EMPLOYEE HEALTH BENEFIT PLAN

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

Effective Date: April 1, 2006

T-8316 (02-07)
TABLE OF CONTENTS

SUMMARY PLAN DESCRIPTION.............................................................................................................. 1

PREFERRED PROVIDER OR NONPREFERRED PROVIDER .............................................................. 5
- Preferred Provider.......................................................................................................................... 5
- Nonpreferred Provider.................................................................................................................. 5
- Referrals.......................................................................................................................................... 5
- Exceptions...................................................................................................................................... 5

MEDICAL EXPENSE BENEFIT........................................................................................................... 7
- Copay................................................................................................................................................ 7
- Deductibles...................................................................................................................................... 7
- Coinsurance..................................................................................................................................... 8
- Out-of-Pocket Expense Limit ......................................................................................................... 8
- Maximum Benefit............................................................................................................................ 8
- Hospital/Ambulatory Surgical Facility............................................................................................. 8
- Facility Providers............................................................................................................................ 9
- Ambulance Services....................................................................................................................... 9
- Emergency Room Services............................................................................................................ 10
- Urgent Care Facility....................................................................................................................... 10
- Physician Services.......................................................................................................................... 10
- Second Surgical Opinion................................................................................................................ 11
- Diagnostic Services and Supplies.................................................................................................. 11
- Transplant....................................................................................................................................... 11
- Pregnancy........................................................................................................................................ 13
- Birthing Center............................................................................................................................... 13
- Sterilization..................................................................................................................................... 13
- Infertility Services............................................................................................................................ 13
- Contraceptives................................................................................................................................. 14
- Well Newborn Care........................................................................................................................ 14
- Well Child Care.............................................................................................................................. 14
- Routine Preventive Care................................................................................................................ 14
- Routine Mammograms................................................................................................................... 15
- Therapy Services............................................................................................................................ 15
- Extended Care Facility.................................................................................................................... 15
- Home Health Care......................................................................................................................... 16
- Hospice Care.................................................................................................................................. 16
- Durable Medical Equipment.......................................................................................................... 17
- Prostheses....................................................................................................................................... 17
- Orthotics.......................................................................................................................................... 17
- Dental Services............................................................................................................................... 18
- Temporomandibular Joint Dysfunction......................................................................................... 18
- Special Equipment and Supplies.................................................................................................. 18
- Cosmetic/Reconstructive Surgery.................................................................................................. 18
- Mastectomy..................................................................................................................................... 19
- Oral and Maxillofacial Services.................................................................................................... 19
- Mental & Nervous Disorders and Chemical Dependency Care.................................................. 19
- Podiatry Services........................................................................................................................... 20
- Private Duty Nursing...................................................................................................................... 20
- Diabetes Self-Management........................................................................................................... 20
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Provisions</td>
<td>68</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>61</td>
</tr>
<tr>
<td>Procedures for Filing Claims, Grievances and Appeals</td>
<td>48</td>
</tr>
<tr>
<td>Post-Service Claim Procedure</td>
<td>48</td>
</tr>
<tr>
<td>Pre-Service Claim Procedure</td>
<td>53</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>61</td>
</tr>
<tr>
<td>Subrogation/Reimbursement</td>
<td>66</td>
</tr>
<tr>
<td>General Provisions</td>
<td>68</td>
</tr>
</tbody>
</table>
SUMMARY PLAN DESCRIPTION

Name of Plan:

Pioneer Educators Health Trust Employee Benefit Plan

Name, Address and Phone Number of Plan Sponsor:

Pioneer Educators Health Trust
c/o Rico Bocala
700 NE Multnomah Street, Suite 1300
Portland, Oregon 97232
(503) 299-3401

Plan Sponsor Identification Number:

35-2198318

Plan Number:

501

Group Number:

4147

Type of Plan:

Welfare Benefit Plan: medical, dental, prescription drug and vision benefits

Type of Administration:

Contract administration: The processing of claims for benefits under the terms of the Plan are provided through a company contracted by the Plan which shall hereinafter be referred to as the claims processor.

Name, Address and Phone Number of Plan Administrator and Fiduciary:

Pioneer Educators Health Trust
c/o Rico Bocala
700 NE Multnomah Street, Suite 1300
Portland, Oregon 97232
(503) 299-3401

Name, Address and Phone Number of Agent for Service of Legal Process:

Jeff Robertson
Bullivant Houser Bailey, P.C.
888 SW Fifth Avenue
Portland, Oregon 97204
(503) 499-4686

Legal process may also be served upon the plan administrator or the Plan trustees at the plan administrator’s address above.
Eligibility Requirements:
For detailed information regarding a person's eligibility to participate in the Plan, refer to the following section:

Eligibility, Enrollment and Effective Date of Coverage, Schedule of Benefits insert

For detailed information regarding a person being ineligible for benefits through reaching maximum benefit levels, termination of coverage or Plan exclusions, refer to the following sections:

Schedule of Benefits
Termination of Coverage
Plan Exclusions

Source of Plan Contributions:
Contributions for Plan expenses are obtained from the employer and from covered employees. The employer evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the employer and the amount to be contributed by the covered employees.

Contributions by the covered employees are deducted from their pay on a pre-tax basis if authorized by the employee on the enrollment form or other applicable forms.

Contributions are subject to a 10-day grace period during which time coverage will remain in force.

Funding Method:
The plan sponsor will maintain a trust for the receipt of money and property to fund the Plan, for the management and investment of such funds, and for the payment of Plan benefits and expenses from such funds.

The employer shall deliver, from time to time to the Trust, amounts of money and property as shall be necessary to provide the Trust with sufficient funds to pay all Plan benefits and reasonable expenses of administering the Plan as the same shall be due and payable. The employer may provide for all or any part of such funding by insurance issued by a company duly qualified to issue insurance for such purpose and may pay the premiums, therefore, directly or by funds deposited in the Trust.

All funds received by the Trust and all earnings of the Trust shall be applied toward payment of Plan benefits and reasonable expenses of administration of the Plan except to the extent otherwise provided by the Plan documents. The plan sponsor may appoint an investment manager or managers to manage (including the power to acquire and dispose of) any assets of the Plan.

Any fiduciary, employee, agent representative, or other person performing services to or for the Plan shall be entitled to reasonable compensation for services rendered and for the reimbursement of expenses properly and actually incurred, unless such person is the employer or already receives full-time pay from the employer.

Covered persons shall look only to the funds in the Trust for payment of Plan benefits and expenses.

Ending Date of Plan Year: March 31st
**Procedures for Filing Claims:**

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, *Claim Filing Procedure.*

The designated *claims processor* is:

CoreSource, Inc.

**Right to Additional Information:**

Participants in the *Plan* should contact the *plan administrator* to obtain additional information, free of charge, about *Plan* coverage of a specific benefit, particular drug, treatment, test or any other aspect of *Plan* benefits or requirements. A *Plan* participant has the right to receive certain additional information. Upon request, the *plan administrator* will provide the participant with:

- Rules related to the *Plan's* drug formulary, including information on whether a particular drug is included or excluded from the formulary;
- Provisions for referrals, if any, for specialty care, behavioral health services and hospital services and how an enrollee may obtain the care or services;
- A copy of the *Plan's* annual report on grievances and appeals as submitted to the Oregon Department of Consumer and Business Services;
- A description of any risk-sharing arrangements with physicians and other providers;
- A description of the *Plan's* efforts to monitor and improve the quality of health services; and
- Information about any *Plan* procedures for credentialing network providers and how to obtain the names, qualifications and titles of the providers responsible for an enrollee’s care.

**Statement of ERISA Rights:**

Participants in the *Plan* are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

1. Examine, without charge, at the *plan administrator's* office and at other specified locations, such as worksites and union halls, all documents governing the *Plan*, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the *Plan* with the U.S. Department of Labor, if applicable.

2. Obtain, upon written request to the *plan administrator*, copies of documents governing the operation of the *Plan*, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description, if applicable. The *plan administrator* may make a reasonable charge for the copies.

3. Receive a summary of the *Plan's* annual financial report. The *plan administrator* is required by law to furnish each participant with a copy of this summary annual report, if applicable.

4. Continue health care coverage for the participant, the participant's spouse or *dependents* if there is a loss of coverage under the *Plan* as the result of a qualifying event. The participant or *dependent* may have to pay for such coverage. Review this summary plan description and the documents governing the *Plan* on the rules governing COBRA continuation coverage rights.
5. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if the participant or dependent has creditable coverage from another plan. The participant or dependent should be issued a certificate of coverage when coverage under the Plan is lost; when the participant or dependent becomes entitled to elect COBRA continuation coverage; when COBRA coverage ceases; if a certificate is requested before losing coverage, or if a certificate is requested within twenty-four (24) months after losing coverage. The participant or dependent should be provided a certificate of creditable coverage, free of charge, from their group health Plan or health insurance insurer.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all Plan participants.

No one, including the employer, a union, or any other person, may fire an employee or discriminate against an employee to prevent the employee from obtaining any benefit under the Plan or exercising their rights under ERISA.

If claims for benefits under the Plan are denied, in whole or in part, the participant must receive a written explanation of the reason for the denial. The participant has the right to have the Plan review and reconsider the claim.

Under ERISA, there are steps participants can take to enforce their rights. For instance, if material is requested from the Plan and the material is not received within thirty (30) days, the participant may file suit in a federal court. In such case, the court may require the plan administrator to provide the materials and pay the participant up to $110 a day until the materials are received, unless the materials were not provided for reasons beyond the control of the plan administrator. If a claim for benefits is denied or ignored in whole or in part and after exhaustion of all administrative remedies, the participant may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if participants are discriminated against for asserting their rights, participants may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who will pay the costs and legal fees. If the participant is successful, the court may order the person who is sued to pay these costs and fees. If the participant loses, the court may order the participant to pay the costs and fees; for example, if it finds the participant's claim frivolous.

Participants should contact the plan administrator for questions about the Plan. For questions about this statement or about rights under ERISA, participants should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in their telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The nearest Regional Office is the Seattle Regional Office, 1111 Third Avenue, Suite 860 MIDCOM Tower, Seattle, Washington 98101-3212, Phone: 206/553-4244.
PREFERRED PROVIDER OR NONPREFERRED PROVIDER

Covered persons have the choice of using either a preferred provider or a nonpreferred provider.

PREFERRED PROVIDER

A preferred provider is a physician, hospital or ancillary service provider that has an agreement in effect with the Preferred Provider Organization (PPO) to accept a reduced rate for services rendered to covered persons. This is known as the negotiated rate. The preferred provider cannot bill the covered person for any amount in excess of the negotiated rate. Covered persons should contact the employer's Human Resources Department for a current listing of preferred providers.

NONPREFERRED PROVIDER

A nonpreferred provider does not have an agreement in effect with the Preferred Provider Organization. This Plan will allow only the customary and reasonable amount as a covered expense. The Plan will pay its percentage of the customary and reasonable amount for the nonpreferred provider services, supplies and treatment. The covered person is responsible for the remaining balance. This results in greater out-of-pocket expenses to the covered person.

REFERRALS

Referrals to a nonpreferred provider are covered as nonpreferred provider services, supplies and treatments. It is the responsibility of the covered person to assure services to be rendered are performed by preferred providers in order to receive the preferred provider level of benefits.

EXCEPTIONS

The following listing of exceptions represents services, supplies or treatments rendered by a nonpreferred provider where covered expenses shall be payable at the preferred provider level of benefits:

1. Emergency treatment rendered at a nonpreferred provider facility or at a preferred provider facility by a nonpreferred provider emergency room physician. If the covered person is admitted to the hospital on an emergency basis, covered expenses shall be payable at the preferred provider level.

2. Nonpreferred anesthesiologist when the operating surgeon is a preferred provider and/or the facility where such services are rendered is a preferred provider.

3. Nonpreferred assistant surgeon if the operating surgeon is a preferred provider.

4. Radiologist or pathologist services for interpretation of x-rays and diagnostic laboratory and surgical pathology tests rendered by a nonpreferred provider when the facility where such services are rendered is a preferred provider.

5. Diagnostic laboratory and surgical pathology tests referred to a nonpreferred provider by a preferred provider.
6. While the covered person is confined to a preferred provider hospital, the preferred provider physician requests a consultation from a nonpreferred provider or a newborn visit is performed by a nonpreferred provider.

7. Medically necessary specialty services, supplies or treatments that are not available from a provider within the Preferred Provider Organization.

8. When a covered dependent child resides outside the service area of the Preferred Provider Organization.

9. Treatment rendered at a facility of the uniformed services or Indian Health Care facility.
MEDICAL EXPENSE BENEFIT

This section describes the covered expenses of the Plan. All covered expenses are subject to applicable Plan provisions including, but not limited to: deductible, copay, coinsurance and maximum benefit provisions as shown on the Schedule of Benefits, unless otherwise indicated. Any portion of an expense incurred by the covered person for services, supplies or treatment that is greater than the customary and reasonable amount for nonpreferred providers or negotiated rate for preferred providers will not be considered a covered expense by this Plan. Specified preventive care expenses will be considered to be covered expenses.

COPAY

The copay is the amount payable by the covered person for certain services, supplies or treatment rendered by a preferred provider. The service and applicable copay are shown on the Schedule of Benefits. The covered person selects a preferred provider and pays the preferred provider the copay. The Plan pays the remaining covered expenses at the negotiated rate. The copay must be paid each time a treatment or service is rendered.

The copay will not be applied toward the following:

1. The calendar year deductible.
2. The maximum out-of-pocket expense limit.
3. The deductible carry-over.
4. The common accident deductible.

DEDUCTIBLES

Individual Deductible

The individual deductible is the dollar amount of covered expense that each covered person must have incurred during each calendar year before the Plan pays applicable benefits. The individual deductible amount is shown on the Schedule of Benefits.

Family Deductible

If, in any calendar year, covered members of a family incur covered expenses that are subject to the deductible that are equal to or greater than the dollar amount of the family deductible shown on the Schedule of Benefits, then the family deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

Common Accident

If two or more covered members of a family are injured in the same accident and, as a result of that accident, incur covered expenses, only one (1) individual deductible amount will be deducted from the total covered expenses of all covered family members related to the accident for the remainder of the calendar year.

Deductible Carry-Over

Amounts incurred during October, November and December and applied toward the deductible of any covered person, will also be applied to the deductible of that covered person in the next calendar year.
COINSURANCE

The Plan pays a specified percentage of covered expenses at the customary and reasonable amount for nonpreferred providers, or the percentage of the negotiated rate for preferred providers. That percentage is specified on the Schedule of Benefits. For nonpreferred providers, the covered person is responsible for the difference between the percentage the Plan paid and one hundred percent (100%) of the billed amount. The covered person’s portion of the coinsurance represents the out-of-pocket expense limit.

OUT-OF-POCKET EXPENSE LIMIT

After the covered person has incurred an amount equal to the out-of-pocket expense limit listed on the Schedule of Benefits for covered expenses (after satisfaction of any applicable deductibles), the Plan will begin to pay one hundred percent (100%) of covered expenses for the remainder of the calendar year.

After a covered family has incurred a combined amount equal to the family out-of-pocket expense limit shown on the Schedule of Benefits, the Plan will pay one hundred percent (100%) of covered expenses for all covered family members for the remainder of the calendar year.

Out-of-Pocket Expense Limit Exclusions

The following items do not apply toward satisfaction of the calendar year out-of-pocket expense limit and will not be payable at one hundred percent (100%), even if the out-of-pocket expense limit has been satisfied:

1. Expenses for services, supplies and treatments not covered by this Plan, to include charges in excess of the customary and reasonable amount or negotiated rate, as applicable.
2. Deductible(s).
4. Expenses incurred as a result of failure to obtain pre-certification.

MAXIMUM BENEFIT

The maximum benefit payable on behalf of a covered person is shown on the Schedule of Benefits. The maximum benefit applies to the entire time the covered person is covered under the Plan, either as an employee, dependent, alternate recipient or under COBRA. If the covered person’s coverage under the Plan terminates and at a later date he again becomes covered under the Plan, the maximum benefit will include all benefits paid by the Plan for the covered person during any period of coverage.

The Schedule of Benefits contains separate maximum benefit limitations for specified conditions. Any separate maximum benefit will include all such benefits paid by the Plan for the covered person during any and all periods of coverage under this Plan. All separate maximum benefits are part of, and not in addition to, the maximum benefit. No more than the maximum benefit will be paid for any covered person while covered by this Plan.

Notwithstanding any provision of this Plan to the contrary, all benefits received by an individual under any benefit option, package or coverage under the Plan shall be applied toward the maximum benefit paid by this Plan for any one covered person during the entire time he is covered by this Plan, such option, package or coverage under the Plan, and also toward the maximum benefit under any other options, packages or coverages under the Plan in which the individual may participate in the future.

HOSPITAL/AMBULATORY SURGICAL FACILITY

Inpatient hospital admissions are subject to pre-certification. Failure to obtain pre-certification will result in a reduction of benefits as specified in the Claim Filing Procedure section of this document.
Covered expenses shall include:

1. **Room and board** for treatment in a hospital, including intensive care units, cardiac care units and similar medically necessary accommodations. Covered expenses for room and board shall be limited to the hospital's semiprivate rate. Covered expenses for intensive care or cardiac care units shall be the customary and reasonable amount for nonpreferred providers and the percentage of the negotiated rate for preferred providers. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the covered person. In a hospital having only private rooms, covered expenses for room and board shall be limited to eighty percent (80%) of the hospital's average private room rate.

2. Miscellaneous hospital services, supplies, and treatments including, but not limited to:
   a. Admission fees, and other fees assessed by the hospital for rendering services, supplies and treatments;
   b. Use of operating, treatment or delivery rooms;
   c. Anesthesia, anesthesia supplies and its administration by an employee of the hospital;
   d. Medical and surgical dressings and supplies, casts and splints;
   e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
   f. Drugs and medicines (except drugs not used or consumed in the hospital);
   g. X-ray and diagnostic laboratory procedures and services;
   h. Oxygen and other gas therapy and the administration thereof;
   i. Therapy services.

3. Services, supplies and treatments described above furnished by an ambulatory surgical facility, including follow-up care provided within seventy-two (72) hours of a procedure.

4. Charges for pre-admission testing (x-rays and lab tests) performed within seven (7) days prior to a hospital admission that are related to the condition that is necessitating the confinement. Such tests shall be payable even if they result in additional medical treatment prior to confinement or if they show that hospital confinement is not medically necessary. Such tests shall not be payable if the same tests are performed again after the covered person has been admitted.

