

Welcome to PacificSource Healthy KidsConnect!

Thank you for choosing PacificSource Health Plans. We are pleased to be partnering with the Office of Private Health Partnerships (OPHP) to offer healthcare to eligible children in Oregon.

About Your Benefits

Enclosed is your Healthy KidsConnect member handbook. This handbook is your guide to the comprehensive healthcare benefits available to the children covered under the Healthy KidsConnect private market insurance program through PacificSource.

Your plan covers medical, dental, vision care, and prescription drugs. The handbook has important information about how to access care and how much of the cost you're responsible for paying. Please remember that you must use PacificSource provider networks for all non-emergency care, unless prior authorization has been received. You must select a primary care practitioner (PCP) from the PacificSource Prime provider directory to be responsible for your medical care. The PCP will coordinate use of healthcare resources to best meet your healthcare needs.

About Healthy KidsConnect

Healthy KidsConnect was authorized by the 2009 Oregon Legislature through the passage of House Bill 2116. OPHP, the state agency leading this new program, is part of the new Oregon Health Authority. Official rules of the Department of Consumer and Business Services (DCBS) Insurance Division require that you be notified of the following:

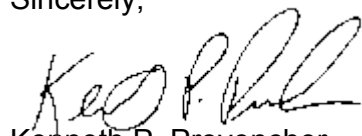
- OPHP is the policyholder for Healthy KidsConnect insurance.
- OPHP can make changes to this group policy including, but not limited to, eligibility, premium, out-of-pocket costs and benefits.
- OPHP will give you timely notification of any changes.
- Your consent is not required for OPHP as the policyholder to make changes.

Questions?

- For questions about the plan's medical, dental, prescription, or vision **benefits** or to select a primary care physician, contact PacificSource Customer Service toll-free at 888.684.5220.
- For questions about your subsidy or **premium payments**, call OPHP toll-free at 888.260.4555.
- For questions about your **eligibility** determination, call Oregon Department of Human Services toll-free at 877.314.5678.

On behalf of the Healthy KidsConnect program and PacificSource, we look forward to helping you get the healthcare you need.

Sincerely,



Kenneth P. Provencher
President, CEO



Healthy KidsConnect for children of families over 300 percent FPL

Welcome to your **Healthy KidsConnect** health and dental plan administered by PacificSource Health Plans. This coverage is to help you 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 Benefit Summaries for your medical plan and any other benefits provided under this policy. 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, our Customer Service staff is available to answer your questions 7:00 am – 5:00 pm PST. Please give us a call, visit us on the Internet 24/7, or stop by our office. We look forward to serving you and your family.

PacificSource Benefits or to Select Primary Care Practitioner

Phone (888) 684-5220 toll-free
E-mail cs@pacificsource.com
PacificSource.com

Healthy KidsConnect Subsidy or Premium Payment

Office of Private Health Partnerships (OPHP)
Phone (888) 260-4555 toll-free

Healthy KidsConnect Eligibility

Oregon Department of Human Services
Phone (877) 314-5678 toll-free

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

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Healthy KidsConnect Managed Care Plan B – Benefit Summaries for children of families over 300 percent FPL

This Healthy KidsConnect Benefit Summaries briefly outline the benefits we cover and your cost sharing requirements. **Eligible American Indian / Alaskan Native children above the 300% FPL are not eligible for HKC subsidy and are responsible for coinsurance, copayments, and premium.** This is not a contract, and does not fully describe the benefit coverage. Please refer to the benefit handbook for exact terms, conditions, provisions, exclusions, and limitations.

POLICY INFORMATION	
Policy Number:	G0017282
Plan Type:	Managed Care Plan B: Over 300 Plan
Medical Network:	PacificSource – <i>Prime PSN (primary care practitioner required)</i>
Pharmacy Retail Network:	CVS Caremark – <i>Value Drug List (VDL)</i>
Pharmacy Mail Order Network	CVS Caremark Mail or Wellpartner
Dental Network:	Advantage Dental

MEDICAL BENEFIT SUMMARY	
Lifetime Maximum Benefit	None
Pre-existing Waiting Period, including Pregnancy	None
Calendar Year Medical Deductible	\$1,000
Calendar Year Maximum Individual Medical Out-of-Pocket (OOP)*	
❖ Per Person	\$6,000
*This is the maximum amount you will pay for covered medical services per calendar year, before your plan will begin paying 100% for covered services. Once the 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 calendar year. Benefits paid in full, transplants, and disallowed charges do not accumulate to the out-of-pocket limit.	
Benefit – Participating Providers	Member Pays
Preventive Care and Services	
❖ Women’s Health Care Services and Men’s Health Care Services	\$0
❖ Routine Immunizations	\$0
❖ Well-Baby Care (0-36 months) and Well-Child Care (3-18 years)	\$0
❖ Outpatient Diabetic Instruction	\$0
❖ Prostate Cancer Screening	\$0
Professional Office Visits	20%, after deductible
Hospital Inpatient Care	20%, after deductible
Outpatient Surgery	20%, after deductible
Skilled Nursing Facility – <i>limited to 60 days</i>	20%, after deductible
Home Health Care – <i>limited to 60 visits</i>	20%, after deductible
Emergency Room – <i>waived if admitted</i>	20%, after deductible
Ambulance, Ground – <i>to nearest facility able to treat condition, 300 mile annual max</i>	20%, after deductible
Ambulance, Air – <i>if ground is medically/physically inappropriate, \$6,000 annual max</i>	20%, after deductible

Benefit – Participating Providers	Member Pays
Maternity Care, Normal Pregnancy	
❖ Pre and postnatal visits – <i>global copay covers all routine professional visits</i>	20%, after deductible
❖ Labor and delivery hospital stay – <i>facility</i>	20%, after deductible
❖ <i>NOTE: Complications of pregnancy covered as any other illness</i>	
Diagnostic X-Ray, Imaging, Lab, and Special Diagnostic Procedures	20%, after deductible
Transplants	20%, after deductible
Hospice Care	20%, after deductible
Rehabilitation – <i>physical, occupational, and speech therapy combined limit</i>	
❖ Inpatient – <i>limited to 60 days per year</i>	20%, after deductible
❖ Outpatient – <i>limited to 60 visits per year</i>	20%, after deductible
Durable Medical Equipment and Supplies	20%, after deductible
Mental Health and Chemical Dependency	
❖ Inpatient Psychiatric Care	20%, after deductible
❖ Residential/Day Treatment – <i>up to 45 days per year</i>	20%, after deductible
❖ Outpatient Treatment	20%, after deductible
Acupuncture, Chiropractic, and Naturopathic (<i>subject to referral by primary care practitioner</i>)	20%, after deductible
Hearing Aid Services	20%, after deductible
Benefit – Non-participating Providers	Member Pays
Non-participating providers	100% –Not covered**
<i>**Services are covered only when obtained from participating providers except in emergencies or when PacificSource provides an out-of-network preauthorization. In these limited circumstances, normal copay or coinsurance would apply.</i>	
Benefit – Providers Outside Oregon	Member Pays
Providers outside Oregon	100% –Not covered***
<i>*** Providers must be based in Oregon. Except for emergencies, services must be provided by an Oregon-based provider within the PacificSource provider network.</i>	

PRESCRIPTION DRUG BENEFIT SUMMARY (subject to the VDL value drug list)	
Calendar Year Prescription Drug Deductible	None
Calendar Year Maximum Prescription Drug Out-of-Pocket	None
Benefit – Participating Retail Pharmacies, 34-day supply	Member Pays
Generic Drug	\$5
Certain Preventive Care Drugs (see below)	\$0
<ul style="list-style-type: none"> Folic Acid for women. Single entity only. Fluoride: Through age 6 years only. Single entity only. Iron: Through age 1 year only. Single entity only. Nicotine Replacement for age 15 years or older: If enrolled in Quit for Life, they will send you an 8-week supply of nicotine patches or gum, or you can get a 12-week supply of bupropion (generic of Zyban) or Chantix at participating pharmacy when prescribed by your doctor. Seasonal Flu Vaccines: Once per calendar year at participating flu shot pharmacy clinics. 	
Preferred Brand (VDL)	\$50 or 50%, whichever is less
Nonpreferred Brand	Not covered, except as described below*
*Nonpreferred prescription drugs are not covered. Exceptions to this are only considered when all equivalent generic and preferred brand drugs have been tried unsuccessfully and certain criteria is met, as determined by PacificSource. In such limited cases, the drug will be covered at the Preferred Brand copay level.	
Benefit – Participating Mail Order Pharmacies, 34-day supply	Member Pays
Generic Drug	\$5
Certain Preventive Care Drugs (see above)	\$0
Preferred Brand (VDL)	\$50 or 50%, whichever is less
Nonpreferred Brand	Not covered, except as described below*
*Nonpreferred prescription drugs are not covered. Exceptions to this are only considered when all equivalent generic and preferred brand drugs have been tried unsuccessfully and certain criteria is met, as determined by PacificSource. In such limited cases, the drug will be covered at the Preferred Brand copay level.	
Benefit – Specialty Drugs, 30-day supply	Member Pays
Specialty Drugs**	\$50 or 50%, whichever is less
**Caremark® Specialty Pharmacy Services is your provider for specialty and biotech drugs often used to treat chronic or genetic disorders. The program is designed to help PacificSource members with the following health conditions maximize the value of their health plan benefits.	
Asthma	Growth hormone deficiency
Crohn's disease	Immune disorders
Enzyme replacement	Multiple sclerosis
Gaucher's disease	Oncology
	Psoriasis
	Pulmonary arterial hypertension
	Pulmonary disease
	RSV prevention
	Rheumatoid arthritis
NOTE: Some specialty drugs that are not self-administered are not covered under this pharmacy benefit, but are covered under the medical plan's office supply benefit.	
Benefit – Non-participating Pharmacies	Member Pays
Non-participating providers	100% - Not covered in most cases**
**Drugs are covered only when obtained from participating pharmacies except in emergencies. In these limited circumstances, normal copays would apply.	
Benefit – Drugs Excluded	Member Pays
Excluded Drugs	100% - Not covered

DENTAL BENEFIT SUMMARY	
Calendar Year Maximum Benefit	\$1,000
Calendar Year Dental Deductible	None
Calendar Year Maximum Dental Out-of-Pocket	
❖ Per Person	\$200
❖ Per Family	\$400
<i>*This is the maximum amount you will pay for covered dental benefits per calendar year, before your plan will begin paying 100% for covered services.</i>	
Benefit – Participating Dental Providers	Member Pays
Diagnostic and Preventive	
❖ Examinations – <i>two per calendar year; separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered</i>	\$0
❖ X-rays – <i>one complete mouth series in any three year period; up to four bite-wing films in a six-month period</i>	\$0
❖ Prophylaxis Cleanings – <i>combined total of three prophylaxis cleanings or periodontal maintenance procedures (see Periodontics) per calendar year</i>	\$0
❖ Fluoride Treatment – <i>two per calendar year through age 18</i>	\$0
❖ Sealants on permanent molars and bicuspids – <i>one application in a five-year period for individuals through age 18</i>	\$0
Restorative, Oral Surgery, and Endodontics – copays are per tooth	
❖ Amalgams or Composite Resin – <i>composite filling in a posterior tooth is limited to the amount that would be paid for a corresponding amalgam restoration; fillings on a tooth surface are limited to once per calendar year</i>	\$10
❖ Extractions and certain other minor surgical procedures – <i>include general anesthesia when administered by dentist in office; a separate charge for alveolectomy performed in conjunction with removal of teeth is not covered</i>	\$10
❖ Root Canal Therapy – <i>one in a three-year period per tooth</i>	\$10
❖ Crowns – <i>restoration of any one tooth in a five-year period covered when teeth cannot be restored with other materials; if can be restored with a material such as amalgam or composite resin, covered charges are limited to the cost of amalgam or non-laboratory composite resin restoration even if another type of restoration is selected by the patient and/or dentist</i>	\$30
Periodontics	
❖ Space maintainers – <i>through age 13</i>	\$10
❖ Periodontal Maintenance – <i>combined total of three periodontal maintenance procedures or prophylaxis cleanings (see Cleanings) per calendar year; separate charge for periodontal charting not covered; periodontal maintenance not covered within three months of periodontal scaling, root planning, or curettage.</i>	\$10
❖ Periodontal scaling and root planing and/or curettage – <i>one procedure per quadrant in any three-year period; treatment of tissue supporting the teeth</i>	\$10
Prostodontics (Removable)	
❖ Complete or Partial Dentures – <i>construction, repair, or reline; replacement of existing device that is unserviceable, cannot be made serviceable, and has been in place for at least five years; construction of fixed bridges</i>	\$30

Benefit – Participating Dental Providers – Continued		Member Pays
❖ Repairs to Complete and Partial Dentures <i>–to make serviceable</i>		\$15
❖ Denture Rebase and Reline Procedures <i>–once every 12 months</i>		\$15
Orthodontics		
❖ Covered if have a diagnosis of cleft palate with cleft lip and preauthorized		\$30
Benefit – Non-participating Dental Providers		Member Pays
Non-participating providers		100% -Not covered**
<i>**Covered only when obtained from participating providers except in emergencies or when PacificSource provides an out-of-network preauthorization. Normal Advantage Dental maximum allowances would apply.</i>		

VISION BENEFIT SUMMARY	
Benefit – Participating Providers	Member Pays
Routine Vision Examinations <i>–one per calendar year</i>	\$0
Vision Therapy Services <i>–six sessions per calendar year</i>	\$0
Radiological Services <i>–by Optometrists or Ophthalmologist</i>	\$0
Benefit – Participating Providers	Maximum Allowance
Prescription Lenses	
❖ One Pair Per Calendar Year <i>–you pay any amount over the maximum allowance.</i>	
○ Single Vision Lenses	\$96
○ Bifocal Lenses	\$134
○ Trifocal Lenses	\$180
○ Contact Lenses (in place of lenses and frames)	\$192
Frames	
❖ One Frame Every Calendar Year <i>–you pay any amount over maximum allowance</i>	\$96
Benefit – Non-participating Providers	Member Pays
Non-participating providers	100% - Not covered

OTHER VISION RELATED BENEFITS	
Covered Under Medical	
The following vision related services are covered under your medical benefit when pre-authorized by PacificSource for medically necessary surgery or treatment.	
❖ Prescription Contact Lenses <i>–one contact lens for each eye undergoing cataract surgery</i>	
❖ Ocular Prosthetics, Artificial Eye <i>–documentation required</i>	
❖ Postsurgical Care, Optometrists Post <i>–operative Care</i>	

DEFINITIONS

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

Affordable Care Act means the federal legislation passed under the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010.

