Reed College

SUMMARY PLAN DESCRIPTION FOR
OREGON INDEPENDENT COLLEGES EMPLOYEE BENEFITS TRUST
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This document is a description of Oregon Independent Colleges Employee Benefits Trust (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are not covered.


Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.
Here is some information about the Plan.

**Name of Plan/Trust:**
Oregon Independent Colleges Employee Benefits Trust

**Type of Plan**
A group health plan (a type of welfare benefits plan that is subject to the provisions of ERISA)

**Plan Year:**
April 1 – March 31

**Original Effective Date:**
May 1, 2003

**Plan Number**
501

**Employees Eligible To Become Enrolled:**
All Active Employees of the Employer participating in the Trust

**Eligibility Waiting Period:**
For newly eligible Employer the employees of such Employer will be eligible as of April 1 coinciding with or immediately following their entry date into the Trust.

**Monthly Premium:**
Please see separate premium/funding endorsement for medical and prescription rates for each Employer.

**Plan Sponsor**
Oregon Independent Colleges Employee Benefits Trust  
c/o Rico Bocala  
Campbell Galt & Newlands, Inc., dba USI Northwest  
700 NE Multnomah Street, Suite 1300  
Portland, OR 97232  
503-299-3401

**Employer Identification Number**
93-036908

**Plan Administrator**
Oregon Independent Colleges Employee Benefits Trust  
c/o Rico Bocala  
Campbell Galt & Newlands, Inc., dba USI Northwest  
700 NE Multnomah Street, Suite 1300  
Portland, OR 97232
Named Fiduciary
Oregon Independent Colleges Employee Benefits Trust
c/o Rico Bocala
Campbell Galt & Newlands, Inc., dba USI Northwest
700 NE Multnomah Street, Suite 1300
Portland, OR 97232
503-299-3401

Agent for Legal Service
Jeff Robertson
Bullivant Houser Bailey, P.C.
888 SW Fifth Avenue
Portland, OR 97204
503-499-4686
Service of legal process may also be made on the Plan Administrator

Employer Contribution:
Determined by the Oregon Independent Colleges Employee Benefits Trust for each individual participating Employer.

Participation Requirement – Employees And Dependents:
The following minimum enrollment requirements must be met:

<table>
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<th>Minimum Enrollment Requirement</th>
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<tr>
<td>Employees</td>
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<tr>
<td>Dependent</td>
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90%
75%

Premium Due Date:
First day of each month with a 10 day grace period for payment.

Open Enrollment:
The 31-day period prior to April 1.
A Plan Participant should contact the Plan Administrator at the above address or telephone number 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. You have the right to receive certain additional information. Upon request, we will provide you 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.

ELIGIBILITY

Eligible Classes of Employees. All Active Regular and Early Retired Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

1. is a full time regular, active employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least .50 FTE or more annually.
2. is an Early Retired Employee who is over age 55 and under age 65 with 20 years of service.
3. is in a class eligible for coverage.
4. completes the employment Waiting Period as an Active Employee. A "Waiting Period" is the time between the first day of employment and the first day of the following month.

Eligible Classes of Dependents. A Dependent is anyone of the following persons:

1. A covered Employee’s Spouse, a Qualified Domestic Partner and unmarried children from birth to the limiting age of 25 years. The Dependent children must be primarily dependent upon the covered Employee for support and maintenance. When the child reaches the limiting age, coverage will end on the last day of the month following the child’s birthday.

   The term "Spouse" shall mean the person recognized as the covered Employee’s husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

   The term “Qualified Domestic Partner” shall mean the person who shares a close personal relationship with the employee and meets the following conditions:

   (a) each domestic partner is at least 18 years of age;
   (b) the domestic partners are responsible for each other’s common welfare;
   (c) the domestic partners share the same permanent residence with the intent to continue doing so indefinitely;
   (d) the domestic partners are jointly financially responsible for basic living expenses including food, shelter, and medical expense;
(e) neither domestic partner is legally married to anyone else, nor has had another qualifying domestic partnership within the 30 days immediately prior to application; and

(f) the domestic partners are not related by blood closer than would bar marriage in the state they reside in.

The term "children" shall include natural children living in the same household as the Employee, adopted children or children placed with a covered Employee in anticipation of adoption or Foster Children. 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 this Plan as covered Dependents.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The phrase "primarily dependent upon" shall mean dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee must declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(2) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

**Eligibility Requirements for Dependent Coverage.** A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

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

**FUNDING**

**Cost of the Plan.** Oregon Independent Colleges Employee Benefit Trust shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.
The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

**ENROLLMENT**

**Enrollment Requirements.** An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. If the covered Employee already has Dependent coverage, a newborn child will be automatically enrolled for 31 days from birth; otherwise, separate enrollment for a newborn child is required.

**Enrollment Requirements for Newborn Children.**

A newborn child of a covered Employee who has Dependent coverage is automatically enrolled in this Plan for 31 days. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

**TIMELY ENROLLMENT**

**Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 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 not be eligible to enroll 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 Plan Administrator will provide translation services to provide assistance to such enrollment.

If two 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.

**SPECIAL ENROLLMENT PERIODS**

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

1. Individuals losing other coverage. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

   a. The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

   b. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

   c. The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated.

   d. The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special
Enrollment right.

(2) **Dependent beneficiaries.** If:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

**ENROLLEE RIGHTS AND RESPONSIBILITIES**

**Enrollee Rights**

1. You have the right to receive services that are prompt, convenient, and suitable for your health needs.

2. You have the right to emergency services when they are medically necessary. Emergency services are available 24 hours a day, 7 days a week.

3. You have the right to receive information about your health problems, about treatment options and about treatment risks.

4. You have the right to information that is easy to understand so you can make an informed choice.

5. You have the right to have your medical records and financial records kept private by the Oregon Independent Colleges Employee Benefits Trust, as allowed by law.

6. You have the right to file a complaint (grievance) with the Oregon Independent Colleges Employee Benefits Trust or with the Oregon Department of Consumer and Business Services.

7. You have the right to be treated privately, with respect and dignity.

8. You have the right to participate in decisions regarding your health care.

9. You have the right to access your medical records, as allowed by law.

10. You have the right to be given information about the Oregon Independent Colleges Employee Benefits Trust, its services, about the doctors providing care, and about your rights and responsibilities as an enrollee.

**Enrollee Responsibilities**

1. You are responsible to read this Notice and other supporting materials.

2. You are responsible for following the rules and limitations that are explained in the Plan Document and Summary Plan Description.
3. You are responsible for contacting only Oregon Independent Colleges Employee Benefits Trust participating providers to arrange medical care when needed.

4. You are responsible for notifying your Oregon Independent Colleges Employee Benefits Trust provider if you have to cancel or reschedule your appointment.

