

**GRADUATE TEACHING
FELLOWS FEDERATION
(GTFF)**

Group No.: 7896

Preferred 90+100 VAR

Effective: September 16, 2004

01-19-2005



PacificSource

HEALTH PLANS

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 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.

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CONTENTS

MEMBER BENEFIT SUMMARY	A
PHARMACY SUMMARY	C
VISION SUMMARY	G
DENTAL SUMMARY	I
USING THE PROVIDER NETWORK	1
PARTICIPATING PROVIDERS	1
NONPARTICIPATING PROVIDERS	2
NETWORK NOT AVAILABLE BENEFITS	3
COVERAGE WHILE TRAVELING	3
FINDING PARTICIPATING PROVIDER INFORMATION	4
BECOMING COVERED	5
ELIGIBILITY	5
ENROLLING DURING THE INITIAL ENROLLMENT PERIOD	5
ENROLLING NEW DEPENDENTS	6
ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD	8
TERMINATING COVERAGE	10
CONTINUATION OF INSURANCE	11
USERRA CONTINUATION	11
SURVIVING, DIVORCED, OR SEPARATED SPOUSES	12
COBRA CONTINUATION	12
INDIVIDUAL PORTABILITY POLICY	14
COVERED EXPENSES	15
PLAN BENEFITS	16
PREVENTIVE CARE SERVICES	16
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	22
TRANSPLANT SERVICES	23
OTHER COVERED SERVICES, SUPPLIES, AND TREATMENTS	24
BENEFIT LIMITATIONS AND EXCLUSIONS	28
EXCLUDED SERVICES	28
EXCLUSION PERIODS	34
CREDIT FOR PRIOR COVERAGE	34
PREAUTHORIZATION	35
UTILIZATION REVIEW	36
COVERED EXPENSES AND LIMITATIONS – DENTAL	38
COVERED DENTAL SERVICES	38
CLASS I SERVICES—DIAGNOSTIC AND PREVENTIVE TREATMENT	38
CLASS II SERVICES—BASIC TREATMENT	39
DENTAL EXCLUSIONS	39
CLAIMS PAYMENT	41
COORDINATION OF BENEFITS	42
THIRD PARTY LIABILITY	43
COMPLAINTS, GRIEVANCES, AND APPEALS	45
GRIEVANCE AND APPEAL PROCEDURES	45

SOURCES FOR INFORMATION AND ASSISTANCE	46
FEEDBACK AND SUGGESTIONS.....	47
RIGHTS AND RESPONSIBILITIES.....	48
PRIVACY AND CONFIDENTIALITY.....	49
PLAN ADMINISTRATION	49
EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA).....	50

MEMBER BENEFIT SUMMARY

POLICY INFORMATION

Group Name: GRADUATE TEACHING FELLOWS FEDERATION (GTFF)
Group Number: 7896
Plan Name: PREFERRED 90+100 VAR

SCHEDULE OF BENEFITS

MAXIMUM LIFETIME BENEFIT\$1,000,000

MAXIMUM PLAN YEAR BENEFIT\$100,000

DEDUCTIBLE.....\$100 per person / \$300 per family per contract year

The deductible is an amount of covered medical expenses the member pays each contract year before the plan's benefits begin. Benefits paid in full and copayments do not accumulate toward meeting the deductible.

OUT-OF-POCKET LIMIT

Participating Providers.....\$1,000 per person per contract year

Nonparticipating Providers.....\$3,000 per person per contract year

Once the participating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges for participating and network not available providers for the rest of that contract year. Once the nonparticipating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges for all providers for the rest of that contract year. Benefits paid in full, nonparticipating provider charges in excess of the PacificSource fee allowance, deductible, emergency room copays, nonparticipating transplant facility charges, and pharmacy charges do not accumulate toward the out-of-pocket limit.

CONTRACT YEAR September 16 – September 15

SERVICE:	PARTICIPATING PROVIDER/ NETWORK NOT AVAILABLE BENEFIT:	NONPARTICIPATING PROVIDER BENEFIT:
PREVENTIVE CARE		
Well Baby Care	90%	70%
Routine Physicals	90%	70%
Routine Gynecological Exams	100% after \$15 copay (no deductible)	70%
Immunizations (all ages)	100% (no deductible)	70%
PROFESSIONAL SERVICES		
Office and Home Visits	90%	70%
Urgent Care Center Visits	90%	70%
Surgery	90%	70%
Chiropractic (20 visit contract year max)	90%	70%
HOSPITAL SERVICES		
Inpatient Room and Board	90%	70%
Inpatient Rehabilitative Care	90%	70%
Skilled Nursing Facility Care	90%	70%
OUTPATIENT SERVICES		
Outpatient Surgery	90%	70%
Diagnostic / Therapeutic Radiology and Lab	90%	70%
CT Scans and MRIs	90%	70%
• Emergency Room Visits	90% after \$50 copay	70% after \$50 copay

- **Emergency room copay and deductible waived if admitted directly to hospital or within 24 hours of an accident. In true medical emergencies, nonparticipating providers are paid at the participating provider level.**

SERVICE:	PARTICIPATING PROVIDER/ NETWORK NOT AVAILABLE BENEFIT:	NONPARTICIPATING PROVIDER BENEFIT:
MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES		
Office Visits	90%	70%
Inpatient Care	90%	70%
Residential Programs	90%	70%
OTHER COVERED SERVICES		
Physical, Occupational, Speech Therapy (30 visit contract yr max)	90%	70%
Allergy Injections	90%	70%
Ambulance (300 mile contract year max.)	80%	80%
Durable Medical Equipment	90%	70%
Home Health Care	90%	70%
Hospice Care (12 day inpatient max.; \$8,000 home max.)	90%	70%

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, nonparticipating providers may not. Services of nonparticipating 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 for the geographical area in which the charge is incurred. For more information, refer to the Payment to Providers section in the proposal or member benefit handbook.

This is a brief summary of benefits. Please refer to additional information provided for further benefit, limit, and exclusion information.

PHARMACY SUMMARY

GTFF 30% COINSURANCE +OC VAR PLAN

Your PacificSource health plan includes coverage for prescription drugs and contraceptives, subject to the limitations and exclusions described below. It also covers diabetic supplies and bee sting kits—see Other Covered Supplies, below.

COINSURANCE

Each time a prescription drug is dispensed, you are responsible for a portion of the cost. Coinsurance amounts under your plan are as follows:

	You Pay:
• From a participating Caremark® pharmacy using the PacificSource Pharmacy Program (see below) up to a 30 day supply:	30%
• From the University of Oregon Health Center Pharmacy after reimbursement (see below) up to a 30 day supply:	30%
• From a nonparticipating pharmacy or participating Caremark® pharmacy without using the PacificSource Pharmacy Program (see below) up to a 30 day supply:	50%

USING THE PACIFICSOURCE PHARMACY PROGRAM

The Caremark® participating pharmacy network includes about 98% of all independent and large chain pharmacies in the United States. It also includes drugstore.com, an Internet-based pharmacy service.

To use the PacificSource pharmacy program, you must show the Caremark® s plan number on your PacificSource ID card at the participating pharmacy to receive your plan’s highest benefit level. The PacificSource pharmacy program cannot be accessed without the Caremark® plan number printed on your PacificSource ID card. That plan number—**V154-9480**—allows the pharmacy to collect the appropriate coinsurance from you and bill PacificSource electronically for the balance. When you use your PacificSource ID card at participating Caremark® pharmacies, the pharmacy will charge you the lesser of your coinsurance or the pharmacy’s discounted drug cost plus service fee.

If you obtain your covered prescription drugs through the University of Oregon Student Health Center Pharmacy, you will need to pay 100% of the drug cost at the pharmacy and then submit the claim to PacificSource for reimbursement.