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

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

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

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

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

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

Benefit plan includes, but not limited to, the following to the extent offered to Members by Agency:

- Insurance or other benefits including medical, dental, vision, and related services and supplies;
- Comparable benefits for Members who rely on spiritual means of healing.

Brand-name medication means prescription medication that has a patent and is marketed and sold by only one source or is listed in widely accepted references as a brand-name medication based on manufacturer and price.

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

Child means an individual 18 year of age or younger.

Claim means a request for payment under the terms of this plan.

Coinsurance means the amount of charges that you must pay a provider on a claim, i.e., the portion of the claim that you pay after we pay the maximum amount for that benefit.

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

Compound medication means two or more medications that a pharmacist mixes together. In order to be covered, compound medications must contain, in therapeutic amount, either one federal legend medication or one state restricted medication. Copayment amounts are assessed on each covered prescription medication claim.

Confidential information shall include, but not limited to:

- Information marked or designated in writing by either party as “confidential” prior to initial disclosure, and;
- Enrollment information, medical records, claims, payment information, and any Protected Health Information (PHI) within the meaning of the Federal Privacy Rule.

Contract includes, where applicable, any similar contract between Contractor and Agency for a previous term.

Contracting agency means any of the following with whom we have contracted to provide services and supplies under this contract: Home health care agency, home infusion therapy agency, or hospice care plan.

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

Contracting durable medical equipment supplier means a supplier of durable medical equipment that has contracted to provide services and supplies to you under this plan.

Copayment means a fixed amount that you pay to a provider for covered medical services.

Cosmetic means services and supplies that are applied to normal structures of the body primarily for the purposes of improving or changing appearance or enhancing self-esteem.

Covered expense is an expense for which benefits are payable under by this policy subject to applicable copayment, coinsurance, out-of-pocket maximum, or other specific limitations.

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

Dentally necessary service or supply means one which is ordered by a physician and which PacificSource’s medical staff or a qualified party or entity and the patient’s dentist determine is:

- Provided for the diagnosis or direct treatment of an injury or illness;
- Appropriate and consistent with the symptoms and findings of diagnosis and treatment of the insured person’s injury or illness;
- Not considered experimental or investigative;
- Provided in accord with generally accepted medical practice;
- The most appropriate supply or level of service that can be provided on a cost effective basis (including, but not limited to, in-patient vs. out-patient care, electric vs. manual wheelchair, surgical vs. medical or other types of care);
- Not for the convenience of the member or a provider of services or supplies.

The fact that a dentist prescribes a service or supply does not automatically mean such service or supply is medically necessary for the insured person and does not mean it is covered by this policy.

Disenrollment means the act of discharging a Member from Contractor's responsibility of this contract.

Drug formulary is a list of preferred medications used to treat various medical conditions. The formulary for this plan is known as the Value Drug List (VDL). The VDL 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 VDL is made up of name brand products. A complete list of medications covered under the VDL is available on the For Members area of our Web site, PacificSource.com. The VDL is developed by CVS Caremark® in cooperation with PacificSource.

Durable medical equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of illness and/or injury and is appropriate for use in your home. Examples include oxygen equipment and wheelchairs.

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

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

Eligibility means the requirements that you must meet in order to qualify for and remain in the Healthy KidsConnect Program. **See “When Coverage Begins” and “When Coverage Ends” sections.**

Emergency medical condition or medical emergency means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. “Emergency Medical Condition” is determined based on the presenting symptoms (not final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.

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

Emergency services means those health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required to stabilize your condition.

Exclusions means specified conditions or circumstances, listed in this plan, for which we pay no benefits. Exclusions may apply to services that are medically necessary.

Generic medication means a prescription medication that is an equivalent medication to the brand-name medication, is marketed and sold by more than one source, and is listed in widely accepted references as a generic medication based on manufacturer and price. Equivalent medication means the Food and Drug Administration (FDA) ensures that the generic has the same effectiveness as the brand-name medication.

Healthy KidsConnect Program means the Healthy Kids Program of the Office Of Private Health Partnerships (OPHP), 250 Church Street SE, Suite 200, Salem, OR 97301. Telephone Salem (503) 373-1656, Toll Free 1-800-542-3104.

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

HIPAA means the Health Insurance and Portability and Accountability Act of 1996, Public Law 104-191, as amended from time to time, and the rules thereunder including the Federal Privacy Rule.

HKC means Healthy KidsConnect.

Home health-care means services and supplies that a licensed home health agency provides to a homebound patient.

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

Hospice means a program designed to provide comfort and supportive services to terminally ill patients and their families.

Hospital means a facility that provides diagnostic and treatment services for inpatient surgical and medical care of persons who are injured or ill. It must be licensed under applicable laws as a general hospital. Its services must be under the supervision of a staff of physicians and must include 24-hour-a-day nursing service by registered nurses. Facilities that are primarily for rest, the aged or convalescence homes are not considered hospitals and neither are facilities operated by the state or federal government.

Illness means a physical illness or mental illness. Physical illness is a disease or bodily disorder. Mental illness is an Axis 1 diagnosis listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, except those specifically excluded in the ***“General Exclusions” subsection in the “Benefit Exclusions” section.***

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

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

In-Network means only the covered services that you receive from participating providers.

Insurance Division means the Insurance Division of the Oregon Department of Consumer and Business Services.

Legal claim means any claim, suit, action, or proceeding between Agency (or any other agency or department of the State of Oregon) and Contractor that arises from or relates to the Contract.

Lifetime maximum means the maximum amount PacificSource will pay for covered expenses incurred by any one person while the person is covered by a PacificSource insurance policy issued to the employer sponsoring this group health benefit plan.

Maternity means, in any one pregnancy, all prenatal services including complications and miscarriage, delivery, postnatal services provided within six months of delivery, and routine nursery care of a newborn child.

Maximum out-of-pocket means the maximum amount you will incur in a calendar year before the plan begins paying at 100% for eligible medical expenses.

Medical emergency means a sudden and unexpected illness or injury, which requires immediate attention.

Medically necessary or **medical necessity** means health care services or supplies that a health care provider, exercising prudent clinical judgment, would provide to you for the purpose of preventing, evaluating, diagnosing, or treating an illness, or injury, disease, or its symptoms, and that are:

- Consistent with the symptoms or diagnosis and treatment of the condition;
- In accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury, or disease;
- not primarily for the convenience of you, your physician, or other health care provider; and
- not more costly than an alternative service or sequence of services, or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury, or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of health care providers practicing in relevant clinical areas, and any other relevant factors.

All treatment is subject to review for medical necessity. Review of treatment may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these.

Member handbook means the document provided to Members which contains the Summary of Benefits and describes the terms and conditions of coverage under a Benefit Plan.

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

Obesity means a condition in which a person has a body mass index of at least 30.0 kg/m² but less than 40.0 kg/m².

Out-of-network means covered services that you receive from providers that have **NO** contract with us to serve the Healthy KidsConnect Program.

Participant means an individual who is an eligible to participate in a Benefit Plan pursuant to Department of Human Services Administrative Rules, also referred to as a Member.

Participating pharmacy means a pharmacy that has a contract with us to submit claims electronically and discount all prescription medications.

Participating provider means a provider that has a contract with us to serve the Healthy KidsConnect Program.

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

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

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

Pharmacist means an individual licensed to dispense prescription medication and counsel a patient about how the medication works and its possible adverse effects.

Pharmacy means any licensed outlet in which prescription medications are regularly compounded and dispensed.

Plan means our Healthy KidsConnect **Medical Benefits Plan, Dental Benefits Plan, Vision Benefits Plan**, and administrative procedures (such as procedures for claims submission, grievances, appeals, external review, and third party liability), all as described in our member handbook.

Post Stabilization Services means Covered Services related to an Emergency Medical Condition that are provided after a Member is Stabilized in order to maintain the Stabilized condition or that are provided under the circumstances to improve or resolve the Member's condition.

Managed Care Plan B means the Healthy KidsConnect Managed Care Plan.

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

Preauthorization means a determination by us prior to provision of services that we will provide reimbursement for the services. Preauthorization does not include referral approval for evaluation and management services between providers.

Prescription medication means medications and biologicals that relate directly to the treatment of an illness or injury and that can legally be dispensed only with a prescription order. By law, they must bear the legend: "Caution – federal law prohibits dispensing without prescription." For purposes of the outpatient prescription medication benefit, prescription medications also include covered insulin and diabetic supplies, self-injectable medications, and compound medications. We require a prescription order for insulin and diabetic supplies.

Prescription order means a written prescription or oral request for prescription medications issued by a professional provider who is licensed to prescribe medications.

Professional provider means any of the following, for medically necessary services, which are within the scope of the professional provider's state license or registry:

- A **physician** (doctor of medicine or osteopathy);
- **podiatrist**;
- **dentist** (doctor of medical dentistry, doctor of dental surgery, or denturist);
- **pharmacist**;
- **psychologist**;
- **Oregon-registered clinical social worker**;
- **certified nurse practitioner**;
- **registered nurse** or **licensed practical nurse**, but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill a patient;
- **physician assistant**; or
- **registered physical, occupational, speech, or audiological therapist**.

The term "**professional provider**" does not include any other class of provider not named previously, and no medical benefit of the plan will be paid for their services. For certain providers, coverage may exist under the **Dental Benefits** or **Vision Benefits** of the plan.

Prophylaxis is a cleaning and polishing of all teeth.

Provider or **health care provider** means a professional provider, or a facility, agency, supplier or program that provides health care services or supplies.

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

Reconstructive means services, procedures, and surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

Residential/partial hospitalization/day care means care in a residential facility, hospital or other facility which provides an organized full-day or part-day program of treatment and is licensed or approved for the particular level of care for which reimbursement is being sought by the Oregon Office of Alcohol and Drug Abuse Programs or by the Oregon Mental Health Division (or the equivalent agencies, if the services are provided outside Oregon).

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

Routine costs of care means medically necessary conventional, items or services covered by the health benefit plan if typically provided absent a clinical trial. Routine costs of care do not include:

- The drug, device, or service being tested in the clinical trial unless the drug, device, or service would be covered for that indication by the policy if provided outside of a clinical trial;

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

Self-injectable medications means outpatient injectable prescription medications intended for self-administration and approved by us for self-injection.

Services means health care diagnosis, treatments, procedures, equipment, medications, or devices. Services include supplies to support a service.

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

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

Spell of illness means the duration of a particular illness that lasts for a period of consecutive days beginning with the first day not part of a previous illness on which you are admitted to a hospital, and ending at the close of the first 60-day period thereafter during which you have neither been a hospital inpatient nor been confined in any other type of facility.

Stabilize means that no material deterioration of the Emergency Medical Condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

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

Summary of Benefits means the front portion of the Members Handbook which summarizes the coverage under a Benefit Plan.

Supplies mean consumable goods to support health care services.

Surgical procedure means any of the following listed operative procedures:

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

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

Transplant means a procedure or a series of procedures by which an organ or tissue is either: removed from the body of one person (called a donor) and implanted in the body of another person (called a recipient), or removed from and replaced in the same person's body (called a self-donor). In treatment of cancer, the term transplant includes any chemotherapy and related course of treatment, which the transplant supports.