**FACILITY PROVIDERS**

Services provided by a facility provider are covered if such services would have been covered if performed in a hospital or ambulatory surgical facility.

**AMBULANCE SERVICES**

Ambulance services must be by a licensed air or ground ambulance.

Covered expenses shall include:

1. Ambulance services for air or ground transportation for the covered person from the place of injury or serious medical incident to the nearest hospital where treatment can be given.

2. Ambulance service is covered in a non-emergency situation only to transport the covered person to or from a hospital or between hospitals for required treatment when such transportation is certified by the attending physician as medically necessary. Such transportation is covered only from the initial hospital to the nearest hospital qualified to render the special treatment.
3. *Emergency* services actually provided by an advance life support unit, even though the unit does not provide transportation.

If the covered person is admitted to a nonpreferred hospital after emergency treatment, ambulance service is covered to transport the covered person from the nonpreferred hospital to a preferred hospital after the patient’s condition has been stabilized, provided such transport is certified by the attending physician as medically necessary.

Benefit payments for ambulance services will be made directly to the ambulance company or jointly to the covered person and the ambulance company.

**EMERGENCY ROOM SERVICES**

Coverage for emergency room treatment is subject to a copay per occurrence as specified on the Schedule of Benefits, unless admitted as an inpatient.

Coverage for emergency room treatment shall be paid in accordance with the Schedule of Benefits provided the condition meets the definition of emergency herein.

Pre-certification is not required for emergency services.

A covered person may receive covered eye care services on an emergency basis without first receiving a referral or prior authorization from a primary care provider.

**URGENT CARE FACILITY**

Covered expenses shall include charges for treatment in an urgent care facility, payable as specified on the Schedule of Benefits.

**PHYSICIAN SERVICES**

Covered expenses shall include:

1. Medical treatment, services and supplies including, but not limited to: office visits, inpatient visits, home visits.

2. Surgical treatment. Separate payment will not be made for inpatient pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

   For related operations or procedures performed through the same incision or in the same operative field, covered expenses shall include the surgical allowance for the highest paying procedure and fifty percent (50%) of the surgical allowance for each additional procedure.

   When two (2) or more unrelated operations or procedures are performed at the same operative session, covered expenses shall include the surgical allowance for each procedure.

3. Surgical assistance provided by a physician if it is determined that the condition of the covered person or the type of surgical procedure requires such assistance. Covered expenses for the services of an assistant surgeon are limited to twenty percent (20%) of the surgical allowance.

4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.

5. Consultations requested by the attending physician during a hospital confinement. Consultations do not include staff consultations that are required by a hospital’s rules and regulations.
6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

**SECOND SURGICAL OPINION**

Benefits for a second surgical opinion will be payable according to the *Schedule of Benefits* if an elective surgical procedure (non-emergency surgery) is recommended by the **physician**.

The **physician** rendering the second opinion regarding the **medical necessity** of such surgery must be a board certified specialist in the treatment of the *covered person's illness or injury* and must not be affiliated in any way with the **physician** who will be performing the actual surgery.

In the event of conflicting opinions, a third opinion may be obtained. The **Plan** will consider payment for a third opinion the same as a second surgical opinion.

The second surgical opinion benefit includes **physician** services and any diagnostic services as may be required.

**DIAGNOSTIC SERVICES AND SUPPLIES**

*Covered expenses* shall include services and supplies for diagnostic laboratory tests, electronic tests, pathology, ultrasound, nuclear medicine, magnetic imaging and x-rays.

**TRANSPLANT**

*Preauthorization Requirement for Organ Transplant*

Expenses *incurred* in connection with any organ or tissue transplant listed on the *Schedule of Benefits* will be covered subject to referral to and preauthorization by the **Health Care Management Organization's** authorized review specialist. (Cornea transplants are not subject to the preauthorization provision, but will be considered on the same basis as any other medical expense coverage under this **Plan**.) Transplant coverage is offered under this **Plan** through a preferred provider network of specialized professionals and facilities. Coverage is also provided for transplant services obtained outside of the preferred network, at a reduced benefit level.

As soon as reasonably possible, but in no event more than ten (10) days* after a *covered person's* attending **physician** has indicated that the *covered person* is a potential candidate for a transplant, the *covered person* or his **physician** should contact the **Health Care Management Organization** for referral to the network's medical review specialist, for evaluation and preauthorization.

A comprehensive treatment plan must be developed for the **Health Care Management Organization's** medical review, and must include such information as diagnosis, the nature of the transplant, the setting of the procedure, (i.e., name and address of the **hospital**), any secondary medical complications, a five (5) year prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment (one or both confirming second opinions may be waived by the **Health Care Management Organization's** medical review specialist).

Additional attending **physician's** statements may also be required. The *covered person* may provide a comprehensive treatment plan independent of the preferred provider network, but this will be subject to medical appropriateness review and may result in non-network benefit coverage.

All potential transplant cases will be assessed for their appropriateness for Health Care Management.
Organ Transplant Network

As a result of the preauthorization review, the covered person will be asked to consider obtaining transplant services from a participating Outcome-Based Transplant Network facility arranged by the Health Care Management Organization. The purpose of designating Outcome-Based Transplant networks is to perform necessary transplants in the most appropriate setting for the procedure, to improve the quality and probability of a successful outcome, and reduce the average cost of the procedures.

There is no obligation for the patient to use a participating transplant network facility. However, benefits for the transplant and its related expenses may vary depending on whether services are provided in or out of the transplant network. If a transplant is performed out of network, but the covered person has received approval from the Health Care Management Organization’s medical review specialist for out of network services, then network benefits will apply to the transplant and its related expenses. If services are provided out of network without approval from the medical review specialist, then out of network benefits will apply.

Transplant Benefit Period

Covered transplant expenses will accumulate during a Transplant Benefit Period, and will be charged toward the transplant benefit period maximums, if any, shown in the Schedule of Benefits. The term "Transplant Benefit Period" means the period beginning on the date of the initial evaluation and ending on the date twelve (12) consecutive months following the date of the transplant. (If the transplant is a bone marrow transplant, the date the marrow is re-infused is considered the date of the transplant.)

Covered Transplant Expenses

The term "covered expenses" with respect to transplants, includes the customary and reasonable expenses for services and supplies which are covered under this Plan (or which are specifically identified as covered only under this provision) and which are medically necessary and appropriate to the transplant, including:

1. Charges incurred in the evaluation, screening and candidacy determination process.
2. Charges incurred for organ transplantation.
3. Charges for organ procurement, including donor expenses not covered under the donor's plan of benefits.

Coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow-up care.

If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or the donor's marrow (allogenic). Coverage will also be provided for search charges to identify an unrelated match, and treatment and storage cost of the marrow, up to the time of re-infusion. (The harvesting of the marrow need not be performed within the transplant benefit period.)

4. Charges incurred for follow-up care, including immunosuppressant therapy.

Re-transplantation

Re-transplantation will be covered for up to two (2) re-transplants, for a total of three (3) transplants per person, while covered by this Plan. Each transplant will be subject to the Preauthorization requirement for Organ Transplant. Each transplant and re-transplant will have a new benefit period and a new maximum benefit, subject to the Plan’s overall per-person maximum benefit while covered by this Plan.
**Accumulation of Expenses**

Expenses *incurred* during any transplant benefit period for the recipient and for the donor will accumulate towards the recipient's benefit and will be included in the Plan's overall per-person *maximum benefit* while covered by this Plan.

**Donor Expenses**

Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this Plan or any other benefit plan covering the donor. In addition medical expense benefits for a donor who is not a *covered person* under this Plan are limited to a maximum of ten thousand dollars ($10,000) per transplant benefit period when the transplant services are provided out of network. This does not include the donor's transportation and lodging expenses.

**Extended Benefits In The Event Of Termination**

In the event of the recipient's termination of membership in an eligible class, if a transplant treatment program has commenced while coverage was in force and benefits had not been exhausted, then benefits will be paid for expenses related to the same organ transplant which are *incurred* during the lesser of a) the remainder of that transplant benefit period or b) one (1) month after termination of the membership, as though coverage had not ended. If the Plan terminates after a transplant treatment program has commenced, only charges *incurred* prior to termination of the Plan shall be eligible for payment. See General Provisions, Plan Termination for further information.

**PREGNANCY**

*Covered expenses* shall include services, supplies and treatment related to *pregnancy* or *complications of pregnancy* for a covered female *employee*, a covered female spouse of a covered *employee*, and *dependent* female children.

The Plan shall cover services, supplies and treatments for abortions for a covered female *employee* or a covered female spouse of a covered *employee* and *dependent* female children.

Complications from an abortion shall be a *covered expense* whether or not the abortion is a *covered expense*.

**BIRTHING CENTER**

*Covered expenses* shall include services, supplies and treatments rendered at a *birthing center* provided the *physician* in charge is acting within the scope of his license and the *birthing center* meets all legal requirements. Services of a midwife acting within the scope of his license or registration are a *covered expense* provided that the state in which such service is performed has legally recognized midwife delivery.

**STERILIZATION**

*Covered expenses* shall include elective surgical sterilization procedures for the covered *employee* or covered spouse. Reversal of surgical sterilization is not a *covered expense*.

**INFERTILITY SERVICES**

*Covered expenses* shall include expenses for infertility testing for *employees* and their covered spouse.

*Covered expenses* for infertility testing are limited to the actual testing for a diagnosis of infertility. Any outside intervention procedures (e.g. artificial insemination) will not be considered a *covered expense*.
CONTRACEPTIVES

Covered expenses shall include charges for medical procedures or supplies related to contraception, including contraceptive devices, contraceptive injections and the surgical implantation and removal of contraceptive devices, such as Norplant implants.

WELL NEWBORN CARE

The Plan shall cover well newborn care while the mother is confined for delivery. Covered expenses for services, supplies or treatment of the newborn child shall be considered charges of the child and as such, subject to a separate deductible and coinsurance from the mother.

Such care shall include, but is not limited to:

1. Physician services.
2. Hospital services.
3. Circumcision.

WELL CHILD CARE

Covered expenses for well child care shall include charges for the following services provided to covered dependent children, up to age nineteen (19): routine pediatric examinations for a reason other than to diagnose an injury or illness; immunizations; laboratory and other tests given in connection with pediatric examinations.

Covered expenses for well child care are limited to:

1. Eight (8) routine well baby check-up examinations during the first twenty-four (24) months following birth, including routine laboratory.
2. One (1) routine well baby check-up examination during each of the third, fourth, fifth, sixth and seventh twelve (12) month periods following birth, including routine laboratory.
3. One (1) routine examination every two (2) years from age seven (7) through age eighteen (18), including routine laboratory.
4. One (1) hearing and eye examination every twenty-four (24) months through age eighteen (18).

ROUTINE PREVENTIVE CARE

Covered expenses for routine services and supplies, including immunizations, that are not required due to illness or injury are limited to:

1. One (1) gynecological examination and Papanicolaou test (Pap Smear) per calendar year. Additional testing is covered at any age as Medically Necessary and upon referral of the woman’s health care provider.
2. One (1) physical examination, prostate examination; colonoscopy, sigmoidoscopy, laboratory tests and x-rays, etc. every four (4) years from age nineteen (19) through thirty-four (34).
3. One (1) physical examination, prostate examination; colonoscopy, sigmoidoscopy, laboratory tests and x-rays, etc. every two (2) years for ages thirty-five (35) and older.
**ROUTINE MAMMOGRAMS**

Routine mammograms shall be covered as follows:

1. One (1) baseline mammogram for women age thirty-five (35) through thirty-nine (39);
2. One (1) mammogram every calendar year for women age forty (40) and over.

Additional testing is covered at any age as Medically Necessary or if a health care provider determines the covered member is at high risk for breast cancer.

**THERAPY SERVICES**

Therapy services provided in a home setting as outlined under Home Health Care are subject to pre-certification. Therapy services must be ordered by a *physician* to aid restoration of normal function lost due to *illness* or *injury*.

**Covered expenses** shall include:

1. Services of a *professional provider* for physical therapy, occupational therapy, speech therapy or respiratory therapy.
2. Radiation therapy and chemotherapy.
3. Dialysis therapy or treatment.
4. Infusion therapy.
5. Vision therapy (orthoptics).

Inpatient occupational and physical therapy benefits are limited to thirty (30) inpatient days per calendar year. Inpatient occupational and physical therapy benefits for head and spinal cord injuries or stroke are increased to sixty (60) days per calendar year. Outpatient benefits are limited to thirty (30) sessions per calendar year. Outpatient benefits are increased to sixty (60) sessions per calendar year for head and spinal cord injuries or stroke.

**EXTENDED CARE FACILITY**

*Extended care facility confinement* is subject to pre-certification. Failure to obtain pre-certification shall result in a reduction of benefits as specified in the *Claim Filing Procedure* section of this document.

*Extended care facility* services, supplies and treatments shall be a *covered expense* provided the *covered person* is under a *physician's* continuous care and the *physician* certifies that the *covered person* must have twenty-four (24) hours-per-day nursing care.

**Covered expenses** shall include:

1. *Room and board* (including regular daily services, supplies and treatments furnished by the *extended care facility*) limited to the *facility's* average *semiprivate* room rate; and
2. Other services, supplies and treatment ordered by a *physician* and furnished by the *extended care facility* for *inpatient* medical care.

*Extended care facility* benefits are limited to one hundred (100) days per calendar year.
HOME HEALTH CARE

Home health care is subject to pre-certification. Failure to obtain pre-certification shall result in a reduction of benefits as specified in the Claim Filing Procedure section of this document.

Home health care enables the covered person to receive treatment in his home for an illness or injury instead of being confined in a hospital or extended care facility. Covered expenses shall include the following services and supplies provided by a home health care agency:

1. Part-time or intermittent nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse;
2. Physical, respiratory, occupational or speech therapy;
3. Part-time or intermittent home health aide services for a covered person who is receiving covered nursing or therapy services;
4. Infusion therapy.
5. Medical social service consultations;
6. Nutritional guidance by a registered dietitian and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be medically necessary.

Covered expenses are limited to one hundred and eighty (180) days per calendar year.

A visit by a member of a home health care team and four (4) hours of home health aide service will each be considered one (1) home health care visit.

No home health care benefits will be provided for dietitian services (except as may be specifically provided herein), homemaker services, maintenance therapy, dialysis treatment, food or home delivered meals, rental or purchase of durable medical equipment or prescription or non-prescription drugs or biologicals.

HOSPICE CARE

Hospice care is subject to pre-certification. Failure to obtain pre-certification shall result in a reduction of benefits as specified in the Claim Filing Procedure section of this document.

Hospice care is a health care program providing a coordinated set of services rendered at home, in outpatient settings, or in facility settings for a covered person suffering from a condition that has a terminal prognosis.

Hospice benefits will be covered only if the covered person's attending physician certifies that:

1. The covered person is terminally ill, and
2. The covered person has a life expectancy of six (6) months or less.

Covered expenses shall include:

1. Confinement in a hospice to include ancillary charges and room and board.
2. Services, supplies and treatment provided by a hospice to a covered person in a home setting.
3. Physician services and/or nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse.
4. Physical therapy, occupational therapy, speech therapy or respiratory therapy.

5. Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be medically necessary.

6. Counseling services provided through the hospice.

7. Bereavement counseling as a supportive service to covered persons in the terminally ill covered person’s immediate family. Benefits will be payable, provided:

   a. On the date immediately before death, the terminally ill person was covered under the Plan and receiving hospice care benefits; and
   b. Services are incurred by the covered person within six (6) months of the terminally ill person’s death.

Charges incurred during periods of remission are not eligible under this provision of the Plan. Any covered expense paid under hospice benefits will not be considered a covered expense under any other provision of this Plan.

**DURABLE MEDICAL EQUIPMENT**

Rental or purchase, whichever is less costly, of medically necessary durable medical equipment that is prescribed by a physician and required for therapeutic use by the covered person shall be a covered expense. A charge for the purchase or rental of durable medical equipment is considered incurred on the date the equipment is received/delivered.

Durable medical equipment that is received/delivered after the termination date of a covered person’s coverage under this Plan is not covered. Repair or replacement of purchased durable medical equipment that is medically necessary due to normal use or a physiological change in the patient's condition will be considered a covered expense.

Equipment containing features of an aesthetic nature or features of a medical nature that are not required by the covered person's condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment that is less costly than the equipment furnished, will be covered based on the usual charge for the equipment that meets the covered person's medical needs.

**PROSTHESES**

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a covered expense. A charge for the purchase of a prosthesis is considered incurred on the date the prosthesis is received/delivered. A prosthesis that is received/delivered after the termination date of a covered person’s coverage under this Plan is not covered. Repair or replacement of a prosthesis that is medically necessary due to normal use or a physiological change in the patient's condition will be considered a covered expense.

**ORTHOTICS**

Orthotic devices and appliances (a rigid or semi-rigid supportive device that restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a covered expense. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered. Replacement will be covered only after five (5) years from the date of original placement, unless a physiological change in the patient's condition necessitates earlier replacement.
DENTAL SERVICES

Covered expenses shall include repair of sound natural teeth or a fractured jaw provided it is the result of an injury. Diagnosis must be made within six (6) months and treatment within twelve (12) months of the date of such injury. Damage to the teeth as a result of chewing or biting shall not be considered an injury under this benefit.

Facility charges for oral surgery or dental treatment that ordinarily could be performed in the provider’s office will be covered only if the covered person has a concurrent hazardous medical condition that prohibits performing the treatment safely in an outpatient setting and only if the covered person has elected dental coverage.

Covered expenses shall also include charges for injury to or care of the mouth, teeth, gums and alveolar processes only if that care is for the following oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
2. Emergency repair due to injury to sound natural teeth.
3. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
4. Excision of benign bony growths of the jaw and hard palate.
5. External incision and drainage of cellulites.
6. Incision of sensory sinuses, salivary glands or ducts.

Covered expenses shall not include charges for dental and oral surgical procedures involving care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Surgical and non-surgical treatment of temporomandibular joint dysfunction (TMJ) or myofascial pain syndrome shall be a covered expense, but shall not include orthodontia or prosthetic devices prescribed by a physician or dentist.