If you use a nonparticipating pharmacy or don’t present your PacificSource ID card at the time of purchase, you will need to file a claim for reimbursement and your benefits will be reduced. We will reimburse you 50% of the retail price.

To submit a claim, send PacificSource your pharmacy receipt, your group name and number, your name and member ID number, and the patient’s name and relationship to you.

OTHER COVERED SUPPLIES

Some diabetic supplies and contraceptive devices are also covered under the medical plan. Supplies covered under the pharmacy plan are in place of, not in addition to, those same covered supplies under the medical plan. Please see your benefit handbook for more details.

Diabetic Supplies

- Insulin and diabetic syringes.
- Lancets and test strips.
- Glucagon recovery kits. You may purchase up to two kits at one time, but no more than four kits in any calendar year (unless otherwise preauthorized by PacificSource).
- Glucostix and glucose monitoring devices are not covered under this pharmacy benefit, but are covered under your medical plan's durable medical equipment benefit.

Bee Sting Kits

Anaphylactic recovery kits (for people with severe allergic reactions to bee stings) are covered. You may purchase up to two kits at one time, but no more than four kits in any calendar year (unless otherwise preauthorized by PacificSource).

Contraceptives

- Oral Contraceptives.
- Depo Provera or Lunelle injections, Ortho Evra Transdermal Patch, NuvaRing Vaginal Contraceptive Ring, or Preven.
- Diaphragm or Cervical Cap.

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.
- Certain drugs require preauthorization by PacificSource in order to be covered. Caremark[®] maintains the list of drugs requiring preauthorization and will request preauthorization on your behalf when necessary.
- Quantities are limited to no more than a 30 day supply of any drug per fill or refill.
- PacificSource may limit certain specified drugs to less than a 30 day supply per coinsurance.
- For drugs purchased at nonparticipating pharmacies or at participating pharmacies without using the PacificSource pharmacy program, reimbursement is limited to an allowable fee. That fee is the wholesale acquisition cost of the medication plus 20%.
- Your share of the cost for prescription drugs does not apply to your medical plan's out-of-pocket maximums. Prescription drug coinsurances are still your responsibility even if the medical plan's out-of-pocket maximum is satisfied.
- Prescription drug benefits are subject to your plan's coordination of benefits provision. (For more information, see Claims Payment—Coordination of Benefits in your Member Benefit Handbook.)
- Your prescription drug plan does not cover:
 - Over-the-counter drugs
 - Drugs for any condition excluded under the health plan. That includes drugs intended to promote fertility, treatments for obesity or weight loss, smoking cessation drugs, experimental drugs, and drugs available without a prescription (even if a prescription is provided).
 - Immunizations (although certain immunizations are covered under your health plan's preventive care benefit – please refer to your Member Benefit Handbook)
 - Viagra and other drugs and devices to treat impotency
 - Drugs used as a preventive measure against hazards of travel
 - Drugs obtained through mail order

GENERAL INFORMATION ABOUT PRESCRIPTION DRUGS

Formulary Drugs

A *drug formulary* is a list of preferred medications used to treat various medical conditions. The 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 doctor and pharmacist in selecting drug products that are safe, effective, and cost efficient. The formulary is made up of both generic and name brand products. Your plan covers both formulary and nonformulary drug. *Nonformulary drugs* are covered medications not on the Caremark® formulary.

The current Caremark® formulary includes over 750 commonly prescribed brand name and generic medications. The formulary is developed by Caremark® in cooperation with PacificSource.

Generic Drugs

Generic drugs are equivalent to name brand medications. Name brand medications (such as Valium) lose their patent protection after a number of years. At that time any drug company can 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 doctor are encouraged to use generic drugs whenever they are available.

VISION SUMMARY

GTFV VISION PLUS VAR

Your group insurance plan covers vision exams, eyeglasses, and contact lenses. The following shows the vision benefits available to you in any 12-month period up to a \$200 maximum.

<u>SERVICE/SUPPLY</u>	<u>PARTICIPATING PROVIDER BENEFIT</u>	<u>NONPARTICIPATING PROVIDER BENEFIT</u>
Eye Exam	100%	40%
Lenses (maximum per pair)		
Single Vision	100%	40%
Bifocal	100%	40%
Trifocal	100%	40%
Frames	100%	40%
*Contacts (in place of glasses)	100%	40%

** Limited to allowance for single vision lens and frames.*

This plan does not cover:

- 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 or scratch resistant coatings.
- Separate charges for contact lens fitting.
- Charges for more than one exam, two lenses, and one frame per person in any 12-month period.
- Replacement of lost, stolen, or broken lenses or frames.
- Duplication of spare eyeglasses or any lenses or frames.
- Visual analysis that does not include refraction.
- Services or supplies not listed as covered expenses.
- Charges for services or supplies covered in whole or in part under any other medical or vision benefits provided by the employer.
- 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.
- 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.
- Medical or surgical treatment of the eye.

Important information about your vision benefits

Your PacificSource health insurance package 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 nonparticipating 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 nonparticipating 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 686-1242 from Eugene-Springfield or (800) 624-6052 from other areas.

DENTAL SUMMARY

GTFF PREVENTIVE 25/1000 VAR

This dental care policy covers the following services when performed by a licensed dentist and when determined to be necessary, usual, and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury, including masticatory function. Such standards are determined by the PacificSource Dental Director and/or Board of Directors. The following services may also be provided by a dental hygienist or denturist to the extent that he/she is operating within the scope of his/her license as required under law in the State of Oregon. Eligible charges are limited to the usual, customary, and reasonable charges of dental providers in the same service area for similar treatment of similar dental conditions.

DEDUCTIBLE – This plan has a plan year deductible of \$25 per person / \$75 per family for Class II services.

MAXIMUM – This plan has a contract year benefit maximum of \$1,000.

CONTRACT YEAR – September 16 – September 15

COVERED SERVICES

Class I Services – Paid at 100%.

- | | |
|------------|--|
| Diagnostic | Routine examination once every six months.
Full mouth x-rays once every five years, bitewings once every six months. Separate charges for review of proposed treatment, certain lab tests, and diagnostic aids are not covered. |
| Preventive | Prophylaxis (cleaning) or periodontal maintenance procedure once every six months.
Fluoride application once every six months to age 16.
Plaque control or oral hygiene or dietary instruction are not covered. |

Class II Services (basic treatment) – Paid at 80% after the plan year deductible is satisfied.

- | | |
|---------------|---|
| Oral Surgery | Extractions and certain other minor surgical procedures. Includes general anesthesia or IV sedation when administered by a dentist in connection with a covered oral surgery and when given in a dental office. A separate charge for anesthesia and/or IV sedation when used for non-surgical procedures is not covered. |
| Restorative | Treatment of tooth decay with amalgam and composite resins (see limitations). A separate charge for anesthesia and/or IV sedation when used for non-surgical procedures is not covered. |
| Endodontic | Procedures for pulpal therapy and root canal therapy. Pulp capping is covered only when there is exposure of the pulp. A separate charge for cultures is not covered. |
| Sealants | Sealants on permanent molars once in any five-year period to age 16. |
| Preventive | Space maintainers. |
| Prostodontics | Repair of dentures and bridges (see limitations). Replacement of dentures and bridges excluded. |

Class III Services (major treatment) – Not covered.

