or see our InTouch for Members brochure.

Health Manager

The Health Manager is your personal online health and wellness center. Powered by WebMD®, our site includes personalized wellness information and a variety of helpful, easy-to-use online tools designed to help you maximize your health. Log into InTouch and click Health Manager to:

- Assess your health
- Research healthcare issues
- Subscribe to newsletters
- Participate in programs to improve your health
- Keep records
- Track your progress and more.

Provider Directory

Our online provider directory makes it easy to find participating healthcare providers for your plan. You can search by specialty, name, location, or other details to access a listing of providers that fit your criteria. Or, you can create your own personalized provider directory to download and print.

To access the directory, go to PacificSource.com and click on Find a Provider > PacificSource Provider Directory.

Please note: These value-added programs are not available with all plans. Check with your plan administrator or our Customer Service Department for details.

PacificSource HEALTH PLANS

Direct: 541.684.5582
Toll Free: 888.977.9299

PacificSource.com

Coverage Away From Home

Your Healthcare Benefits When Traveling

The First Health® Network

The First Health® Network is a national healthcare provider network that includes physicians, hospitals, and other outpatient care facilities. We have a contract in place which makes First Health providers available when you need medical care outside of Oregon, Idaho, Montana, and southwest Washington. You will receive your plan's participating provider benefits when you use First Health providers for services outside your plan's service area.

How can I find a First Health provider?

No matter where you're traveling within the United States, you can find First Health providers over the Internet or by phone.

- Online: You can look up providers in your area using First Health's online provider directory. To get there, go to our website, PacificSource.com, click on Find a Provider, and then click the First Health Network link.
- By phone: Call First Health toll-free at (800) 226-5116. Representatives are available 24 hours a day, seven days a week. They'll help you find a physician, hospital, or other outpatient provider in your area, or tell you if a specific provider or facility participates with First Health. Si habla Español—Spanish speaking representatives are available as well.

What if the provider I want to use is not a member of the First Health Network?

If the provider does not participate with First Health and a First Health provider is available in that area, you will receive your plan's nonparticipating provider benefits unless it is a true medical emergency. If you have a true medical emergency, go directly to the nearest emergency room or appropriate facility, and there will be no reduction in benefits.

What if there are no First Health Network providers where I'm traveling?

The First Health Network is growing and adding new providers around the country all the time. If a First Health provider is not available where you are

continued on reverse

First Health® Network is national healthcare network available when traveling outside Oregon, Idaho, Montana, and southwest Washington.

Assist America® is global emergency services company that can help you get the care you need when traveling 100 miles or more from home or abroad.

PacificSource HEALTH PLANS

traveling, your plan pays your covered expenses based on a usual, customary, and reasonable charge for that area. First Health provider availability is based on PacificSource criteria.

What If I need to be hospitalized when I'm out of the area?

For a non-emergency hospitalization, have your physician preauthorize your hospital treatment by calling our Health Services Department at (888) 691-8209. Our staff can also help locate a First Health hospital in the area.

You may also call First Health yourself at (800) 226-5116 to find out if there is a participating hospital in the area. Then check with your physician to see if he or she has hospital privileges with a participating First Health hospital. Finally, have your physician preauthorize your admission by calling our Health Services Department at (888) 691-8209.

For emergency care outside your service area:

For a true medical emergency, call 911 or go directly to the nearest hospital emergency room or appropriate treatment facility. An emergency medical condition is an injury or sudden illness so severe that a prudent layperson with an average knowledge of health and medicine would expect that failure to receive immediate medical attention would risk seriously damaging the health of a person or fetus. Examples of true medical emergencies include severe bleeding, sudden abdominal or chest pains, suspected heart attacks, serious burns, poisoning, unconsciousness, convulsions or seizures, and difficulty breathing. In true medical emergencies, your plan pays benefits at the participating provider level even if you are treated at a nonparticipating hospital.

If you are admitted to a hospital after your emergency condition is stabilized, your physician should contact our Health Services Department as soon as possible.

How are my claims paid when I receive treatment outside the service area?

If you use a First Health provider, simply show your PacificSource member ID card. The provider will send your claim to us automatically and you will not have to file any paperwork.