5. You are responsible for getting a preauthorization for referral services, when needed, as explained in the Plan Document and Summary Plan Description.

6. You are responsible for carrying and using any applicable identification card. Always identify yourself as an Oregon Independent Colleges Employee Benefits Trust enrollee before you receive health services.

7. You are responsible for providing information to your provider so that he or she can give proper care to you.

8. You are responsible for following instructions you have agreed on with your health care provider.

**EFFECTIVE DATE**

**Effective Date of Employee Coverage.** An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

1. The Eligibility Requirement.
2. The Active Employee Requirement.
3. The Enrollment Requirements of the Plan.

**Active Employee Requirement.**

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

**Effective Date of Dependent Coverage.** A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

**TERMINATION OF COVERAGE**

*When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.*

**When Employee Coverage Terminates.** Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

1. The date the Plan is terminated or the Employer withdraws as part of the Plan.
2. The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the COBRA Continuation Options.)
3. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

The Plan will send a Notice of Termination at least 10 days before the expiration of the grace period if termination occurs due to nonpayment of the premium.

**Continuation for Divorced or Separated Spouse or Upon Death of Employee for Surviving Spouse Who is 55 Years or Older.** A person may continue coverage under the Plan beyond 36 months until they are covered by another group health plan or until age 65, whichever comes first, with respect to the spouse and any dependent children whose coverage under the Plan otherwise would terminate because of the death of the Employee if the surviving spouse is 55 years of age or older at the time of the death and upon dissolution of marriage with, or legal separation from, the Employee.
Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the end of the 6 calendar month period that next follows the month in which the person last worked as an Active Employee.

For leave of absence or layoff only: the end of the 6 calendar month period that next follows the month in which the person last worked as an Active Employee.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, with the exception of an Employee returning to work directly from COBRA coverage. This Employee does not have to satisfy the employment Waiting Period or Pre-Existing Conditions provision.

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 termination of benefits. Any obligation under this section continues until the end of hospitalization or benefits are exhausted under this Plan, whichever occurs earliest.

Workers’ 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 premium that includes the Employee and the Employer portion of the premium and such coverage will be maintained until the earliest of the Employee takes full-time employment with another employer or six-months from the date of payment.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The 18 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.
When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

(1) The date the Plan or Dependent coverage under the Plan is terminated.
(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Options.)
(3) The date a covered Spouse loses coverage due to loss of dependency status. (See the COBRA Continuation Options.)
(4) On the first date that a Dependent child ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Options.)
(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
OPEN ENROLLMENT

Every 3/1, the annual open enrollment period, all eligible Employees and their eligible Dependents will be able to enroll in the Plan or, in the case of those that are already enrolled, change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the open enrollment period will become effective 4/1 and remain in effect until the next 4/1 unless there is a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods and Pre-Existing Conditions Limits will be considered satisfied when changing from one plan to another plan.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.
MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

In the event that any benefit or primary care delivery office or site is terminated, the Plan Administrator will notify all Participants affected by such new benefit option as soon as administratively practicable.

The Plan does not maintain any risk-sharing arrangements with physicians or other providers.

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Hospitalizations

Please see the Cost Management section in this booklet for details.

The Plan is a plan which contains a Network Provider Organization.

- **Name:** Innovative Care Management
- **Address:** 10121 SE Sunnyside Road, Suite 208
  Clackamas, OR  97015
- **Telephone:** 1-800-862-3338

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-network Provider is used. It is the Covered Person’s choice as to which Provider to use.

Under the following circumstances, the higher in-Network payment will be made for certain non-Network services:

- If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area. Depending on the network selected, the service area includes the State of Oregon and various other states throughout the country.
- If a Covered Person receives certain essential services by a non-Network provider at an in-Network facility and the provider did not allow the covered person an opportunity to select an in-Network provider, or if the covered person is physically or mentally unable to communicate care decisions.

Additional information about this option, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed.

Emergency Medical Condition

Care for an Emergency Medical Condition is available 24 hours a day, 7 days a week. If you or a member of your family needs immediate assistance for a medical emergency, call 9-1-1 or go directly to an emergency room. Please see the Limitations and Exclusions of your particular plan entitled “Emergency Care Guidelines” for further specific information based on your plan option.

In an emergency, call 9-1-1 for assistance, go to the nearest emergency room, or seek care from your preferred provider.

The final determination as to whether such services were rendered in connection with an Emergency Medical
Condition will be determined by the Claims Administrator. The Claims Administrator must be notified within 48 hours or as soon as reasonably possible after receiving the care.

Failure to notify the Plan within this time frame may result in the denial of your claim. If after normal business hours, a message can be left advising the Plan of the emergency.

Covered services are considered to be an Emergency Medical Condition only until your condition has stabilized sufficiently to permit either discharge or transfer.

Your Coverage includes Medically Necessary follow-up care for an Emergency Medical Condition if that care cannot be delayed without adverse medical effects.

Follow-up care for any Emergency Medical Condition should be obtained from your usual provider whenever possible. However, follow-up care by another provider will be covered as long as the care required continues to meet the definition of an Emergency Medical Condition.
EPO Plan

Provider Network – Managed Healthcare Northwest

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<tr>
<td>Calendar Year Deductible</td>
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<tr>
<td>Out-of-Pocket Maximum per calendar year</td>
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**Preventive Care**

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<tbody>
<tr>
<td>Office visits including physical exams</td>
<td>100% after $20 copay per visit</td>
</tr>
<tr>
<td>Well-baby and well-child care</td>
<td>100% after $20 copay per visit</td>
</tr>
<tr>
<td>Immunizations (all ages)</td>
<td>100%</td>
</tr>
<tr>
<td>Annual women’s exams (including Pap and mammogram)</td>
<td>100% after $15 copay per visit</td>
</tr>
</tbody>
</table>

**Other Provider Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Office visits) allergy shots, therapeutic injections and in-office surgery</td>
<td>100% after $20 copay per visit</td>
</tr>
<tr>
<td>Lab and X-ray services</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Maternity Care**

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity fees/providers</td>
<td>100% after $50 copay per pregnancy</td>
</tr>
<tr>
<td>Maternity hospital stay (includes newborn care)</td>
<td>100% after $100/day (maximum of $500 per stay)</td>
</tr>
</tbody>
</table>

**Women’s Health & Cancer Rights**

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mastectomy related benefits including reconstruction, surgery, prostheses, treatment of physical complications</td>
<td>Office visit – 100% after $20 copay per visit Inpatient – 100% after $100/day (maximum of $500 per stay)</td>
</tr>
</tbody>
</table>

**Inpatient Hospital Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital stay (including rehabilitation/or mental health/chemical dependency admission)</td>
<td>100% after $100/day (maximum of $500 per stay)</td>
</tr>
</tbody>
</table>

**Outpatient Hospital Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient day surgery</td>
<td>100% after $50 copay</td>
</tr>
<tr>
<td>Emergency room (copay waived if admitted)</td>
<td>100% after $100 copay</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>100% after $20 copay</td>
</tr>
</tbody>
</table>

**Other Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance (copay waived if admitted)</td>
<td>100% after $50 copay per transport</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>100% after $20 copay per session</td>
</tr>
<tr>
<td>Mental Illness/Chemical Dependency</td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient Durable Medical Equipment and Supplies</td>
<td>80%</td>
</tr>
</tbody>
</table>

**Using your EPO Plan**

Your EPO Plan consists of a group of hospitals, physicians and other providers who have a contractual agreement with the Trust to provide health care services to EPO participants. Participants will not be covered when seeking care outside of the network, except for an Emergency Medical Condition or when preauthorized by the Trust. Your EPO offers coverage only through contracted providers.