EXCLUSIONS

- 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 adjustments and relines.
- Periodontic Services. Diagnosis and treatment of diseases of the connective tissues around and supporting the teeth. Root planing.
- All other services or supplies not specifically included in this Plan as covered dental services.
- Surgical placement or removal of implants or attachments to implants are not covered.
- Services provided or compensable under workers' compensation or employer's liability laws, by any federal, state, or provincial government agency, or without cost to the patient, by any municipality, county or other political subdivision or community agency, except when insufficient to pay up to the limits of this policy. This does not apply to Medicaid.
- Services or supplies caused by or provided to correct congenital or developmental malformations including, but not limited to cleft palate, maxillary and/or mandibular malformations, enamel hypoplasia, and fluorosis.
- Services or supplies for any disturbance of the temporomandibular joint.
- Services or supplies for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or stabilizing teeth.
- Splints, night guards, or appliances used to increase vertical dimensions, restore the occlusion, or correct habits such as tongue thrust and grinding of teeth. Periodontal splinting including crowns and bridgework used in conjunction with periodontal splinting.
- Dental services started prior to the date the individual became eligible for such services under the Program.
- Hypnosis, prescribed drugs, premedications, analgesics (e.g. nitrous oxide), or any other euphoric drugs.
- Hospital charges for services or supplies or additional fees charged by the dental provider for hospital treatment.
- General anesthesia or IV sedation except when administered by a dentist in conjunction with covered oral surgery in office.
- Experimental procedures or supplies.
- Charges for missed or broken appointments.
- Orthodontic services (treatment of malalignment of teeth and/or jaws). Extractions for orthodontic purposes are covered.
- Procedures, appliances, restorations or other services which are primarily for cosmetic purposes.
- Gnathologic recordings or similar procedures.
- Any condition, disease, ailment, injury or diagnostic service provided or would have been provided had the patient enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, including amendments thereto.
- Claims submitted more than 15 months after the date of rendition of the service.

USING THE PROVIDER NETWORK

This section explains how your plan's benefits differ when you use participating and nonparticipating 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.

Risk-sharing Arrangements

Your PacificSource health plan may include "risk-sharing" arrangements with physicians and other providers. Under a risk-sharing arrangement, the healthcare providers responsible for delivering services are subject to some financial risk or reward for the services they deliver.

EXAMPLE

A health plan has a risk-sharing arrangement with a group of heart surgeons. The surgeons agree to provide all the heart operations needed by the health plan's members, and the health plan agrees to pay the surgeons a fixed monthly amount for those services.

If you would like more specific information about any risk-sharing arrangements between PacificSource and your plan's providers, please contact our Customer Service Department.

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 shown on your Member Benefit Summary. Depending on your plan, those amounts can include a deductible, copayment, or coinsurance payment.

PacificSource contracts directly with participating providers throughout our Oregon service area and in bordering communities in southwest Washington and western Idaho. We also have an agreement with a nationwide provider network, The First Health® Network, that includes more than 275,000 participating physicians and 3,900 participating hospitals. The First Health providers outside our service area are also considered PacificSource participating providers under your plan.

It is not safe to assume that when you are treated at a participating medical facility, all services are performed by participating providers. Whenever possible, you should arrange for professional services such as surgery, 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.



NONPARTICIPATING PROVIDERS

When you receive services or supplies from a nonparticipating 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, copayment, and coinsurance amounts shown on your Member Benefit Summary.

Allowable Fee

PacificSource bases payment to nonparticipating 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), Concentra Preferred Systems, Ingenix, Inc., 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 Ingenix UCR at the 85th percentile. A usual, customary, and reasonable charge (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 nonparticipating providers, we determine the allowable fee, then pay the nonparticipating provider at the percentage shown in the “Nonparticipating Provider” column of your Member Benefit Summary. Our allowable fee is often less than the nonparticipating 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 copayments required by the plan. In any case, after any copayments or deductibles, the amount PacificSource pays to a nonparticipating provider will not be less than 50% 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 nonparticipating 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.



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.



Example of Provider Payment

The following illustrates how payment could be made for a covered service billed at \$120. In this example, the Member Benefit Summary shows that participating providers are paid at 80 percent and nonparticipating providers at 70 percent. This is only an example; your plan's benefits may be different.

	Participating Provider	Nonparticipating Provider
Provider's usual charge	\$120	\$120
PacificSource's negotiated provider discount	\$20	\$0
PacificSource's allowable fee	\$100	\$100
Percent of payment from Benefit Summary	80%	70%
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 shown on your Member 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. Reasonable geographic access is determined by PacificSource using specific criteria.

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 nonparticipating provider of that service or supply.
- PacificSource determines the allowable fee for that service or supply (the term "allowable fee" is explained above under the Nonparticipating Providers section).
- We apply the Network Not Available benefit level shown on your Member Benefit Summary to the allowable fee to calculate covered expenses.
- You are responsible for any copayments, coinsurance, deductibles, and amounts over the allowable fee.

COVERAGE WHILE TRAVELING

Your PacificSource plan provides benefits when you travel outside the boundaries of the PacificSource provider network. Currently, the PacificSource provider network covers:

- All of Oregon
- In Washington: Clark, Cowlitz, Klickitat, Pacific, Skamania, and Wahkiakum Counties
- In Idaho: Gem, Payette, and Washington Counties



When you need medical services outside those areas, you can save out-of-pocket expense by using the participating providers available through our contracted national provider network, The First Health® Network, whenever possible.

Nonemergency Care While Traveling

To find a participating provider outside the region covered by the PacificSource provider network, call The First Health® Network at (800) 449-9905. (The phone number is also printed on your PacificSource ID card for convenience.) Representatives are available Monday through Friday, 7 a.m. to 7 p.m. Central time to help you find a participating physician, hospital, or other outpatient provider.

- 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 nonparticipating provider, your plan's nonparticipating provider benefits will apply.



For participating providers outside of the service area, call First Health at (800)449-9905. The First Health staff will help you find a participating provider in the area where you are traveling.

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 Medical Affairs Department at (800) 624-6052 as soon as possible to authorize your admission. If you are admitted to a nonparticipating 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 Web site, www.pacificsource.com. Simply click on "Provider Directory" 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) 449-9905 if you live outside the area covered by the PacificSource provider network.



BECOMING COVERED

ELIGIBILITY

Employees

You are eligible if you are a graduate teaching fellow employed as such 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. You are also eligible if you are on an approved leave of absence under the Medical and Family leave Act of 1933.

Your initial eligible for participation on the group health plan is contingent upon your completion of a 0.20 FTE for the term in which you are enrolling.

Family Members

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

- Your legal spouse or qualified domestic partner.
- You, your spouse's, or qualified domestic partner's unmarried dependent children under age 23.
- You, your spouse's, or qualified domestic partner's unmarried children age 23 or over who are mentally or physically disabled. To qualify as dependents, they must have been continuously unable to support themselves since age 23 because of a mental or physical disability. PacificSource requires documentation of the disability from the child's physician, and will review the case before authorizing coverage.

"Dependent children" means any natural, step, and adopted, or foster children, you or your qualified domestic partner are legally obligated to support or contribute support for. It 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.

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 October 15, or 31 days from the date you receive your Graduate Teaching Fellows appointment. A new application must be submitted if you have a lapse in coverage. If you are enrolling dependents, premium for dependents must be paid at the time the application is submitted. If you are enrolling a domestic partner, a notarized Affidavit of Domestic Partnership must be attached to the application. (Affidavit forms are available in the GTFF office.) File the application with the GTFF office.



ENROLLING NEW DEPENDENTS

You may obtain insurance for newly acquired or newly eligible dependents by submitting a completed application during one of the group's two open enrollment periods (August 16 to September 15 and February 16 to March 15). To continue insurance for newborn children you must submit a new dependent application before the child is 31 days old. To continue insurance for an adopted child or a child placed for adoption you must submit a new dependent application within 31 days of adoption or placement. Even if it does not affect your premium, we must be notified if family members are added or dropped from coverage.

Newborns

You or your qualified domestic partner's newborn baby is eligible for enrollment under this plan during the 31-day initial enrollment period after birth. To add the child to your coverage, you must submit an enrollment application listing the child as your dependent.