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include medically necessary special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; diabetic supplies, including test strips, lancets, syringes and needles, insulin pumps, and blood sugar measurement devices; crutches; electronic pacemakers; oxygen and the administration thereof; the initial pair of eyeglasses or contact lenses due to cataract surgery; soft lenses or sclera shells intended for use in the treatment of illness or injury of the eye; support stockings, such as Jobst stockings, limited to two (2) pairs per calendar year; a wig or hairpiece when required due to chemotherapy, surgery or burns, limited to one (1) while covered by this Plan; surgical dressings and other medical supplies ordered by a professional provider in connection with medical treatment, but not common first aid supplies.

COSMETIC/RECONSTRUCTIVE SURGERY

Cosmetic surgery or reconstructive surgery shall be a covered expense provided:

1. A covered person receives an injury as a result of an accident and as a result requires surgery. Cosmetic or reconstructive surgery and treatment must be for the purpose of restoring the covered person to his normal function immediately prior to the accident.
2. It is required to correct a congenital anomaly, for example, a birth defect, for a child under age eighteen (18).

**MASTECTOMY**

This *Plan* intends to comply with the provisions of the federal law known as the Women's Health and Cancer Rights Act of 1998.

*Covered expenses* will include eligible charges related to *medically necessary* mastectomy.

For a *covered person* who elects breast reconstruction in connection with such mastectomy, *covered expenses* will include:

1. Reconstruction of a surgically removed breast; and
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.

Prostheses (and *medically necessary* replacements) and physical complications from all stages of mastectomy, including lymphedemas will also be considered *covered expenses* following all *medically necessary* mastectomies. A single pre-certification determination will apply to all covered mastectomy-related services that are part of the covered person’s course or plan of treatment.

**ORAL AND MAXILLOFACIAL SERVICES**

The following oral and maxillofacial services are covered:

1. Oral and surgical care for tumors and cysts (benign or malignant);
2. Treatment of cleft lip, cleft palate, or other maxillofacial congenital anomalies; and
3. Maxillofacial prosthetic services for restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma, or birth and developmental deformities when the services are performed for the purpose of (a) controlling or eliminating infection or pain, or (b) restoring facial configuration or functions such as speech, swallowing, or chewing.

**MENTAL & NERVOUS DISORDERS AND CHEMICAL DEPENDENCY CARE**

The *Plan* intends to comply with the Chemical Dependency and Mental Health Parity laws effective January 2007. *Covered expenses* for medically necessary *inpatient* and *outpatient* treatment, services or supplies for the treatment of *mental and nervous disorders* and *chemical dependency* shall be treated as other medical benefits provided in this *Plan*, and subject to the deductibles and coinsurance set forth in the *Schedule of Benefits*.

*Inpatient or Partial Confinement*

Subject to the pre-certification provisions of the *Plan*, the *Plan* will pay the applicable *coinsurance*, as shown on the *Schedule of Benefits*, for *confinement in a hospital* or *treatment center* for treatment, services and supplies related to the treatment of *mental and nervous disorders* and *chemical dependency*. Two (2) days of *partial confinement* will be considered as one day of *inpatient confinement*.

*Covered expenses* shall include:

1. *Inpatient hospital confinement*;
2. Individual psychotherapy;
3. Group psychotherapy;
4. Psychological testing;
5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same professional provider.

Outpatient

The Plan shall pay the applicable coinsurance, as shown on the Schedule of Benefits, for outpatient treatment, services and supplies related to the treatment of mental and nervous disorders and chemical dependency.

Covered expenses shall not include charges for:
1. Educational or correctional services or sheltered living provided by a school or halfway house;
2. A long-term residential mental health program that lasts longer than 45 days;
3. Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present;
4. A court-ordered sex offender treatment program;
5. A screening interview or treatment program under ORS 813.021;
6. Non-medically necessary inpatient or outpatient chronic or long-term psychotherapy (defined as services provided in excess of crisis intervention or short-term therapy);
7. Services or supplies for the treatment of paraphilia or other adult gender identity disorders.

PODIATRY SERVICES

Covered expenses shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or débridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

PRIVATE DUTY NURSING

Private duty nursing services in the patient's home are subject to pre-certification. Failure to obtain pre-certification shall result in a reduction of benefits as specified in the Claim Filing Procedure section of this document.

Medically necessary services of an inpatient private duty nurse shall be a covered expense when not custodial in nature and the hospital’s intensive care unit is filled or the hospital has no intensive care unit.

Medically necessary services of an outpatient private duty nurse shall be a covered expense when not custodial in nature. The only charges covered for outpatient nursing care are those shown under Home Health Care. Outpatient private duty nursing care on a 24-hour shift basis is not covered.

DIABETES SELF-MANAGEMENT

Covered expenses shall include reimbursement for supplies, equipment and diabetes self-management programs associated with the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes prescribed by a health care professional legally authorized to prescribe such items.
“Diabetes self-management program” means one (1) program of assessment and training after diagnosis and no more than three (3) hours per year of assessment and training upon a material change of condition, medication or treatment that is provided by an education program credentialed or accredited by a state or national entity accrediting such programs; or program provided by a properly licensed physician, a registered nurse, a nurse practitioner, a certified diabetes educator or a licensed dietitian with demonstrated expertise in diabetes.

**INBORN ERRORS OF METABOLISM**

Clinical visits, biochemical analysis, treatment and medical foods are covered for inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues.

Coverage includes diagnosis, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. Precertification is required.

“Medical foods” are defined as those formulated to be consumed or administered enterally under the supervision of a physician, as defined in ORS 677.010, that are specifically processed or formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts, that are for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained therein, or have other specific nutrient requirements as established by medical evaluation and that are essential to optimize growth, health and metabolic homeostasis.

**SURCHARGES**

Any excise tax, sales tax, surcharge, (by whatever name called) imposed by a governmental entity for services, supplies and/or treatments rendered by a professional provider; physician; hospital; facility or any other health care provider shall be a covered expense under the terms of the Plan.

**OUTPATIENT CARDIAC/PULMONARY REHABILITATION PROGRAMS**

Covered expenses shall include charges for qualified medically necessary outpatient cardiac/pulmonary rehabilitation programs.

**SLEEP DISORDERS**

Covered expenses shall include charges for sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors.

**MEDICAL EXCLUSIONS**

In addition to Plan Exclusions, no benefit will be provided under this Plan for medical expenses for the following:

1. Charges for services, supplies or treatment for the reversal of surgical sterilization procedures.

2. Charges for services, supplies or treatment related to the treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, in-vitro fertilization, surrogate mother, fertility drugs when used for treatment of infertility, embryo implantation, or gamete intrafallopian transfer (GIFT).

3. Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment. However, treatment of congenital hermaphroditism is a covered expense.
4. Charges for treatment or surgery for sexual dysfunction or inadequacies unless related to injury or organic illness.

5. Charges for hospital admission on Friday, Saturday or Sunday unless the admission is an emergency situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, hospital expenses will be payable commencing on the date of actual surgery.

6. Charges for inpatient room and board in connection with a hospital confinement primarily for diagnostic tests, unless it is determined by the Plan that inpatient care is medically necessary.

7. Charges for services, supplies or treatment of mental retardation, learning disabilities and autism for covered persons age seven (7) years or older.

8. Charges for biofeedback therapy.

9. Charges for services, supplies or treatments that are primarily educational in nature, except as specified in Medical Expense Benefit, Diabetic Self-Management; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

10. Charges for marriage, family, career or legal counseling.

11. Except as specifically stated in Medical Expense Benefit, Dental Services, charges for or in connection with: treatment of injury or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.

12. Charges for routine vision examinations and eye refractions; eyeglasses or contact lenses, except as specified herein.

13. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.

14. Except as medically necessary for the treatment of metabolic or peripheral-vascular illness, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

15. Charges for services, supplies or treatment that constitute personal comfort or beautification items, whether or not recommended by a physician, such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment.

16. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.

17. Charges for prescription drugs that are covered under the Prescription Drug Program or for the Prescription Drug copay applicable thereeto. Outpatient prescription drugs are paid under the Prescription Drug Program and under no other provision of this Plan.

18. Orthopedic shoes are not covered unless they are part of a leg brace and are included in the orthopedist’s charge or therapeutic extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes and determined to be medically necessary under the Plan.
19. Expenses for a **cosmetic surgery** or procedure and all related services, except as specifically stated in *Medical Expense Benefit, Cosmetic/Reconstructive Surgery.*

20. Charges incurred as a result of, or in connection with, any procedure or treatment excluded by this *Plan* that has resulted in medical complications.

21. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and **hospital confinements** for weight reduction programs.

22. Charges for surgical weight reduction procedures and all related charges, even if resulting from morbid obesity.

23. Charges for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches.

24. Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid; or for a cochlear implant, except as specified herein.

25. Charges for **chiropractic care**, except as provided for on the *Schedule of Benefits.*

26. Charges for treatment or services by a chiropractor, except as provided for on the *Schedule of Benefits.*

27. Charges for routine or periodic physical examinations, such as annual physical, screening examination, employment physical, or any related charges, such as premarital lab work, mammogram, and other care not associated with treatment or diagnosis of an **illness or injury**, except as specified herein.

28. Charges related to faith healing services or homeopathy. Acupuncture treatment or naturopathy will be covered as shown on the Alternative Care *Schedule of Benefits.*

29. Orthognathic surgery to change the position of a bone of the upper or lower jaw (except when necessary due to an injury or except when performed on a person who has been enrolled since birth).

30. Charges for **custodial care**, domiciliary care or rest cures.

31. Charges for travel or accommodations, whether or not recommended by a **physician**, except as specifically provided herein.

32. Charges for wigs, artificial hairpieces, artificial hair transplants, or any drug - prescription or otherwise - used to eliminate baldness or stimulate hair growth, except as specified herein.

33. Charges for expenses related to hypnosis.

34. Charges for the expenses of the donor of an organ or tissue for transplant to a recipient who is not a **covered person** under this *Plan.*

35. Charges for professional services billed by a **physician** or Registered Nurse, Licensed Practical Nurse or Licensed Vocational Nurse who is an employee of a **hospital** or any other facility and who is paid by the **hospital** or other facility for the service provided.

36. Charges for environmental change including **hospital** or **physician** charges connected with prescribing an environmental change.
37. Charges for room and board in a facility for days on which the covered person is permitted to leave (a weekend pass, for example).

38. Charges for chelation therapy, except as treatment of heavy metal poisoning.

39. Charges for sex therapy, diversional therapy or recreational therapy. Massage therapy will be limited as shown on the Alternative Care Schedule of Benefits.

40. Charges for procurement and storage of one's own blood, unless incurred within three (3) months prior to a scheduled surgery.

41. Charges for holistic medicines or providers of naturopathy, except as shown on the Alternative Care Schedule of Benefits.

42. Charges for or related to the following types of treatment:
   a. primal therapy;
   b. rolfing;
   c. psychodrama;
   d. megavitamin therapy;
   e. visual perceptual training.

43. Charges for structural changes to a house or vehicle.

44. Charges for exercise programs for treatment of any condition

45. Charges for any services, supplies or treatment not specifically provided herein.
PRESCRIPTION DRUG PROGRAM

PHARMACY OPTION

Participating pharmacies have contracted with the Plan to charge covered persons reduced fees for covered prescription drugs.

PHARMACY OPTION COPAY

The copay is applied to each covered pharmacy drug charge and is shown on the Schedule of Benefits. The copay amount is not a covered expense under the Medical Expense Benefit. Any one prescription is limited to a thirty-four (34) day supply.

If a drug is purchased from a nonparticipating pharmacy or a participating pharmacy when the covered person’s ID card is not used, the covered person must pay the entire cost of the prescription, including copay, and then submit the receipt to the prescription drug card vendor for reimbursement.

If a brand name is requested, or if a physician prescribes a brand name drug when a generic is available, the covered person is responsible for the difference in cost between the brand name and generic drug in addition to the copay.

MAIL ORDER OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs that may be prescribed for heart disease, high blood pressure, asthma, etc.).

MAIL ORDER OPTION COPAY

The copay is applied to each covered mail order prescription charge and is shown on the Schedule of Benefits. The copay is not a covered expense under the Medical Expense Benefit. Any one prescription is limited to a ninety (90) day supply or thirty (30) day supply for self-injectable medication.

If a brand name is requested, or if a physician prescribes a brand name drug when a generic is available, the covered person is responsible for the difference in cost between the brand name and generic drug in addition to the copay.

COVERED PRESCRIPTION DRUGS

1. Drugs prescribed by a physician that require a prescription either by federal or state law, including injectables and insulin, except drugs excluded by the Plan.

2. Compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.

3. Insulin, insulin needles and syringes and diabetic supplies when prescribed by a physician.

4. Allergy serums.

5. Oral contraceptives, regardless of the reason prescribed.

6. Diaphragms.

7. Any other drug that, under the applicable state law, may be dispensed only upon the written prescription of a qualified prescriber.
LIMITS TO THIS BENEFIT

This benefit applies only when a covered person incurs a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a physician.
2. Refills up to one year from the date of order by a physician.

EXPENSES NOT COVERED

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin.
2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.
3. Immunization agents or biological sera, blood or blood plasma.
4. A drug or medicine labeled: “Caution - limited by federal law to investigational use.”
5. Experimental drugs and medicines, even though a charge is made to the covered person, including DESI drugs (drugs determined by the FDA as lacking substantial evidence of effectiveness).
6. Any charge for the administration of a covered prescription drug.
7. Any drug or medicine that is consumed or administered at the place where it is dispensed.
8. A drug or medicine that is to be taken by the covered person, in whole or in part, while hospital confined. This includes being confined in any institution that has a facility for dispensing drugs.
9. A charge for prescription drugs that may be properly received without charge under local, state or federal programs.
10. A charge for injectables or any prescription directing administration by injection (other than insulin and self-administered injectables).
11. A charge for prescription drugs for smoking cessation purposes, including smoking deterrent patches.
12. A charge for infertility medication.
13. A charge for contraceptive devices other than diaphragms.
15. A charge for minerals.
17. A charge for medications that are cosmetic in nature (i.e., treating hair loss, wrinkles, etc.).
18. A charge for growth hormones.
19. A charge for weight loss drugs.
20. A charge for Tretinoins, all dosage forms, for **covered persons** age 26 and over.

21. A charge for non-legend drugs, other than as specifically listed herein.

22. A charge for Hematinics.

23. A charge for drugs used in the treatment of erectile dysfunction (i.e., Viagra).


25. A charge for stolen, lost, spilled or destroyed prescription medications.

Any prescription drug covered under the Prescription Drug Program will **not** be covered under the Medical Expense Benefit, except as specified in Medical Expense Benefit, Prescription Drugs.

**NOTICE OF AUTHORIZED REPRESENTATIVE**

The **covered person** may provide the **plan administrator** or their designee with a written authorization for an authorized representative to represent and act on behalf of a **covered person** and consent to release of information related to the **covered person** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department.

**APPEALING A DENIED POST-SERVICE PRESCRIPTION DRUG CLAIM**

The “**named fiduciary**” for purposes of an appeal of a denied Prescription Drug Post-Service Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the **claims processor**.

A **covered person**, or the **covered person’s** authorized representative, may request a review of a denied claim by making written request to the **named fiduciary** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the **covered person** feels the claim should not have been denied.

The following describes the review process and rights of the **covered person**:

1. The **covered person** has a right to submit documents, information and comments.

2. The **covered person** has the right to access, free of charge, **relevant information** to the claim for benefits.

3. The review takes into account all information submitted by the **covered person**, even if it was not considered in the initial benefit determination.

4. The review by the **named fiduciary** will not afford deference to the original denial.

5. The **named fiduciary** will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.

6. If original denial was, in whole or in part, based on medical judgment:
   a. The **named fiduciary** will consult with a **professional provider** who has appropriate training and experience in the field involving the medical judgment; and
   b. The **professional provider** utilized by the **named fiduciary** will be neither:
i. An individual who was consulted in connection with the original denial of the claim, nor
ii. A subordinate of any other professional provider who was consulted in connection with
the original denial.

7. If requested, the named fiduciary will identify the medical or vocational expert(s) who gave advice in
connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON A POST SERVICE
PRESCRIPTION DRUG CLAIM APPEAL

The plan administrator or their designee shall provide the covered person (or authorized representative) with a
written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.
2. Reference to specific Plan provisions on which the denial is based.
3. A statement that the covered person has the right to access, free of charge, relevant information to the
claim for benefits.
4. A statement that if the covered person’s appeal is denied, the covered person has the right to bring a civil
5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal
Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
6. If the denial was based on medical necessity, experimental/investigational treatment or similar exclusion
or limit, the Plan will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the
claimant’s medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.
The Plan will not provide benefits for any of the items listed in this section, regardless of medical necessity or recommendation of a physician or professional provider.

1. Charges for services, supplies or treatment from any hospital owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.

2. Charges for an injury sustained or illness contracted while on active duty in military service, unless payment is legally required.

3. Charges for services, treatment or supplies for treatment of illness or injury that is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

4. Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Workers' Compensation law, Employer's liability law, or occupational disease law, even though the covered person fails to claim rights to such benefits or fails to enroll or purchase such coverage.

5. Charges in connection with any illness or injury arising out of or in the course of any employment intended for wage or profit, including self-employment.

6. Charges made for services, supplies and treatment which are not medically necessary for the treatment of illness or injury, or which are not recommended and approved by the attending physician, except as specifically stated herein, or to the extent that the charges exceed customary and reasonable amount or exceed the negotiated rate, as applicable.

7. To the extent that payment under this Plan is prohibited by any law of any jurisdiction in which the covered person resides at the time the expense is incurred.

8. Charges for services rendered and/or supplies received prior to the effective date or after the termination date of a person's coverage.

9. Any services, supplies or treatment for which the covered person is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.

10. Charges for services, supplies or treatment that are considered experimental/investigational.

11. Charges incurred outside the United States if the covered person traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

12. Charges for services, supplies or treatment rendered by any individual who is a close relative of the covered person or who resides in the same household as the covered person.

13. Charges for services, supplies or treatment rendered by physicians or professional providers beyond the scope of their license; for any treatment, confinement or service that is not recommended by or performed by an appropriate professional provider.
14. Charges for illnesses or injuries suffered by a covered person due to the action or inaction of any party if the covered person fails to provide information as specified in the section, Subrogation/Reimbursement.

15. Claims not submitted within the Plan's filing limit deadlines as specified in the section, Claim Filing Procedure.

16. Charges for telephone or e-mail consultations, completion of claim forms, charges associated with missed appointments.

17. This Plan will not pay for any charge that has been refused by another plan covering the covered person as a penalty assessed due to non-compliance with that plan's rules and regulations, if shown on the primary carrier's explanation of benefits.