**Coverage Outside the Service Area for Dependent Children**

For dependent children who reside outside the service area, we will extend benefits for treatment of an illness, injury and preventive care.
Preventive Care Schedule

Well-baby Care
- Newborn: Nursery care, including initial exam
- First two years: 8 well-baby exams

Physical Exams
- Age 2-6: Every year
- Age 7-18: Every 2 years
- Age 19-34: Every 4 years
- Age 35+: Every 2 years

Women’s Exams
- Annual breast & pelvic: Every calendar year
- Mammograms
  - Age 35-40: Once during this time
  - Age 40+: Every calendar year

Eye and Hearing Exams
- Through age 18: Every 24 months

Immunizations (Not covered for travel or passport purposes)
- All ages: As indicated by provider

Emergency Care Guidelines
- For an emergency medical condition, covered services include the emergency medical screening exam consisting of the medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an emergency medical condition.
- Some examples of an emergency medical condition are:
  - Suspected heart attack
  - Serious burn
  - Loss of consciousness
  - Poisoning
  - Bleeding that does not stop
- Covered services do not include the non-emergency use of an emergency room. This means, services which could be delayed until you can be seen in your attending physicians office (i.e., treatment of minor illnesses such as flu, sore throats, check-ups, follow-up visits, and prescription medication requests).

Mental Illness and Chemical Dependency Schedule*

Mental Illness Treatment Setting
- Adults: 16 Days, 21 Days, 36 Visits
- Children: 17 Days, 21 Days, 36 Visits

Chemical Dependency Treatment Setting
- Adults: 14 Days, 21 Days, 27 Visits
- Children: 32 Days, 30 Days, 39 Visits

*Per 24 consecutive calendar months and subject to limitations designated under state and federal law.

These Benefits Are Limited
- Transplant benefit payments are based on the recipient’s eligibility, not the donors.

Inpatient rehabilitation benefits are limited to 30 inpatient days per calendar year. Inpatient rehabilitation benefits for head and spinal cord injuries or stroke are increased to 60 days per calendar year.

Outpatient rehabilitation benefits are limited to 30 sessions per calendar year. Benefits are increased to 60 sessions, per calendar year, for head and spinal cord injuries or stroke. Physical exercise programs are not included.

Skilled Nursing Facility care is limited to 100 days per calendar year.

Home Health Care is limited to 180 visits per calendar year.

Nutritional counseling is limited to one visit per lifetime.

Infertility and temporomandibular joint disorder services are subject to a 50% copay.

Dental care is limited to the treatment of an accidental injury to natural teeth or a fractured jaw. Diagnosis must be made within 6 months and treatment within 12 months after the injury.

Services And Supplies Not Covered
- Charges in excess of the amount allowed according to the terms of the contract.
- Services related to or supporting in-vitro fertilization, reversal of sterilization procedures, and impotence medications.
- Services ordered or provided by a nonparticipating provider except for an emergency medical condition.
- Orthognathic surgery.
- Custodial care, personal hygiene, and other forms of supervised self-care.
- Services and supplies provided for obesity or weight reduction, including complications arising from such treatment.
- Chronic or long-term psychotherapy (defined as services provided in excess of crisis intervention or short-term therapy).
- Services or supplies for the treatment of personality disorders, paraphilia or other gender identity disorders.
- Cosmetic/reconstructive services and supplies, including complications arising from such services.
- Treatment(s), procedures, equipment, medications, devices, and supplies that are experimental or investigational.
- Treatment for addiction to tobacco, tobacco products, nicotine substitutes, or foods.
- Appliances or equipment primarily for personal comfort or convenience, and therapeutic devices including eyeglasses and hearing aids.
- Routine physical, mental, eye, hearing examinations, or eye exercises (except where specifically listed).
- Surgery to alter the refractive character of the eye.
- Self-help training or instructional programs (except where specifically listed).
- Acupuncture, naturopathy, faith healing services, homeopathy, and chiropractic even when provided by plan participants (except where specifically listed).
## POS Plan

Reed College Provider Network – Beech Street

<table>
<thead>
<tr>
<th>Lifetime maximum benefit</th>
<th>In-Plan $2,000,000</th>
<th>Out of Plan $2,000,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual deductible per calendar year</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Maximum Family deductible per calendar year</td>
<td>$750</td>
<td>$1,500</td>
</tr>
<tr>
<td>Out-of-pocket maximum per calendar year (copays, deductibles and services paid at 100% do not accumulate towards the out-of-pocket maximum)</td>
<td>$2,000 individual / $6,000 family</td>
<td>$6,000 individual / $18,000 family</td>
</tr>
</tbody>
</table>

### Preventive Care

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>We Pay</th>
<th>We Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits including physical exams</td>
<td>100% after $20 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Well-baby &amp; well-child care</td>
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<td>60% after deductible</td>
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<td>Annual women's exams (including Pap and mammogram)</td>
<td>100% after $15 copay</td>
<td>100% after $15 copay</td>
</tr>
<tr>
<td>Immunizations through age 18</td>
<td>100%</td>
<td>100%</td>
</tr>
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</table>

### Other Provider Services

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<tr>
<th>Other Provider Services</th>
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<td>Mastectomy related benefits including reconstruction, surgery, prostheses, treatment of physical complications</td>
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### Inpatient Hospital Services

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<th>Inpatient Hospital Services</th>
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<th>We Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital stay (including rehabilitation or mental health/chemical dependency admission)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
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### Outpatient Hospital Services

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<tr>
<th>Outpatient Hospital Services</th>
<th>We Pay</th>
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<tr>
<td>Outpatient day surgery</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
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<tr>
<td>Emergency room (copay waived if admitted)</td>
<td>80% after $100 copay</td>
<td>80% after $100 copay</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>100% after $20 copay</td>
<td>100% after $20 copay</td>
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### Other Services

<table>
<thead>
<tr>
<th>Other Services</th>
<th>We Pay</th>
<th>We Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>80% after deductible</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Mental Illness/Chemical Dependency</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient Durable Medical Equipment and Supplies</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

### Using your POS Plan

You may use your POS Plan as a managed care organization, in which case you are responsible for your copay; and you must choose your health care provider from a list of participating providers (“In-Plan”) which will be provided to you, and you will be responsible to obtain certain prior authorization or precertification for certain referrals and services. You are not required to designate a Primary Care Physician. You may choose to receive coverage from a non-participating provider (“Out-of-Plan”) in which case you are responsible for a deductible and a stated portion of the charges as detailed above unless such coverage is for an Emergency Medical Condition.