- If additional premium is required, then the baby's eligibility for enrollment will end 31 days after birth if PacificSource has not received an enrollment application and premium. Premium is charged from the date of birth and prorated for the first month.
- If no additional premium is required, then the baby'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.

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 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 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 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 Placed in Your Guardianship

If a court appoints you custodian or guardian of an eligible 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, 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 will then 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 date specified by the court order.

Domestic Partners

In order for a domestic partner to qualify for enrollment, all the following criteria must be met:

1. The employee and partner are each eighteen (18) years of age or older;
2. The employee and partner share a close personal relationship;
3. The employee and partner are not related by blood closer than would bar marriage in the State of Oregon or the state where they have a permanent residence and are domiciled.
4. The employee and partner are jointly financially responsible for each other's common welfare, including basic living expenses.
5. The employee and partner have lived together as a domestic partnership with the intent to continue to do indefinitely and have met all other criteria set forth in this section for a minimum of six (6) months;
6. Neither the employee nor the partner is married to anyone else or has another domestic partner;
7. Neither the employee nor the partner has had another domestic partner in the previous six (6) months;
8. The employee and partner were mentally competent to consent to contract when their domestic partnership began and remain mentally competent;
9. The employee and partner each acknowledge that they are bound by and subject to all provisions of the health plan in which they enroll and any additional provisions of the domestic partnership endorsement;



10. The employee and partner each acknowledge they understand that falsification of information contained in their Affidavit of Domestic Partnership or their enrollment application may result in the termination of their enrollment in the health plan and could result in a claim for damages for losses sustained by the health plan because of such falsification;
11. The employee and partner each acknowledge that they understand that any coverage obtained by reason of statements attested to in their Affidavit of Domestic Partnership will terminate if they fail to meet any of the requirements as well as any applicable requirements of the underlying health plan and the domestic partner endorsement;
12. The employee and partner agree to notify the health plan policyholder in writing within 31 days of any change which would cause them to fail to meet any requirement of their Affidavit of Domestic Partnership, the underlying health plan, or the domestic partnership endorsement.

Children of domestic partners. Children of enrolled domestic partners are eligible on the same terms and conditions as dependent children of enrolled employees.

Eligible partners: A qualified domestic partner may enroll by submitting an enrollment application and a completed domestic Partnership Affidavit which has been signed by both the employee and the partner and accepted by PacificSource. The enrollment application and affidavit must be submitted during the employee's initial eligibility period or within 31 days of the domestic partner first becoming eligible according to the criteria set forth in the Eligibility section of the policy.

Termination of a domestic partner's coverage. A domestic partner's eligibility for benefits under this policy will terminate upon the death of the employee, or at the end of the domestic partnership due to a change in one or more of the qualifying criteria specified in the Eligibility section, whichever occurs first. The employee and partner are required by the domestic partnership affidavit to give written notice to the policyholder within 31 days of any change in a qualifying criteria.

Termination of coverage for a domestic partner's children. Coverage for children of a domestic partner not related to the enrolled employee by birth or adoption will terminate upon the death of the employee or partner, termination of the domestic partnership, or loss of eligibility as a dependent child according to the terms of the policy, whichever occurs first.

Continuation and conversion to portability coverage. Domestic partners and their children have the same rights to individual portability coverage as dependents of other enrolled employees. Domestic partners and their children may not continue this policy's coverage under state or federal (COBRA) continuation laws independent of the employee.

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD

Returning to Work after a Layoff

If you are laid off and then rehired by your employer within six months, you will not have to satisfy another probationary waiting period. Your health coverage will resume the day you 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 re-enroll your family members by submitting an enrollment application within the 31-day initial enrollment period following your return to work.



Employees returning to work after a layoff are not subject to new exclusion periods for pre-existing and other conditions. If the employee's exclusion periods were satisfied (or partially satisfied) before the layoff, they will be credited at the same level when the employee returns to work. However, your dependents will be subject to new exclusion periods unless they have creditable coverage during the layoff. For information about exclusion periods and creditable coverage, please see "Exclusion Periods" and "Credit for Prior Coverage" in the Benefit Limitations and Exclusions section of this handbook.



If you are laid off and rehired within six months, you will not have to satisfy a new probationary waiting period or new exclusion periods.

Returning to Work after a Leave of Absence

If your employer grants you a non-FMLA leave of absence, you can continue coverage of 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.

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 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 that 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. You and your family members may enroll in this plan later if you qualify under Rule #1 or Rule #2 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 or Rule #2 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, 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. 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, 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, birth, or placement for adoption. In the case of marriage, coverage begins on the 16th day of the month after the marriage. In the case of birth or placement for adoption, coverage begins on the date of birth or placement.

Late Enrollment-Open Enrollment

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 enrollment time frames allowed; or
- Enrolled 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.

Dependents may enroll by submitting a completed application during the next open enrollment period designated by the group (August 16 through September 15 or February 16 through March 15).

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.

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.

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.



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 or legally separate, 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 following 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.

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 or become legally separated
- 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 18 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, DIVORCED, OR SEPARATED SPOUSES

If your group has 20 or more employees, and you die, divorce, or legally separate, and your spouse is 55 or older, your spouse 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 your employer group has 20 or more employees and is not an association group, church, or branch of the federal government, you have continuation rights under federal COBRA continuation laws. Local governments also have similar continuation rights under the Public Health Service Act.

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 or legal separation	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, separation, 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.



If your employer has 20 or more employees and is not an association group, church, or branch of the federal government, you have continuation rights under federal COBRA continuation laws.

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 either medical/vision/dental or medical/vision coverage. You may not elect dental only, vision only, or medical coverage only.

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 legally separate, 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.



COBRA regulations require you to notify your employer within 60 days if you become divorced or legally separated, or if your child no longer qualifies as a dependent.

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.

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.

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 plan, 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 (877) 657-9797.



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 PacificSource guidelines. Also remember that just because a service or supply is a covered benefit under this plan does not necessarily mean PacificSource will pay all charges.

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

“Medically necessary” means services and supplies required for diagnosis or treatment of illness or injury that, in the judgment of PacificSource, are:

- Consistent with the symptoms or diagnosis and treatment of the condition
- Consistent with standards of good medical practice
- As likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply
- Not for your, your family member’s, or your provider’s convenience
- The least costly method of medical service which can be safely provided

Services and supplies intended to diagnose or screen for a medical condition are not considered medically necessary in the absence of signs or symptoms of the condition, or abnormalities on prior testing.



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 PacificSource pays all related charges.

Plan Year Maximum

The plan year maximum benefit on your Member Benefit Summary is the total amount PacificSource will pay for any person’s medical expenses during the contract year.

Your Annual Out-of-Pocket Limit

This plan has an out-of-pocket limit provision to protect you from excessive medical expenses. The Member Benefit Summary shows your plan’s annual out-of-pocket limits for participating and/or nonparticipating 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:

- Prescription drugs
- Charges over the allowable fee for services of nonparticipating providers



- Incurred charges that exceed amounts allowed under this plan
- Emergency room copayments
- Transplants performed at non-contracting facilities

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

PLAN BENEFITS

This plan provides benefits for the following services and supplies as outlined on your Member Benefit Summary. These services and supplies may require you to satisfy a deductible, make a copayment, 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 the Member 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 everyone over two years old 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 18-39: One exam every five years
 - Ages 40-59: One exam every two years
 - Ages 60 and over: One exam every year

Routine physical exams may include routine lab work and other diagnostic testing procedures ordered by your practitioner in connection with the exam. For men age 50 and over, coverage includes one routine prostrate rectal exam and one prostrate specific antigen test per year. One flexible sigmoidoscopy every 5 years for men and women age 50 and over is also covered.