18. Benefits that are payable under any one section of this Plan shall not be payable as a benefit under any other section of this Plan. For example, if a benefit is eligible under both the Medical Expense Benefit section and the Dental Expense Benefit section, and is paid under the Medical Expense Benefit, the remaining balance will not be paid under the Dental Expense Benefit.

The Plan does not exclude pre-existing conditions from coverage.
ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

This section identifies the Plan’s requirements for a person to participate in the Plan.

EMPLOYEE ELIGIBILITY

Refer to the Schedule of Benefits insert for employee eligibility requirements.

EMPLOYEE ENROLLMENT

An employee must file a written application with the employer for coverage hereunder for himself within thirty-one (31) days of becoming eligible for coverage. The employee shall have the responsibility of timely forwarding to the employer all applications for enrollment hereunder.

EMPLOYEE(S) EFFECTIVE DATE

Refer to the Schedule of Benefits insert for employee’s effective date.

DEPENDENT(S) ELIGIBILITY

The following describes dependent eligibility requirements. The employer may require proof of dependent status.

1. The term "spouse" means the spouse of the employee under a legally valid existing marriage with a person of the opposite sex, unless court ordered separation exists.

   The term "domestic partner" means that the dependent:

   a. Is the same or opposite sex as the employee;
   b. Is at least eighteen (18) years of age and competent to enter into a contract;
   c. Is not legally married or the domestic partner of another individual;
   d. Is not related to the employee by blood closer that which would bar marriage in the state thy reside in;
   e. Has allowed at least six (6) months to pass since the termination of any previous domestic partnership;
   f. Has lived as a couple with the employee in a shared residence for at least six (6) consecutive months; and
   g. Has submitted documentation, as required by the employer, to verify the interdependent relationship with the employee including a joint affidavit with the employee that the relationship is an exclusive mutual commitment that is the functional equivalent of a marriage, that is, the domestic partner and employee:

      i. Are jointly responsible for each other for the necessities of life including each others debts;
      ii. Intend to remain in the relationship indefinitely; and
      iii. Would enter into a legal marriage if the opportunity were available; and have agreed that in the event of dissolution of the domestic partnership there will be a substantially equal division of any earning acquired during the partnership and of property acquired with those earnings, i.e. there will be a division of property similar to that required of a married couple in the event of divorce.
2. The term "child" means the *employee's* natural children, foster children placed with a *covered employee*, adopted children or children placed with a *covered employee* in anticipation of adoption; the natural or adopted children of a domestic partner living in the same household as the *covered employee* and domestic partner, provided:

a. The child is less than twenty-three (23) years of age, and qualifies as a tax dependent under IRC Section 152 (Dependent Defined), and;

b. The child is unmarried, and;

c. The child is principally dependent upon the *employee* for support and maintenance, and;

d. The child is not regularly employed by one or more *employers* on a full-time basis, exclusive of scheduled vacation periods.

Step-children who reside in the *employee's* household may also be included as long as a natural parent remains married to the *employee* and also resides in the *employee's* household.

If a *covered employee* is the legal guardian of an unmarried child or children, these children may be enrolled in the Plan as *covered dependents*.

Enrollment will not be denied because a child was (a) born out of wedlock; (b) is not claimed on the parent’s federal tax return; or (c) does not reside with the parent or within the Plan Service Area.

3. An eligible child shall also include any other child of an *employee* or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) that has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this *Plan*, even if the child is not residing in the *employee's* household. Such child shall be referred to as an *alternate recipient*. *Alternate recipients* are eligible for coverage only if the *employee* is also covered under this *Plan*. An application for enrollment must be submitted to the *employer* for coverage under this *Plan*. The *employer/plan administrator* shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the *Plan* pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the *employer/plan administrator* shall determine whether such order is a Qualified Medical Child Support Order (QMCSO), as defined in Section 609 of ERISA, or a National Medical Support Notice (NMSN), as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

The *employer/plan administrator* reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency that issued the order, up to and including the right to seek a hearing before the court or agency.

4. Adopted children, who are less than eighteen (18) years of age at the time of adoption, shall be considered eligible from the date the child is *placed for adoption*.

5. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the *employee* for support due to a mental and/or physical disability, and who was covered under the *Plan* prior to reaching the maximum age limit or due to other loss of dependent's eligibility and who lives with the *employee*, will remain eligible for coverage under this *Plan* beyond the date coverage would otherwise be lost.

Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by the *employer*, but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

a. Cessation of the mental and/or physical disability;

b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.
Every eligible employee may enroll eligible dependents. If both the husband and wife are employees, each individual may be covered as either an employee or a dependent or both. Eligible children may be enrolled as dependents of one or both parents.

**DEPENDENT ENROLLMENT**

An employee must file a written application with the employer for coverage hereunder for his eligible dependents within thirty-one (31) days of becoming eligible for coverage; and within thirty-one (31) days of marriage or the acquiring of children or birth of a child. The employee shall have the responsibility of timely forwarding to the employer all applications for enrollment hereunder.

**DEPENDENT(S) EFFECTIVE DATE**

Eligible dependent(s), as described in Eligibility, will become covered under the Plan on the later of the dates listed below, provided the employee has enrolled them in the Plan within thirty-one (31) days of meeting the Plan's eligibility requirements.

1. The date the employee's coverage becomes effective.
2. The date the dependent is acquired, provided any required contributions are made and the employee has applied for dependent coverage within thirty-one (31) days of the date acquired.
3. Newborn children shall be covered from birth, provided the employee has applied for dependent coverage within thirty-one (31) days of birth.
4. Coverage for a newly adopted or to be adopted child shall be effective on the date the child is placed for adoption.

**SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)**

An employee or dependent who did not enroll for coverage under this Plan because he was covered under other group coverage or had health insurance coverage at the time he was initially eligible for coverage under this Plan, may request a special enrollment period if he is no longer eligible for the other coverage. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Termination of the other coverage (including exhaustion of COBRA benefits)
2. Cessation of employer contributions toward the other coverage
3. Legal separation or divorce
4. Termination of other employment or reduction in number of hours of other employment
5. Death of dependent or spouse
6. Cessation of other coverage because employee or dependent no longer resides or works in the service area and no other benefit package is available to the individual
7. Cessation of dependent status under other coverage and dependent is otherwise eligible under employee’s plan
8. An incurred claim that would exceed the other coverage’s maximum benefit limit. The maximum benefit limit is all-inclusive and means that no further benefits are payable under the other coverage because the specific total benefit pay out maximum has been reached under the other coverage. The right for special enrollment continues for thirty (30) days after the date the claim is denied under the other coverage.
Notwithstanding any provision of this Plan to the contrary, all benefits received by an individual under any benefit option, package or coverage under the Plan shall be applied toward the maximum benefit paid by this Plan for any one covered person for such option, package or coverage under the Plan, and also toward the maximum benefit under any other options, packages or coverages under the Plan in which the individual may participate in the future.

The end of any extended benefits period, that has been provided due to any of the above, will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage).

The employee or dependent must request the special enrollment and enroll no later than thirty-one (31) days from the date of loss of other coverage.

The effective date of coverage as the result of a special enrollment shall be the date of loss of other coverage.

**SPECIAL ENROLLMENT PERIOD (NEW DEPENDENT)**

An employee who is not covered under the Plan, but who acquires a new dependent may request a special enrollment period. For the purposes of this provision, the acquisition of a new dependent includes:

1. Marriage.
2. Birth of a dependent child.
3. Adoption or placement for adoption of a dependent child.

The employee must request the special enrollment within thirty-one (31) days of the acquisition of the dependent.

The effective date of coverage as the result of a special enrollment shall be:

1. In the case of marriage, the first day of the first calendar month following the plan administrator's receipt of the completed enrollment form;
2. In the case of a dependent's birth, the date of such birth;
3. In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

**TIMELY ENROLLMENT**

The enrollment will be “timely” if the completed form is received by the employer no later than thirty-one (31) days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period. Any eligible individual who does not timely enroll within the meaning of this section or qualify for a Special Enrollment Period will be considered a Late Enrollee and will be excluded from coverage for up to 12 months or until the next Open Enrollment date as specified in this Plan.

In the event that a non-English speaker wishes to enroll in the Plan and encounters difficulty due to a language barrier, the employer will provide translation services to assist in such enrollment.

If two (2) employees [the mother and father of the child(ren)] are covered under the Plan and the employee who is covering the dependent children terminates coverage, the dependent coverage may be continued by the other covered employee with no waiting period as long as coverage has been continuous.
OPEN ENROLLMENT

Open enrollment is the period designated by the employer during which the employee may change benefit plans or enroll in the Plan if he did not do so when first eligible or does not qualify for a special enrollment period. An open enrollment will be permitted once in each calendar year. A covered employee who fails to make an election or to change enrollment during the open enrollment period will automatically retain his or her present coverage.

During this open enrollment period, an employee and his dependents who are covered under this Plan or covered under any employer sponsored health plan may elect coverage or change coverage under this Plan for himself and his eligible dependents. An employee must make written application as provided by the employer during the open enrollment period to change benefit plans.

The effective date of coverage as the result of an open enrollment period will be the following April 1st.

Except for a status change listed below, the open enrollment period is the only time an employee may change benefit options or modify enrollment. Status changes include:

1. Change in family status. A change in family status shall include only:
   a. Change in employee's legal marital status;
   b. Change in number of dependents;
   c. Termination or commencement of employment by the employee, spouse or dependent;
   d. Change in work schedule;
   e. Dependent satisfies (or ceases to satisfy) dependent eligibility requirements;
   f. Change in residence or worksite of employee, spouse or dependent.

2. Change in the cost of coverage under the employer's group medical plan.

3. Cessation of required contributions.

4. Taking or returning from a leave of absence under the Family and Medical Leave Act of 1993.

5. Significant change in the health coverage of the employee or spouse attributable to the spouse's employment.

6. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act of 1996.

7. A court order, judgment or decree.

8. Entitlement to Medicare or Medicaid.

9. A COBRA qualifying event.
TERMINATION OF COVERAGE

RENEWAL, MODIFICATION AND DISCONTINUANCE

This agreement is renewable with respect to all covered persons at the option of the employer except:

1. For non-payment of the required contributions by the employer.
2. For fraud of misrepresentation by the employer, or with respect to the coverage of a covered person by the covered person or the covered person’s representative.
3. For non-compliance with minimum participation requirements.
4. For non-compliance with the contribution requirements.
5. When the trust discontinues offering or renewing this group health benefit plan in this state or in a specified service area within this state. In order to discontinue the plan the trust:
   a. Must give notice of the decision to the director of the Department of Consumer and Business Services and to all employers covered by the plan;
   b. May not cancel coverage under the plans for 180 days after the date of the notice required above if coverage is discontinued in the entire state, or, except as provided in (6) below, in a specified service area;
   c. May not cancel coverage under the plans for 90 days after the date of the notice required above if coverage is discontinued in the specified service area because of an inability to reach an agreement with providers to provide services under the plans with the service area; and
   d. Must discontinue offering or renewing, or offering and renewing all health benefit plans covered by the trust in this state or in the specified service area.
6. When the trust discontinues offering and renewing a group health benefit plan in a specified service area within this state because of an inability to reach an agreement with providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the trust:
   a. Must give notice of the decision to the director and to all employers covered by the plan;
   b. May not cancel coverage under the plan for 90 days after the date of the notice required above;
   and
   c. Must offer in writing to each employer covered by the Plan any other group health benefit plans the trust may offer in the specified service area. The trust will offer any such plans at least 90 days prior to the discontinuation.
7. When the trust discontinues offering or renewing, or offering and renewing, health benefit plan for all groups in this state or in a specified service area within this state other than a plan discontinued above, with respect to plans that are being discontinued, the trust must:
   a. Offer in writing to each employer covered by the Plan, any and all health benefit plans that the trust offers in the specified service area.
   b. Offer the plans at least 90 days prior to discontinuation.
   c. Act uniformly without regard to the claims experience of the affected employers or the health status of any current or prospective enrollee.

When the director orders the trust to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of coverage would not be in the best interest of the covered persons or would impair our ability to meet contractual obligations when, in the case of a
health benefit plan that delivers coverage services through a specified network of healthcare providers, there is no longer any covered person who lives or works in the service area of the provider network.

8. When in the case of a health benefit plan that is offered only through one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

9. For misuse of a provider network provision, which means a disruptive, unruly or abusive action taken by a member that threatens the physical health or wellbeing of healthcare staff and seriously impairs the trust’s ability or the ability of our participating providers to provide services to a covered person.

The trust may modify this agreement at the time of renewal. The modification is not a discontinuation of this agreement. Written notice of modifications will be given to the employer at least 30 days prior to the effective date of the renewal. The 30-day notice requirement does not apply to normal and customary administrative changes that do not have an actuarial impact, such as formulary changes, or to a decrease or increase required by state or federal law.

Notwithstanding any provision to the contrary, the trust may rescind an agreement for fraud, material misrepresentation or concealment by an employer and the coverage of a covered person may be rescinded for fraud, material misrepresentation or concealment by the covered person.

In the event the termination of this agreement on one of the grounds specified in this agreement, termination will be effective as to the employer and all covered persons and enrolled dependents irrespective of whether monthly premiums have been received for periods beyond the termination date. However, in no event will this agreement continue beyond the last day of the month for which monthly premiums have been received. Contributions will be charged and collected for any period between the date through which contributions are paid and the termination date. If the agreement is to terminate due to the required contributions not paid when due, we will provide a written notice to the employer, specifying the last date the contributions may be paid (no less than 10 days from the date of the notice) in order to reinstate the agreement.

We shall notify the employer by mail on a form that complies with applicable law within 10 days after this agreement is terminated and not replaced by the employer. This provision shall apply when an employer terminates participation in a multiple employer trust as well as in the event of termination of this agreement when held by a multiple employer trust. If notice is not given as required by this article, coverage shall continue from the date notice should have been provided until the date notice is received and contributions for that period shall be waived.

**TERMINATION OF EMPLOYEE COVERAGE**

Except as provided in the Plan's Continuation of Coverage (COBRA), coverage will terminate on the earliest of the following dates:

1. The date the employer terminates the Plan and offers no other group health plan.
2. The last day of the month in which the employee ceases to meet the eligibility requirements of the Plan.
3. The last day of the month in which employment terminates, as defined by the employer's personnel policies.
4. The date the employee becomes a full-time, active member of the armed forces of any country.
5. The end of the period for which the employee has made any required contributions.
6. The last day of the month during which the employee retires, unless the employee is eligible for retiree coverage.
TERMINATION OF DEPENDENT(S) COVERAGE

Except as provided in the Plan's Continuation of Coverage (COBRA), coverage will terminate on the earliest of the following dates:

1. The date the employer terminates the Plan and offers no other group health plan.
2. The date the employee's coverage terminates.
3. The date such person ceases to meet the eligibility requirements of the Plan.
4. The end of the period the employee ceases to make any required contributions on the dependent's behalf.
5. The date the dependent becomes a full-time, active member of the armed forces of any country.
6. The date the Plan discontinues dependent coverage for any and all dependents.
7. The date the dependent becomes eligible as an employee.

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for employees and/or dependents, when the employee is on an authorized leave of absence from the employer. In no event will coverage continue for more than three (3) months after the employee's active service ends.

DISABILITY

Coverage may be continued for a limited time, contingent upon payment of any required contributions for employees and/or dependents, if the employee stops active work because of an employer-certified disability. In no event will coverage continue for more than three (3) months after the employee's active service ends.

SEVERANCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for employees and/or dependents, as the result of a severance package agreement for the length of time negotiated between the employee and employer. For additional information regarding a severance package, please contact the Human Resources Department.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An employee who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this Plan for up to twelve (12) weeks during any twelve (12) month period.

Contributions

During this leave, the employer will continue to pay the same portion of the employee's contribution for the Plan. The employee shall be responsible to continue payment for eligible dependent's coverage and any remaining employee contributions. If the covered employee fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

Reinstatement
If coverage under the Plan was terminated during an approved FMLA leave, and the employee returns to active work immediately upon completion of that leave, Plan coverage will be reinstated on the date the employee returns to active work as if coverage had not terminated, provided the employee makes any necessary contributions and enrolls for coverage within thirty-one (31) days of his return to active work.

Repayment Requirement

The employer may require employees who fail to return from a leave under FMLA to repay any contributions paid by the employer on the employee's behalf during an unpaid leave. This repayment will be required only if the employee's failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the employee's control.

Worker’s Compensation

If an employee incurs an injury or illness for which a workers’ compensation claim is filed, the Plan will continue with respect to that employee upon timely payment of the required contribution that includes the employee and the employer portion of the contribution and such coverage will be maintained until the employee takes full-time employment with another employer or six months from the date of payment, whichever is earliest.

Termination and Hospitalization

The Plan shall continue its obligation to any participant in this Plan who is hospitalized on the date of termination if the Plan is terminated and immediately replaced by a group health insurance policy issued by another insurer. Any payment is subject to the terms, limitations and conditions of the policy except those relating to the termination of benefits. Any obligation under this section continues until the end of the hospitalization or benefits are exhausted under this Plan, whichever occurs first.

CONTINUATION FOR DIVORCED, SEPARATED OR SURVIVING SPOUSE WHO IS 55 YEARS OR OLDER

Continuation of coverage (including coverage for dependent children) is available for a legal spouse who is age fifty-five (55) or older and eligibility for coverage ends due to legal separation, termination of marriage or the employee’s death. Continuation under this section is not available for any dependent electing coverage under the Continuation of Coverage (COBRA) section.

In order to be eligible for continued coverage under this section, the spouse must give written notice of the legal separation, termination of marriage or death of the employee, to the plan administrator within:

1. Thirty (30) days of the date of the employee’s death;
2. Sixty (60) days of the date of legal separation; or
3. Sixty (60) days of the date of entry of the divorce decree.

Within fourteen (14) days of receipt of the above notice, the plan administrator shall notify the spouse that coverage can be continued, and will provide an election form to the spouse. The spouse must return the election form within sixty (60) days after the plan administrator mails it. Failure of the spouse to exercise the election within sixty (60) days of the notification shall terminate the right to continued benefits under this section.

If the plan administrator fails to notify the spouse within the required fourteen (14) days, contributions shall be waived until the date the notice is received by the spouse.
The monthly contribution rate for continued coverage will be the monthly rate that would have been charged if the spouse was an individual under this Plan plus the contribution rate for coverage of dependent children, if any. Each monthly contribution (except the initial payment) must be paid by the spouse to the plan administrator within thirty (30) days of the contribution due date. The initial payment must be paid by the spouse to the plan administrator within forty-five (45) days of the date the election to continue coverage is made.