### Coverage Outside the Service Area for Dependent Children

For dependent children who reside outside the service area, we will extend benefits for treatment of an illness, injury or preventive care at the in-plan benefit level.
LIMITATIONS AND EXCLUSIONS

This is a benefit summary only. For a complete list of benefits and the limitations and exclusions that apply to them, please refer to the benefits booklet or the group master contract.

Preventive Care Schedule

Well-baby Care
- Newborn: Nursery care, including initial exam
- First two years: 8 well-baby exams

Physical Exams
- Age 2-6: Every year
- Age 7-18: Every 2 years
- Age 19-34: Every 4 years
- Age 35+: Every 2 years

Women’s Exams
- Annual breast & pelvic: Every calendar year
- Mammograms:
  - Age 35-40: Once during this time
  - Age 40+: Every calendar year

Eye and Hearing Exams
- Through age 18: Every 24 months

Immunizations
- All ages: As indicated by provider

Emergency Care Guidelines
- For an emergency medical condition, covered services include the emergency medical screening exam consisting of the medical history, examination, ancillary tests, and medical determinations required to ascertain the nature and extent of an emergency medical condition.
- Some examples of an emergency medical condition are:
  - Suspected heart attack
  - Serious burn
  - Loss of consciousness
  - Poisoning
  - Bleeding that does not stop
- Covered services do not include the non-emergency use of an emergency room. This means, services which could be delayed until you can be seen in your attending physicians office (i.e., treatment of minor illnesses such as flu, sore throats, check-ups, follow-up visits, and prescription medication requests).

Mental Illness and Chemical Dependency Schedule*

Mental Illness Treatment Setting
- Inpatient Care: 16 Days, 17 Days
- Residential/partial-hospitalization/day care: 21 Days, 21 Days
- Outpatient Care: 36 Visits, 36 Visits

Chemical dependency Treatment Setting
- Inpatient Care: 14 Days, 32 Days
- Residential/partial-hospitalization/day care: 21 Days, 30 Days
- Outpatient Care: 27 Visits, 39 Visits

*Per 24 consecutive calendar months and subject to limitations designated under state and federal law.

These Benefits Are Limited
- Inpatient rehabilitation benefits are limited to 30 inpatient days per calendar year. Inpatient rehabilitation benefits for head and spinal cord injuries or stroke are increased to 60 days per calendar year.
- Outpatient rehabilitation benefits are limited to 30 sessions per calendar year. Benefits are increased to 60 sessions, per calendar year, for head and spinal cord injuries or stroke. Physical exercise programs are not included.
- Skilled Nursing Facility care is limited to 100 days per calendar year.
- Home Health Care is limited to 180 visits per calendar year.
- Infertility and temporomandibular joint disorder services are subject to a 50% copayment.
- Dental care is limited to the treatment of an accidental injury to natural teeth or a fractured jaw. Diagnosis must be made within 6 months and treatment within 12 months after the injury.
- Nutritional counseling is limited to one visit per lifetime.

Services And Supplies Not Covered
- Charges in excess of the amount allowed according to the terms of the contract.
- Services related to or supporting in-vitro fertilization, reversal of sterilization procedures, and impotence medications.
- Orthognathic surgery.
- Custodial care, personal hygiene, and other forms of supervised self-care.
- Services and supplies provided for obesity or weight reduction, including complications arising from such treatment.
- Chronic or long-term psychotherapy (defined as services provided in excess of crisis intervention or short-term therapy).
- Services or supplies for the treatment of personality disorders, paraphilia or other gender identity disorders.
- Cosmetic/reconstructive services and supplies, including complications arising from such services.
- Treatment(s), procedures, equipment, medications, devices, and supplies that are experimental or investigational.
- Treatment for addiction to tobacco, tobacco products, nicotine substitutes, or foods.
- Appliances or equipment primarily for personal comfort or convenience, and therapeutic devices including eyeglasses and hearing aids.
- Routine physical, mental, eye, hearing examinations, or eye exercises (except where specifically listed).
- Surgery to alter the refractive character of the eye.
- Acupuncture, naturopathy, faith healing services, homeopathy, and chiropractic even when provided by plan participants (except where specifically listed).
Reed College

Prescription Medication Plan

Your Prescription Medication Plan Features
- Mail order service for medications taken regularly for chronic conditions.
- Up to a 90-day supply for mail order medications is provided.
- Up to a 30-day supply for self-injectable medications for mail order.
- Preferred Medication List, which offers quality generics and selected brands including contraceptives.
- Hypodermic needles and syringes.
- Preferred copay for medications on the Preferred Medication List.
- Medications that are required by law to be dispensed by prescription.

Pharmacy Purchased Medications (present ID card with new prescription or refill)

<table>
<thead>
<tr>
<th>At Participating Pharmacies</th>
<th>Generic Medications</th>
<th>*Preferred Brand Medications</th>
<th>Non-Preferred Brand Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayment</td>
<td>$15 copay for each prescription filled. (maximum quantity is 34-day supply)</td>
<td>$30 copay for each prescription filled. (maximum quantity is 34-day supply)</td>
<td>$50 copay for each prescription filled. (maximum quantity is 34-day supply)</td>
</tr>
</tbody>
</table>

Mail Order Purchased Medications

| Copayment | $30 copay for a 90-day supply of each prescription filled. | $60 copay for a 90-day supply of each prescription filled. | $100 copay for a 90-day supply of each prescription filled. |

Please note: There is no annual out-of-pocket maximum.

LIMITATIONS AND EXCLUSIONS

These Benefits Are Limited
- The maximum quantity for pharmacy purchased medications is a 34-day supply. Some medications may be limited by quantity rather than day supply or may require preauthorization by the health plan.
- The maximum quantity for mail order purchased medications is a 90-day supply. Some medications may be limited by quantity rather than day supply or may require preauthorization by the health plan.
- The maximum quantity for mail order purchased self-injectable medications is a 30-day supply. Some medications may be limited by the quantity rather than day supply or may require preauthorization by the health plan.
- Compound medications are only covered when one ingredient is a federal legend or state restricted drug.
- If a brand name drug is requested, or if a physician prescribes a brand name drug when a generic is available, you will be responsible for the difference in cost between the brand name and generic drug in addition to your copay.