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

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

Usual and customary or reasonable charge means:

- Usual — not more than the provider's, dispenser's or vendor's usual charge for a given service or supply; and
- Customary — an amount which falls within the range of usual charges for the service or supply billed by most professional providers, dispensers or vendors of the same or similar service or supply in the service area; or
- Reasonable — an amount, determined by us, according to our proprietary database on health care billings; or use of pharmacy or Medicare data, which is usual (not more than the provider's normal charge) and customary (falls within the range of average charges for a service or supply billed by most providers or vendors for the same or similar service or supply in the service area).

In areas where our members have reasonable geographic access to a participating provider, the allowable fee for professional services is based on our standard participating provider reimbursement rate or a contracted reimbursement rate. In areas where our members do not have reasonable access to a participating provider where they reside, the allowable fee is based on the usual, customary, and reasonable charge (UCR) at the 85th percentile for medical and based on the Advantage Dental maximum allowance for dental. 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.

We, us, or our, refers to your Healthy KidsConnect insurance company.

When coverage begins means:

- The first of the month after we have received your completed enrollment materials from the Healthy KidsConnect Program.
- From birth or placement for adoption, in the case of a newborn or adoptee enrolled in accordance with the requirements of the Healthy KidsConnect Program.

When coverage ends is when you have:

- Become age 19 (see Individual Portability Policy section for information on other options).
- Become eligible or entitled to Medicare.
- Become eligible for Medicaid/Oregon Health Plan (OHP).
- Not paid your premiums.
- Moved out of the State of Oregon.
- Otherwise fail to satisfy the eligibility requirements of the Healthy KidsConnect Program.

You or your means the person enrolled in Healthy KidsConnect.

USING THE PROVIDER NETWORK

This section explains how your policy'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 financial responsibility for the charges you incur.

Healthy KidsConnect and PacificSource are not liable for quality of medical care. Members have the sole right to choose their physician or hospital. All healthcare providers are independent contractors. PacificSource cannot be held liable for any claim or damages for injuries you experience while receiving medical services or supplies.

YOUR PRIMARY CARE PRACTITIONER

A primary care practitioner (PCP) is a participating family practitioner, pediatrician, internist, nurse practitioner, or women's care specialist for your plan who you choose to be responsible for your medical care. Your PCP is responsible for providing preventive care services, treating your illnesses, and coordinating all your medical care including specialist services, hospital services, and urgent medical needs.

When enrolling in this plan, you must each select a PCP from the plan's provider directory. Your family members may each choose a different PCP, or share the same one. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from this plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Your PCP is extremely important since the PCP will be the first person you call when you need medical care. The PCP assumes primary responsibility for medical care, requests referral for more specialized services when needed, and maintains your medical records. If your PCP is unavailable when you call, ask for the physician on call for your PCP.

Once you have chosen a PCP, you may want to phone the practitioner's office and introduce yourself as a new PacificSource patient. When you call, you may arrange for your medical records to be transferred and find out how to contact your PCP after hours.

Changing PCPs

You may change your PCP by contacting PacificSource Customer Service

PacificSource Customer Service:

Phone (541) 684-5582 or (888) 977-9299

E-mail cs@pacificsource.com

The PCP change will be effective on the first of the month after we receive your request. Please note that when you change your PCP, all current specialist referrals from your former PCP become invalid and you need to request new referrals from your new PCP.

REFERRALS

When you and your PCP decide that services of a specialist are necessary, your PCP will request a referral on your behalf. Your PCP will contact the appropriate referral management coordinator and request that you be referred to a participating specialist. If the referral is approved, you may see the specialist designated on the referral authorization. The referral authorization will specify which services may be performed by the specialist, such as consultations, tests, or surgery.

Services that Do Not Require a Referral

Referral authorization is not required for the following types of treatment:

- **Women's routine gynecological exams.** You may visit your PCP or any participating women's healthcare provider without a referral for annual preventive gynecological exams.
- **Obstetric care and delivery.** You do not need a referral to access maternity and delivery care from a participating women's healthcare provider. Women's healthcare providers include obstetricians, gynecologists, physician assistants specializing in women's health, and certified nurse midwives.
- **Mental health and chemical dependency outpatient services.** You do not need a referral for office visits to a participating mental health or chemical dependency provider.

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. Those amounts can include a copayment or coinsurance payment.

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

Risk-sharing Arrangements. Your Healthy KidsConnect health plan administered by PacificSource may include “risk-sharing” arrangements with physicians and other providers. A participating provider contracts with PacificSource to furnish medical services and supplies to members enrolled in health benefit plans for a set fee. That fee is called the contracted reimbursement rate. By agreement, a participating provider may not bill a member for any amount in excess of the contracted reimbursement rate. However, the agreement does not prohibit the provider from collecting copayments, coinsurance, and non-covered services from the member. And, if PacificSource was to become insolvent, a participating provider agrees to continue to provide covered services to a member for the duration of the period for which premium was paid to PacificSource on behalf of the member. Again, the participating provider may only collect applicable copayments, coinsurance, and amounts for non-covered services from the member.

Nonparticipating Providers. Services or supplies from a nonparticipating provider are not covered except in true medical emergencies or when the nonparticipating provider has received preauthorization from PacificSource. In these circumstances, you will be responsible for copayment, and coinsurance amounts shown on the Summary of Benefits.

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.

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 Prime plans.
- On the PacificSource Web site, PacificSource.com. Simply click on “Provider Directory” and you can easily look up participating providers on the Prime PSN network 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.

Termination of Provider Contracts.

PacificSource will notify you if you have received services in the previous three months from a provider whose contractual relationship with PacificSource has terminated in accordance with the terms and conditions of the agreement with the individual provider or provider organization.

ELIGIBILITY

Definitions

Child(ren) means an uninsured child(ren) ages 0 through 18 who are legal residents of Oregon.

FPL means the Federal Poverty Level which is determined by the federal government each year.

Member means a Child enrolled in a Healthy KidsConnect benefit plan. Contractors may also refer to members as “enrollees” or “participants”.

Eligibility Criteria

Children in families with incomes over 300 percent FPL who do not have access to a qualified employer-sponsored insurance plan are eligible to enroll in this plan.

- Premiums are on a sliding scale based on income — families over 300 percent FPL will pay the entire premium. Third party providers with opportunity for financial gain from a child's enrollment may not pay premiums on behalf of the child.
- Any children (as defined above) will be eligible for the Plan. This may include newly adopted children and dependents of enrolled children.
- Children in families over 300 percent FPL are eligible to enroll the first day of the open enrollment month (April or October) following the date PacificSource receives your completed enrollment from Healthy KidsConnect.
- Children must be without insurance for two months to be eligible, unless they qualify for one on the following exceptions to the period of uninsurance including:
 - The Child has a condition that without treatment would be life-threatening or cause permanent loss of function or disability;
 - The Child's private health insurance premium was reimbursed under the policy for reimbursement of cost-effect Employer Sponsored Health Insurance;
 - The Child's insurance premium was subsidized by FHIAP;
 - A member of the filing group was a victim of domestic violence; or
 - The Child lost coverage due to the loss of employment of a parent.
- Children are eligible for one year, and may continue to be enrolled as long as they remain eligible for Healthy Kids.

Enrollment After the Initial Eligibility Period

If you lose coverage due to not paying your premiums or not otherwise satisfying the eligibility requirements of the Healthy KidsConnect Program, you will be subject to a waiting period as follows:

- Children in families over 300 percent FPL must wait six months from date of loss of coverage and then will be eligible to re-enroll at the following open enrollment period (April or October).

Individual Portability Policy

When coverage under this policy ends, you may be able to purchase an individual portability policy. If you are eligible, you may purchase the policy when you lose coverage under this plan. 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.
- 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 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 the terms of the plan. Also remember that just because a service or supply is a covered benefit under this plan does not necessarily mean all billed charges will be paid.

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

Questions Regarding Benefits and Coverage

This plan contains information about the benefits specific to the Healthy KidsConnect plans. Please be sure to read carefully for the terms, conditions, provisions, limitations, and exclusions of this plan.

NO LIFETIME MAXIMUM BENEFIT

This plan has no maximum lifetime medical benefit.

DEDUCTIBLE AND MAXIMUM OUT-OF-POCKET EXPENSES

Medical Deductible

This plan has a \$1,000 per person annual calendar year medical deductible.

Your Maximum Out-Of-Pocket Expense

This plan has a separate maximum **out-of-pocket expense** for you and your covered family, each calendar year for medical and dental. The maximum out-of-pocket expense is the maximum set amount that you will incur in a calendar year, beginning in January, before we begin paying a 100% for in-network covered expenses for that type of service. You will continue to be responsible for pharmacy copayments or coinsurance after the medical maximum out-of-pocket expense has been met.

- Medical Maximum Out-of-Pocket \$6,000 per person
- Pharmacy Maximum Out-of-Pocket None
- Dental Maximum Out-of-Pocket \$200 per person or \$400 per family

You are responsible for the coinsurance or copayment amount for each covered medical service listed in the following **Summary of Benefits** until your medical out-of-pocket covered expenses reach your maximum out-of-pocket expense amount. The maximum out-of-pocket medical amount accumulates based your own covered expenses.

Payment for covered expense is subject to all conditions and limitations of this policy including stated dollar limits on specific services or supplies and the maximum lifetime benefit.

There is **no** maximum out-of-pocket for medical, pharmacy, or dental on your out-of-network services. Out-of-network expenses do not count towards your maximum out-of-pocket total.

Other services which **do not** accumulate toward the maximum out-of-pocket:

- Women's preventive services
- Men's preventive services
- Routine physical examinations
- Colorectal cancer screenings and exams
- Immunizations
- PKU test
- Well-baby/well-child care
- Transplant facilities
- Outpatient diabetic instruction
- Ambulance services
- Alternative services
- Emergency room, unless you are admitted to the hospital
- Other benefits paid in full
- Disallowed charges

SUMMARY OF BENEFITS

To receive benefits, you must be enrolled with us for PPO Plan A. Listed below are your medical benefits, exclusions that apply to specific benefits, coinsurance and copayment amounts, and out-of-pocket expenses. **American Indian / Alaskan Native children above the 300% FPL are not eligible for HKC subsidy and are responsible for copayments and premiums.**

You must select a **primary care practitioner (PCP)** from the PacificSource Prime provider directory to be responsible for your continuing medical care. The PCP will coordinate use of healthcare resources to best meet your healthcare needs.

Services are covered only when obtained from in-network providers except in emergencies or when the plan provides an out-of-network preauthorization. In these circumstances, the normal copayment would apply.

Alternative Services in-network 20% after deductible / out-of-network—not covered

Acupuncture therapy, care received from chiropractors, and/or naturopathic care may be approved for services within the scope of the provider's license, subject to referral by primary care physician. Eligible providers of acupuncture are doctors of medicine or osteopathy or registered acupuncturists. *The coinsurance you pay **DOES NOT** apply towards the medical maximum out-of-pocket expense.*

Exclusions: Nutritional supplements are not covered. Diagnoses, which are considered plan exclusions such as obesity, smoking cessation, are ineligible for coverage.

Ambulance Services in-network 20% after deductible / out-of-network 20% after deductible

State certified ambulance is covered 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 covered up to \$6,000 per calendar year, but only when ground transportation is medically or physically inappropriate.

Biofeedback Therapy in-network 20% after deductible / out-of-network—not covered

This plan covers biofeedback to treat migraine headaches or urinary incontinence when provided by an otherwise eligible practitioner. Benefits are limited to a lifetime maximum of ten sessions. Covered expenses for biofeedback therapy services are limited to treatment of tension or migraine headaches.

Chemotherapy in-network 20% after deductible / out-of-network—not covered

Covered expenses include radium, radio isotopic, and X-ray therapy; prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells; treatment planning and simulation; professional services for administration and supervision; and treatments including the therapist, facility, and equipment charges.

Contraceptive Devices in-network 20% after deductible / out-of-network—not covered

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.

Durable Medical Equipment in-network 20% after deductible / out-of-network—not covered

We cover the following medically necessary supplies and appliances when required by standard treatment practices for the treatment of an illness or injury:

- Blood or blood plasma
- Casts, trusses, limb or back braces, and crutches
- Ostomy supplies
- Mastectomy supplies
- Medically necessary PKU formulas
- Nonprescription elemental enteral formula for home use when ordered by your authorized physician as long as:
 - The formula is medically necessary for the treatment of severe intestinal malabsorption; and the formula comprises the sole or an essential source of your nutrition.
- Nutritional supplies and medical assessment equipment necessary to diagnose, monitor and control disorders of inborn metabolic disorders
- One contact lens for each eye undergoing cataract surgery
- Prosthetics, artificial limbs, artificial eyes and orthotic devices
- Maxillofacial prosthetic devices that are medically necessary for the restoration and management of head and facial structures that cannot be replaced by living tissue, are defective due to disease, trauma, or developmental deformity to control or eliminate infection and pain and restore facial configuration and function
- Rental (not to exceed the reasonable purchase price if the item can be purchased) of a wheelchair, hospital-type bed, oxygen, or other durable medical equipment unique to medical care or treatment

Covered durable medical equipment must be medically necessary and may not serve solely as a comfort or convenience item. The following items are not durable medical equipment and, therefore, are not covered: deluxe equipment with mechanical or electrical features such as motor-driven wheelchairs and chair lifts; environmental controls or environmental enhancements such as air conditioners, humidifiers, air filters, and portable whirlpool pumps.