If you use a nonparticipating provider, the provider may or may not bill us directly. If not, you will need to pay for the services up front, then send a claim to PacificSource for reimbursement. Your claim must include a copy of the provider's itemized bill, along with your name, PacificSource member ID number, group name and number, and the patient's name. If you were treated for an accidental injury, please include the date, time, place, and circumstances of the accident as well.

Assist America®

If you experience a medical emergency when you're traveling 100 miles or more away from your primary residence or abroad, Assist America can help. Assist America provides a variety of services to help you get the care you need, including medical consultation and evaluation, medical referrals, critical care monitoring and if medically necessary, evacuation to the nearest facility that can appropriately treat your situation. When you are ready to be discharged from a hospital and need medical assistance to return home (or to a rehabilitation facility), Assist America will arrange for your transportation and provide an escort, if necessary.

Call them as soon as possible during your medical emergency (once your situation is non-life threatening). Services arranged by Assist America are provided at no cost to you. Once you are under the care of a physician or medical facility, your PacificSource coverage applies.

For more information about Assist America's services, visit the For Our Members section of our website, at PacificSource.com.

If you have questions, you are welcome to contact our Customer Service Department at 888.977.9299 or email cs@pacificsource.com.

PacificSource HEALTH PLANS

Direct: 541.684.5582
Toll Free: 888.977.9299

PacificSource.com

Global Emergency Services and **Assist America**

Your PacificSource benefit package includes a unique global emergency services program provided by Assist America.

Assist America immediately connects you to doctors, hospitals, pharmacies, and other services to help you with a medical emergency when you're 100 miles or more from home, or traveling in a foreign country.

Assist America's Operations Center is staffed 24 hours a day, 365 days a year with trained multilingual and medical personnel, including nurses and doctors. One simple phone call to the number on your Assist America identification card will connect you to:

- A global network of pre-qualified medical providers
- A state-of-the-art Operations Center with worldwide response capabilities
- Experienced crisis management professionals
- Air and ground ambulance service providers

Assist America completely arranges and pays for all of the assistance services it provides without limits on the covered cost. This alleviates many of the obstacles and potential expenses that can be caused by medical emergencies away from home.

It is important to keep your identification card with you at all times so that you can call for services whenever you need them.

Assist America is not travel or medical insurance, rather it is a provider of global emergency services.

- Assist America's services do not replace medical insurance; during medical emergencies away from home. All medical costs incurred should be submitted to PacificSource and are subject to the policy limits of your health coverage.
- All services must be arranged and provided by Assist America. No claims for reimbursement of assistance services will be accepted.

continued on next page

When you're planning a vacation or business trip, the last thing you need to worry about it what will happen if you need medical attention away from home.

assist america®

PacificSource HEALTH PLANS

If you have questions you are welcome to contact our Customer Service department at 888.977.9299 or email cs@pacificsource.com.

Key Services

Medical Consultation, Evaluation & Referral
Calls to Assist America's Operations Center are evaluated by medical personnel and referred to English-speaking, Western-trained doctors and hospitals.

Hospital Admission Guarantee
Assist America will guarantee hospital admission outside the United States by validating your health coverage or by advancing funds to the hospital.

Emergency Medical Evacuation
If adequate medical facilities are not available locally, Assist America will use whatever mode of transport, equipment, and personnel necessary to evacuate you to the nearest facility capable of providing a high standard of care.

Critical Care Monitoring
Assist America's medical personnel will maintain regular communication with your attending physician and hospital and relay information to the family.

Medical Repatriation
If you still require medical assistance upon being discharged from a hospital, Assist America will repatriate you home or to a rehabilitation facility with a medical or non-medical escort, as necessary.

Prescription Assistance
If you need a replacement prescription while traveling, Assist America will help in filling that prescription.

Emergency Message Transmission
Assist America will receive and transmit emergency messages for you.

Compassionate Visit
If you are traveling alone and will be hospitalized for more than seven days, Assist America will provide economy, round-trip, common carrier transportation to the place of hospitalization for a designated family member or friend.

Care of Minor Children
Assist America will arrange for the care of children left unattended as the result of a medical emergency and pay for any transportation costs involved in such arrangements.

Return of Mortal Remains
In the event of a member's death, Assist America will render every possible assistance. This service includes arranging preparation of the remains for transport, procuring required documentation, providing the necessary shipping container, and paying for transport.

Emergency Trauma Counseling
Assist America will provide initial telephone-based counseling and referrals to qualified counselors as needed or requested.