Services And Supplies Not Covered
- Impotence medications
- Fertility medications
- Nonprescription medications
- Medications prescribed for cosmetic purposes
- Medications with no proven therapeutic indication
- Retin-A for anyone 26 years of age or over
- Renova
- Lamisil and Sporanox
- Topical minoxidil
- Smoking cessation products
- Experimental or investigational medications
- Medications prescribed for weight loss or the treatment of obesity (including, but not limited to amphetamines)
- Vitamins and fluoride, except those required by law to be dispensed by prescription
- Prescription medications newly approved by the FDA may be excluded for up to 18 months from the FDA approval date
- Injectable medications, except those defined as self-injectable
- Medications dispensed in a facility while a patient in a hospital, skilled nursing facility, nursing home, or other health care institution
- Stolen, lost, spilled, or destroyed prescription medications

*See the Preferred Medication List.
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Dental Plan II - Fee For Service

Choices of Providers
Any licensed dentist

Maximum benefit per calendar year
$1,500 per person, $4,500 per family

Individual deductible per calendar year
$50

Family deductible per calendar year
$150

Preventive Services
- Examinations
- Cleaning
- X-rays
- Fluoride treatments
  100% of UCR* paid (deductible waived)

Restorative Services
- Fillings
- Simple extractions
- Space maintainers
- Root canal therapy
- Periodontal scaling, root planning, and maintenance
- Emergency treatment
  80% of UCR* paid after deductible

Complicated Services
- Periodontal surgery
  80% of UCR* paid after deductible

Major Services
- Crowns
- Bridges
- Dentures
  50% of UCR* paid after deductible

Orthodontia
- Benefit for adult and children
  50% of UCR* paid to a lifetime maximum of $1,500

*UCR – Usual, Customary and Reasonable, is a charge which is not higher than the usual charge made by the provider, and does not exceed the usual charge made by most providers of like services in the same area.
LIMITATIONS AND EXCLUSIONS

Preventive Services Schedule

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Exams</td>
<td>Twice in any calendar year.</td>
</tr>
<tr>
<td>Cleaning</td>
<td>Twice in any calendar year.</td>
</tr>
<tr>
<td>X-rays</td>
<td></td>
</tr>
<tr>
<td>Full mouth</td>
<td>Once every five years.</td>
</tr>
<tr>
<td>Bitewing</td>
<td>Once each calendar year.</td>
</tr>
<tr>
<td>Fluoride</td>
<td>Twice in any calendar year; covered only for age 17 and under.</td>
</tr>
<tr>
<td>Sealants</td>
<td>Once every four years; covered only for age 17 and under.</td>
</tr>
</tbody>
</table>

These Benefits Are Limited

- Crowns are covered only when a tooth cannot be restored with a filing or by any other means.
- Periodontal scaling and root planning, per quadrant, is limited to twice in a calendar year.
- Emergency services are limited to those provided for relief, not cure. Benefits are limited to $50 per incident.
- The need for surgical extraction must be documented by X-ray.
- Replacement of an existing denture or crown is covered only when seven or more years have passed since the date of the most recent placement.
- We may limit payment to the treatment method with the lesser charge.
- The date incurred for prosthetics is considered the prep date.

These Services Are Not Covered

- Services you could have received in a hospital operated by a government agency.
- Services or supplies for which your employer is required to provide benefits by workers' compensation, liability, or other laws. This applies even if you waive your rights to those benefits.
- Services or supplies you receive from a dental or medical department maintained on behalf of any employer.
- Models of teeth and surrounding tissue for purposes of study and treatment planning.
- Services or supplies for which no charge is normally made in the absence of insurance.
- A fee for writing a prescription for drugs or for filling our claim forms.
- Any charge over the usual and customary or reasonable charge for services or supplies.
- Services and supplies to teach nutrition and oral hygiene techniques.
- Services and supplies not specifically listed.

- Services or supplies you receive before your coverage starts or after your coverage ends.
- Services that are not necessary dental care.
- Replacement of teeth missing when this coverage begins, except necessary replacement of crown, bridge, or denture.
- Appliances or restorations used for periodontal splinting (except for documented cases of bruxism), to increase vertical dimensions, to restore the occlusion (bite), or to correct habits such as tongue thrusting.
- Cosmetic dental services.
- Inlays.
- Implants and attachment devices.
- Recording of jaw movements or positions.
- Temporary dentures.
- Local anesthesia charged separately with fillings.
- General anesthesia, except when necessary for complex oral surgery or due to the existence of a concurrent medical condition.
- Premedications, take-home medicines, and supplies.
- Experimental or investigational services.
- Temporomandibular (jaw joint) and related problems.
- Services for which a third party is responsible.
- Work-related conditions.
- Services provided by a member of your immediate family or household.
- Services or supplies for which you could have obtained payment if you had applied under any city, county, state, or federal law.
- The treatment of any condition caused by or arising out of service in the armed forces.
How In-Plan and Out-of-Plan services affect benefit payments

Point of Service plans give participants the option of seeing In-Plan or Out-of-Plan health care providers. Whatever their choice, participants still receive a level of benefits for covered services. As the example illustrates, benefits are higher and out-of-pocket expenses are lower when participants choose to receive covered services in-plan.

In-plan providers agree to accept contracted amounts as payment in full for covered services. Because members are held harmless for any billed charges that exceed contracted amounts, In-plan providers cannot bill members for any balances beyond deductibles, copayments and coinsurance amounts for covered services.

For most covered services, benefits to Out-of-plan providers are paid at a lower percentage. Benefit payments are also based on Usual, Customary and Reasonable (UCR) amounts that are generally different from and may be lower than contracted amounts accepted by In-plan providers for the same service. In addition, Out-of-plan providers can bill participants for any amounts that exceed the maximum amount paid by the plan.

**Example of how benefits are paid to In-Plan and Out-of-Plan Providers for the same service.** This example assumes any deductible has already been met.

<table>
<thead>
<tr>
<th>In-Plan Provider: 0% Member Share of Cost - $20 (PPO) Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network provider’s billed charge for office visit $200</td>
</tr>
<tr>
<td>Plan pays 100% of amount less co-payment:</td>
</tr>
<tr>
<td>Member pays $20 co-payment</td>
</tr>
<tr>
<td>Total amount of $200 charge member pays In-Plan Provider $20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out-of-Plan Provider: 40% Member Share of Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network provider’s billed charge for office visit $200</td>
</tr>
<tr>
<td>Plan pays 60% of amount: 60% X $200</td>
</tr>
<tr>
<td>Member pays 40% share of cost: 40% X $200</td>
</tr>
<tr>
<td>Total amount of $200 charge member pays Out-of-Plan provider $80</td>
</tr>
</tbody>
</table>
Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

**DEDUCTIBLE**

**Deductible Amount.** This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

**Deductible Three Month Carryover.** Covered expenses incurred in, and applied toward the deductible in October, November and December will be carried over to the deductible in the next Calendar Year if the deductible has not been fully met.