We pay covered benefits at the usual and customary and reasonable charges.

Emergency Room Services in-network 20% after deductible / out-of-network 20% after deductible

If you receive services for an emergency medical condition, you are responsible for the emergency room copayment. If you are admitted as an inpatient to the hospital while seeking emergency room services the copayment may be waived.

We will cover emergency services from a nonparticipating provider if a prudent layperson possessing an average knowledge of health and medicine, would reasonably believe that the time required to go to an participating provider would place your health, or the health of your fetus, in the case of a pregnant woman, in serious jeopardy.

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.

Home or Office Visits in-network 20% after deductible / out-of-network—not covered

A visit means that a professional provider actually examined you. Covered expenses include physician consultations in addition to second opinion surgery consultations.

Home Health Care in-network 20% after deductible / out-of-network—not covered

We cover up to 60 intermittent medically necessary home health care visits per calendar year. A visit must be for intermittent care of no more than two hours in duration. A physician must order the home health care services. Providers who deliver home health care must be registered or licensed practical nurses; physical, occupational, speech, or respiratory therapists; or licensed social workers.

Homebound means that your condition is such that there exists a normal inability to leave home. If you do leave home, the absences must be infrequent, or short duration and mainly for the reason of receiving medical services.

This home health care benefit excludes home care services provided as part of a hospice treatment plan.

- **Maximum visits.** There is a two-visit maximum allowed in any one day for the services of a registered or licensed practical nurse. The maximum visits allowed for each other classification of home health care provider is one visit per day.
- **Preauthorization.** If an agency other than a contracting agency provides the home health care, contact the case management department before receiving such care.

Covered expenses for home health care exclude:

- More than one visit of any one kind of rehabilitation on any one day;
- rehabilitative care provided in your home and covered under the inpatient or outpatient rehabilitation care benefit;
- recreational or educational therapy;
- self-help or training;
- home health aide; or

- treatment of psychotic or psychoneurotic conditions.

Home Infusion Therapy in-network 20% after deductible / out-of-network—not covered

We cover home infusion therapy services and supplies as described in this section that a physician orders and determines to be medically necessary, that an accredited home infusion therapy agency provides and that the therapy regimen requires.

Limited services. Home infusion therapy is limited to the following:

- Aerosolized pentamidine;
- blood product administration;
- enteral nutrition (under certain circumstances);
- hydration therapy;
- intravenous medication therapy;
- intravenous/subcutaneous pain management;
- SynchroMed pump management therapy;
- terbutaline infusion therapy; or
- total parenteral nutrition.

Covered expenses include only the following medically necessary services and supplies:

- Ancillary medical supplies;
- collection, analysis, and reporting of the results of laboratory testing services required to monitor response to therapy;
- durable medical equipment;
- nursing services associated with:
 - administrative therapy;
 - emergency care;
 - patient and/or alternative care giver training;
 - visits necessary to monitor intravenous therapy regimen.
- pharmacy compounding and dispensing services; and
- solutions, medications, and pharmaceutical additives.

If an agency other than a contracting agency provides the home infusion therapy, ask your physician to contact our case management department before receiving such care.

Nutritional Counseling..... in-network 20% after deductible / out-of-network—not covered

This plan covers intensive 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, for management of anorexia nervosa or bulimia nervosa (to a lifetime maximum of five visits), or for obesity (up to 12 visits). Pharmacological treatments are not covered.

Hospice Care Benefits in-network 20% after deductible / out-of-network—not covered

The following definitions apply only to this hospice care section:

- Approved hospice is a private or public hospice agency or organization approved by Medicare or accredited by the Joint Commission on Accreditation of Hospitals.
- Home health aide is an employee of an approved hospice who provides intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist.
- Hospice treatment plan is a written plan of care established and periodically reviewed by your attending physician. The physician must certify in the plan that you are terminally ill. The plan must describe the services and supplies for medically necessary or palliative care to be provided by the approved hospice.
- Palliative care is care primarily for the relief or control of distressing symptoms, not cure.
- Terminally ill means your condition has reached a point where recovery can no longer be expected and you are facing imminent death.

See Palliative Hospice Care section below.

Palliative Hospice Care in-network 20% after deductible / out-of-network—not covered

We cover palliative hospice care as described in this section when provided by a Medicare or state-certified hospice care provider. A hospice care program is a coordinated program for home and inpatient care, available 24 hours a day. It uses an interdisciplinary team of personnel to provide palliative and supportive services to a patient-family unit experiencing a life threatening disease with a limited prognosis. The services include acute, respite, and home care to meet the physical, psychological, and special needs of a patient-family unit during the final stages of illness and dying.

Palliative hospice care means medical services provided by a hospice care program that alleviates symptoms or affords temporary relief of pain but are not intended to affect a cure. If you elect palliative hospice care, then you are not eligible for any other benefits for active treatment of the terminal illness.

In order to qualify for palliative hospice care, your physician must certify that you are terminally ill with a life expectancy of six months or less if the illness runs its normal course.

■ Palliative hospice care benefits are limited to the following levels of care:

- Routine home care;
- continuous home care;
- inpatient respite care; and
- inpatient hospice care.

Additionally, covered expenses for palliative hospice care include the following when provided under any of the levels of care listed on the previous section:

- Durable medical equipment;
- medications, including infusion therapy;
- care by any enrollee of the hospice interdisciplinary team; and
- any other supplies required for the palliative hospice care.

If you elect to discontinue palliative hospice care before this benefit has been exhausted, you will forfeit any remaining hospice benefit and we will not be obligated to pay for any additional palliative hospice care for you.

Palliative Hospice Care Preauthorization

If an agency other than a contracting agency provides palliative hospice care, you must contact our case management department before receiving such care. If palliative hospice care is provided by a provider that has not contracted with us, we strongly urge you to ask your provider to contact our Preauthorization Department before receiving such care to avoid a denial or reduction of benefits due to lack of medical necessity.

Hospital Care

We pay for services provided in a hospital. A physician must authorize hospitalization and it must be medically necessary for acute care and services for illness or injury. All clinical decisions regarding length of stay in a health care facility, transfer between levels of care and follow-up care are the decision of the treating physician in consultation with you and subject to medical necessity as defined by us. The benefits are explained on the following page.

Covered expenses consist of the following:

- The charge for a semiprivate room or billed charges, whichever is less, up to the hospital's most common rate for a room with two beds.
- Isolation care when medically necessary to protect other patients from contagion or to protect you from contracting the illnesses of others.
- Use of an intensive care or coronary care unit. We establish our definition of an intensive care or coronary care unit by using the criteria of the Joint Commission on Accreditation of Hospitals as a guide, but we reserve the right to decide whether the unit in a particular hospital is qualified for coverage.
- The use of the facility for surgery performed in a hospital outpatient department.

- Other hospital services and supplies that are necessary for diagnosis and treatment, and that the hospital ordinarily furnishes. These include, but are not limited to, operating and recovery rooms, traction equipment, and special diets.
- Covered services provided in a participating hospital.
- Inpatient mental health and chemical dependency services.

Number Of Inpatient Hospital Days Covered

We will provide benefits for unlimited days of hospital inpatient care for most conditions. Inpatient services for some conditions may be limited to a lesser number of days. If benefits under this plan change while you are in the hospital, we will determine what the covered expenses are according to the benefits in effect when the stay began. The same rule applies to stays in other kinds of medical facilities.

Pre-Admission Testing in-network 20% after deductible / out-of-network—not covered

We cover expenses for necessary pre-admission testing.

Hospital Inpatient Care in-network 20% after deductible / out-of-network—not covered

We cover hospital inpatient care, including intensive care and coronary care; and inpatient care for mental illness or chemical dependency. Unlimited number of days per stay.

Semiprivate Room..... in-network 20% after deductible / out-of-network—not covered

Hospital Outpatient Care in-network 20% after deductible / out-of-network—not covered

We pay for medically necessary hospital outpatient care, including, but not limited to:

Outpatient Surgery..... in-network 20% after deductible / out-of-network—not covered

Outpatient Rehabilitative Hospital Care..... in-network 20% after deductible / out-of-network—not covered

Maximum of 60 days per calendar year.

Emergency room in-network 20% after deductible / out-of-network 20% after deductible

Imaging and Invasive Diagnostic Services..... in-network 20% after deductible / out-of-network—not covered

We cover imaging services such as MRI and CT scans, and diagnostic procedures that require entry into the body cavity, such as angiograms and endoscopy when they are medically necessary.

X-ray/radium therapy, chemotherapy in-network 20% after deductible / out-of-network—not covered

Diagnostic X-ray and laboratory for accident, illness, and pre-admission testing

Imaging and invasive diagnostic

Inpatient Rehabilitation Hospital Care in-network 20% after deductible / out-of-network—not covered

We limit covered expenses for rehabilitative care to 60 days for each calendar year for inpatient care in a hospital that has a specialized department for providing such care and services. These benefits are available only as long as you require the full rehabilitative team approach and services on an inpatient basis. This plan covers up to 60 days each calendar year for rehabilitative services that a professional provider delivers to you when not confined in a hospital. Rehabilitative services are physical, occupational, or speech therapy, necessary to restore or improve lost function caused by illness or injury. In order for this plan to cover expenses for these services and therapies, it must be medically necessary and part of a written treatment plan that a licensed physician prescribes. Inpatient rehabilitative care must be preauthorized and be part of a licensed physician's formal written program to improve and restore lost function following illness or injury, and it must be consistent with the condition that is under treatment.

Mastectomy Services in-network 0% / out-of-network—not covered

The plan covers surgery, reconstruction, prosthesis, and treatment of physical complications of all stages of mastectomy. This benefit applies while enrolled in Healthy KidsConnect coverage regardless of whether or not you were covered by us at the time of any previous treatment.

If you received benefits in connection with a mastectomy following breast cancer and, in consultation with the attending physician, choose to have breast reconstruction while enrolled in the plan, we will provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas. Reconstruction benefits are subject to the same provisions as any other benefit provided under this plan (e.g., coinsurance and maximum out-of-pocket expenses). This benefit is limited to surgery related to breast reconstruction following a mastectomy necessary because of illness or injury.

Maternity Care, Professional in-network 20% after deductible / out-of-network—not covered

Pregnancy care, childbirth, and related conditions are covered for you.

Maternity Care, Facility in-network 20% after deductible / out-of-network—not covered

This plan complies with the Newborns' and Mothers' Health Protection Act of 1996. We will not limit benefits for the mother and her newborn's length of inpatient stay to less than 48 hours for a normal delivery and 96 hours for a cesarean section. However, the attending physician in consultation with the mother may decide on an early discharge. Such discharges do not need to be preauthorized.

Maxillofacial Prosthetic Services in-network 20% after deductible / out-of-network—not covered

We will cover services considered necessary for adjunctive treatment for restoration and management of head and facial structures and that cannot be replaced with living tissue and that are defective because of disease, trauma or birth, and developmental deformities when such restoration and management are performed for the purpose of:

- Controlling or eliminating infection;

- controlling or eliminating pain; or
- resorting facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.

Mental Health/Chemical Dependency Care in-network 20% after deductible / out-of-network—not covered

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.

Mental Health and Chemical Dependency Defined

Mental or nervous conditions health means all disorders listed in the “Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition” except for: Mental Retardation (diagnostic codes 317, 318.0, 318.1, 318.2, 319); Learning Disorders (diagnostic codes 315.00, 315.1, 315.2, 315.9) Paraphilias (diagnostic codes 302.4, 302.81, 302.89, 302.2, 302.83, 302.84, 302.82, 302.9); Gender Identity Disorders in Adults (diagnostic codes 302.85, 302.6, 302.9 - this exception does not extend to children and adolescents 18 years of age or younger); and “V” codes (diagnostic codes V15.81 through V71.09 – this exception does not extend to children five years of age or younger for diagnostic codes V61.20, V61.21, and V62.82).

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

Providers Eligible for Reimbursement

Eligible providers of mental health and chemical dependency services are persons or facility that meet the credentialing requirements of PacificSource, if credentialing is required, is otherwise eligible to receive reimbursement under the policy and is either a healthcare facility, a residential program or facility, a day or partial hospitalization program, an outpatient services, or an individual behavioral health or medical professional authorized for reimbursement under Oregon law.