Coverage will be continued until the earliest of:

1. The date the spouse becomes covered under any other group health plan;
2. The date the spouse becomes eligible for federal Medicare coverage;
3. The last day of the month for which contributions were paid to the plan administrator if coverage terminates due to non-payment of contributions; or
4. The date the Plan terminates or the date the employer terminates participation under this Plan.

CERTIFICATES OF CREDITABLE COVERAGE

The plan administrator shall provide each terminating covered person with a Certificate of Creditable Coverage, certifying the period of time the individual was covered under this Plan. For employees with dependent coverage, the certificate provided may include information on all covered dependents. This Plan intends to, at all times, comply with the provisions of the Health Insurance Portability and Accountability Act of 1996.

PORTABILITY RIGHTS – CONTINUATION OPTIONS UNDER OREGON MEDICAL INSURANCE POOL

If an individual’s coverage under the Trust terminates and that coverage was continuously in effect for a period of 180 days or more, the individual is eligible for coverage under the Oregon Medical Insurance Pool (“OMIP”) if an application for coverage is made not later than the 63rd day after the date of first eligibility and the individual is an Oregon resident at the time of such application. Please see the Oregon Medical Insurance Pool rules for more information at www.omip.state.or.us.

CONTINUITY OF CARE

If the covered person is undergoing treatment with a participating provider on the date our contract with that participating provider will terminate, the covered person may be able to continue to receive care from that provider, subject to the following conditions:

1. The covered person must be undergoing an active course of treatment that is medically necessary on the date the contract would otherwise terminate; and
2. The benefits available to the covered person under this agreement, in relation to that course of treatment, would otherwise be eliminated or reduced to a benefit level below the benefit level specified in the plan for out-of-network providers if the covered person continued to receive care from that provider; and
3. The contract terminates for reasons allowed under Oregon statute; and both the covered person and the provider agree that it is desirable to continue the course of treatment with that provider; and
4. If the course of treatment is related to the covered person’s pregnancy, the covered person has already entered the second trimester of that pregnancy; and the provider agrees to continue the relationship with us as a participating provider, in relation to the course of treatment for that covered person, as if the contract between that provider and us had not terminated. This relationship shall continue for the duration of that course of treatment.
When a contract with a participant provider will terminate, we will notify all members who we know, or reasonably should know, are under the care of that participating provider. If we first learn that a covered person is affected at a later date, we will notify that covered person within 10 days of identifying that covered person.

The notice will be in writing and notify affected covered persons of the termination and the right to continuity of care as provided under this section. The notice will be provided as soon as we are aware of the termination, but in no event later than 10 days following the effective date of the termination. The date of the notice will be the earlier of the date the notice was received by the covered person, and the date we receive or approve the request for continuity of care.

A course of treatment continued under this provision will be treated as if the provider was still a participating provider, until the following dates:

1. For pregnancy; the later of
   a. 45 days following the birth of the child; and
   b. When the care for that pregnancy ends.

2. For all other conditions, when the care for that condition ends.

3. However, in no instance shall the provisions of this section extend beyond the 120th day following the date the covered person was notified of the termination of the contract with the participating provider and the covered person’s right to continuity of care.
CONTINUATION OF COVERAGE

This section will also apply to domestic partners and domestic partner’s children at Linfield College, Pacific University, Reed College, Western States Chiropractic College and Willamette University.

COBRA continuation is not available to domestic partners and domestic partner’s children at Lewis & Clark College.

In order to comply with federal regulations, this Plan includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This continuation of coverage may be commonly referred to as "COBRA coverage" or "continuation coverage."

The coverage that may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical, prescription drug, dental and vision benefits as provided under the Plan.

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a covered person to lose coverage under this Plan or cause an increase in required contributions, even if such loss of coverage or increase in required contributions does not take effect immediately, and allow such person to continue coverage beyond the date described in Termination of Coverage:

1. Death of the employee.
2. The employee's termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the Plan. This event is referred to below as an "18-Month Qualifying Event."
3. Divorce or legal separation from the employee.
4. The employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.
5. A dependent child no longer meets the eligibility requirements of the Plan.
6. The last day of leave under the Family and Medical Leave Act of 1993, or an earlier date on which the employee informs the employer that he or she will not be returning to work.
7. The call-up of an employee reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered employee, or a child's loss of dependent status, the employee or dependent must submit a completed Qualifying Event Notification form to the plan administrator (or its designee) within sixty (60) days of the latest of:
   a. The date of the event;
   b. The date on which coverage under this Plan is or would be lost as a result of that event; or
   c. The date on which the employee or dependent is furnished with a copy of this Plan Document and Summary Plan Description.
A copy of the Qualifying Event Notification form is available from the plan administrator (or its designee). In addition, the employee or dependent may be required to promptly provide any supporting documentation as may be reasonably requested for purposes of verification. Failure to provide such notice and any requested supporting documentation will result in the person forfeiting their rights to continuation of coverage under this provision.

Within fourteen (14) days of the receipt of a properly completed Qualifying Event Notification, the plan administrator (or its designee) will notify the employee or dependent of his rights to continuation of coverage, and what process is required to elect continuation of coverage. This notice is referred to below as "Election Notice."

2. When eligibility for continuation of coverage results from any qualifying event under this Plan other than the ones described in Paragraph 1 above, the employer must notify the plan administrator (or its designee) not later than thirty (30) days after the date on which the employee or dependent loses coverage under the Plan due to the qualifying event. Within fourteen (14) days of the receipt of the notice of the qualifying event, the plan administrator (or its designee) will furnish the Election Notice to the employee or dependent.

3. In the event it is determined that an individual seeking continuation of coverage (or extension of continuation coverage) is not entitled to such coverage, the plan administrator (or its designee) will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. This notice is referred to here as the "Non-Eligibility Notice." The Non-Eligibility Notice will be furnished in accordance with the same time frame as applicable to the furnishing of the Election Notice.

4. In the event an Election Notice is furnished, the eligible employee or dependent has sixty (60) days to decide whether to elect continued coverage. Each person who is described in the Election Notice and was covered under the Plan on the day before the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the employee or dependent chooses to have continuation coverage, he must advise the plan administrator (or its designee) of this choice by returning to the plan administrator (or its designee) a properly completed Election Notice not later than the last day of the sixty (60) day period. If the Election Notice is mailed to the plan administrator (or its designee), it must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:

   a. The date coverage under the Plan would otherwise end; or
   b. The date the person receives the Election Notice from the plan administrator (or its designee).

5. Within forty-five (45) days after the date the person notifies the plan administrator (or its designee) that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the period in which the initial payment is made. Thereafter, payments for the continuation coverage are to be made monthly, and are due in advance, on the date specified by the plan administrator (or its designee).

**COST OF COVERAGE**

1. The Plan requires that covered persons pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. Except for the initial payment (see above), payments must be remitted to the plan administrator (or its designee) by or before the first day of each period during the continuation period. The payment must be remitted on a timely basis in order to maintain the coverage in force.

2. For a person originally covered as an employee or as a spouse, the cost of coverage is the amount applicable to an employee if coverage is continued for himself alone. For a person originally covered as a child and continuing coverage independent of the family unit, the cost of coverage is the amount applicable to an employee.
WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the initial payment is made within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

FAMILY MEMBERS ADDED DURING CONTINUATION

A spouse or dependent child newly acquired during continuation coverage is eligible to be enrolled as a dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A dependent acquired and enrolled after the original qualifying event, other than a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

EXTENSION OF CONTINUATION COVERAGE

In the event any of the following events occur during the period continuation coverage resulting from an 18-Month Qualifying Event, it is possible for a dependent's continuation coverage to be extended:

1. Death of the employee.
2. Divorce or legal separation from the employee.
3. The child's loss of dependent status.

Written notice of such event must be provided by submitting a completed Additional Extension Event Notification form to the plan administrator (or its designee) within sixty (60) days of the latest of:

1. The date of that event;
2. The date on which coverage under this Plan would be lost as a result of that event if the first qualifying event had not occurred; or
3. The date on which the employee or dependent is furnished with a copy of this Plan Document and Summary Plan Description.

A copy of the Additional Extension Event Notification form is available from the plan administrator (or its designee). In addition, the dependent may be required to promptly provide any supporting documentation as may be reasonably required for purposes of verification. Failure to properly provide the Additional Extension Event Notification and any requested supporting documentation will result in the person forfeiting their rights to extend continuation coverage under this provision. In no event will any extension of continuation coverage extend beyond thirty-six (36) months from the later of the date of the first qualifying event or the date as of which continuation coverage began.

Only a person covered prior to the original qualifying event or a child born to or placed for adoption with a covered employee during a period of COBRA coverage may be eligible to continue coverage through an extension of continuation coverage as described above. Any other dependent acquired during continuation coverage is not eligible to extend continuation coverage as described above.

A person who loses coverage on account of an 18-Month Qualifying Event may extend the maximum period of continuation coverage from eighteen (18) months to up to twenty-nine (29) months in the event both of the following occur:
1. That person (or another person who is entitled to continuation coverage on account of the same 18-Month Qualifying Event) is determined by the Social Security Administration, under Title II or Title XVI of the Social Security Act, to have been disabled before the sixtyith (60th) day of continuation coverage; and

2. The disability status, as determined by the Social Security Administration, lasts at least until the end of the initial eighteen (18) month period of continuation coverage.

The disabled person (or his representative) must submit written proof of the Social Security Administration's disability determination to the plan administrator (or its designee) within the initial eighteen (18) month period of continuation coverage and no later than sixty (60) days after the latest of:

1. The date of the disability determination by the Social Security Administration;
2. The date of the 18-Month Qualifying Event;
3. The date on which the person loses (or would lose) coverage under this Plan as a result of the 18-Month Qualifying Event; or
4. The date on which the person is furnished with a copy of this Plan Document and Summary Plan Description.

Should the disabled person fail to notify the plan administrator (or its designee) in writing within the time frame described above, the disabled person (and others entitled to disability extension on account of that person) will then be entitled to whatever period of continuation he or they would otherwise be entitled to, if any. The Plan may require that the individual pay one hundred and fifty percent (150%) of the cost of continuation coverage during the additional eleven (11) months of continuation coverage. In the event the Social Security Administration makes a final determination that the individual is no longer disabled, the individual must provide notice of that final determination no later than thirty (30) days after the later of:

1. The date of the final determination by the Social Security Administration; or
2. The date on which the individual is furnished with a copy of this Plan Document and Summary Plan Description.

**END OF CONTINUATION**

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months [or twenty-nine (29) months if continuation coverage is extended due to certain disability status as described above] from the date continuation began because of an 18-Month Qualifying Event or the last day of leave under the Family and Medical Leave Act of 1993.

2. Twenty-four (24) months from the date continuation began because of the call-up to military duty.

3. Thirty-six (36) months from the date continuation began for dependents whose coverage ended because of the death of the employee, divorce or legal separation from the employee, or the child's loss of dependent status.

4. The end of the period for which contributions are paid if the covered person fails to make a payment by the date specified by the plan administrator (or its designee). In the event continuation coverage is terminated for this reason, the individual will receive a notice describing the reason for the termination of coverage, the effective date of termination, and any rights the individual may have under this Plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right. This notice is referred to below as an "Early Termination Notice."
5. The date coverage under this Plan ends and the employer offers no other group health benefit plan. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

6. The date the covered person first becomes entitled, after the date of the covered person's original election of continuation coverage, to Medicare benefits under Title XVIII of the Social Security Act. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

7. The date the covered person first becomes covered under any other employer's group health plan after the original date of the covered person's election of continuation coverage, but only if such group health plan does not have any exclusion or limitation that affects coverage of the covered person's pre-existing condition. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

8. For the spouse or dependent child of a covered employee who becomes entitled to Medicare prior to the spouse’s or dependent's election for continuation coverage, thirty-six (36) months from the date the covered employee becomes entitled to Medicare.

SPECIAL RULES REGARDING NOTICES

1. Any notice required in connection with continuation coverage under this Plan must, at minimum, contain sufficient information so that the plan administrator (or its designee) is able to determine from such notice the employee and dependent(s) (if any), the qualifying event or disability, and the date on which the qualifying event occurred.

2. In connection with continuation coverage under this Plan, any notice required to be provided by any individual who is either the employee or a dependent with respect to the qualifying event may be provided by a representative acting on behalf of the employee or the dependent, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.

3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:
   a. A single notice addressed to both the employee and the spouse will be sufficient as to both individuals if, on the basis of the most recent information available to the Plan, the spouse resides at the same location as the employee; and
   b. A single notice to the employee or the spouse will be sufficient as to each dependent child of the employee if, on the basis of the most recent information available to the Plan, the dependent child resides at the same location as the individual to whom such notice is provided.

PRE-EXISTING CONDITIONS

While this plan does not contain an exclusion for pre-existing conditions, in the event that a covered person becomes eligible for coverage under another employer-sponsored group health plan, and that group health plan has an applicable exclusion or limitation regarding coverage of the covered person's pre-existing condition, the covered person's continuation coverage under the Plan will not be affected by enrollment under that other group health plan. This Plan shall be primary payer for the covered expenses that are excluded or limited under the other employer sponsored group health plan and secondary payer for all other expenses.

MILITARY MOBILIZATION

If an employee is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the employee and the employee's dependent may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).
When the leave is less than thirty-one (31) days, the employee or employee's dependent may not be required to pay more than the employee's share, if any, applicable to that coverage. If the leave is thirty-one (31) days or longer, then the plan administrator (or its designee) may require the employee or employee's dependent to pay no more than one hundred and two percent (102%) of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or  
2. A period beginning on the day that the leave began and ending on the day after the employee fails to return to employment within the time allowed.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty, the employee or the employee's dependent will be reinstated without pre-existing conditions exclusions or a waiting period, regardless of their election of COBRA continuation coverage.

**PLAN CONTACT INFORMATION**

Questions concerning this Plan, including any available continuation coverage, can be directed to the plan administrator.

**ADDRESS CHANGES**

In order to help ensure the appropriate protection of rights and benefits under this Plan, covered persons should keep the plan administrator (or its designee) informed of any changes to their current addresses.
PROCEDURES FOR FILING CLAIMS, GRIEVANCES AND APPEALS

A “pre-service claim” is a claim for a Plan benefit that is subject to the prior certification rules, as described in the section, Pre-Service Claim Procedure. All other claims for Plan benefits are “post-service claims” and are subject to the rules described in the section, Post-Service Claim Procedure. The Covered Person shall have the opportunity to file a grievance or appeal an adverse claim decision as set forth below.

POST-SERVICE CLAIM PROCEDURE

FILING A CLAIM

1. Claims should be submitted to address noted below:

   For Providence Preferred Provider claims:

       Providence Preferred PPO
       P.O. Box 3236
       Portland, OR 97208

   For Managed HealthCare NW claims:

       Managed HealthCare Northwest, Inc.
       1120 N.W. 20th Ave Suite 200
       Portland, OR 97209

   For all other claims:

       CoreSource, Inc.
       P.O. Box 2920
       Clinton, Iowa 52733-2920

   The date of receipt will be the date the claim is received by the claims processor.

2. All claims submitted for benefits must contain all of the following:

   a. Name of patient.
   b. Patient’s date of birth.
   c. Name of employee.
   d. Address of employee.
   e. Name of employer and group number.
   f. Name, address and tax identification number of provider.
   g. Employee Social Security Number.
   h. Date of service.
   i. Diagnosis (applies to medical claims only).
   j. Description of service and procedure number.
   k. Charge for service.
   l. The nature of the accident, injury or illness being treated.
3. All claims not submitted within twelve (12) months from the date the services were rendered will not be a covered expense and will be denied.

The covered person may ask the health care provider to submit the claim directly to the claims processor or to the Preferred Provider Organization as outlined above, or the covered person may submit the bill with a claim form. However, it is ultimately the covered person’s responsibility to make sure the claim for benefits has been filed.

NOTICE OF AUTHORIZED REPRESENTATIVE

The covered person may provide the plan administrator (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a covered person and consent to the release of information related to the covered person to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department.

NOTICE OF CLAIM

A claim for benefits should be submitted to the claims processor within ninety (90) calendar days after the occurrence or commencement of any services by the Plan, or as soon thereafter as reasonably possible.

Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within that time; and (2) such claim was furnished as soon as possible, but no later than twelve (12) months after the loss occurs or commences, unless the claimant is legally incapacitated.

Notice given by or on behalf of a covered person or his beneficiary, if any, to the plan administrator or to any authorized agent of the Plan, with information sufficient to identify the covered person, shall be deemed notice of claim.

TIME FRAME FOR BENEFIT DETERMINATION

After a completed claim has been submitted to the claims processor, and no additional information is required, the claims processor will generally complete its determination of the claim within thirty (30) calendar days of receipt of the completed claim unless an extension is necessary due to circumstances beyond the Plan’s control.

After a completed claim has been submitted to the claims processor, and if additional information is needed for determination of the claim, the claims processor will provide the covered person (or authorized representative) with a notice detailing information needed.

The notice will be provided within thirty (30) calendar days of receipt of the completed claim and will state the date as of which the Plan expects to make a decision.

The covered person will have forty-five (45) calendar days to provide the information requested, and the Plan will complete its determination of the claim within fifteen (15) calendar days of receipt by the claims processor of the requested information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

NOTICE OF BENEFIT DENIAL

If the claim for benefits is denied, the plan administrator (or its designee) shall provide the covered person (or authorized representative) with a written Notice of Benefit Denial within the time frames described immediately above.

The Notice of Benefit Denial shall include an explanation of the denial, including:

1. The specific reasons for the denial.
2. Reference to the Plan provisions on which the denial is based.

3. A description of any additional material or information needed and an explanation of why such material or information is necessary.

4. A description of the Plan’s claim review procedure and applicable time limits.

5. A statement that if the covered person’s appeal (Refer to Appealing a Denied Post-Service Claim below) is denied, the covered person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

7. If denial was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the Plan will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the covered person’s medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

**APPEALING A DENIED POST-SERVICE CLAIM**

**Level One Appeal**

The “named fiduciary” for purposes of a level one appeal of a Post-Service Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the claims processor.

A covered person, or the covered person’s authorized representative, may request a review of a denied claim by making written request to the named fiduciary within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the covered person feels the claim should not have been denied.