- One **routine gynecological exam** each contract year. Exams may include Pap smear, pelvic exam, breast exam, blood pressure check, and weight check. Exams may also include an annual mammogram for women 35 and over, or as recommended by a physician for women with a high-risk condition. Covered lab services are limited to occult blood, urinalysis, and complete blood count.
- **Immunizations**, limited to the following:
 - Diphtheria, pertussis, and tetanus (DPT) vaccines
 - Polio vaccine
 - Measles, mumps, and rubella (MMR) vaccines
 - Hemophilus influenza B vaccine



- Hepatitis A vaccine for the following members:
 - Children ages 2 through 18
 - Adults over age 18 only if there is a history of Hepatitis C
- Hepatitis B vaccine
- Pneumococcal vaccine for all children through age 2, and for those at high risk through age 4
- Varicella vaccine (chicken pox)
- Influenza vaccine, subject to limitations

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.
- Physical, occupational, or speech therapy provided by a licensed **physical therapist, occupational therapist, speech therapist, or physician**. Total covered expense for physical and occupational therapy combined is limited to 30 visits in any 12-month period beginning with the first date of service. If rehabilitative services are required following head or spinal cord injury, we may allow up to 60 visits each contract year.
 - Physical or occupational 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.
 - Speech therapy requires preauthorization by PacificSource, and will only be allowed when needed to correct stuttering, hearing loss, peripheral speech mechanism problems, and deficits due to neurological disease or injury. Speech therapy for developmental language and phonological disorders is only considered medically necessary for patients at least 2 ½ years old who are unable to communicate basic needs. The plan does not cover speech therapy for learning disorders or oral/facial motor therapy for strengthening and coordination of speech-producing muscles and structures.
 - Functional capacity evaluations, work hardening, vocational rehabilitation, driving evaluations and training programs, community reintegration, motion analysis, and oral motor therapy for TMJ dysfunction are not covered services.



- 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.
- Services of a licensed audiologist for medically necessary **audiological (hearing) tests**. Hearing aids are not covered by this plan.
- 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.
- 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



If you become pregnant, contact PacificSource Customer Service. We'll explain your benefits and enroll you in our free prenatal care program.

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** are covered for up to 14 days per stay. We may authorize care beyond 14 days when the attending physician reports that additional skilled nursing care is necessary for treatment of an illness or injury. However, this plan covers a maximum of 100 skilled nursing facility days per stay. For benefits to renew after each stay, you or your insured dependent must be discharged from the facility and 90 consecutive days must pass before re-admission.

OUTPATIENT SERVICES

This plan covers the following outpatient care services:

- **Diagnostic CT scans and MRIs.** 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, the benefit shown on your Member Benefit Summary for Outpatient Services - CT Scans and MRIs applies.
- **Diagnostic radiology and laboratory procedures** provided or ordered by a physician, nurse 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 copayment shown on your Member Benefit Summary covers medical screening and any diagnostic tests needed for emergency care, such as radiology, laboratory work, CT scans, and MRIs. The copayment does not cover further treatment provided on referral from the emergency room.

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 transplants. 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 shown on your Member Benefit Summary for Professional Services - Office Visit applies.
 - For surgeries or outpatient services performed in an ambulatory surgery center or outpatient hospital setting, both the benefits shown on your Member 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



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 shown on your Member Benefit Summary even if you are treated at a nonparticipating hospital. If you are admitted to a nonparticipating 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.



If you have an emergency medical condition, go directly to the nearest emergency room or appropriate facility. Care for a true medical emergency is covered at the participating provider percentage even if you are treated at a nonparticipating hospital.

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.

Only the following providers of mental health and chemical dependency services are eligible for reimbursement:

- Licensed medical or osteopathic physicians (M.D. or D.O.), including psychiatrists, licensed psychologists (Ph.D.) and psychology associates, registered nurse practitioners (N.P.), and licensed clinical social workers (L.C.S.W.).



- Programs licensed by a state mental health division for alcoholism, chemical dependency, or mental disturbance.
- Hospitals and other facilities licensed for inpatient or residential treatment of mental health conditions or chemical dependency.



In order to be covered, inpatient and residential mental health and chemical dependency treatment must be preauthorized by PacificSource.

Covered Mental Health and Dual Diagnosis Services

This plan covers the following mental health services:

- Assessment and evaluation to make a definitive diagnosis of a mental disorder
- Treatment provided in hospital inpatient facilities, residential programs or facilities, day or partial hospitalization programs, or outpatient services. Treatment in inpatient and residential settings requires preauthorization by PacificSource.
- Treatment of dual diagnosis. Dual diagnosis means a condition involving both mental health and chemical dependency which requires the simultaneous treatment of both conditions. For dual diagnosis conditions, the facility or program must be accredited for treatment of dual diagnosis, and services must be preauthorized by PacificSource.

Benefits for treatment for mental health and dual diagnosis conditions are limited to the following maximums in any 24-month period, beginning with the first day of service:

Adults 18 and older:

Inpatient	14 days
Residential	27 days
Outpatient	29 visits

Children 17 and younger:

Inpatient	15 days
Residential	27 days
Outpatient	32 visits

Covered Chemical Dependency Services

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

For chemical dependency, this plan covers treatment provided in hospital inpatient facilities, residential programs or facilities, day or partial hospitalization programs, or outpatient services. Treatment in inpatient and residential settings requires preauthorization by PacificSource.



Benefits for treatment of chemical dependency are limited to the following maximums in any 24-month period, beginning with the first day of service:

Adults 18 or older:

Inpatient	14 days
Residential	19 days
Outpatient	32 visits

Children 17 or younger:

Inpatient	19 days
Residential	24 days
Outpatient	42 visits

Preauthorization and Review Requirements

- Coverage of all inpatient and residential treatment requires preauthorization by PacificSource. Only emergency admissions are covered without prior approval, and then PacificSource must be notified within 48 hours.
- Coverage of outpatient mental health treatment does not require preauthorization. However, ongoing outpatient treatment may be subject to review to determine if continued treatment is medically necessary.
- Medication management by an M.D. (such as a psychiatrist) does not require review.



The plan does not cover treatment for tobacco or food dependencies or addictions.

Transfer or Extension of Benefits

The benefits shown above for mental health, dual diagnosis, and chemical dependency treatment include the maximum benefits available for each treatment category (inpatient, residential, and outpatient). Unused benefits in one treatment category cannot be transferred to another treatment category, and these benefits cannot be extended for any reason.

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 shown on your Member Benefit Summary for home health care.



- This plan covers **hospice services** when preauthorized by PacificSource up to a maximum of \$8,000. 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 does not provide services of a primary caregiver such as a relative or friend, and private duty nursing is not a covered benefit. PacificSource uses specific criteria to determine eligibility for hospice benefits. For more information, please contact PacificSource Customer Service.
- We will pay covered charges for short-term **hospice inpatient** services and supplies for up to 12 days during the period of covered hospice care.

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. Also, 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 or animal organs and tissues are not covered. Travel and living expenses are not covered for the recipient's family members or the donor, and travel and housing expenses for the recipient are limited to \$5,000.

If the recipient or self-donor is enrolled under this plan, we will pay up to a maximum of \$8,000 per covered transplant for donor costs. Donor costs means the covered expense of removing the tissue from the donor's body and preserving or transporting it to the site where the transplantation is performed as well as any other charges pertaining to locating and procuring the organ. If the donor is insured this plan the recipient is not, we will not pay any benefits toward donor costs. Expenses incurred by an enrolled donor which results from complications and unforeseen effects of the donation will be covered as any other illness.



For detailed transplant criteria, please see the group policy or contact the PacificSource Customer Service Department.