Eligible providers are:

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

Preauthorization and Review Requirements

- All mental health and chemical dependency treatment is subject to review for medical necessity and/or appropriateness. Preauthorization by PacificSource is required for treatment in inpatient and residential settings. Outpatient treatment is subject to review for medical necessity. Review of treatment may involve concurrent review of the continuation of treatment, post-treatment review, or a combination of these. Benefits for long-term residential mental health programs exceeding 45 days of treatment per calendar year will not be authorized.
- Treatment in inpatient, residential settings requires preauthorization by PacificSource.
- Coverage of all inpatient and residential treatment requires preauthorization by PacificSource. Additional review may involve concurrent review of the continuation of treatment, post-treatment review, or a combination of these. Only emergency admissions are covered without prior approval, and then PacificSource must be notified within two business days.
- Medication management by an M.D. (such as a psychiatrist) does not require review.

Newborn Nursery Carein-network 20% after deductible / out-of-network—not covered

We cover routine nursery care of an enrolled newborn infant while the mother is confined in the hospital and receiving maternity benefits under this plan. However, we cover professional services for well-baby care under the well-baby care benefit. This plan does not provide coverage for pediatric standby charges for vaginal delivery. Please Note: We cover an ill or injured newborn under the other medical provisions of this plan.

Outpatient Diabetic Self-Management... in-network 20% after deductible / out-of-network—not covered

This plan covers services and supplies used in outpatient diabetic self-management programs when they are provided by a health care professional or by a credentialed or accredited diabetic education program for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes. For the purposes of this benefit, a health care professional means a licensed physician, registered nurse, nurse practitioner, certified diabetes educator, or licensed dietician with demonstrated expertise in diabetes.

We will pay for one outpatient diabetic self-management program of assessment and training after diagnosis, including up to three hours per year of assessment and training when there is a material change of condition. Diabetic medication and supplies that are not included in the charge for the outpatient diabetic self-management program are covered under the prescription medication benefit under this plan. Diabetic insulin and supplies are covered under the prescription medication benefit.

Outpatient Rehabilitation in-network 20% after deductible / out-of-network—not covered

This plan covers up to 60 visits each calendar year for all outpatient rehabilitative services that a professional provider delivers to a patient who is not confined in a hospital. Rehabilitative services are physical, occupational, or speech therapy services necessary to restore or improve lost function caused by illness or injury. In order for us to cover the therapy, it must be part of a written plan of treatment that a physician prescribes.

Expenses exclude the following: more than one session of any one kind of rehabilitation on any one day; rehabilitative care provided in your home are covered under the home health care benefit; recreational or educational therapy; self-help or training; or treatment of psychotic or psychoneurotic conditions.

Maximum of 60 visits per calendar year for all rehabilitative care combined.

Preventive Care Services in-network 0% / out-of-network—not covered

Adult Routine Physical Examinations

We cover the following physical examinations and related laboratory tests and X-ray examinations (as long as a third party is not liable for these charges) for adults age 18: Routine periodic health appraisals, routine physical examinations, and physical examinations required for school and/or to participate in athletics. Handling fees are not covered.

- Age 18 – Once

Colorectal Screenings

We cover the following services for colorectal cancer screening for any individual at high risk:

- one fecal occult blood test each calendar year;
- one flexible sigmoidoscopy every five years;
- one colonoscopy every ten years; or
- one double contrast barium enema every five years.

Those that are at high risk for colorectal cancer for the purpose of this plan are:

- Individuals who have a family history of colorectal cancer; or
- a prior occurrence of cancer or precursor neoplastic; polyps; or a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, chronic disease, or ulcerative colitis.

Men's Preventive Services

We will provide coverage for prostate cancer screening examinations including a digital rectal examination and a prostate-specific antigen test (PSA) for males.

PKU Testing

We cover one PKU test to detect the presence of Phenylketonuria (PKU).

If the test detects the presence of PKU, we cover the formulas determined to be medically necessary for the treatment of PKU. *We cover necessary formulas for treatment under the supplies, appliances, and durable medical equipment section of this plan.*

Well-Baby Care

Well-baby care covers physical examinations provided by a professional provider, including the standard in-hospital examination at birth, diagnostic X-rays, and laboratory services for an enrolled baby up to age 36 months.

Well-Child Care

We cover physical examinations and any related laboratory tests and X-ray examinations for you as often up to the following amounts:

Children

Age 3-18 years, one examination every calendar year.

Immunizations

We cover immunizations recommended by the Centers for Disease Control and Prevention, American Academy of Pediatrics, American Academy of Family Physicians, or a similar standard-setting body for you through age 18. Covered expenses do not include immunizations for more elective, investigative, unproven, or discretionary reasons such as the sole purpose of travel, occupation, or residence in a foreign country.

Women's Preventive Services

We cover women's breast, pelvic, and Pap smear examinations once every calendar year. However, we cover more frequent examinations if they are medically necessary and the woman's health care provider recommends them. By breast examination, we mean a complete and thorough exam of the breast for women age 18, including but not limited to a clinical breast examination, performed by a health care provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer. Any medically necessary follow up exams will be covered according to the general medical benefits of this plan and subject to any coinsurance. We cover any covered expenses for laboratory, X-ray procedures, or mammography that accompany the examination according to the diagnostic X-rays and laboratory services.

Any plan copayment stated on your Member Benefit Summary are waived for the following preventive care services when provided by a participating provider:

- Services that have a rating of "A" or "B" from the U.S. Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- Preventive care and screening for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA);
- Preventive care and screening for women supported by the HRSA that are not included in the USPSTF recommendations.

Links to the lists of recommended preventive care and screenings from the USPSTF, CDC, and HRSA can be found on the PacificSource Web site, PacificSource.com. Current USPSTF recommendations include the September 2002 recommendations regarding breast cancer screening, mammography, and prevention, not the November 2009 recommendations.

Professional Provider Services in-network 20% after deductible / out-of-network—not covered

Care received from certain professional providers must meet specific criteria as described below.

Dentist (doctor of medical dentistry or doctor of dental surgery). This medical benefit covers treatment of accidental injury to natural teeth or fractured jaw rendered within 12 months after the injury, or for surgery that does not involve repair, removal or replacement of teeth, gums or supporting tissue. The injury must be one that occurred while you were enrolled under this plan. You have additional dental coverage under the **Dental Benefits** portion of this plan.

Oregon-Registered Clinical Social Worker. This plan covers services rendered upon the written referral of a physician, a physician’s assistant, or psychologist.

RN or LPN. This plan covers services rendered upon the written referral of a physician if nurses customarily bill those services to patients.

Therapists. This plan covers services of registered physical, occupational, speech, or audiological therapists for rehabilitative services. We require that a physician write a referral for all but the physical therapist. Any medically necessary follow up exams will be covered according to the general medical benefits of this plan and subject to any copayment.

Professional Provider Visits in Hospitalin-network 20% after deductible / out-of-network—not covered

Covered expenses include professional provider visits to you during a covered hospital or skilled nursing facility stay. We do not cover separately, visits relating to surgery performed during a hospital stay because these visits are ordinarily included in the surgeon’s fee. Covered expenses also include physician consultations with written reports during each hospital stay. We do not cover staff consultations required by hospital rules. These benefits apply only if you are eligible for hospital or skilled nursing facility benefits. For hospital inpatient treatment of mental health/chemical dependency, covered expenses are limited to durational visit limits.

Routine Costs of Clinical Trials

Routine costs of clinical trials are covered (see “routine costs of care” in the Definitions section). Benefits are only provided for routine costs of care associated with qualifying clinical trials. Expenses for services or supplies that are not considered routine costs of care are not covered. PacificSource is not, based on the coverage provided, liable for any adverse effects of a clinical trial.

Skilled Nursing Facility Care in-network 20% after deductible / out-of-network—not covered

We cover care in a skilled nursing facility up to 60 days per spell of illness per calendar year. For benefits to renew after each stay, you must be discharged from the facility and 90-consecutive days must pass before readmission to a hospital or a skilled nursing facility. We limit payments for covered expenses to 80% of the participating provider contract rate or the daily service rate, up to the maximum amount we would pay if you were in a semiprivate hospital room. Your attending physician must give us proof of medical necessity, that we find acceptable, showing that you would require hospitalization if care in a skilled nursing facility were not possible.

Covered expenses exclude routine nursing care, non-medical self-help or training, personal hygiene or custodial care. Covered expenses exclude an admission to a skilled nursing facility that began before you enrolled in Healthy KidsConnect or for a stay where care is provided principally for:

- Mental deficiency or retardation; or
- mental illness.

Limited to 60 days per spell of illness per calendar year. Limited to semiprivate room plus medically necessary ancillary.

Smoking Cessation in-network 0% / out-of-network—not covered

Tobacco use cessation program services are covered 100% when provided by a PacificSource approved program. Coverage is limited to a maximum lifetime benefit of two quit attempts. Approved programs are limited to members age 15 or older. Benefits may be limited to a lifetime maximum value of \$500. Specific nicotine replacement therapy will only be covered according to the program’s description. If this policy includes benefits for prescription drugs, tobacco cessation related medication prescribed in conjunction with an approved tobacco cessation program will be covered to the same extent this policy covers other prescription medications.

Special Dental Care in-network 20% after deductible / out-of-network—not covered

We cover the treatment of accidental injury to natural teeth or a fractured jaw after you have paid any coinsurance. To qualify for coverage, you must receive the treatment from a physician or dentist while you are enrolled under this plan, and within 12 months after the injury except when completion is delayed due to healing time following medically necessary surgery.

For purposes of this special dental care benefit, injury does not include accidents that occur during eating, biting, or chewing. You have additional dental coverage under the *Dental Benefits* portion of this plan.

Special Facility Care in-network 20% after deductible / out-of-network—not covered

This plan includes care provided in a special facility. A special facility is an ambulatory surgical facility, surgical center, or birthing center. Covered expenses include use of the procedure room and other services and supplies that are medically necessary for treatment.

Audiology/Hearing Aid Services in-network 20% after deductible / out-of-network—not covered

This plan includes audiology and hearing aid services. The provision must be supported by a written order and a therapy treatment plan signed by the prescribing practitioner.

A written order is required for the initial evaluation. For therapy, must specify the ICD-9-CM diagnosis code, service, amount and duration required. Written orders must be submitted with the preauthorization request and a copy must be on file in the provider's therapy record. The written order and the treatment plan must be reviewed and signed by the prescribing practitioner every six months. Authorization of payment to an audiologist or hearing aid dealer for a hearing aid will be considered only after examination for ear pathology and written prescription for a hearing aid by an ear, nose, and throat specialist (ENT) or general practitioner who has training to examine the ear and performs within the scope of his/her practice, i.e. primary care physician (not appropriate is an orthopedic specialist, chiropractor, gynecologist, etc.). Cochlear implants are covered.

Surgery..... in-network 20% after deductible / out-of-network—not covered

This plan covers surgery (operative and cutting procedures), including treatment of fractures, dislocations and burns, and includes the services of the primary surgeon, assistant surgeon, the anesthesiologist or certified anesthesiologist. It also covers surgical supplies such as sutures and sterile setups when surgery is performed in the physician’s office. When more than one surgical procedure is performed through the same incision during a single operative session, we cover only the major procedure.

For bilateral procedures or procedures performed through different incisions in a single operative session, benefits will be applied as follows:

Surgical Procedure Eligible for Benefits Percent of Covered Expenses

First.....	100%
Second	50%
Third and subsequent.....	25%

We will review procedures individually beyond the third procedure for medical appropriateness. Whether or not we cover the procedure will depend on the outcome of that review.

Telemedical Health Services

This plan covers medically necessary telemedical health services for health services covered by this policy when provided in person by a healthcare professional when the telemedical health service does not duplicate or supplant a health service that is available to the patient in person. The location of the patient receiving telemedical health services may include, but is not limited to: hospital; rural health clinic; federally qualified health center; physician’s office; community mental health center; skilled nursing facility; renal dialysis center; or site where public health services are provided. Coverage of telemedical health services are subject to the same deductible, copayment, or coinsurance requirements that apply to comparable health services provided in person.

Temporomandibular Joint Services in-network 20% after deductible / out-of-network—not covered

Temporomandibular joint (TMJ) disorders are covered under the plan the same as for other injuries or musculoskeletal disorders up to a \$3,000 lifetime maximum. All diagnostic and surgical procedures for TMJ services require preauthorization.

Termination of Pregnancy in-network 20% after deductible / out-of-network—not covered

Therapeutic Injections in-network 20% after deductible / out-of-network—not covered

We cover therapeutic injections, such as allergy shots, when given in a professional provider’s office, except when comparable results can be obtained safely with home self-care or thorough oral use of a prescription medication. Therapeutic injection benefits apply only to administrative charges. Medicine charges for serum, vaccine, or mixture in connection with the therapeutic injection are not part of this benefit, but may be paid under the provisions of the plan, subject to any coinsurance. Vitamin and mineral injections are not covered unless medically necessary for treatment of a specific medical condition.

Transplants in-network 20% after deductible / out-of-network—not covered

Benefits for services and supplies (including medications) rendered in connection with a transplant, including pre-transplant procedures such as ventricular assist devices (VADs), organ or tissue harvesting (donor costs), postoperative care (including anti-rejection medication treatment) and transplant-related chemotherapy for cancer are limited as described here.