The following describes the review process and rights of the covered person:

1. The covered person has the right to submit documents, information and comments.

2. The covered person has the right to access, free of charge, relevant information to the claim for benefits.

3. The review takes into account all information submitted by the covered person, even if it was not considered in the initial benefit determination.

4. The review by the named fiduciary will not afford deference to the original denial.

5. The named fiduciary will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.

6. If original denial was, in whole or in part, based on medical judgment:
a. The named fiduciary will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment; and
b. The professional provider utilized by the named fiduciary will be neither:
   i. An individual who was consulted in connection with the original denial of the claim, nor
   ii. A subordinate of any other professional provider who was consulted in connection with the original denial.

7. If requested, the named fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

**NOTICE OF BENEFIT DETERMINATION ON APPEAL**

The plan administrator (or its designee) shall provide the covered person (or authorized representative) with a written notice of the appeal decision within thirty (30) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.
2. Reference to specific Plan provisions on which the denial is based.
3. A statement that the covered person has the right to access, free of charge, relevant information to the claim for benefits.
4. A statement that if the covered person’s appeal is denied, the covered person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
6. If the denial was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the Plan will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant’s medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

**Level Two Voluntary Appeal (May Include External Review)**

The “named fiduciary” for purposes of a level two appeal of a Post-Service Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the plan administrator.

A covered person, or the covered person’s authorized representative, may request a review of a denied claim by making written or verbal request to the named fiduciary within one hundred eighty (180) calendar days from receipt of notification of the level one denial and stating the reasons the covered person feels the claim should not have been denied. Written requests may be sent to the following address:
If the **covered person** decides to proceed with the voluntary second level appeal, the internal review appeal will be determined by an appeal panel comprised of reviewers not previously involved in the case. The covered person and any representative of the covered person shall have the opportunity to appear before the review board. Within seven (7) calendar days of receipt of an appeal, the **covered person** or their representative will receive an acknowledgement letter from the **plan administrator**. The **plan administrator**’s appeal coordinator will notify the **covered person** or their representative, in writing, of the decision within thirty (30) days of receiving the appeal.

This final internal appeal, which is voluntary on the part of the **covered person**, may qualify for a further voluntary appeal, external review. External review is available only for certain types of appeals described below and will be decided by an Independent Review Organization (IRO). Appeals qualifying for external appeal must first have been considered through internal review, unless the **covered person** and the **named fiduciary** for level two appeals have mutually agreed to waive that requirement.

**External Review**

If an External Review is requested, the request for external review will be forwarded to the Department of Consumer and Business Services (DCBS).

The IRO will review the external review request based upon:

1. An adverse determination based on medically necessity (i.e. cosmetic or nonparticipating provider services);
2. An adverse determination for treatment determined as experimental or investigational; or
3. For purposes of continuity of care (no interruption of an active course or treatment).

In order to have the appeal decided by an IRO, the **covered person** or their representative must sign a waiver granting the independent review organization access to medical records; and have exhausted all other appeal opportunities under this Plan unless the **covered person** and the **named fiduciary** for level two have mutually agreed to waive that requirement.

The IRO is assigned by the DCBS and is not connected with the Plan in any way. The **covered person** is not responsible for the costs of the independent review.

A written response to an appeal will be sent to the **covered person** or their representative within twenty (20) days of the IRO receiving the appeal. **The Plan is not bound by the decision made by the IRO. However, the Plan may nevertheless follow the decision of the IRO. If the Plan does not follow the decision of the IRO, a suit may be filed against the Plan.** Please refer to the Claims Procedures within this document for further information regarding appeals.

For more information regarding external review, please contact CoreSource, Inc. at 1-866-280-4120.
Assistance From The Department Of Consumer And Business Services

You also have the right to file a complaint and seek assistance from the director of the DCBS at:

Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, Oregon 97310
503 947-7984
E-mail: http://www.cbs.state.or.us/external/ins/

FOREIGN CLAIMS

In the event a covered person incurs a covered expense in a foreign country, the covered person shall be responsible for providing the claim information to the claims processor.

PRE-SERVICE CLAIM PROCEDURE

HEALTH CARE MANAGEMENT

Health care management is the process of evaluating whether proposed services, supplies or treatments are medically necessary and appropriate to help ensure quality, cost-effective care.

Certification of medical necessity and appropriateness by the Health Care Management Organization does not establish eligibility under the Plan nor guarantee benefits.

FILING A PRE-CERTIFICATION CLAIM

This pre-certification provision will be waived by the Health Care Management Organization if the covered expense is rendered outside of the continental United States.

All inpatient admissions, partial hospitalizations and home health care (excluding supplies and durable medical equipment), residential treatment, hospice care, extended care facility and private duty nursing are to be certified by the Health Care Management Organization. For non-urgent care, the covered person (or their authorized representative) must call the Health Care Management Organization at least fifteen (15) calendar days prior to initiation of services. If the Health Care Management Organization is not called at least fifteen (15) calendar days prior to initiation of services for non-urgent care, benefits may be reduced. For urgent care, the covered person (or their authorized representative) must call the Health Care Management Organization within forty-eight (48) hours or the next business day, whichever is later, after the initiation of services. Please note that if the covered person needs medical care that would be considered as urgent or emergency care, then there is no requirement that the Plan be contacted for prior approval.

Covered persons shall contact the Health Care Management Organization by calling the telephone number on their I.D. Card.

When a covered person (or authorized representative) calls the Health Care Management Organization, he or she should be prepared to provide all of the following information:

1. Employee’s name, address, phone number and Social Security Number.
2. Plan’s name.
3. If not the employee, the patient’s name, address, phone number.
4. Admitting physician’s name and phone number.

5. Name of facility or home health care agency.

6. Date of admission or proposed date of admission.

7. Condition for which patient is being admitted.

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

However, hospital maternity stays in excess of forty-eight (48) or ninety-six (96) hours as specified above must be pre-certified.

If the covered person (or authorized representative) fails to contact the Health Care Management Organization prior to the hospitalization, home health care, residential treatment, hospice care, extended care facility or private duty nursing and within the timelines detailed above, the amount of benefits payable for covered expenses incurred shall be reduced by five hundred dollars ($500). If the Health Care Management Organization declines to grant the full pre-certification requested, benefits for days not certified as medically necessary by the Health Care Management Organization shall be denied. (Refer to Post-Service Claim Procedure discussion above.)

Pre-certification determinations relating to benefit coverage and medical necessity will be binding on the plan if obtained within 30 days prior to the date the service is provided.

NOTICE OF AUTHORIZED REPRESENTATIVE

The covered person may provide the plan administrator (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a covered person and consent to release of information related to the covered person to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department. Notwithstanding the foregoing, requests for pre-certification and other pre-service claims or requests by a person or entity other than the covered person may be processed without a written authorization if the request or claim appears to the plan administrator (or its designee) to come from a reasonably appropriate and reliable source (e.g., physician’s office, individuals identifying themselves as immediate relatives, etc.).

TIME FRAME FOR PRE-SERVICE CLAIM DETERMINATION

1. In the event the Plan receives from the covered person (or authorized representative) a communication that fails to follow the pre-certification procedure as described above but communicates at least the name of the covered person, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the covered person (or the authorized representative) will be orally notified (and in writing if requested), within five (5) calendar days of the failure of the proper procedure to be followed.

2. After a completed pre-certification request for non-urgent care has been submitted to the Plan, and if no additional information is required, the Plan will generally complete its determination of the claim within a reasonable period of time, but no later than fifteen (15) calendar days from receipt of the request.
After a pre-certification request for non-urgent care has been submitted to the Plan, and if an extension of time to make a decision is necessary due to circumstances beyond the control of the Plan, the Plan will, within fifteen (15) calendar days from receipt of the request, provide the covered person (or authorized representative) with a notice detailing the circumstances and the date by which the Plan expects to render a decision. If the circumstances include a failure to submit necessary information, the notice will specifically describe the needed information. The covered person will have forty-five (45) calendar days to provide the information requested, and the Plan will complete its determination of the claim no later than fifteen (15) calendar days after receipt by the Plan of the requested information. Failure to respond in a timely and complete manner will result in a denial.

CONCURRENT CARE CLAIMS

If an extension beyond the original certification is required, the covered person (or authorized representative) shall call the Health Care Management Organization for continuation of certification.

If a covered person (or authorized representative) requests to extend a previously approved hospitalization or an ongoing course of treatment, and;

1. The request involves non-urgent care, then the extension request must be processed within fifteen (15) calendar days after the request was received.

2. The inpatient admission or ongoing course of treatment involves urgent care, and

   a. The request is received at least twenty-four (24) hours before the scheduled end of a hospitalization or course of treatment, then the request must be ruled upon and the covered person (or authorized representative) notified as soon as possible taking into consideration medical exigencies but no later than twenty-four (24) hours after the request was received; or

   b. The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment, then the request must be ruled upon and the covered person (or authorized representative) notified as soon as possible but no later than seventy-two (72) hours after the request was received; or

   c. The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment and additional information is required, the covered person (or authorized representative) will be notified within twenty-four (24) hours of the additional information required. The covered person (or authorized representative) has forty-eight (48) hours to provide such information (may be oral unless written is requested). Upon timely response, the covered person (or authorized representative) will be notified as soon as possible but no later than forty-eight (48) hours after receipt of additional information. Failure to submit requested information timely will result in a denial of such request.

If the Health Care Management Organization determines that the hospital stay or course of treatment should be shortened or terminated before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved, then the Health Care Management Organization shall:

1. Notify the covered person of the proposed change, and

2. Allow the covered person to file an appeal and obtain a decision, before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved.

If, at the end of a previously approved hospitalization or course of treatment, the Health Care Management Organization determines that continued confinement is no longer medically necessary, additional days will not be certified. (Refer to Appealing a Denied Pre-Service Claim discussion below.)
NOTICE OF PRE-SERVICE CLAIM DENIAL

If a pre-certification request is denied in whole or in part, the plan administrator (or its designee) shall provide the covered person (or authorized representative) with a written Notice of Pre-Service Claim Denial within the time frames above.

The Notice of Pre-Service Claim Denial shall include an explanation of the denial, including:

1. The specific reasons for the denial.
2. Reference to the Plan provisions on which the denial is based.
3. A description of any additional material or information needed and an explanation of why such material or information is necessary.
4. A description of the Plan’s claim review procedure and applicable time limits.
5. A statement that if the covered person’s appeal (Refer to Appealing a Denied Pre-Service Claim below) is denied, the covered person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If denial was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the Plan will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the covered person’s medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING A DENIED PRE-SERVICE CLAIM

Level One Appeal

The “named fiduciary” for purposes of a level one appeal of a Pre-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the claims processor.

A covered person (or authorized representative) may request a review of a denied Pre-Service claim by making a verbal or written request to the named fiduciary within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the covered person feels the claim should not have been denied. If the covered person (or authorized representative) wishes to appeal the denial when the services in question have already been rendered, such an appeal will be considered as a separate post-service claim. (Refer to Post-Service Claim Procedure discussion above.)

The following describes the review process and rights of the covered person:

1. The covered person has a right to submit documents, information and comments.
2. The covered person has the right to access, free of charge, relevant information to the claim for benefits.
3. The review takes into account all information submitted by the covered person, even if it was not considered in the initial benefit determination.

4. The review by the named fiduciary will not afford deference to the original denial.

5. The named fiduciary will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.

6. If original denial was, in whole or in part, based on medical judgment:
   a. The named fiduciary will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment.
   b. The professional provider utilized by the named fiduciary will be neither:
      i. An individual who was consulted in connection with the original denial of the claim, nor
      ii. A subordinate of any other professional provider who was consulted in connection with the original denial.

7. If requested, the named fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF PRE-SERVICE DETERMINATION ON APPEAL

The plan administrator (or its designee) shall provide the covered person (or authorized representative) with a written Notice of Appeal Decision as soon as possible, but not later than thirty (30) calendar days from receipt of the appeal (not applicable to urgent care claims).

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the decision, including:

1. The specific reasons for the denial.
2. Reference to specific Plan provisions on which the denial is based.
3. A statement that the covered person has the right to access, free of charge, relevant information to the claim for benefits.
4. A statement that if the covered person’s appeal is denied, the covered person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
5. A statement that the covered person has the right to access, free of charge, information about the voluntary appeal process.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the denial was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the Plan will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant’s medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.
Level Two Voluntary Appeal

The “named fiduciary” for purposes of a level two voluntary appeal of a Pre-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the claims processor.

The Health Care Management Organization, upon request by the covered person (or authorized representative) within one hundred eighty (180) calendar days from receipt of notification of a level one pre-service appeal denial, will conduct a level two voluntary appeal. This appeal is comprised of a panel of three professional providers that were not consulted in connection with the original pre-service denial. The covered person’s decision as to whether to submit a previously denied appeal to the voluntary appeal process will have no effect on the covered person’s rights to any other benefits under the Plan. There are no fees or costs imposed as a condition to use of the voluntary appeal process.

Upon receipt of the request to conduct a voluntary appeal, a determination will be made within thirty (30) calendar days. Notification of the outcome of the review will be communicated verbally and in writing.

With respect to pre-service claims, the Plan agrees not to later assert a defense of failure to exhaust available administrative remedies against a covered person who chooses not to make use of the voluntary appeal process.

With respect to pre-service claims, the Plan agrees that any statute of limitations or other defense based on timelines is tolled while the dispute is under submission to the voluntary appeal process.

Upon written request, more information about the voluntary appeal process is available, free of charge, from the Health Care Management Organization.

Level Three Voluntary Appeal (May Include External Review)

The “named fiduciary” for purposes of a level three appeal of a Pre-Service Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the plan administrator.

A covered person, or the covered person’s authorized representative, may request a review of a denied claim by making written or verbal request to the named fiduciary within one hundred eighty (180) calendar days from receipt of notification of the level one denial and stating the reasons the covered person feels the claim should not have been denied. Written requests may be sent to the following address:

Pioneer Educators Health Trust  
c/o Rico Bocala  
USI Northwest  
700 NE Multnomah Street, Suite 1300  
Portland, OR  97232

If the covered person decides to proceed with the voluntary third level appeal, the internal review appeal will be determined by an appeal panel comprised of reviewers not previously involved in the case. The covered person and any representative of the covered person shall have the opportunity to appear before the review board. Within seven (7) calendar days of receipt of an appeal, the covered person or their representative will receive an acknowledgement letter from the plan administrator. The plan administrator’s appeal coordinator will notify the covered person or their representative, in writing, of the decision within thirty (30) days of receiving the appeal.

This final internal appeal, which is voluntary on the part of the covered person, may qualify for a further voluntary appeal, external review. External review is available only for certain types of appeals described below and will be decided by an independent review organization (IRO). Appeals qualifying for external appeal must first have been considered through internal review, unless the covered person and the named fiduciary for level three appeals have mutually agreed to waive that requirement.

External Review
If an External Review is requested, the request for external review will be forwarded to the Department of Consumer and Business Services (DCBS).

The IRO will review the external review request based upon:

1. An adverse determination based on medically necessity (i.e. cosmetic or nonparticipating provider services);
2. An adverse determination for treatment determined as experimental or investigational; or
3. For purposes of continuity of care (no interruption of an active course or treatment).

In order to have the appeal decided by an IRO, the covered person or their representative must sign a waiver granting the independent review organization access to medical records; and have exhausted all other appeal opportunities under this Plan unless, the covered person and the named fiduciary for level two have mutually agreed to waive that requirement.

The IRO is assigned by the DCBS and is not connected with the Plan in any way. The covered person is not responsible for the costs of the independent review.

A written response to an appeal will be sent to the covered person or their representative within twenty (20) days of the IRO receiving the appeal. The Plan is not bound by the decision made by the IRO. However, the Plan may nevertheless follow the decision of the IRO. If the Plan does not follow the decision of the IRO, a suit may be filed against the Plan. Please refer to the Claims Procedures within this document for further information regarding appeals.

For more information regarding external review, please contact CoreSource, Inc. at 1-866-280-4120.

Assistance From The Department Of Consumer And Business Services

You also have the right to file a complaint and seek assistance from the director of the DCBS at:

Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, Oregon 97310
503 947-7984
E-mail: http://www.cbs.state.or.us/external/ins/

CASE MANAGEMENT

In cases where the covered person’s condition is expected to be or is of a serious nature, the Health Care Management Organization may arrange for review and/or case management services from a professional qualified to perform such services. The plan administrator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost-effective result without a sacrifice to the quality of care.

In addition, the Health Care Management Organization may recommend (or change) alternative methods of medical care or treatment, equipment or supplies that:

1. Are not covered expenses under this Plan; or
2. Are covered expenses under this Plan but on a basis that differs from the alternative recommended by the Health Care Management Organization.
The recommended alternatives will be considered as *covered expenses* under the *Plan* provided the expenses can be shown to be viable, *medically necessary*, and are included in a written case management report or treatment plan proposed by the *Health Care Management Organization*.

Case management will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that *covered person* or any other *covered person*. 


COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent duplication of benefits. It applies when the covered person is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed one hundred percent (100%) of "allowable expenses." Only the amount paid by this Plan will be charged against the maximum benefit.

The Coordination of Benefits provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses incurred while covered under this Plan, part or all of which would be covered under this Plan. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this Plan.

When this Plan is secondary, "Allowable Expense" will include any deductible or coinsurance amounts not paid by the Other Plan(s).

This Plan is not eligible to be elected as primary coverage in lieu of automobile benefits. Payments from automobile insurance will always be primary and this Plan shall be secondary only.

When this Plan is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the covered person for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) do not include flexible spending accounts (FSA), health reimbursement accounts (HRA), health savings account (HSA), individual medical, dental or vision insurance policies. Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for covered persons in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type plans;
2. Hospital or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage for students that is sponsored by, or provided through, a school or other educational institution;
5. Any coverage under a government program and any coverage required or provided by any statute;
6. Group automobile insurance;
7. Individual automobile insurance coverage;
8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;
9. Any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;
10. Labor/management trustees, union welfare, employer organization, or employee benefit organization plans.

"This Plan" shall mean that portion of the employer's Plan that provides benefits that are subject to this provision.

"Claim Determination Period" means a calendar year or that portion of a calendar year during which the covered person for whom a claim is made has been covered under this Plan.

**EFFECT ON BENEFITS**

This provision shall apply in determining the benefits for a covered person for each claim determination period for the Allowable Expenses. If this Plan is secondary, the benefits paid under this Plan may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expenses.