All services, supplies, and treatments for transplant procedures must be preauthorized by PacificSource to be covered.

Payment of Transplant Benefits

If a transplant is performed at a participating 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 Member 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 copayments shown on your Member Benefit Summary. This plan then pays either 70 percent of the amount that would have been paid to a participating facility. Services of nonparticipating medical professionals are paid at the nonparticipating provider percentages shown on the Member 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 **ambulance** when private transportation is inappropriate because a medical condition requires paramedic support. Benefits are provided for emergency ambulance service to the nearest facility able to treat the condition. The cost of ground transportation is covered for up to 300 miles each calendar year. Air transportation is also covered up to the amount that would have been paid for ground ambulance.
- 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 10 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 PacificSource's criteria. PacificSource may require a signed loan receipt/subrogation agreement before providing coverage for this benefit. Please contact PacificSource Customer Service for more information.
- **Breast reconstruction** with or without prosthesis, including reconstruction of the opposite breast to achieve cosmetic symmetry, is covered after a medically necessary mastectomy.
- 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 at the percentages on your Member Benefit Summary for outpatient hospital benefits. Preauthorization by PacificSource is required, and benefits are limited to a lifetime maximum of \$1,000.
 - Phase III (long-term outpatient) services are not covered.



- **Circumcision** for a newborn is covered when performed within three months of birth and may be performed without preauthorization. A circumcision beyond age 3 months must be medically necessary and preauthorized.
- This plan covers IUD, Norplant, 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, contraceptive sponges, female condoms, and spermicides 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
 - When necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury
 - 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 at the amount shown on your Member 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.
 - The 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 **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 **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.

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. If the cost of the purchase, rental, repair, or replacement is over \$500, preauthorization by PacificSource is required.

Purchase, rental, or lease of a power-assisted wheelchair (including batteries and other accessories) is covered up to a maximum benefit of \$5,000. Benefits for a power-assisted wheelchair are available in place of, not in addition to, benefits for a manual wheelchair.

The durable medical equipment benefit also covers lenses to correct a specific vision defect resulting from a severe medical or surgical problem, such as stroke, neurological disease, trauma, or eye surgery other than refraction procedures. Coverage is subject to specific criteria, and this benefit is subject to limitations including a \$200 maximum allowance for lenses and frames. Please contact PacificSource Customer Service for more information.

- This plan covers nonprescription **elemental enteral formula** ordered by a physician for home use. Formula is covered when needed to treat severe intestinal malabsorption. Coverage is provided at the amount shown on your Member Benefit Summary for durable medical equipment.
- This plan covers routine **foot care** for patients with diabetes mellitus.
- This plan covers medically necessary **foot orthotics**, including related charges for evaluation and casting, up to a lifetime maximum benefit of \$500. Foot orthotics must be custom made or fitted and prescribed by a by a licensed physician or podiatrist to be covered.
- **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. 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.
- Office visit and **diagnostic** procedures to determine the presence of **infertility** are covered. Treatment of infertility is not covered. Procedures performed in the process of treatment of infertility, that may or may not have a direct impact on infertility (i.e. adhesion removal) are subject to medical necessity and must be preauthorized.
- **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.
- 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. Nutritional supplies are covered at the amount shown on your Member Benefit Summary for durable medical equipment.
- 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 \$1,000, and preauthorization by PacificSource is required.
- Outpatient **pulmonary rehabilitation** programs are covered for patients with severe chronic lung disease that interferes with normal daily activities despite optimal medication management. Benefits are limited to a lifetime maximum of \$1,000, and a physician's prescription and preauthorization by PacificSource are required.
- Medically necessary treatment for **sleep apnea and other sleeping disorders** is covered when preauthorized by PacificSource. Coverage of oral devices is limited to a lifetime maximum benefit of \$500, including 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.
- **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 **tubal section and vasectomy** procedures.



This plan covers durable medical equipment such as crutches, wheelchairs, orthopedic braces, oxygen equipment, and prostheses. A prescription is required, and expense over \$500 requires preauthorization. Equipment used for nonmedical purposes is not covered.

SPECIAL BENEFITS

In the following situation, we will waive any deductible requirement and pay 100% of charges, up to stated maximums, for repatriation of remains and medical evacuation of an insured person to that person's home country. This benefit will only be provided when the insured person is outside their home country for the purpose of attending the University of Oregon or to participate in a University of Oregon program related to obtaining their degree.

Repatriation of Remains

The maximum benefit available for all services related to the repatriation of an insured person's remains is \$7,500.



Medical Evacuation

The maximum benefit available for all services related to the medical evacuation of an insured person is \$10,000.

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.

Maximum Lifetime Benefit

The maximum lifetime benefit on your Member Benefit Summary is the total amount PacificSource will pay for any person's medical expenses during their lifetime. Your lifetime maximum benefit is like an account, and it works like this:

- Each time we pay benefits for your care, we deduct that amount from your lifetime maximum benefit account.
- If you were insured under another PacificSource policy before this plan, the amount we paid for your care under that policy is subtracted from your lifetime maximum account under this plan.



The maximum lifetime benefit on your Member Benefit Summary is the total amount PacificSource will pay for your medical expenses during your lifetime.

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. If your employer provides optional benefits for an exclusion listed below, then the exclusion does not apply to the extent that coverage exists under the optional benefit. For example, if your employer provides optional chiropractic coverage, then the exclusion for chiropractic care listed below under "Types of Treatment" does not apply to you.

This is only a summary of excluded services, supplies, and expenses. For details, please refer to the General Exclusions section of your group health policy.

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

- Acupuncture
- Biofeedback other than for migraine headaches or urinary incontinence, which is limited to 10 sessions



- Chelation therapy, unless preauthorized by PacificSource for certain medical conditions or heavy metal toxicities
- Chiropractic care
- 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
- Family planning services and supplies other than sterilization
- 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 by PacificSource as medically necessary for the diagnosis and standard treatment of specific diseases
- Homeopathic treatment
- Infertility - Services or supplies to prevent, or treat sterility, infertility, impotency, frigidity, or sexual dysfunction
- Instructional or educational programs, except diabetes self-management programs
- Jaw - Services or supplies for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants, or improving placement of dentures
- Massage, massage therapy, or neuromuscular re-education, even as part of a physical therapy program
- Maternity care for surrogate mothers
- Motion analysis, including physician review
- Myeloablative high dose chemotherapy, except when the related transplant is covered
- Naturopathic treatment
- 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
- Physical or occupational therapy for developmental delays and disorders, sensory integration disorders, motor skills disorders, or learning disorders
- 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 (except as allowed under the preventive care benefit). Also excluded are total body CT imaging, CT colonography, and bone density testing.
- Self-help or training programs
- Smoking cessation aids or treatment to modify tobacco use or promote general fitness
- Snoring - Services or supplies for the diagnosis or treatment of snoring or upper airway resistance disorders, including somnoplasty
- Speech therapy for developmental language disorders, phonological disorders, and learning disorders, and facial motor therapy for strengthening and coordination of speech-producing muscles and structures
- 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



This plan does not cover weight loss programs or treatment for obesity.



This plan does not cover fertility treatments or surgery to reverse voluntary sterilization.