We will cover expenses for certain medically necessary and non-experimental transplantation procedures. Eligible transplants must be preauthorized through a case manager.

This plan only covers transplants of human body organs and tissues. Transplants of artificial or animal organs and tissues are not covered. Travel and housing expenses for the recipient and one caregiver are limited to \$5,000 per transplant.

X-rays And Laboratory Tests in-network 20% after deductible / out-of-network—not covered

Medically necessary diagnostic X-rays and laboratory tests are covered when a professional provider orders them. The X-rays for tests must be related to diagnosis or treatment of an illness or injury. This benefit includes services performed or provided by laboratories, radiology facilities, hospitals, and physicians (including services in conjunction with office visits).

DISEASE MANAGEMENT PROGRAM

If you have been diagnosed with select chronic disease condition(s), we can provide you with disease management programs. Those eligible for disease management are identified using a combination of methods, and referral, or you may self-enroll. The **chronic disease management program** addresses asthma, diabetes, high-risk maternity, and smoking cessation.

Our **rare disease management program** is available to members with one of fifteen chronic, but rare, diseases including cystic fibrosis, rheumatoid arthritis, multiple sclerosis, lupus, Parkinson's disease, and hemophilia. The program provides clinical support and specialized education around the member's disease/condition. The goal is to assure optimal care, decrease complications, and improve health outcomes.

Our **prenatal program** uses early prenatal education and intervention to reduce the severity and incidence of pre-term births and other pregnancy-related complications. Program components include a maternity specific Web site, educational resources, 24-hour toll-free phone access to nurse consultants, and prenatal care management, including health educators and coordination of care. Members receive educational materials and periodic phone calls from the nurse. Those identified as high-risk will be contacted more frequently.

PacificSource contracts with Caremark® **Specialty Pharmacy** to provide high cost, mostly injectable medications and biotech drugs to members. Through this program, members receive individual follow-up care and support by a patient care team that includes a clinical pharmacist; comprehensive disease specific education and counseling; and access to a 24-hour call in line for any questions around the medication and its administration. This program also allows PacificSource to have patient support by specialists, the very best contractual rates, and decrease waste for these very expensive medications.

PRESCRIPTION MEDICATION BENEFIT

USING THE PACIFICSOURCE PHARMACY PROGRAM

The CVS Caremark[®] pharmacy network includes about 98% of all retail 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 CVS Caremark[®] plan number on your PacificSource ID card at the participating pharmacy to receive your plan's highest benefit level. When obtaining prescription drugs at a participating CVS Caremark[®] retail pharmacy, the PacificSource pharmacy program can only be accessed through the pharmacy plan number printed on your PacificSource ID card. That plan number allows the pharmacy to collect the appropriate copay from you and bill PacificSource electronically for the balance.

When you use your PacificSource ID card at participating pharmacies, the pharmacy will charge you the lesser of your copay or the pharmacy's discounted drug cost plus service fee.

Mail order prescription service is also available through your plan for most prescription drugs. If you take a medication on a regular basis, mail order service is a convenient way to order prescriptions and have them delivered directly to your home. There is no shipping or handling charge for standard delivery. For more information, please visit the For Members area of our Web site, PacificSource.com

Prescription medication must be medically necessary and must be the result of a prescription order. Any balances over the maximum amount available under this prescription medication benefit are not eligible for payment under any other provision of the plan.

Our value drug list (VDL) shows the brand-name medications we cover. We also cover generic drugs for covered services. We will not exclude coverage of a prescription medication for a particular indication solely on the grounds that the indication has not been approved by the United States Food and Drug Administration, if the Oregon Health Resources Commission determines that the medication is recognized as effective for the treatment of that indication.

The chart below outlines your copayment costs for a 30-day supply:

Generics.....	\$5
Certain preventive care drugs.....	\$0
Preferred brands.....	50% or \$50, whichever is less
Non-preferred brand.....	Not covered*

**Non-preferred prescription drugs are not covered. Exceptions to this are only considered when all equivalent generic and preferred drugs have been tried unsuccessfully and certain criteria are met, as determined by PacificSource. In such cases, would be covered at the preferred brand copayment level.*

OTHER COVERED PHARMACEUTICALS

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

Contraceptives

- Oral contraceptives
- Depo Provera or Lunelle injections, Ortho Evra Transdermal Patch, NuvaRing Vaginal Contraceptive Ring, or Preven.
- Diaphragm or cervical caps are available.

Diabetic Supplies

- Insulin and diabetic syringes.
- Lancets and test strips.
- Glucagon recovery kits for your plan's Preferred Brand copay. You may purchase up to two kits at a time, but no more than four in any calendar year (unless 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 available for your Preferred brand copay. You may purchase up to two kits at one time, but no more than four kits in any calendar year (unless otherwise preauthorized).

Tobacco Cessation

Program specific tobacco cessation medications are covered with active participation in a plan approved tobacco cessation program.

Oral Chemotherapy Medications

Prescribed, orally administered anticancer medications are covered under your pharmacy benefit. If you prefer, you can have these medications covered under your medical plan's chemotherapy benefit instead. If you choose to use your medical benefits, these drugs would be subject to any deductibles, coinsurance, out-of-pocket limits, or pre-existing conditions that apply to your medical plan.

CAREMARK® SPECIALTY PHARMACY PROGRAM

Caremark® Specialty Pharmacy Services is your provider for many specialty and biotech drugs often used to treat chronic or genetic disorders. The program is designed to help PacificSource members with the following health conditions maximize the value of their health plan benefits:

Asthma	Hepatitis C	Pulmonary arterial hypertension
Crohn's disease	Hormonal therapies	Pulmonary disease
Enzyme replacement	Immune disorders	RSV prevention
Gaucher's disease	Multiple sclerosis	Rheumatoid arthritis
Growth hormone deficiency	Oncology	
Hematopoietics	Psoriasis	

A complete list of medications covered under this program is available on the For Members area of our Web site, PacificSource.com. If you are using a covered medication, you will be contacted and invited to participate in the program. The Caremark® Specialty Pharmacy Program offers:

- Personal attention from a pharmacist-led CareTeam that provides condition-specific education, medication administration instruction, and expert advice to help you manage your therapy
- Easy access to pharmacists and other health experts 24 hours a day, seven days a week
- Easy ordering with a dedicated toll-free number
- Confidential and convenient delivery of medications to the location of your choice

BENEFIT LIMITATIONS

There are limitations on the benefits available under this plan of certain conditions and services. These limitations are explained in the following paragraphs.

Breast Reconstruction

Limited to surgery following a mastectomy that was necessary due to illness or injury.

Growth Hormones

Growth hormones are generally not an expense eligible for benefits under this plan. Benefits will be provided for the treatment of the following conditions when the use of growth hormones meets our medical criteria and the treatment has been preauthorized for the following conditions:

- Growth hormone deficiency
- Failure in children secondary to chronic renal insufficiency prior to transplant, or for the promotion of wound healing in patients with severe, active burns while hospitalized.
- Turner's syndrome
- Prader-Willi syndrome
- Neonatal hypoglycemia associated with growth hormone deficiency

Home Health Care

- **Maximum visits.** There is a two-visit maximum allowed in any one day for the services of a registered or licensed practical nurse. The maximum visits allowed for each other classification of home health care provider is one visit per day.
- **Rehabilitative care.** This plan covers up to 60 days each calendar year for rehabilitative services that a professional provider delivers to a patient who is not confined in a hospital. Rehabilitative services are physical, occupational, speech, or respiratory therapy services necessary to restore or improve lost function caused by illness or injury. In order for us to cover the therapy, it must be part of a written plan of treatment that a physician prescribes. Home health care provided by a licensed social worker is paid according to the home health care benefit. This plan covers services rendered by an Oregon-registered clinical social worker upon the written referral of a physician or psychologist.

Home health care benefits exclude:

- More than one visit of any one kind of rehabilitation on one day;
- rehabilitative care provided in your home and covered under the home health care benefit;
- recreational or educational therapy;
- self-help or training; or
- treatment of psychotic or psychoneurotic conditions.

Outpatient Prescription Limitations

- **Maximum quantities.** The largest allowable quantity at one time for outpatient prescription medications purchased from a participating pharmacy, or mail order, is a 34-day supply. Your copayment is always based on each dispensing.
- **Refills.** This plan allows refills from a pharmacy after 75 percent of the supply from the previous prescription order is used. You are responsible for the full cost of any prescription medications that are denied at the participating pharmacy because you have refilled them “too soon.”
- **Medication dispensing limits.** There are certain prescription medications that have medication dispensing limits. Medication dispensing limits (MDL) means the quantity or dispensing frequency of a prescription medication that we determine is medically necessary before it is dispensed. MDL apply to prescription medications that are used to treat a limited number of conditions or that have limited durations of therapy. Any prescription medications with MDL that are purchased without MDL authorization are not covered under this prescription medication plan, even if purchased from a participating pharmacy. Participating providers, including participating pharmacies, are notified which prescription medications have MDL. Only providers prescribing medications or pharmacies filling medications can request MDL authorization. The participating pharmacy will let you know if MDL authorization is necessary for the medication.
- Specialty drug pharmacies specialize in distributing specialty drugs and providing pharmacy care management services to assist patients in effectively managing their condition. Benefits are available when the member uses participating specialty pharmacy. The specialty pharmacy program is not available through retail pharmacies, except under certain conditions if preauthorized by PacificSource. An up-to-date list of drugs that require preauthorization and/or are subject to pharmaceutical service restrictions is available on our website.
- Certain drugs require preauthorization by PacificSource in order to be covered. An up-to-date list of drugs requiring preauthorization is available on the For Members area of our Web site, PacificSource.com.
- Certain drugs are subject to step-therapy protocols. An up-to-date list of drugs requiring preauthorization is available on the For Members area of our Web site, PacificSource.com.
- Your share of the cost for prescription drugs does not apply to your medical plan’s out-of-pocket maximum. They do, however, apply to your pharmacy out-of-pocket maximum.

Transplants

(See “Transplant Exclusions” subsection in the “Benefit Exclusions” section)

Benefits for services, supplies, and medications rendered in connection with a transplant, including pre-transplant procedures such as organ or tissue harvesting are limited as indicated on the following pages.

Definitions for the Transplant Benefit

- A **contracting transplant facility** means a health care facility with which we have contracted or arranged to provide facility transplant services for you.
- **Contracted amount** means the amount that the contracting transplant facility has agreed to accept as payment in full for facility transplant services for a specific type of transplant.
- **Covered transplant** means medically appropriate transplant of one of the following organs or tissues only when determined by us to be medically necessary, and no others:
 - Allogenic or syngeneic hematopoietic stem cells whether harvested from bone marrow or peripheral blood, or from any other source;
 - autologous hematopoietic stem cells whether harvested from bone marrow or peripheral blood, or from any other source;
 - heart;
 - heart/lung;
 - lung;
 - pancreas;
 - liver;
 - pediatric small bowel; or
 - small bowel/liver/multivisceral.

Covered transplant does not include transplant of blood, blood derivatives (except peripheral stem cells), cornea, or any other organ or tissue not specifically listed.

- **Donor costs** mean all costs, direct and indirect (including program administration costs), incurred in connection with: medical services required to remove the organ or tissue from either the donor's or self-donor's body; preserving it; and transporting it to the site where the transplant is performed; and related and unrelated donor search cost.
- **Facility transplant services** means all medically necessary services and supplies provided by a health care facility in connection with a covered transplant except donor costs and anti-rejection medications.
- **Medically appropriate for purposes of this transplant limitation** means the recipient or self-donor meets our medical necessity criteria for a transplant.
- **Professional provider transplant services** means all medically necessary services and supplies provided by a professional provider in connection with a covered transplant except donor costs and anti-rejection medications.

Facility Benefits

We will waive any otherwise applicable coinsurance of the plan and pay 100 percent of the contracted amount for facility transplant services for you if a covered transplant is performed at a contracting transplant facility.

Transplant services do not accumulate toward the maximum out-of-pocket amount under the plan.

Professional Provider Benefits

We will pay for professional provider transplant services according to the benefit under ***“Professional Provider Services” subsection in the “Summary of Benefits” section*** of this plan.

Donor Cost Benefits

We will pay donor costs incurred in connection with a covered transplant if the recipient is covered under this plan. We will not pay toward donor costs if the donor is covered under this plan and the recipient is not. Complications and unforeseen effects of the donation will be covered as any other illness under the terms of the plan only if the donor or self-donor is enrolled under the plan.

Anti-rejection Medication Benefits

We will pay according to the prescription medication benefit under the plan for anti-rejection medications following the covered transplant.

Transplant Preauthorization Requirement

All transplant procedures must be preauthorized for type of transplant and must be medically appropriate according to our established criteria. Failure to preauthorize as described will result in a denial of benefits. Please ask your provider to contact the case management nurse who will work with you and your physician in selecting a transplant facility and negotiating for services.