**Family Unit Limit.** When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

**Deductible For A Common Accident.** This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

**BENEFIT PAYMENT**

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

**OUT-OF-POCKET LIMIT**

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

**MAXIMUM BENEFIT AMOUNT**

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person.

**COVERED CHARGES**

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

1. **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

   Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

2. **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse or Dependents.

   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 48 hours following a vaginal
delivery, or less than 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 48 hours (or 96 hours as applicable). In any case, plans and
issuers may not, under Federal law, require that a provider obtain authorization from the plan or the
issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing
Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility;
(b) the attending Physician certifies that the confinement is needed for further care of the condition
that caused the Hospital confinement; and
(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed
course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered charges for a Covered Person's care in these facilities is limited to 100 days per calendar
year.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

(d) Charges for multiple surgical procedures will be a covered expense subject to the following
provisions:

(i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be
determined based on the Usual and Reasonable Charge that is allowed for the primary
procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional
procedure performed through the same incision. Any procedure that would not be an integral
part of the primary procedure or is unrelated to the diagnosis will be considered "incidental"
and no benefits will be provided for such procedures;

(ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on
separate operative fields, benefits will be based on the Usual and Reasonable Charge for
each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is
normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual
and Reasonable percentage allowed for that procedure; and

(iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed
20% of the surgeon's Usual and Reasonable allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.).
Covered charges for this service will be included to this extent:

(e) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not
Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive
Care Unit.

(f) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not
Custodial in nature. The only charges covered for Outpatient nursing care are those shown
below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on
a 24-hour-shift basis is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are
covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility
confinement would otherwise be required. The diagnosis, care and treatment must be certified by the
attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to 180 visits per calendar
year.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may
be, or four hours of home health aide services.
(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children). Bereavement services must be furnished within six months after the patient's death.

(8) **Women’s Health Care Provider.** A Participant may request a women’s health care provider.

(9) **Services Provided by State Hospital or State Approved Program.** Services provided by a state hospital or state-approved program will not be excluded purely because the services were provided by any hospital owned or operated by the State of Oregon or any state approved community mental health and developmental disabilities program.

(10) **Women’s Health and Cancer Rights Act.** If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

These benefits will be provided subject to the same deductible and co-payments applicable to other medical benefits provided under this Plan. If you would like more information on WHCRA benefits, contact the Plan Administrator.

(11) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary. Payments will be made jointly to the provider of the ambulance care and transportation and to the participant.

(b) **Anesthetic;** oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(d) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(e) Initial **contact lenses** or glasses required following cataract surgery.

(f) Payment, coverage or reimbursement for supplies, equipment and **diabetes** self-management programs associated with the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes prescribed by a health care professional legally authorized to prescribe such items. "Diabetes self-management program" means one program of assessment and training after diagnosis and no more than three 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.

(g) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

(h) Coverage for a nonprescription elemental **enteral** formula for home use, if the formula is medically necessary for the treatment of severe intestinal malabsorption and a physician has a written order for the formula and the formula comprises the sole source, or an essential source, or nutrition.

(i) Care, supplies and services for the diagnosis and treatment of **infertility** and limited to a 50% benefit.

(j) Medically Necessary services for care and treatment of jaw joint conditions, including **Temporomandibular Joint syndrome** and limited to a 50% benefit.

(k) **Laboratory studies**.

(l) **Maxillofacial Prosthetic Services** necessary for adjunctive treatment.

(m) Treatment of **Mental Disorders and Substance Abuse**. Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

Physician's visits are limited to one treatment per day.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(n) Treatment of inborn errors of **metabolism** that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist.

(o) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(p) **Occupational therapy/Physical Therapy/Rehabilitation** by a licensed occupational therapist. Therapy must improve a body function and result from an Injury or Sickness. Inpatient rehabilitation benefits are limited to 30 inpatient days per calendar year. Inpatient rehabilitation benefits for head and spinal cord injuries or stroke are increased to 60 days per calendar year. Outpatient rehabilitation benefits are limited to 30 sessions per calendar year. Benefits are increased to 60 sessions per calendar year for head and spinal cord injuries or stroke.
Covered expenses do not include recreational programs, maintenance therapy, supplies used in occupational therapy or physical exercise programs.

(q) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

If the organ or tissue donor is a Covered Person and the recipient is not, then, the Plan will cover donor organ or tissue charges for:

- evaluating the organ or tissue;
- removing the organ or tissue from the donor.

No transportation charges will be considered. The Plan will always pay secondary to any other coverage.

(r) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(s) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

(t) **Prescription Drugs** (as defined).

(u) **Routine Preventive Care**. Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

**Charges for Routine Well Adult Care.** Routine well adult care is care by a Physician that is not for an Injury or Sickness.

**Charges for Routine Well Child Care.** Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

(v) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(w) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

1. This mammoplasty coverage will include reimbursement for:
2. reconstruction of the breast on which a mastectomy has been performed,
3. surgery and reconstruction of the other breast to produce a symmetrical appearance, and
4. coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,
5. in a manner determined in consultation with the attending Physician and the patient.

(u) **Services** performed by a nurse practitioner or physician’s assistant.

(v) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

(w) **Sterilization procedures.**

(x) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations and includes any such procedures performed by a dentist if such procedures would be compensable if performed by a licensed physician.

(y) Coverage of **Well Newborn Nursery/Physician Care.**
(z) **Charges for Routine Nursery Care.** Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

(aa) This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

(bb) The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

(cc) Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

(dd) 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 48 hours following a vaginal delivery, or less than 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 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(ee) **Charges for Routine Physician Care.** The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

(ff) Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

(gg) Charges associated with the initial purchase of a **wig after chemotherapy**.

(hh) Diagnostic **x-rays**.
Cost Management Services Phone Number
Innovative Care Management
800-862-3338

Please refer to the Employee ID card for the phone number.

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 48 hours in advance of services being rendered or within 48 hours after an emergency.

An enrollee is entitled to a written summary of information that the Plan may consider in its utilization review of a particular condition or disease to the extent the Plan maintains such criteria. To receive this information you may contact Innovative Care Management at the above telephone number.

*Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.*

**UTILIZATION REVIEW**

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Hospitalizations

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what is payable by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

**Here's how the program works.**

**Precertification.** Before a Covered Person enters a Medical Care Facility on a non-emergency basis, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card at least **48 hours before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery

If there is an emergency admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator within 48 hours of the first business day after the admission.