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
- 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
- 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 specialist or by any other provider:

- Diagnoses: Treatment of mental retardation, learning disorders, motor skills disorders, communication disorders, developmental delays and disorders, pervasive developmental disorders (such as autism), disruptive behavior disorders, factitious disorders, sexual and gender identity disorders, impulse control disorders, paraphilias (except for pedophilia, which is covered), relational problems, caffeine-related disorders, nicotine-related disorders, sensory integration disorders, and conduct disorders
- Types of treatment: Neurodevelopmental therapy, sensory integration training, biofeedback (other than as specifically noted under the Covered Expenses – Other Covered Services, Supplies, and Treatments section), hypnotherapy, academic skills training, narcoanalysis, and social skills training. Recreation therapy is only covered as part of a mental health inpatient or residential program.
- Adolescent wilderness treatment programs
- Counseling or training for career issues, personal growth, assertiveness, sensitivity, image therapy, relaxation, stress management, parenting skills, or family education
- Court-mandated diversion or chemical dependency education classes, court-mandated psychological evaluations for child custody cases, and mental evaluations to adjudicate legal rights
- Self-help or training programs, including programs to help stop smoking
- Sensory movement group therapy or marathon group therapy
- Sexual dysfunction - Psychological evaluation for sexual dysfunction or inadequacy
- Voluntary mutual support groups such as Alcoholics Anonymous
- Any mental health service unrelated to the treatment or diagnosis of a mental disorder
- Services of any provider not listed as eligible for reimbursement under the Covered Expenses - Mental Health and Chemical Dependency Services section

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

- Drugs and biologicals that can be self-administered (including injectibles), 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 prescribed primarily for comfort, or intended to alter the physical environment. This includes appliances like 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 for physical or occupational therapy, or used primarily in athletic or recreational activities. This includes exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal problems.
- Hearing aids
- Modifications to vehicles or structures to prevent, treat, or accommodate a medical condition
- Personal items such as telephones, televisions, and guest meals during a stay at a hospital or other inpatient facility



This plan does not cover equipment commonly used for nonmedical purposes such as air conditioners, air purifiers, whirlpools, saunas, tanning lights, pillows and athletic or recreational equipment.

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, in PacificSource's judgment, 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 research or clinical trials; or
- Is considered by any governmental agency or subdivision to be experimental or investigational, not reasonable and necessary, or any similar finding.

When making decisions 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.

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 in PacificSource's judgment
- 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.)
- 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 information PacificSource needs to determine eligibility for payment
- 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 your policy provides on-the-job health coverage by endorsement. This includes illness or injury caused by any for-profit activity, whether through employment or self-employment, regardless of the availability of workers' compensation.
- 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
- 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. Also, your prior coverage must have been a group health plan, individual health insurance plan (including student plans), Medicaid, Medicare, CHAMPUS, state health benefits risk pool, or public health plan. 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).



If you had qualifying healthcare coverage no more than 63 days before enrolling in this plan, you can receive credit toward this plan's exclusion periods. It is your responsibility to show proof of creditable prior coverage.

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 PacificSource's written authorization before the services are performed. This process is called "preauthorization." Your medical provider can request preauthorization from the PacificSource Medical Affairs Department by phone, fax, mail, or e-mail. 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.

Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. 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. You'll find the most current preauthorization list on our Web site, www.pacificsource.com, under "For Members." The list of procedures and services requiring preauthorization includes, but is not limited to, the following:

- **Ambulance transports** (air or ground) between medical facilities, except in emergencies
- CT-scan measurements of **bone density**
- **Breast reconstruction**, including reduction and implants
- Outpatient **cardiac** (Phase II) and **pulmonary rehabilitation**
- **Chelation therapy**
- **Cosmetic and reconstructive procedures** including skin peels, scar revisions, facial plastic procedures or reconstruction, and procedures to remove superficial varicosities or other superficial vascular lesions
- **Durable medical equipment** expense over \$500, including purchase, rental, repair, lease, or replacement, or rental for longer than three months
- **Elective medical admissions**, such as preadmission, or admission to a hospital for diagnostic testing or procedures normally done in an outpatient setting, and **transfers to nonparticipating facilities**
- **Experimental or investigational** procedures or surgeries
- **Extensions** of previously authorized benefits, such as physical or occupational therapy
- **Gamma knife procedures**
- **Genetic (DNA) testing**
- **Home health**, outpatient and home IV infusion, and hospice services, and enteral nutrition supplies
- **Hospitalization for dental procedures** when covered under this plan, including pediatric dental procedures



- **Kidney dialysis**
- **Laparoscopies** of the female reproductive system
- **Mental health and chemical dependency** inpatient or residential treatment, including intensive outpatient mental health treatment
- Multidisciplinary **pain management** and rehabilitation evaluations and programs
- **PET scans**
- **Radiofrequency neurotomy**
- **Rehabilitation** or skilled nursing facility admissions
- Surgical procedures, supplies, and equipment for **sleep apnea and other sleeping disorders**
- **Speech therapy** services
- **Surgeries or procedures** in a hospital or ambulatory center during any exclusion period
- **Transplantation** of organ, bone marrow, and stem cells, including evaluations, related donor services, and HLA tissue typing. Preauthorization is not required for corneal transplants.
- **Varicose vein procedures**

If your (or your provider's) preauthorization request is approved, it is valid for 90 days. However, if your coverage under this plan ends before the service is performed, the preauthorization will become invalid.

If your (or your provider's) preauthorization request is denied and you believe the denial is inappropriate, you may appeal our decision. Please see the Complaints, Grievances, and Appeals - Appealing a Preauthorization Denial section for more information.



Coverage of certain medical services requires PacificSource's written authorization before the services are performed.



If treatment is not preauthorized, you will be held responsible for the expense if it is not medically necessary or is not covered by this plan.

UTILIZATION REVIEW

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

PacificSource reserves the right to delegate a third party to assist with or perform the function of utilization management. In all cases, PacificSource will have final authority in utilization management decisions.



Authorization of Hospital Admissions

When a PacificSource member is admitted to a hospital within the area covered by the PacificSource provider network (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 of each admission is documented in the report as either pending, approved, or denied, and the patient's related claims are processed accordingly.

As part of the utilization review process, PacificSource determines 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 Medical Affairs 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 so we can either extend the length of stay or begin planning for the patient's discharge. The PacificSource Medical Director may review the case to determine if extended hospitalization meets our criteria for coverage.

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

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 determination, we request further information and attempt to provide a decision 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 Medical Director for a decision regarding coverage.



Questions About Specific Utilization Review Decisions

If you would like information on how we reached a particular utilization review decision, please contact our Medical Affairs Department by phone at (541) 684-5584 or (800) 624-6052, or by e-mail at medaffairs@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.

COVERED EXPENSES AND LIMITATIONS – DENTAL

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.

COVERED DENTAL SERVICES

This dental plan covers the following services when performed by a licensed dentist and when determined to be necessary, reasonable, and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury, including masticatory function. Such standards are determined by the PacificSource Dental Director and/or Board of Directors. 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 two classes, starting with preventive care and advancing into basic dental procedures.

CLASS I SERVICES—DIAGNOSTIC AND PREVENTIVE TREATMENT

- **Examinations** (routine or other diagnostic exams) are covered once per person every 6 months. Separate charges for review of a proposed treatment plan are not covered.
- **Mouth x-rays and/or panorex** are covered to one complete mouth series and/or panorex in any five-year period and but limited to two 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/or periodontal maintenance)** are covered to a combined total of one procedure per person every 6 months. The limitation for dental cleaning applies to any combination of prophylaxis and/or periodontal maintenance (dental cleaning) in the calendar year. Root planing and scaling are not covered. 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 one application every 6 months and only for children up to the age of 16 years.

CLASS II SERVICES—BASIC TREATMENT

- **Composite, plastic, or similar restoration** in a posterior tooth is covered to the amount that would be paid for corresponding amalgam restoration. A separate charge for anesthesia when used during restorative procedures is not a covered benefit.
- **Surgical extractions** and other minor oral surgery procedures are covered, including general anesthesia administered by a dentist in a dental office. A separate charge for alveolectomy performed in conjunction with removal of teeth is not a covered benefit.
- **Pulp capping** is covered only when there is an exposure to the pulp (unless otherwise preauthorized by PacificSource).
- **Root canal therapy** is covered on the same tooth only for one charge in a three-year period.
- **Repair of dentures and bridges.** Replacement of dentures and bridges is excluded.
- The **application of sealants** is covered to one application in a five-year period to permanent molars and only of children up to age 16.
- **Space maintainers** to preserve the space between teeth caused by the premature loss of a primary tooth.