If the rules set forth below would require this Plan to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this Plan.

**ORDER OF BENEFIT DETERMINATION**

Each plan will make its claim payment according to the first applicable provision in the following list of provisions that determine the order of benefit payment:

1. **No Coordination of Benefits Provision**
   If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).

2. **Member/Dependent**
   The plan that covers the claimant directly pays before a plan that covers the claimant as a dependent.

3. **Dependent Children of Parents not Separated or Divorced**
   The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

4. **Dependent Children of Separated or Divorced Parents**
   When parents are separated or divorced, the birthday rule gender rule does not apply, instead:
   a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.
   b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody, if any, pays fourth.
5. **Active/Inactive**  
The plan covering a person as an active (not laid off or retired) *employee* or as that person's *dependent* pays first. The plan covering that person as a laid off or retired *employee*, or as that person's *dependent* pays second.

6. **Limited Continuation of Coverage**  
If a person is covered under another group health plan, but is also covered under this *Plan* for continuation of coverage due to the Other Plan's limitation for *pre-existing conditions* or exclusions, the Other Plan shall be primary.

7. **Longer/Shorter Length of Coverage**  
If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

**COORDINATION WITH MEDICARE**

Individuals may be eligible for *Medicare* Part A at no cost if they: (i) are age 65 or older, (ii) have been determined by the Social Security Administration to be disabled, or (iii) have end stage renal disease. Participation in *Medicare* Parts B and D are available to all individuals who make application and pay the full cost of the coverage.

In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII, Parts A and B Social Security Act, as enacted or amended. Medicare eligibility and how benefit limits are determined are affected by disability and employment status. Please contact your customer service team if you have questions. In general, the following will apply:

1. When an *employee* becomes entitled to *Medicare* coverage (due to age or disability) and is still in an eligible class, the *employee* may continue health coverage under this *Plan* at the same level of benefits and contribution rate that applied before reaching *Medicare* entitlement.

2. When a *dependent* becomes entitled to *Medicare* coverage (due to age or disability) and the *employee* is still actively at work, the *dependent* may continue health coverage under this *Plan* at the same level of benefits and contribution rate that applied before reaching *Medicare* entitlement.

3. If the *employee* and/or *dependent* is also enrolled in *Medicare* (due to age or disability), this *Plan* shall pay as the primary plan. If, however, the *Medicare* enrollment is due to end stage renal disease, the *Plan*’s primary payment obligation will end at the end of the thirty (30) month “coordination period” as provided in *Medicare* law and regulations.

4. Notwithstanding Paragraphs 1 to 3 above, if the *employer* (including certain affiliated entities that are considered the same *employer* for this purpose) has fewer than one hundred (100) *employees*, when a covered *dependent* becomes entitled to *Medicare* coverage due to *total disability*, as determined by the Social Security Administration, and the *employee* is actively-at-work, *Medicare* will pay as the primary payer for claims of the *dependent* and this *Plan* will pay secondary.

5. If the *employee* and/or *dependent* elect to discontinue health coverage under this *Plan* and enroll under the *Medicare* program, no benefits will be paid under this *Plan*. *Medicare* will be the only payor.

This section is subject to the terms of the *Medicare* laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

**LIMITATIONS ON PAYMENTS**

In no event shall the *covered person* recover under this *Plan* and all Other Plan(s) combined more than the total Allowable Expenses offered by this *Plan* and the Other Plan(s). Nothing contained in this section shall entitle the
covered person to benefits in excess of the total maximum benefits of this Plan during the claim determination period. The covered person shall refund to the employer any excess it may have paid.

**RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION**

For the purposes of determining the applicability of and implementing the terms of this Coordination of Benefits provision, the Plan may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information, regarding other insurance, with respect to any covered person. Any person claiming benefits under this Plan shall furnish to the employer such information as may be necessary to implement the Coordination of Benefits provision.

**FACILITY OF BENEFIT PAYMENT**

Whenever payments that should have been made under this Plan in accordance with this provision have been made under any Other Plan, the employer shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the employer shall be fully discharged from liability.

**AUTOMOBILE BENEFITS**

The Plan’s liability for expenses arising out of an automobile accident shall always be secondary to any automobile insurance, irrespective of the type of automobile insurance law that is in effect in the employee’s state of residence. Currently, there are three (3) types of state automobile insurance laws.

1. No-fault automobile insurance laws.
2. Financial responsibility laws.
3. Other automobile liability insurance laws.

No Fault Automobile Insurance Laws. In no event will the Plan pay any claim presented by or on behalf of an employee for lost wages or medical benefits that would have been payable under an automobile insurance policy but for an election made by the principal named insured under the automobile policy that reduced covered levels and/or subsequent premium. This is intended to exclude, as a covered expense, lost wages or medical expenses arising from an automobile accident that are payable under an automobile insurance policy or that would have been payable under an automobile insurance policy but for such an election.

1. In the event an employee shall incur lost wages or medical expenses as a result of injuries sustained in an automobile accident while “covered by an automobile insurance policy,” as an operator of the vehicle, as a passenger, or as a pedestrian, benefits will be further limited to medical expenses, that would in no event be payable under the automobile insurance; provided however that benefits payable due to a required deductible under the automobile insurance policy will be paid by the Plan up to the amount equal to that deductible.

2. For the purposes of this section the following people are deemed “covered by an automobile insurance policy.”
   a. An owner or principal named insured individual under such policy.
   b. A family member of an insured person for whom coverage is provided under the terms and conditions of the automobile insurance policy.
   c. Any other person who, except for the existence of the Plan, would be eligible for medical expense benefits under an automobile insurance policy.
Financial Responsibility Laws. The *Plan* will be secondary to any potentially applicable automobile insurance even if the state’s “financial responsibility law” does not allow the *Plan* to be secondary.

Other Automobile Liability Insurance. If the state does not have a no-fault automobile insurance law nor a “financial responsibility” law, the *Plan* is secondary to automobile insurance coverage or to any other person or entity who caused the *accident* or who may be liable for the *employee’s* lost wages or medical expenses pursuant to the general rule for *Subrogation*.
SUBROGATION/REIMBURSEMENT

The **Plan** is designed to only pay **covered expenses** for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a **covered person** in a time of need, however, the **Plan** may pay **covered expenses** that may be or become the responsibility of another person, provided that the **Plan** later receives reimbursement for those payments (hereinafter called “Reimbursable Payments”).

Therefore, by enrolling in the **Plan**, as well as by applying for payment of **covered expenses**, a **covered person** is subject to, and agrees to, the following terms and conditions with respect to the amount of **covered expenses** paid by the **Plan**:

1. **Assignment of Rights (Subrogation).** The **covered person** automatically assigns to the **Plan** any rights the **covered person** may have to recover all or part of the same **covered expenses** from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the **Plan**. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a **covered person** or paid to another for the benefit of the **covered person**. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the **covered person** constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the **Plan** to pursue any claim that the **covered person** may have, whether or not the **covered person** chooses to pursue that claim. By this assignment, the **Plan’s** right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. **Equitable Lien and other Equitable Remedies.** The **Plan** shall have an equitable lien against any rights the **covered person** may have to recover the same **covered expenses** from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the **Plan**. The equitable lien also attaches to any right to payment from workers’ compensation, whether by judgment or settlement, where the **Plan** has paid **covered expenses** prior to a determination that the **covered expenses** arose out of and in the course of employment. Payment by workers’ compensation insurers or the employer will be deemed to mean that such a determination has been made.

This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the **covered person**, the **covered person’s** attorney, and/or a trust) as a result of an exercise of the **covered person’s** rights of recovery (sometimes referred to as “proceeds”). The **Plan** shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the **plan administrator**, the **Plan** may reduce any future **covered expenses** otherwise available to the **covered person** under the **Plan** by an amount up to the total amount of Reimbursable Payments made by the **Plan** that is subject to the equitable lien.

This and any other provisions of the **Plan** concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated by the United States Supreme Court in Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002) and Sereboff v. Mid-Atlantic Medical Services, Inc., 126 S.Ct. 1869 (2006). The provisions of the **Plan** concerning subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the “make whole” rule and the “common fund” rule.
3. **Assisting in Plan’s Reimbursement Activities.** The *covered person* has an obligation to assist the *Plan* to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the *covered person*, and to provide the *Plan* with any information concerning the *covered person’s* other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity [including their insurer(s)] that may be obligated to provide payments or benefits to or for the benefit of the *covered person*. The *covered person* is required to (a) cooperate fully in the *Plan’s* (or any *Plan* fiduciary’s) enforcement of the terms of the *Plan*, including the exercise of the *Plan’s* right to subrogation and reimbursement, whether against the *covered person* or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the *Plan* as a co-payee for the amount of the Reimbursable Payments and notifying the *Plan*), (c) sign any document deemed by the *plan administrator* to be relevant to protecting the *Plan’s* subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term “information” includes any documents, insurance policies, police reports, or any reasonable request by the *plan administrator* or *claims processor* to enforce the *Plan’s* rights.

The *plan administrator* has delegated to the *claims processor* the right to perform ministerial functions required to assert the *Plan’s* rights; however, the *plan administrator* shall retain discretionary authority with regard to asserting the *Plan’s* recovery rights.
GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The Plan is administered through the USI NW; Rico Bocala. The plan administrator shall have full charge of the operation and management of the Plan. The plan administrator has retained the services of an independent claims processor experienced in claims review.

The plan administrator is the named fiduciary of the Plan except as noted herein. The claims processor is the named fiduciary of the Plan for pre-service and post-service claim appeals. As the named fiduciary for appeals, the claims processor maintains discretionary authority to review all denied claims under appeal for benefits under the Plan.

APPLICABLE LAW

All provisions of the Plan shall be construed and administered in a manner consistent with the requirements under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

ASSIGNMENT

The Plan will pay benefits under this Plan to the employee unless payment has been assigned to a hospital, physician, or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the Plan unless the claims processor is notified in writing of such assignment prior to payment hereunder.

Preferred providers normally bill the Plan directly. If services, supplies or treatments have been received from such a provider, benefits are automatically paid to that provider. The covered person’s portion of the negotiated rate, after the Plan’s payment, will then be billed to the covered person by the preferred provider.

This Plan will pay benefits to the responsible party of an alternate recipient as designated in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible covered person is entitled to receive benefits under this Plan. Such right to benefits is not transferable.

CLERICAL ERROR

No clerical error on the part of the employer or claims processor shall operate to defeat any of the rights, privileges, services, or benefits of any employee or any dependent(s) hereunder, nor create or continue coverage that would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

Any provision of the Plan that is in conflict with statutes that are applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).
EFFECTIVE DATE OF THE PLAN

The effective date of this Plan is April 1, 2006.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a hospital or to make a free choice of the attending physician or professional provider. However, benefits will be paid in accordance with the provisions of this Plan, and the covered person will have higher out-of-pocket expenses if the covered person uses the services of a nonpreferred provider.

INCAPACITY

If, in the opinion of the employer, a covered person for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the Plan of the qualification of a guardian or personal representative for his estate, the employer may on behalf of the Plan, at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the employer or by the employee covered under this Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing and signed by the employer or by the covered person, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the Plan prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the Plan. No such action shall be brought after the expiration of two (2) years from the date the expense was incurred, or one (1) year from the date a completed claim was filed, whichever occurs first.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the employer shall not be liable for any obligation of the covered person incurred in excess thereof. The employer shall not be liable for the negligence, wrongful act, or omission of any physician, professional provider, hospital, or other institution, or their employees, or any other person. The liability of the Plan shall be limited to the reasonable cost of covered expenses and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the plan administrator is unable to locate the covered person to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the covered person for the forfeited benefits within the time prescribed in the applicable Claim Filing Procedure section of this document.

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The Plan will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a state plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid
either in enrolling that individual as a **covered person** or in determining or making any payment of benefits to that individual. The *Plan* will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a state Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a state Medicaid Plan and this *Plan* has a legal liability to make payments for the same services, supplies or treatment, payment under the *Plan* will be made in accordance with any state law that provides that the state has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the *Plan*.

**MISREPRESENTATION**

If the **covered person** or anyone acting on behalf of a **covered person** makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the *Plan*, or otherwise misleads the *Plan*, the *Plan* shall be entitled to recover its damages, including legal fees, from the **covered person**, or from any other person responsible for misleading the *Plan*, and from the person for whom the benefits were provided. Any material misrepresentation on the part of the **covered person** in making application for coverage or service shall render the coverage under this *Plan* null and void.

**PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN**

The *Plan*, at its own expense, shall have the right to require an examination of a person covered under this *Plan* when and as often as it may reasonably require during the pendency of a claim.

**PLAN IS NOT A CONTRACT**

The *Plan* shall not be deemed to constitute a contract between the **employer** and any **employee** or to be a consideration for, or an inducement or condition of, the employment of any **employee**. Nothing in the *Plan* shall be deemed to give any **employee** the right to be retained in the service of the **employer** or to interfere with the right of the **employer** to terminate the employment of any **employee** at any time.

**PLAN MODIFICATION AND AMENDMENT**

The **employer** may modify or amend the *Plan* from time to time at its sole discretion, and such amendments or modifications that affect **covered persons** will be communicated to the **covered persons**. Any such amendments shall be in writing, setting forth the modified provisions of the *Plan*, the effective date of the modifications, and shall be signed by the **employer**'s designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the *Plan* on file with the **employer**, or a written copy thereof shall be deposited with such master copy of the *Plan*. Appropriate filing and reporting of any such modification or amendment with governmental authorities and to **covered persons** shall be timely made by the **employer**.

**PLAN TERMINATION**

The **plan administrator** reserves the right to terminate the *Plan* at any time. Upon termination, the rights of the **covered persons** to benefits are limited to claims incurred up to the date of termination. Any termination of the *Plan* will be communicated to the **covered persons**.

Upon termination of this *Plan*, all claims incurred prior to termination, but not submitted to either the **employer** or **claims processor** within twelve (12) months of the effective date of termination of this *Plan*, will be excluded from any benefit consideration.

**PRIOR PLAN COVERAGE**

**Employees** and **dependents** who are covered under the **employer's prior plan** as of the day immediately prior to the effective date of this *Plan* shall be covered hereunder, provided they have elected coverage under this *Plan*. 

70
Employees who have not satisfied the prior plan's waiting period shall become effective under this Plan upon completing the waiting period of the prior plan.

Prior plan benefits and limitations shall be applied to this Plan. For example, satisfaction of the prior plan's calendar year deductible shall satisfy this Plan's calendar year deductible requirement; time applied toward satisfaction of the pre-existing condition limitation under the prior plan shall be credited under this Plan; benefits paid under the prior plan shall be applied toward the maximum benefits limitations of this Plan.

PRONOUNS

All personal pronouns used in this Plan shall include either gender unless the context clearly indicates to the contrary.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the Plan in excess of the maximum amount of payment necessary, the Plan will have the right to recover these excess payments. If the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan may recover that incorrect payment, whether or not it was made due to the Plan's or the Plan's designee's own error, from the person or entity to whom it was made or from any other appropriate party.

STATUS CHANGE

If an employee or dependent has a status change while covered under this Plan (i.e. dependent to employee, COBRA to active) and no interruption in coverage has occurred, the Plan will provide continuous coverage with respect to any pre-existing condition limitation, deductible(s), coinsurance and maximum benefit.

TIME EFFECTIVE

The effective time with respect to any dates used in the Plan shall be 12:01 a.m. as may be legally in effect at the address of the plan administrator.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.
HIPAA PRIVACY

The following provisions are intended to comply with applicable Plan amendment requirements under Federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DISCLOSURE BY PLAN TO PLAN SPONSOR
The Plan may take the following actions only upon receipt of a Plan amendment certification:

1. Disclose protected health information to the plan sponsor.

2. Provide for or permit the disclosure of protected health information to the plan sponsor by a health insurance issuer or HMO with respect to the Plan.

USE AND DISCLOSURE BY PLAN SPONSOR
The plan sponsor may use or disclose protected health information received from the Plan to the extent not inconsistent with the provisions of this HIPAA PRIVACY Section or the privacy rule.

OBLIGATIONS OF PLAN SPONSOR
The plan sponsor shall have the following obligations:

1. Ensure that:

   a. Any agents (including a subcontractor) to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information; and

   b. Adequate separation between the Plan and the plan sponsor is established in compliance with the requirement in 45 C.F.R. 164.504(f)(2)(iii).

2. Not use or further disclose protected health information received from the Plan, other than as permitted or required by the Plan documents or as required by law.

3. Not use or disclose protected health information received from the Plan:

   a. For employment-related actions and decisions; or

   b. In connection with any other benefit or employee benefit plan of the plan sponsor.

4. Report to the Plan any use or disclosure of the protected health information received from the Plan that is inconsistent with the use or disclosure provided for of which it becomes aware.

5. Make available protected health information received from the Plan, as and to the extent required by the privacy rule:

   a. For access to the individual;

   b. For amendment and incorporate any amendments to protected health information received from the Plan; and

   c. To provide an accounting of disclosures.

6. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the privacy rule.
7. Return or destroy all protected health information received from the **Plan** that the **plan sponsor** still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the **Plan** was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

8. Provide protected health information only to those individuals, under the control of the **plan sponsor** who perform administrative functions for the **Plan**; (i.e. eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information for any reason other than for **Plan** administrative functions nor to release protected health information to an unauthorized individual.

9. Provide protected health information only to those entities required to receive the information in order to maintain the **Plan** (i.e. claim administrator, case management vendor, pharmacy benefit manager, claim subrogation, vendor, claim auditor, network manager, stop-loss insurance carrier, insurance broker/consultant, and any other entity subcontracted to assist in administering the **Plan**).

10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.

11. Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the **plan sponsor** on behalf of the **Plan**. Specifically, such safeguarding entails an obligation to:
   a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the **plan sponsor** creates, receives, maintains, or transmits on behalf of the **Plan**;
   b. Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
   c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
   d. Report to the **Plan** any security incident of which it becomes aware.

**EXCEPTIONS**

Notwithstanding any other provision of this **HIPAA PRIVACY** Section, the **Plan** (or a health insurance issuer or HMO with respect to the **Plan**) may:

1. Disclose summary health information to the **plan sponsor** if the **plan sponsor** requests it for the purpose of:
   a. Obtaining premium bids from health plans for providing health insurance coverage under the **Plan**; or
   b. Modifying, amending, or terminating the **Plan**;

2. Disclose to the **plan sponsor** information on whether the individual is participating in the **Plan**, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the **Plan**;

3. Use or disclose protected health information:
   a. With (and consistent with) a valid authorization obtained in accordance with the **privacy rule**;
   b. To carry out treatment, payment, or health care operations in accordance with the **privacy rule**; or
   c. As otherwise permitted or required by the **privacy rule**.
DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in **bold and italics** throughout the document:

**Accident**
An unforeseen event resulting in *injury*.

**Alternate Recipient**
Any child of an *employee* or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) that has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this *Plan*.