Failure to follow this procedure may reduce reimbursement received from the Plan.

The utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment and notify the patient or health provider of its decision within two business days. Qualified health care personnel will be available for same-day telephone responses to inquiries concerning certification of continued length of stay. If no response is received within this period from the utilization review administrator, the request will be deemed as approved. Please refer to “How to Submit a Grievance” within this document for further information.

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by $500.00.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

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<thead>
<tr>
<th>Procedure</th>
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<tr>
<td>Appendectomy</td>
<td>Hernia surgery</td>
<td>Spinal surgery</td>
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<tr>
<td>Cataract surgery</td>
<td>Hysterectomy</td>
<td>Surgery to knee, shoulder, elbow or toe</td>
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<tr>
<td>Cholecystectomy (gall bladder removal)</td>
<td>Mastectomy surgery</td>
<td>Tonsillectomy and adenoidecomy</td>
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<tr>
<td>Deviated septum (nose surgery)</td>
<td>Prostate surgery</td>
<td>Tympanotomy (inner ear)</td>
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<tr>
<td>Hemorrhoidectomy</td>
<td>Salpingo-oophorectomy (removal of tubes/ovaries)</td>
<td>Varicose vein ligation</td>
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PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

1. performed on an outpatient basis within seven days before a Hospital confinement;
(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

Covered charges for this testing will be payable at 80% for in-network services and 60% for out-of-network services even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

AMBULATORY SURGERY

Certain surgical procedures can be performed safely and efficiently outside of a Hospital. Ambulatory surgical facilities are equipped for many uncomplicated surgical operations, such as some biopsies, cataract surgeries, tonsillectomies and adenoidectomies, dilation and curettages, and similar procedures.

Ambulatory surgical charges will be paid at the rate of 80% for in-network and 60% for out-of-network, and the deductible waived for covered surgical procedures, when such procedures are performed on an outpatient rather than an inpatient basis.

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;
-- contacting the family to offer assistance and support;
-- monitoring Hospital or Skilled Nursing Facility;
-- determining alternative care options; and
-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.
DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

**Active Employee** is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time or part-time basis.

**Ambulatory Surgical Center** is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

**Birthing Center** means any freestanding health facility, place, professional office or Employer which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located. The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

**Brand Name** means a trade name medication.

**Calendar Year** means January 1st through December 31st of the same year.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Cosmetic Dentistry** means dentally unnecessary procedures.

**Covered Person** is an Employee, or Dependent who is covered under this Plan.

**Creditable Coverage** means only those coverages required to be included as such under Section 701(c) of ERISA such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare, and shall exclude those coverages that are permitted to be excluded under Section 701(c) of ERISA. Creditable Coverage does not include coverage consisting solely of dental or vision benefits. Creditable coverage means 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.

**Custodial Care** is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

**Dentist** is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

**Domestic Partner** is a person who shares a close personal relationship with the employee and responsible for each other’s common welfare.

**Durable Medical Equipment** means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

**Emergency Medical Condition** means a medical condition that manifests itself by symptoms of sufficient severity 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 a fetus in the case of a pregnant woman, in serious jeopardy.

**Employee** means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.
Employer is the individual’s participating employer in the Oregon Independent Colleges Employee Benefits Trust.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care and treatment which does 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 and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan Administrator will decide whether a drug or device is experimental and/or investigational within the terms of the Plan and to the extent of its fullest legally allowed discretion. The Plan Administrator will be guided by the following principles:

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, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Employer 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 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, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If Reliable Evidence shows that the 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, its efficacy or its efficacy as compared with a 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, service, 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.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Foster Child means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration
approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

**Genetic Information** means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

**Home Health Care Agency** is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

**Home Health Care Plan** must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

**Home Health Care Services and Supplies** include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

**Hospice Agency** is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

**Hospice Care Plan** is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

**Hospice Care Services and Supplies** are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

**Hospice Unit** is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

**Hospital** is an Employer which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

**Illness** means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes pregnancy, childbirth, miscarriage or complications of pregnancy.

**Infertility** means incapable of producing offspring.

**Injury** means an accidental physical Injury to the body caused by unexpected external means.

**Intensive Care Unit** is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at
least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous
and constant attendance 24 hours a day.

**Late Enrollee** means an individual who enrolls in the Plan subsequent to the initial enrollment period or a
subsequent open enrollment period during which the individual was eligible for coverage but declined to enroll
and may be excluded for up to 12 months or until the next open enrollment date, whichever is earlier. An
individual will not be considered a Late Enrollee to the extent such individual qualifies for a special enrollment
period in accordance with 42 U.S.C. 300gg as amended and in effect on July 1, 1997; a court has ordered that
coverage be provided for a spouse or minor child under the Plan and request for enrollment is made within 30
days after issuance of the court order; 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 the Plan.

**Legal Guardian** means a person recognized by a court of law as having the duty of taking care of the person
and managing the property and rights of a minor child.

**Lifetime** is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is
understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the
lifetime of the Covered Person.

**Medical Care Facility** means a Hospital, a facility that treats one or more specific ailments or any type of Skilled
Nursing Facility.

**Medically Necessary** care and treatment is recommended or approved by a Physician or Dentist; is consistent
with the patient’s condition or accepted standards of good medical and dental practice; is medically proven to be
effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of
medical and dental services; is not conducted for research purposes; and is the most appropriate level of
services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not
mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically
Necessary.

**Medicare** is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security
Act, as amended.

**Mental Disorder** means any disease or condition, regardless of whether the cause is organic, that is classified
as a Mental Disorder in the current edition of *International Classification of Diseases*, published by the U.S.
Department of Health and Human Services or is listed in the current edition of *Diagnostic and Statistical Manual
of Mental Disorders*, published by the American Psychiatric Association.

**Morbid Obesity** is a diagnosed condition in which the body weight exceeds the medically recommended weight
by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and
mobility as the Covered Person.

**No-Fault Auto Insurance** is the basic reparations provision of a law providing for payments without determining
fault in connection with automobile accidents.

**Outpatient Care and/or Services** is treatment including services, supplies and medicines provided and used at
a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services
rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

**Partial Hospitalization** is an outpatient program specifically designed for the diagnosis or active treatment of a
Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is
necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a
psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations
and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is
providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is
made for room and board.

**Pharmacy** means a licensed establishment where covered Prescription Drugs are filled and dispensed by a
pharmacist licensed under the laws of the state where he or she practices.