Lost Luggage or Document Assistance
You can contact Assist America for assistance in locating lost luggage, documents, or personal belongings.

Interpreter & Legal Referrals
Assist America will refer you to interpreters and legal personnel, as necessary.

Take Us With You When You Travel

Please clip out this card and carry it with your PacificSource ID card when you travel.

If you require medical assistance and are more than 100 miles from your permanent residence or abroad, call Assist America's Operations Center at:

800-872-1414 Toll free inside the U.S.A.

609-986-1234 Outside the U.S.A. (Precede number by U.S. access code.)

or via e-mail: medservices@assistamerica.com

The holder of this card is a member of Assist America and is entitled to its medical and personal services.

El portador de esta tarjeta es miembro de Assist America y tiene derecho a los servicios personales y de asistencia médica de Assist America.

Le titulaire de cette carte est membre d'Assist America et a droit à l'assistance médicale et aux services personnels d'Assist America.

ATTENTION

This is not a medical insurance card. Claims for reimbursement for services not provided by Assist America will not be accepted.

assist america®
GLOBAL EMERGENCY SERVICES

Reference Number 01-AA-PSH-10073

Name

assist america® PacificSource HEALTH PLANS

Pre-Trip Information

Web-based country profiles that include visa requirements, immunization and inoculation recommendations, and security advisories for any travel destination are available from Assist America.

Conditions

Assist America will not provide services in the following instances:

- Travel undertaken specifically for securing medical treatment
- Injuries resulting from participation in acts of war or insurrection
- Commission of unlawful acts
- Attempts at suicide
- Incidents involving the use of drugs unless prescribed by a physician
- Transfer of member from one medical facility to another medical facility of similar capabilities and providing a similar level of care

Assist America will not evacuate or repatriate a member:

- Without medical authorization
- With mild lesions, simple injuries such as sprains, simple fractures, or mild sickness which can be treated by local doctors and do not prevent you from continuing your trip or returning home.
- With a pregnancy over six months
- With mental or nervous disorders unless hospitalized

Exclusions

- Trips exceeding 90 days from legal residence without prior notification to Assist America (separate purchase of expatriate coverage is available)

While assistance services are available worldwide, transportation response time is directly related to the location/jurisdiction where an event occurs. Assist America is not responsible for failing to provide services caused by strikes or conditions beyond is control, including by way of example and not by limitation, weather conditions, availability of airports, flight conditions, availability of hyperbaric chambers, communications systems, or where rendering of service is limited or prohibited by local law or edict.

All consulting physicians and attorneys are independent contractors and not under the control of Assist America.

Assist America is not responsible or liable for any malpractice committed by professionals rendering services to a member.

continued on next page

Take Us With You When You Travel

Please clip out this card and carry it with your PacificSource ID card when you travel.

WHEN CALLING THE ASSIST AMERICA OPERATIONS CENTER, BE PREPARED WITH:

- Your name, telephone number and relationship to the patient
- Patient's name, age, gender, reference number and employer
- Description of the patient's condition
- Name, location and telephone number of hospital, if applicable
- Name and telephone number of attending physician
- Information on where the doctor can be immediately reached

CALL ASSIST AMERICA WHEN TRAVELING 100 MILES OR MORE AWAY FROM HOME OR IN ANOTHER COUNTRY AND:

- You require medical or counseling assistance
- You require legal assistance
- You experience local language problems

All services must be arranged and provided by Assist America. No claims for reimbursement will be accepted.

If you have questions you are welcome to contact our Customer Service department at 888.977.9299 or email cs@pacificsource.com.

PacificSource HEALTH PLANS

Direct: 541.684.5582
Toll Free: 888.977.9299

PacificSource.com

PacificSource
HEALTH PLANS

We're in it for the people.

Customer Service

Idaho
208.333.1596 Local *(Boise)*
800.688.5008 Toll-free

Montana
406.442.6589 Local *(Helena)*
877.590.1596 Toll-free

Oregon
541.684.5582 Local *(Eugene/Springfield)*
888.977.9299 Toll-free
541.225.3631 Fax
cs@pacificsource.com Email

Headquarters

PO Box 7068
Springfield, OR 97475-0068
541.686.1242 Local *(Eugene/Springfield)*
800.624.6052 Toll-free

Website

PacificSource.com