The preauthorization requirement is a part of the benefit administration of the plan and is not a treatment recommendation. The actual course of medical treatment you choose remains strictly a matter between you and your physician.

Transplant Preauthorization Procedure

To preauthorize, your physician must contact our case management before the transplant admission. Preauthorization should be obtained as soon as possible after you have been identified as a possible transplant candidate.

Only our written approval of a proposed transplant will constitute preauthorization. If time is a factor, preauthorization will be made by telephone followed by written confirmation. Preauthorization can be obtained by writing to our transplant coordinator.

BENEFIT EXCLUSIONS

We will not pay for the following:

Cosmetic/Reconstructive Surgery

We do not cover services and supplies for cosmetic or reconstructive purposes, including complications resulting from cosmetic or reconstructive surgery. However, we do provide coverage if the surgery is performed:

- To correct a functional disorder;
- to correct a disorder that results from accidental injury that occurs while a person is covered by this plan;
- to correct congenital anomalies; or
- for the reconstruction of the involved breast following a mastectomy necessary because of illness or injury and for all stages of reconstructive breast reduction on the nondiseased breast to make it equal in size with the diseased breast after final reconstructive surgery on the diseased breast has been performed, or for prostheses and physical complications from all stages of mastectomy, including lymphoedemas.

Experimental or Investigational Services

We do not cover services, which are, in our judgment, experimental or investigational for your specific illness or injury. Services, which support or are performed in connection with the experimental or investigational services, are also excluded.

For purposes of this exclusion, experimental or investigational services include, but are not limited to, any services, which at the time they are rendered and for the purpose and in the manner they are being used:

- Have not yet received final Food and Drug Administration approval for other than experimental, investigational, or clinical testing; or
- are provided under a written protocol or are the same services provided to other patients under a written protocol for the diagnoses; or
- are determined by us, in consultation with medical advisors, to be in a research status prior to general use in the medical community in Oregon. We will consider a service to be in a research status prior to general use in the medical community in Oregon, if two or more of the following indicators apply to a service at the time of preauthorization request or claim review:
 - The service is not performed in Oregon; or
 - the service is the subject of a Phase I, II or III trial; or
 - the service has not been the subject of a study published in peer reviewed medical literature. Peer reviewed medical literature means a U.S. scientific publication which requires that manuscripts be submitted to acknowledged experts inside or outside the editorial office for their considered opinions or recommendations regarding publication of the manuscript. Additionally, in order to qualify as peer reviewed medical literature, the manuscript must actually have been reviewed by acknowledged experts before publication; or

- studies published in peer reviewed medical literature indicate the need for further investigation on dosage, means of administration, long term effects or other factors important to efficacy and patient safety; or
- no federal government agency or national professional medical society or organization, which has done a formal evaluation, has declared the service to be appropriate medical practice.

Experimental or investigational dental or vision services are excluded under the same standards. An experimental or investigational service is not made eligible for coverage even if your doctor considers that other services will be ineffective or not as effective as the service or that the service is the one most likely to prolong life.

General Exclusions

We will not cover:

- **Appliances or equipment** commonly used for nonmedical purposes, marketed to the general public and available without a prescription, intended to alter the physical environment, or used primarily in athletic or recreational activities. Items such as the following are specifically excluded from coverage:
 - Adjustable power beds sold as furniture
 - Air conditioners
 - Air purifiers
 - Blood pressure monitoring equipment
 - Compression/cooling combination units
 - Computer or electronic devices
 - Computer software for monitoring (including coagulation monitoring), recording, or reporting asthmatic, diabetic, or similar clinical tests or data
 - Conveyances (including scooters) other than conventional wheelchairs
 - Cooling pads
 - Equipment purchased on the Internet
 - Exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal symptoms
 - Heating pads
 - Heat lamps
 - Humidifiers, except as part of CPAP apparatus
 - Light boxes
 - Mattress or mattress pads, except for healing of pressure sores
 - Orthopedic shoes

- Pillows
- Replacement costs for worn or damaged durable medical equipment that would otherwise be replaceable without charge under warranty or other agreement
- Spas
- Saunas
- Shoe modifications, except when incorporated into a brace or prosthesis
- Structural alterations in order to prevent, treat, or accommodate a medical condition (including but not limited to grab bars and railings)
- Tanning lamps
- Vehicle alterations to order to prevent, treat, or accommodate a medical condition
- Whirlpool baths
- Applied behavioral analysis for any diagnosis
- Custodial care or day care including routine nursing care and rest cures, hospitalization for environmental change, or help with daily activities such as walking, getting in or out of bed, bathing, dressing, eating, and preparing meals
- Dental services, except as specifically provided in the **“Special Dental Care” subsection in the “Summary of Benefits” section and in our Dental Benefits Plan.** The dental services excluded from the medical benefit plan are services to prevent, diagnose or treat disease of the teeth, gingiva, the periodontal tissue and the alveolus, including services to repair defects, which have developed because of tooth loss, and/or to restore the ability to chew.
- Educational programs for which drivers are referred by the judicial system, or for volunteer mutual support groups.
- Eye examinations and routine eye exercises, except as specifically provided in the **Vision Benefits Plan.**
- Family planning services and supplies to diagnose, prevent, or treat sterility, infertility (except sterilization), artificial insemination, invitro fertilization, or to surgically to correct voluntary sterilization.
- Home health aides.
- Inpatient hospital staff consultations that the hospital rules require.
- Inpatient services after your termination from this plan. The only exception occurs if you are in the hospital on the day the coverage ends. This plan will continue to provide benefits for that hospitalization until your discharge from the hospital.
- Instruction or training programs, except as covered under the disease management benefit. Examples of instruction or training programs excluded from coverage are:
 - Instruction to learn to self-administer medications or nutrition, except as provided in the outpatient diabetic instruction and nutritional counseling benefits;
 - self-management education courses;

- training to control weight or provide general fitness;
 - programs that teach you how to use durable medical equipment, except for prosthetics or orthotics; or
 - training how to care for your family.
- Massage or massage therapy.
 - Motion analysis, including physician review.
 - Myeloablative high dose chemotherapy, except when the related transplant is covered.
 - Jaw - Services or supplies for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants, or improving placement of dentures.
 - Treatment of erectile dysfunction, frigidity, sexual dysfunction, inadequacy, or services and supplies related to sex change procedures.
 - Off the shelf orthopedic shoes and orthopedic inserts.
 - Orthognathic surgery, which includes services and supplies to change the position of a bone of the upper or lower jaw (except when necessary due to an accidental injury that occurred while enrolled under this plan or when performed on a person who has been covered by our plan since birth).
 - Personal items, such as telephones, televisions and guest meals, in a hospital or skilled nursing facility.
 - Physical exercise or fitness programs, even though they may be prescribed for a specific condition, and health or fitness club memberships.
 - Private nursing service for hospital or skilled nursing facility inpatients.
 - Routine tests and screening procedures not specified by this plan, except that routine preadmission testing is covered. Screening tests, imaging, and exams solely for screening, and not associated with a specific diagnosis, sign of disease, or abnormality on prior testing (including but not limited to total body CT imaging, CT colonography, and bone density testing), except as allowed under the preventive care benefit.
 - Services and supplies you received while in the custody of any law enforcement authority or while in jail or prison.
 - Services or supplies that are not medically necessary for the diagnosis or treatment of an illness or injury.
 - Services and supplies provided by your immediate family.
 - Skilled nursing care for mental illness, mental deficiency, or retardation.
 - Surgical procedures, which alter the refractive character of the eye, except as, covered under our **Vision Benefits Plan**. Examples of surgical procedures **excluded** from medical benefits are:
 - radial keratotomy, Lasik, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia or astigmatism.

- reversals or revisions of surgical procedures, which alter the refractive character of the eye and complications of all of these procedures.
- Telephone consultations, missed appointments, completion of claim forms or completion of reports requested by us in order to process claims.
- The fitting, provision, or replacement of eyeglasses, except as specifically provided in the ***Vision Benefits Plan***.
- Services for corns, calluses, removal of nails (except complete removal), hypertrophy or hyperplasia of the skin of the feet, and other routine foot care (except for treatment of diabetes mellitus).
- Services for weight control or obesity. This includes surgery and/or any other services provided for weight control or obesity and/or any complications arising out of or related to such services. These services are not covered whether or not you have other medical conditions related to or caused by overweight or obesity, or the treatment of those conditions.
- 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 sensory integration disorders, motor skills disorders, or learning disorders.
- 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 except as expressly provided for in the Covered Expenses – Professional Services section of this handbook, and facial motor therapy for strengthening and coordination of speech-producing muscles and structures.
- Vocational rehabilitation, functional capacity evaluations, work hardening programs, community reintegration services, and driving evaluations and training
- Treatment of any condition caused by or arising out of service in the armed forces of any country or from war or insurrection.
- Services you received before the effective date of your enrollment in this plan or after the date of your termination from this plan.
- Services of providers who are not eligible for reimbursement under this plan. An individual, organization, facility, or program is not eligible for reimbursement for services or supplies, regardless of whether this plan includes benefits for such services or supplies, unless the individual, organization, facility, or program is licensed by the state in which services are provided as an independent practitioner, hospital, ambulatory surgical center, skilled nursing facility, durable medical equipment supplier, or mental and/or chemical healthcare facility. And, to the extent PacificSource maintains credentialing requirements the practitioner or facility must satisfy those requirements in order to be considered an eligible provider.

SURGERIES AND PROCEDURES EXCLUSIONS AND LIMITATIONS

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

HOSPICE CARE EXCLUSIONS AND LIMITATIONS

In addition to other exclusions listed in the **“Benefit Exclusions” section**, we will not pay for the following hospice services and supplies:

- Care that is not palliative;
- more than one visit of any one kind of rehabilitation on any one day;
- deluxe equipment with mechanical or electrical features such as motor-driven wheelchairs and chair lifts;
- environmental controls or environmental enhancements such as air conditioners, humidifiers, air filters and portable whirlpool pumps;
- food services, such as Meals on Wheels;
- homemaker or housekeeping services, except those that home health aids provide as ordered in the hospice treatment plan;
- legal and financial counseling services;
- normal necessities of living, including but not limited to food, clothing, and household supplies;
- pastoral and spiritual counseling;

- recreational or educational therapy; self-help or training;
- rehabilitative care provided in your home and covered under the home health care benefit;
- Separate charges for reports, records or transportation;
- services provided to other than the terminally ill patient, including bereavement counseling;
- services that your family or volunteer workers provide;
- services in excess of the benefit limitations;
- services not included in hospice treatment plan or not specifically set forth in a hospice benefit;
- services provided more than six months after the initial date of covered hospice care, unless specifically approved by us;
- supportive environmental materials, including but not limited to hand rails, ramps, air conditioners and telephones; or
- treatment of psychotic or psychoneurotic conditions.

MENTAL HEALTH AND CHEMICAL DEPENDENCY EXCLUSIONS

We will not cover the following when administering benefits under the plan for treatment of mental health conditions and chemical dependency conditions:

Counseling Or Treatment In The Absence Of Illness

Services in the absence of illness are excluded. For example, we will not cover:

- academic skills training;
- aversion therapy;
- biofeedback (other than as specifically noted under the Covered Expenses section);
- court-ordered screening interviews or drug or alcohol treatment programs;
- court-ordered sex offender treatment programs;
- diagnostic codes V 15.81 through V71.09 (DSM-IV-TR, Fourth Edition) except V61.20, V61.21, and V62.82 when used with children five years of age or younger;
- educational or correctional services or sheltered living provided by a school or halfway house;
- educational, social, image, behavioral or recreational therapy;
- employee assistance plan services;
- equine/animal therapy;
- family counseling (however family counseling will be covered when you have a covered diagnosis and the family counseling is part of the treatment);
- food dependencies (including caffeine-related disorders not related to caffeine induced anxiety disorder);

- Gender Identity Disorders in Adults (GID);
- hypnotherapy;
- learning disorders;
- marathon group therapy;
- mental retardation;
- narcosynthesis;
- neurodevelopmental therapy;
- nicotine-related disorders.
- paraphilias;
- premarital or marital counseling;
- psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present;
- recreation therapy outside a inpatient or residential treatment setting;
- residential mental health programs exceeding 45 days of treatment per calendar year;
- sensitivity training;
- sensory integration training or movement groups;
- social skill training;
- support groups;
- urinary incontinence; or
- wilderness programs.

Developmental And Learning Disabilities

We will not cover services for developmental and/or learning disabilities in the absence of an illness or when it is not medically necessary.

Mental Health Services For Certain Conditions

We will not cover services for Paraphilias no matter your age. We will not cover any “V Code” diagnoses except the following when medically necessary for a child five years of age or younger:

- parent-child relational problems;
- neglect or abuse; or
- bereavement.

By “V Code”, we mean diagnosis codes as described in the most recent edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-IV TR) that describe relational problems, problems related to abuse or neglect or other issues that may be the focus of assessment or treatment, such as occupational or academic problems.

Sexual Dysfunction

Services and supplies for sexual dysfunction regardless of cause, except for counseling services provided by covered, licensed mental health practitioners.