DENTAL EXCLUSIONS

This plan does not cover the following:

- **Benefits not stated** – Any services and supplies not specifically described as covered
- **Biopsies or histopathologic exams** – A separate charge for a biopsy or histopathologic exam
- Charges for **broken appointments**
- **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, congenitally missing teeth, peg laterals, cleft palate, maxillary and/or mandibular (upper and lower jaw) malformation, enamel hypoplasia, and fluorosis (discoloration of teeth).
- **Drugs and medications** that are prescribed drugs, premedication, desensitizing medicaments, analgesics (e.g., nitrous oxide or IV sedation), any other euphoric drugs, or any take-home medicine or supplies distributed by a provider



- **Diagnostic casts** – Diagnostic casts (study models), gnathological recordings, occlusal appliances, occlusal equilibration procedures, or similar procedures
- **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, in PacificSource's judgment, experimental or investigational for the diagnosis and treatment of the patient
- **Gnathologic recordings** or similar procedures
- **General anesthesia** except when administered by a dentist in connection with oral surgery in his/her office
- **Hospital charges** or additional fees charged by the dentist for hospital treatment
- **Hypnosis**
- **Implants** – Surgical preparation, surgical placement, or removal of implants or attachments
- **Infection control** – A separate charge for infection control or sterilization
- **Orthodontic services** – Treatment of malalignment of teeth and/or jaws, or any ancillary services expressly performed because of orthodontic treatment. Extractions for orthodontic purposes are covered.
- **Periodontic Services** – Diagnosis and treatment of diseases of the connective tissues around and supporting the teeth. Root planing 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 adjustments and relines.
- **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 or which you are not legally required to pay.** This includes services provided by you or an immediate family member.
- **Splints, night guards, or appliances used to increase vertical dimensions,** restore the occlusion, or correct habits such as tongue thrust and grinding of teeth. Periodontal splinting including crowns and bridgework used in conjunction with periodontal splinting.
- **Temporomandibular joint (TMJ)** – Any services or supplies for treatment of any disturbance of the temporomandibular joint (TMJ)



- **Third party liability, motor vehicle liability, motor vehicle insurance coverage, workers' compensation** – Any services or supplies for which a third party is responsible for paying, except to the extent that such payments are insufficient to cover the cost of dental services covered by this plan
- **Treatment after insurance ends** – Services or supplies provided after enrollment in this plan ends
- **Treatment not 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

CLAIMS PAYMENT

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 nonparticipating 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
Attn: Claims
PO Box 7068
Eugene OR 97401-0068*



Claims Payment Practices

Unless additional information is needed to process your claim, we will make every effort to pay or deny your claim within 30 days of receipt. If a claim cannot be paid within 30 days of receipt because additional information is needed, 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.

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.

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 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.

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 may be required to satisfy each of those deductibles before benefits are available. This plan’s rules for coordination of benefits were drafted by the National Association of Insurance Commissioners and adopted by the Oregon Department of Consumer and Business Services.

Here is how this plan’s benefits are coordinated with your other 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 not separated or divorced, the parent whose birthday falls first in a calendar year 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 separated or divorced:
 - If the parent with custody has not remarried, their coverage is primary.
 - If the parent with custody has remarried, the custodial parent's coverage is primary, the stepparent's coverage pays second, and the coverage of the natural parent without custody pays third.
 - 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 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.



If you 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.

Coordination with Medicare

- *Employers with 20 or more employees:* For people who are Medicare eligible, this plan is usually primary and Medicare is secondary. This rule only applies to active employees and their enrolled dependents.
- *Medicare disabled and end-stage renal disease (ESRD) patients:* The rule 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 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.



- You may subtract a proportionate share of the reasonable attorney's fees you incurred from the money you 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.



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

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. This is true regardless of whether workers' compensation benefits are available to you.

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 decision 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.

Unresolved Issues

As a PacificSource member, you can usually find the help you need to resolve outstanding issues simply by calling the PacificSource Customer Service Department.

GRIEVANCE AND APPEAL PROCEDURES

- **Initial Grievance:** If you believe PacificSource has denied benefits to which you are entitled, you may file an initial grievance. You may do so within 180 days from receipt of our notification that your claim is denied in full or in part.
- **First Level of Appeal:** If you have received our response to your initial grievance and you still believe we are in error, you may file an appeal. Your appeal and any additional information you want us to consider should be forwarded to us within 60 days of the initial grievance response.
- **Second Level of Appeal:** If you are not satisfied with the first level appeal decision, you may request an additional review. Your appeal and any additional information not presented with your first appeal should be forwarded to us within 60 days of the first level appeal response.
- **Independent Review:** You may have the right to have your case reviewed by an external independent review organization. If we denied benefits because we determined that services were not medically necessary or were experimental or investigational, you have this right. In addition, if you believe you have a right to continue treatment with a provider who is no longer eligible for payment by PacificSource, your appeal may be reviewed externally. Your request for an independent review must be made within 180 days of the date of the second level of appeal response. External independent review is available at no cost to you, but is only an option for issues of medical necessity, experimental or investigational treatment, and continuity of care after all internal grievance levels are exhausted.

Appealing a Preauthorization Denial

If you believe PacificSource inappropriately denied a preauthorization request, you have the right to appeal the decision. Either you or your healthcare provider can appeal the decision. An appropriate medical consultant, peer review committee, or both will review your appeal. PacificSource will acknowledge your appeal within one week and make a decision on the appeal within 30 days (or sooner if there is an urgent medical situation).



How to Submit Grievances or Appeals

Before submitting a grievance, 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 e-mail at cs@pacificsource.com. Issues can often be resolved at this level. Otherwise, you may file a grievance or appeal by:

- **writing** to PacificSource, Attn: Grievance Review, PO Box 7068, Eugene, OR 97401
- **e-mailing** a message to cs@pacificsource.com, with “Grievance” as the subject
- **faxing** your message to (541) 686-2051

SOURCES FOR INFORMATION AND ASSISTANCE

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 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.

Para asistirle en español, por favor llame el numero (800) 624-6052, extensión 1009, de Lunes a Viernes, 8:00 a.m. hasta 5:00 p.m.



If you have a question, concern, or complaint about your plan, please contact PacificSource Customer Service.

Assistance Outside PacificSource

If you believe we have not responded to your grievance appropriately, you have the right to file a complaint or seek other assistance from the Oregon Insurance Division. You may contact them by calling (503) 947-7984, or writing to the Oregon Insurance Division, Consumer Protection Unit, 350 Winter Street NE, Room 440-2, Salem OR 97310, or on the Internet at www.cbs.state.or.us/external/ins/

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 e-mail 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 federal 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, Consumer Protection Unit, 350 Winter Street NE, Room 440-2, Salem, OR 97310, phone (503) 947-7984, Web www.cbs.state.or.us/external/ins/.

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 Web site, www.pacificsource.com. You may also write to us at:

*PacificSource
Attn: Vice President of Operations
PO Box 7068
Eugene OR 97401-0068*



We welcome your feedback and suggestions, and encourage you to help shape our corporate policies and practices.



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.



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 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
Eugene OR 97401-0068



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.



PacificSource will provide your employer with information to notify you of any changes to this plan. Your employer will then communicate the changes to you. Be sure to read and save any communications you receive about your PacificSource coverage.

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 Pension and Welfare Benefit 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 6 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 - Grievance and 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 - Grievance and 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