**Ambulatory Surgical Facility**
A *facility* provider with an organized staff of *physicians* that has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc., that:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an *outpatient* basis;
2. Provides treatment by or under the supervision of *physicians* and nursing services whenever the *covered person* is in the *ambulatory surgical facility*;
3. Does not provide *inpatient* accommodations; and
4. Is not, other than incidentally, a *facility* used as an office or clinic for the private practice of a *physician*.

**Birthing Center**
A *facility* that meets professionally recognized standards and complies with all licensing and other legal requirements that apply.

**Chemical Dependency**
A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-IV (diagnostic and statistical manual of mental disorders) criteria.

**Chiropractic Care**
Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

**Claims Processor**
CoreSource, Inc.
Close Relative
The employee’s spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the employee’s spouse.

Coinsurance
The benefit percentage of covered expenses payable by the Plan for benefits that are provided under the Plan. The coinsurance is applied to covered expenses after the deductible(s) have been met, if applicable.

Complications of Pregnancy
A disease, disorder or condition that is diagnosed as distinct from pregnancy, but is adversely affected by or caused by pregnancy. Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).
2. Ectopic pregnancy.
3. Toxemia with convulsions (Eclampsia).
4. Pernicious vomiting (hyperemesis gravidarum).
5. Nephrosis.
6. Cardiac Decompensation.
7. Missed Abortion.
8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during pregnancy even if prescribed by a physician; morning sickness; or like conditions that are not medically termed as complications of pregnancy.

Concurrent Care
A request by a covered person or their authorized representative to the Health Care Management Organization prior to the expiration of a covered person’s current course of treatment to extend such treatment OR a determination by the Health Care Management Organization to reduce or terminate an ongoing course of treatment.

Confinement
A continuous stay in a hospital, treatment center, extended care facility, hospice, or birthing center due to an illness or injury diagnosed by a physician. Later stays shall be deemed part of the original confinement unless there was either complete recovery during the interim from the illness or injury causing the initial stay, or unless the latter stay results from a cause or causes unrelated to the illness or injury causing the initial stay.

Copay
A cost sharing arrangement whereby a covered person pays a set amount to a provider for a specific service at the time the service is provided.

Cosmetic Surgery
Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.
Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a physician, professional provider or covered facility for the treatment of an illness or injury and that are not specifically excluded from coverage herein. Covered expenses shall include specified preventive care services.

Covered Person

A person who is eligible for coverage under this Plan, or becomes eligible at a later date, and for whom the coverage provided by this Plan is in effect.

Creditable Coverage

Any of the following coverages: Group coverage (including FEHBP and Peace Corps); Individual Coverage (including student health plans); Medicaid; Medicare; CHAMPUS; Indian Health Service or tribal organization coverage; state high risk pool coverage; and public health plans. Creditable coverage does not include coverage only for a specified disease or illness or hospital indemnity (income) insurance. Coverage is Creditable only if there has not been a gap in coverage exceeding 63 days.

Custodial Care

Care provided primarily for maintenance of the covered person or that is designed essentially to assist the covered person in meeting his activities of daily living and that is not primarily provided for its therapeutic value in the treatment of an illness or injury. Custodial care includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered custodial care without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and board and skilled nursing services are not, however, considered custodial care (1) if provided during confinement in an institution for that coverage is available under this Plan, and (2) if combined with other medically necessary therapeutic services, under accepted medical standards, that can reasonably be expected to substantially improve the covered person's medical condition.

Customary and Reasonable Amount

The lesser of (i) and (ii), where: (i) is any negotiated fee assessed for services, supplies or treatment by a nonpreferred provider; and where (ii) is fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is incurred and is comparable in severity and nature to the illness or injury. Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill, or experience. Except as to negotiated fees described above, the customary and reasonable amount is determined form a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges. The percentage applicable to this Plan is 90% and is applied to CPT codes or HIAA Code Analysis using HIAA tables.

Dentist

A Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.), other than a close relative of the covered person, who is practicing within the scope of his license.

Dependent

For complete information regarding eligibility for dependents, refer to the Eligibility, Enrollment and Effective Date, Dependent Eligibility section of this document.
**Durable Medical Equipment**

Medical equipment that:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is generally not used in the absence of an illness or injury;
4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered *durable medical equipment*. *Durable medical equipment* includes, but is not limited to: crutches, wheel chairs, hospital beds, etc.

**Effective Date**

The date of this Plan or the date on which the covered person’s coverage commences, whichever occurs later.

**Emergency**

An accidental injury, or the sudden onset of an illness where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:

1. Placing the covered person’s life in jeopardy, or
2. Causing other serious medical consequences, or
3. Causing serious impairment to bodily functions, or
4. Causing serious dysfunction of any bodily organ or part.

**Emergency Medical Condition**

A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person or fetus in the case of a pregnant woman in serious jeopardy.

**Employee**

Refer to the Schedule of Benefits insert for employee definition.

**Enrollee**

An employee, dependent of the employee or an individual otherwise eligible for coverage who has enrolled for coverage under the terms of the Plan.

**Enrollment Date**

A covered person's enrollment date is the first day of any applicable service waiting period or the date of hire. For a covered person who enrolls in the Plan as the result of a Special Enrollment Period or as the result of timely enrollment or open enrollment period, if available, the enrollment date is the first date of coverage.

**Experimental/Investigational**

Services, supplies, drugs and treatment that do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial,
qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator, or their designee must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator or their designee shall be guided by a reasonable interpretation of Plan provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator or their designee will be guided by the following examples of experimental services and supplies:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. If the drug, device, medical treatment or procedure, was not reviewed and approved by the treating facility’s institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

3. If “reliable evidence” shows that the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials, is in the research, experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or

4. If “reliable evidence” shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

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

Extended Care Facility

An institution, or distinct part thereof, operated pursuant to law and one that meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an inpatient basis, for persons convalescing from illness or injury, professional nursing services, and physical restoration services to assist covered persons to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse.

2. Its services are provided for compensation from its covered persons and under the full-time supervision of a physician or Registered Nurse.

3. It provides twenty-four (24) hour-a-day nursing services.

4. It maintains a complete medical record on each covered person.
5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of mental and nervous disorders.

6. It is approved and licensed by Medicare.

This term shall also apply to expenses incurred in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

**Facility**

A healthcare institution that meets all applicable state or local licensure requirements.

**Full-time**

*Employees* who are regularly scheduled to work not less than twenty (20) hours per work week or has an FTE of .53 or greater.

**Generic Drug**

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or *physician* and must be clearly designated by the pharmacist or *physician* as generic.

**Grievance**

A written complaint submitted by or on behalf of an enrollee regarding the (a) availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (b) claims payment, handling, or reimbursement for health care services; or (c) matters pertaining to the relationship between the enrollee and the Plan.

**Group Eligibility Waiting Period**

The period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins. See the Schedule of Benefits for details.

**Health Benefit Plan**

Any Hospital expense, medical expense or Hospital or medical expense policy or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

**Health Care Management**

A process of evaluating if services, supplies or treatment are *medically necessary* and appropriate to help ensure cost-effective care.

**Health Care Management Organization**

The individual or organization designated by the *Plan* for the process of evaluating whether the service, supply, or treatment is *medically necessary*. The *Health Care Management Organization* is CoreSource, Inc.

**Home Health Aide Services**

Services that may be provided by a person, other than a Registered Nurse, that are *medically necessary* for the proper care and treatment of a person.
**Home Health Care**
Includes the following services: private duty nursing, skilled nursing visits, *hospice* and IV Infusion therapy for the purposes of pre-service claims only.

**Home Health Care Agency**
An agency or organization that meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.

2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one *physician* and at least one Registered Nurse. It must provide for full-time supervision of such services by a *physician* or Registered Nurse.

3. It maintains a complete medical record on each *covered person*.

4. It has a full-time administrator.

5. It qualifies as a reimbursable service under *Medicare*.

**Hospice**
An agency that provides counseling and medical services and may provide *room and board* to a terminally ill *covered person* and that meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.

2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.

3. It is under the direct supervision of a *physician*.

4. It has a Nurse coordinator who is a Registered Nurse.

5. It has a social service coordinator who is licensed.

6. It is an agency that has as its primary purpose the provision of *hospice* services.

7. It has a full-time administrator.

8. It maintains written records of services provided to the *covered person*.

9. It is licensed, if licensing is required.

**Hospital**
An institution that meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located that pertain to *hospitals*.

2. It is engaged primarily in providing medical care and treatment to *ill* and *injured* persons on an *inpatient* basis at the *covered person*’s expense.

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an *illness* or *injury*; and such treatment is provided by or under the supervision of a *physician* with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.
4. It qualifies as a hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations. This condition may be waived in the case of emergency treatment in a hospital outside of the United States.

5. It must be approved by Medicare. This condition may be waived in the case of emergency treatment in a hospital outside of the United States.

Under no circumstances will a hospital be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a facility designed exclusively for physical rehabilitative services where the covered person received treatment as a result of an illness or injury.

The term hospital, when used in conjunction with inpatient confinement for mental and nervous disorders or chemical dependency, will be deemed to include an institution that is licensed as a mental hospital or chemical dependency rehabilitation and/or detoxification facility by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Illness
A bodily disorder, disease, physical sickness, or pregnancy of a covered person.

Incurred or Incurred Date
With respect to a covered expense, the date the services, supplies or treatment are provided.

Injury
A physical harm or disability that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include illness or infection of a cut or wound.

Inpatient
A confinement of a covered person in a hospital, hospice, or extended care facility as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for room and board.

Intensive Care
A service that is reserved for critically and seriously ill covered persons requiring constant audio-visual surveillance that is prescribed by the attending physician.

Intensive Care Unit
A separate, clearly designated service area that is maintained within a hospital solely for the provision of intensive care. It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the hospital;

2. Special life saving equipment that is immediately available at all times;

3. At least two beds for the accommodation of the critically ill; and

4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

This term does not include care in a surgical recovery room, but does include cardiac care unit or any such other similar designation.
Late Enrollee
An individual who enrolls in a group Health Benefit Plan subsequent to the Initial Enrollment Period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a Late Enrollee if:

1. The individual qualifies for a special enrollment period in accordance with 42 USC § 300gg as amended
2. The individual applies for coverage during an open enrollment period;
3. A court has ordered that coverage be provided for a spouse or minor child under a covered Participant’s Health Benefit plan and request for enrollment is made within 31 days after issuance of the court order;
4. The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or
5. The individual’s coverage under Medicaid, Medicare, CHAMPUS, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan, has been involuntarily terminated within 63 days of applying for coverage in a group health benefit plan.

Leave of Absence
A period of time during which the employee does not work, but that is of a stated duration after which time the employee is expected to return to active work.

Maximum Benefit
Any one of the following, or any combination of the following:

1. The maximum amount paid by this Plan for any one covered person during the entire time he is covered by this Plan.
2. The maximum amount paid by this Plan for any one covered person for a particular covered expense. The maximum amount can be for:
   a. The entire time the covered person is covered under this Plan, or
   b. A specified period of time, such as a calendar year.
3. The maximum number as outlined in the Plan as a covered expense. The maximum number relates to the number of:
   a. Treatments during a specified period of time, or
   b. Days of confinement, or
   c. Visits by a home health care agency.

Medically Necessary (or Medical Necessity)
Service, supply or treatment that is determined by the claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator or their designee to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the covered person’s illness or injury and that could not have been omitted without adversely affecting the covered person’s condition or the quality of the care rendered; and
2. Supplied or performed in accordance with current standards of medical practice within the United States;
3. Not primarily for the convenience of the covered person or the covered person’s family or professional provider; and

4. Is an appropriate supply or level of service that safely can be provided; and

5. Is recommended or approved by the attending professional provider.

The fact that a professional provider may prescribe, order, recommend, perform or approve a service, supply or treatment does not, in and of itself, make the service, supply or treatment medically necessary and the claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator or its designee, may request and rely upon the opinion of a physician or physicians. The determination of the claims processor, named fiduciary for post-service claim appeals, named fiduciary for pre-service claim appeals, employer/plan administrator or its designee shall be final and binding.

**Medicare**

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; Part C, Miscellaneous provisions regarding both programs; and Part D, Medicare Prescription Drug Benefit, including any subsequent changes or additions to those programs.

**Mental and Nervous Disorder**

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-IV (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

**Morbid Obesity**

A diagnosed condition in which the body weight is one hundred (100) pounds or more over the medically recommended weight in the most recent Metropolitan Life Insurance Company tables for a person of the same height, age and mobility as the covered person, or having a BMI (body mass index) of forty (40) or higher, or having a BMI of thirty-five (35) in conjunction with any of the following co-morbidities: coronary artery disease, type II diabetes, clinically significant obstructive sleep apnea or medically refractory hypertension (blood pressure > 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management).

**Named Fiduciary for Post-Service Claim Appeals**

CoreSource, Inc.

**Named Fiduciary for Pre-Service Claim Appeals**

CoreSource, Inc.

**Negotiated Rate**

The rate the preferred providers have contracted to accept as payment in full for covered expenses of the Plan.

**Nonparticipating Pharmacy**

Any pharmacy, including a hospital pharmacy, physician or other organization, licensed to dispense prescription drugs that does not fall within the definition of a participating pharmacy.

**Nonpreferred Provider**

A physician, hospital, or other health care provider that does not have an agreement in effect with the Preferred Provider Organization at the time services are rendered.
Nurse
A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.) who is practicing within the scope of the license.

Outpatient
A covered person shall be considered to be an outpatient if he is treated at:

1. A hospital as other than an inpatient;
2. A physician's office, laboratory or x-ray facility; or
3. An ambulatory surgical facility; and

The stay is less than twenty-three (23) consecutive hours.

Partial Confinement
A period of less than twenty-four (24) hours of active treatment in a facility licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services.
2. Treatment of mental and nervous disorders.

It may include day, early evening, evening, night care, or a combination of these four.

Participating Pharmacy
Any pharmacy licensed to dispense prescription drugs that is contracted within the pharmacy organization.

Pharmacy Organization
The pharmacy organization is RxAmerica.

Physician
A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), other than a close relative of the covered person who is practicing within the scope of his license.

Placed For Adoption
The date the employee assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan
"Plan" refers to the benefits and provisions for payment of same as described herein. The Plan is the Pioneer Educators Health Trust.

Plan Administrator
The plan administrator is responsible for the day-to-day functions and management of the Plan. The plan administrator is the USI NW; Rico Bocala.
Plan Sponsor
The plan sponsor is Pioneer Educators Health Trust

Plan Year End
The plan year end is March 31st.

Pre-existing Condition
A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period preceding the enrollment date. This plan does not exclude coverage for pre-existing conditions.

Preferred Provider
A physician, hospital or other health care provider who has an agreement in effect with the Preferred Provider Organization at the time services are rendered. Preferred providers agree to accept the negotiated rate as payment in full.

Preferred Provider Organization
An organization that selects and contracts with certain hospitals, physicians, and other health care providers to provide services, supplies and treatment to covered persons at a negotiated rate.

Pregnancy
The physical state that results in childbirth or miscarriage.

Prior Plan
Any plan of group accident and health benefits provided by the employer (or its predecessor) for an employee group that has been replaced by coverage under this Plan.

Privacy Rule

Professional Provider
A person or other entity licensed where required and performing services within the scope of such license. The covered professional providers include, but are not limited to:

Audiologist
Certified Addictions Counselor
Certified Biofeedback Therapist
Certified Registered Nurse Anesthetist
Chiropractor, for Alternative Care Plan only.
Clinical Laboratory
Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)
Dental Hygienist
Dentist
Dietitian
Dispensing Optician
Midwife
Nurse (R.N., L.P.N., L.V.N.)
Nurse Practitioner
Occupational Therapist
Optician
Optometrist
Physical Therapist
Physician
Physician's Assistant
Podiatrist
Psychologist
Respiratory Therapist
Speech Therapist

Qualified Prescriber
A physician, dentist or other health care practitioner who may, in the legal scope of their license, prescribe drugs or medicines.

Reconstructive Surgery
Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

Relevant Information
Relevant information, when used in connection with a claim for benefits or a claim appeal, means any document, record or other information:

1. Relied on in making the benefit determination; or
2. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
3. That demonstrates compliance with the duties to make benefit decisions in accordance with Plan documents and to make consistent decisions; or
4. That constitutes a statement of policy or guidance for the Plan concerning the denied treatment or benefit for the covered person’s diagnosis, even if not relied upon.

Required By Law
The same meaning as the term “required by law” as defined in 45 CFR 164.501, to the extent not preempted by ERISA or other Federal law.

Room and Board
Room and linen service, dietary service, including meals, special diets and nourishments, and general nursing service. Room and board does not include personal items.

Routine Examination
A comprehensive history and physical examination that would include services as defined in Medical Expense Benefit, Routine Preventive Care/Wellness Benefit.

Semiprivate
The daily room and board charge that a facility applies to the greatest number of beds in its semiprivate rooms containing two (2) or more beds.
**Total Disability or Totally Disabled**

The employee is prevented from engaging in his regular, customary occupation or from an occupation for which he or she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit; or a dependent is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health.

**Treatment Center**

1. An institution that does not qualify as a hospital, but that does provide a program of effective medical and therapeutic treatment for chemical dependency, and

2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:

   a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
   b. It provides a program of treatment approved by the physician.
   c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the covered person.
   d. It provides at least the following basic services:

      i. Room and board.
      ii. Evaluation and diagnosis.
      iii. Counseling.
      iv. Referral and orientation to specialized community resources.

**Urgent Care**

An emergency or an onset of severe pain that cannot be managed without immediate treatment.

**Urgent Care Facility**

A facility that is engaged primarily in providing minor emergency and episodic medical care and that has:

1. A board-certified physician, a registered nurse (RN) and a registered x-ray technician in attendance at all times;

2. Has x-ray and laboratory equipment and life support systems.

An urgent care facility may include a clinic located at, operated in conjunction with, or that is part of a regular hospital.

**Well Child Care**

Preventive care rendered to dependent children through the age of eighteen (18).