Sexual Reassignment

Treatment, surgery or counseling services for sexual reassignment.

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS

We will not cover:

- Administration or injection of prescription or nonprescription medications.
- Any medication not specifically described as a benefit under the prescription medication benefit.
- Devices or appliances of any type, even if they may require a prescription order. Some devices and appliances maybe covered under the other provisions of this plan.
- Drugs for any condition excluded under the health plan. That includes drugs intended to promote fertility, treatments for obesity or weight loss, tobacco cessation drugs (except as specifically provided for under Other Covered Pharmaceuticals), experimental drugs, drugs used for cosmetic purposes, and drugs available without a prescription (even if a prescription is provided).
- Drugs used as a preventive measure against hazards of travel.
- Fertility medications.
- Immunization agents, biological sera, blood or blood plasma.
- Injectable prescription medications, except those defined as self-injectable. Excluded are all injectable medications administered in a physician's office, hospital, outpatient facility, or skilled nursing facility.
- Newly approved prescription medications. This plan may exclude, for up to 18 months from the federal Food and Drug Administration (FDA) approval date, prescription medications that the FDA newly approves. The list of newly approved prescription medications currently excluded is provided to participating pharmacies and is available on our Web site and in paper form.
- Nonprescription medications, which are medications that are over the counter drugs or by law do not require a prescription order (even if a written prescription is provided) and which are not, included in the outpatient prescription medications that this plan covers.
- Medications dispensed in a facility to you while a patient in a hospital, skilled nursing facility, nursing home or other health care facility.
- Prescription medications for cosmetic purposes, including but not limited to: Tretinoin (i.e. Retin-A); Renova; topical Minoxidil or other medications used to treat baldness; and medications used to treat nail fungus, such as Sporanox and Lamisil.
- Prescription medications for weight loss or treatment of obesity.
- Prescription medications for which claims are submitted 12 months or more after the date of purchase.

- Prescription medications that are not medically necessary.
- Prescription medications with no proven therapeutic indication.
- Refills needed for stolen, lost, spilled or destroyed prescription medications.
- Vitamins and fluoride, except those that by law require a prescription order.
- Insulin and diabetic supplies without a prescription order.

VISION EXCLUSIONS

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 coatings or scratch resistant coatings.
- Separate charges for contact lens fitting.
- Replacement of lost, stolen, or broken lenses or frames.
- Duplication of spare eyeglasses or any lenses or frames.
- 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.

DENTAL EXCLUSIONS

This plan does not cover the following:

- **Aesthetic dental procedures** – Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.
- **Antimicrobial agents** – Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.
- **Biopsies** – A separate charge for a biopsy of oral tissue or histopathologic exam.
- **Bone replacement grafts** to prepare sockets for implants after tooth extraction.

- Charges for broken appointments.
- Collection of cultures and specimens.
- Connector bar or stress breaker.
- **Cosmetic/reconstructive services and supplies** – Procedures, appliances, restorations, or other services that are primarily for cosmetic purposes. This includes services or supplies rendered primarily to correct congenital or developmental malformations, including but not limited to, peg laterals, cleft palate, maxillary and mandibular (upper and lower jaw) malformation, enamel hypoplasia, and fluorosis (discoloration of teeth). However, the replacement of congenitally missing teeth is covered.
- **Denture replacement** made necessary by loss, theft, or breakage.
- **Diagnostic casts** – Diagnostic casts (study models), gnathological recordings, occlusal appliances, occlusal equilibration procedures, or similar procedures.
- **Drugs and medications** that are prescribed drugs, premedication drugs, analgesics (e.g., nitrous oxide or non-intravenous sedation), any other euphoric drugs, or any take-home medicine or supplies distributed by a provider.
- **Educational programs** – Instructions and/or training in plaque control and oral hygiene.
- **Experimental or investigational procedures** – Services, supplies, protocols, procedures, devices, drugs or medicines, or the use thereof that are experimental or investigational for the diagnosis and treatment of the patient. An experimental or investigational service is not made eligible for benefits by the fact that other treatment is considered by the member's dental care provider to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.
- **Fractures of the mandible** – Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.
- **General anesthesia** except when administered by a dentist in connection with oral surgery in his/her office.
- **Gingivectomy, gingivoplasty or crown lengthening** in conjunction with crown preparation or fixed bridge services done on the same date of service.
- **Hospital charges** or additional fees charged by the dentist for hospital treatment.
- Hypnosis.
- **Infection control** – A separate charge for infection control or sterilization.
- **Intra and extra coronal splinting** – Devices and procedures for intra and extra coronal splinting to stabilize mobile teeth.
- Oral surgery treating any fractured jaw.
- **Orthodontic services** – Treatment of malalignment of teeth and/or jaws, or any ancillary services expressly performed because of orthodontic treatment, except as provided for on the Dental Benefit Summary.

- **Orthognathic surgery** – Surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship to the facial bones.
- Periodontal probing, charting, and re-evaluations.
- Photographic images.
- **Pin retention** in addition to restoration.
- Precision attachments.
- Pulpotomies on permanent teeth.
- **Removal of clinically serviceable amalgam restorations** to be replaced by other materials free of mercury, except with proof of allergy to mercury.
- **Services for rebuilding or maintaining chewing surfaces** due to teeth out of alignment or occlusion, or for stabilizing the teeth.
- **Sinus lift grafts** to prepare sinus site for implants.
- **Tooth transplantation** – Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization. This exclusion does not relate to the re-implantation of a tooth into its original socket after it has been avulsed.
- **Treatment after insurance ends** – Services or supplies provided after enrollment in this plan ends.
- **Treatment not dentally necessary** according to acceptable dental practice or treatment not likely to have a reasonably favorable prognosis.
- **Treatment prior to enrollment** – Dental services begun before you or your family member became eligible for those services under this plan.

PREAUTHORIZATION

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

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

Your medical provider can request preauthorization from the PacificSource Health Services Department by phone, fax, mail, or 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.

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 Healthy KidsConnect plan. Remember, any time you are unsure if an expense will be covered, contact the PacificSource Customer Service Department.

Because of the changing nature of medicine, PacificSource continually reviews new technologies and standards of medical practice. The list of procedures and services requiring preauthorization is therefore subject to revision and update. ***The following list is not intended to suggest that all the items included are necessarily covered by the benefits of this policy.*** You'll find the most current preauthorization list on our Web site, PacificSource.com. The list of procedures and services requiring preauthorization includes, but is not limited to, the following:

- Advanced diagnostic imaging
- Ambulance transports (air or ground) between medical facilities, except in emergencies
- Artificial intervertebral disc replacement
- Back surgeries – instrumented
- Breast Brachytherapy (Accelerated Partial Breast Irradiation (PBI))
- Breast reconstruction, including reduction and implants
- Chelation therapy
- Chondrocyte implants
- Cochlear implants
- 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 \$800, including purchase, rental, repair, lease, or replacement, or rental for longer than three months, except for the initial purchase or CPAP/BiPAP equipment which does not require preauthorization
- Dynamic elbow/knee/shoulder flexion devices
- 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
- Enhanced external counterpulsation
- Excimer laser for psoriasis
- Experimental or investigational procedures or surgeries
- Extensions of previously authorized benefits, such as physical or occupational therapy, mental health treatment, or chemical dependency treatment
- Genetic (DNA) testing
- Home health, outpatient and home IV infusion, and hospice services, and enteral nutrition supplies
- Homeopathic treatment
- Hospitalization for dental procedures when covered under this plan, including pediatric dental procedures

- Hyperbaric oxygen
- Ingestible telemetric gastrointestinal capsule imaging system (wireless capsule enteroscopy)
- Intradiscal electrothermal therapy (IDET)
- Kidney dialysis
- Laparoscopies of the female reproductive system and hysterosalpingograms, hysteroscopies and chromotubations
- Mental health and chemical dependency inpatient or residential treatment, including intensive outpatient mental health treatment
- Mobile Cardiac Outpatient Telemetry (MCOT) e.g., CardioNet Ambulatory ECG or HEARTlink Telemetry
- MRIs during an exclusion period
- Multidisciplinary developmental pediatric evaluations
- Multidisciplinary pain management and rehabilitation evaluations and programs
- Neurostimulators – implantable
- Parenteral nutrition
- Percutaneous vertebroplasty and balloon-assisted vertebroplasty (kyphoplasty)
- PET scans
- Proton beam treatment delivery
- Radiofrequency procedure including radiofrequency neurotomy
- Rehabilitation or skilled nursing facility admissions
- Skin substitutes (e.g., Apligraf, Dermagraft, or other)
- Stereotactic radio surgery
- Surgical procedures and tongue retaining orthodontic appliances for sleep apnea and other sleeping disorders
- Surgeries or procedures in a hospital or ambulatory center during any exclusion period
- Transmyocardial revascularization (TMR)
- 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

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

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

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

CASE MANAGEMENT

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

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

INDIVIDUAL BENEFITS MANAGEMENT

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

UTILIZATION REVIEW

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

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

Authorization of Hospital Admissions

When a PacificSource member is admitted to a hospital within the area covered by 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 with regard to available benefits for each admission is documented in the report.

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

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

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

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

Extension of Hospital Stays

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

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

Timeliness for Responding to Coverage Request

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

Questions About Specific Utilization Review Decisions

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

CLAIMS PAYMENT

How to File a Claim

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

If you receive care from a 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

Claim Handling Procedures

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

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

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

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

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

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

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

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

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

Questions About Claims

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

Benefits Paid in Error

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

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

COORDINATION OF BENEFITS

You are not eligible to be enrolled in the Healthy KidsConnect program if you are covered under another health plan, or are eligible for Medicare. No dual enrollment or double coverage is allowed.

If you become enrolled under another health plan or Medicare, please notify the Oregon Department of Human Services toll-free at (877) 314-5678.

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.

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

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

When we receive a claim that might involve a third party, we will send you a questionnaire to help us determine responsibility.

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

- If PacificSource pays any claim determined to be the responsibility of another party, you will hold the right of recovery against the other party in trust for PacificSource.
- PacificSource is entitled to reimbursement for any paid claims if there is a settlement or judgment from the other party. This is so regardless of whether the other party or insurer admits liability or fault.
- 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.

Motor Vehicle and Other Accidents

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

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

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

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

This plan does not cover any work-related illness or injury, including those arising from self-employment.

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

COMPLAINTS, GRIEVANCES, AND APPEALS

Questions, Concerns, or Complaints

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

If you have a question, concern, or complaint about your PacificSource coverage, please contact our Customer Service Department. Many times our Customer Service staff can answer your question or resolve an issue to your satisfaction right away.

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.

PacificSource agrees to be bound by decisions of independent review organizations and act in accordance with the decisions of the independent review organizations notwithstanding the policy's definition of medical necessity.

Appealing a Preauthorization Determination

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 determination. 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 lc@pacificsource.com, with “Grievance” as the subject
- **faxing** your message to (541) 225-3628

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

Timelines for Responding to Grievances and Appeals

PacificSource will acknowledge receipt of an initial grievance or first or second appeal no later than seven days after receipt. A decision in response to the grievance or appeal will be made within 30 days after receiving notice of the grievance or appeal. If more time is required to resolve the initial grievance, PacificSource may allow an additional 15 days by giving you or your representative notice of the delay, including a specific reason, before the thirty-day period ends.

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

SOURCES FOR INFORMATION AND ASSISTANCE

Assistance in Other Languages

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

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, 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
- 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, 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, PacificSource.com. You may also write to us at:

*PacificSource
Attn: Executive Vice President and Chief Operating Officer
PO Box 7068
Eugene OR 97401-0068*

RIGHTS AND RESPONSIBILITIES

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

Your Rights as a Member:

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

Your Responsibilities as a Member:

- You are responsible for reading this benefit handbook and all other communications from PacificSource, and for understanding your plan's benefits. You are responsible for contacting PacificSource Customer Service if anything is unclear to you.
- You are responsible for making sure your provider obtains preauthorization for any services that require it before you are treated.
- You are responsible for providing PacificSource with all the information required to provide benefits under your plan.
- You are responsible for giving your healthcare provider complete health information to help accurately diagnose and treat you.
- You are responsible for telling your providers you are covered by PacificSource and showing your ID card when you receive care.
- You are responsible for being on time for appointments, and calling your provider ahead of time if you need to cancel. You are responsible for any fees the provider charges for late cancellations or "no shows."
- You are responsible for following the treatment plans or instructions agreed on by you and your healthcare provider.
- You are responsible for contacting PacificSource if you believe you are not receiving adequate care.

PRIVACY AND CONFIDENTIALITY

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

Disclosure outside PacificSource is allowed only when necessary to provide your coverage, or when otherwise allowed by law. Except when certain statutory exceptions apply, Oregon law requires us to have written authorization from you (or your representative) before disclosing your personal information outside PacificSource. An example of one exception is that we do not need written authorization to disclose information to a designee performing utilization management, quality assurance, or peer review on our behalf.