**Physician** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.),
Doctor of Podiatry (D.P.M.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed
Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, Nurse Practitioner, Physician’s Assistant and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

**Plan** means Oregon Independent Colleges Employee Benefits Trust, which is a benefits plan for certain participating employers of Oregon Independent Colleges Employee Benefits Trust and is described in this document.

**Plan Participant** is any Employee, Dependent, Qualified Domestic Partner or Early Retired Employee who is covered under this Plan.

**Plan Year** is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

**Pregnancy** is childbirth and conditions associated with Pregnancy, including complications.

**Prescription Drug** means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend "Caution: federal law prohibits dispensing without prescription" unless the Health Resources Commission determines that the drug is recognized as effective for treatment of that indication in publications that the commission determines to be equivalent to: the American Hospital Formulary Services drug information, “Drug Facts and Comparisons” (Lippincott-Raven Publishers), the United States Pharmacopoeia drug information, or other publications that have been identified by the United States Secretary of Health and Human Services as authoritative; or in the majority of relevant peer-reviewed medical literature; or by the United States Secretary of Health and Human Services; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

**Early Retired Employee** is a former Active Employee of the Employer who retired while employed by the Employer under the formal written plan of the Employer, is over age 55 and under age 65 with 20 years of service, and elects to contribute to the Plan the contribution required.

**Sickness** is: for a covered Employee, covered Spouse, covered Dependent covered Early Retiree or Qualified Domestic Partner: illness, disease or pregnancy.

**Skilled Nursing Facility** is a facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

2. Its services are provided for compensation and under the full-time supervision of a Physician.

3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

4. It maintains a complete medical record on each patient.

5. It has an effective utilization review plan.

6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

7. It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital or any other similar nomenclature.

**Substance Abuse** is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

**Temporomandibular Joint** (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.
**Total Disability (Totally Disabled)** means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

**Usual and Reasonable Charge** is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator will determine whether a charge is Usual and Reasonable by reference to the database from Medical Data Research (MDR) defining “Usual, Customary, and Reasonable”. The Plan will reimburse for services at the 90th percentile. You may request a copy of MDR’s methodology manual upon request.

**Using Your EPO Plan** – Your EPO Plan consists of a group of hospitals, physicians and other providers who have a contractual agreement with the Trust to provide health care services to EPO participants. Participants will not be covered when seeking care outside of the network, except for an Emergency Medical Condition or when preauthorized by the Trust. Your EPO offers coverage only through contracted providers.

**Using Your POS Plan** – You may use your POS Plan as a managed care organization, in which case you are responsible for your copayment; and you must choose your health care provider from a list of participating providers (“In-Plan”) which will be provided to you, and you will be responsible to obtain certain prior authorization or precertification for certain referrals and services. You are not required to designate a Primary Care Physician. You may choose to receive coverage from a non-participating provider (“Out-of-Plan”) in which case you are responsible for a deductible and a stated portion of the charges as detailed above unless such coverage is for an Emergency Medical Condition.
Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

Note: All exclusions related to Dental are shown in the Dental Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

**Services Otherwise Available**
This exclusion includes:

- services and supplies for which payment could be obtained in whole or in part if you or your enrolled dependent had applied for payment under any city, county, state, or federal law except for Medicaid coverage;
- services and supplies you or your enrolled dependent could have received in a hospital or program operated by a government agency or authority; unless reimbursement under this contract is otherwise required by law;
- charges for services and supplies for which you or your enrolled dependent cannot be held liable because of an agreement between the provider rendering the service and another third party payor which has already paid for such service or supply; and
- services and supplies for which no charge is made, or for which no charge is normally made in the absence of insurance.

**Services-Related Conditions**
The treatment of any condition caused by or arising out of service in the armed forces of any country or from an insurrection.

**Pre-Existing Conditions**
The Plan does not maintain an exclusion for Claims resulting from Preexisting Conditions.

**Third Party Liability**
Services and supplies for treatment of illness or injury for which a third party is responsible to the extent of any recovery received from or on behalf of the third party.

**Motor Vehicle Coverage**
Services and supplies for treatment of illness or injury to the extent you or your enrolled dependent recovers or is entitled to recover from motor vehicle insurance including, but not limited to, primary medical payments coverage, uninsured motorist, or underinsured motorist coverage.

**Work-Related Conditions**
Services and supplies for treatment of illness or injury arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense for the service or supply is paid under workers’ compensation. The only exception would be if you or your enrolled dependent is exempt from state or federal workers’ compensation law.

**Experimental or Investigational Services**
Treatments, procedures, equipment, medications, devices, and supplies (hereafter called services) which are, in our judgment, experimental or investigational for the specific illness or injury of the enrollee receiving services are excluded. Services which support or are performed in connection with the experimental or investigational services are also excluded. For purposes of this exclusion, experimental or investigational services include, but are not limited to, any services which at the time they are rendered and for the purpose and in the manner they are being used:
■ have not yet received final US Food and Drug Administration (FDA) approval for other than experimental, investigational, or clinical testing. However, if a medication is prescribed for other than its FDA approved use and the medication is recognized as effective for the use for a particular diagnosed condition, benefits for the medication when so used will not be excluded under this exclusion. To be considered effective for other than its FDA approved use, the Oregon Health Resources Commission must have determined that the medication is effective for the treatment of that condition; or

■ are determined by us to be in an experimental and/or investigational status. The following will be considered in making the determination whether the service is in an experimental and/or investigational status:
  o whether there is sufficient scientific evidence to permit conclusions concerning the effect of the services on health outcomes. “Scientific evidence” consists of: well-designed and well-conducted clinical trials documenting improved health outcomes published in peer reviewed medical (or dental) literature. Peer reviewed medical (or dental) literature means a US scientific publication which requires that manuscripts be submitted to acknowledged experts inside or outside the editorial office for their considered opinions or recommendations regarding publication of the manuscript. Additionally, in order to qualify as peer reviewed medical (or dental) literature, the manuscript must actually have been reviewed by acknowledged experts before publication; and evaluations by national professional medical (or dental) organizations, national consensus panels or other national technology evaluation bodies which have published a technology assessment or practice guideline based on peer reviewed medical (or dental) literature;
  o whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;
  o whether the scientific evidence demonstrates that the services’ beneficial effects outweigh any harmful effects;
  o whether any improved health outcome from the service is attainable outside investigational settings; and
  o the advice of participating professional providers medical (or dental).

AN EXPERIMENTAL OR INVESTIGATIONAL SERVICE IS NOT MADE ELIGIBLE FOR BENEFITS BY THE FACT THAT OTHER TREATMENT IS CONSIDERED BY AN ENROLLEE’S DOCTOR TO BE INEFFECTIVE OR NOT AS EFFECTIVE AS THE SERVICE OR THAT THE SERVICE IS PRESCRIBED AS THE MOST LIKELY TO PROLONG LIFE.

Care of Inmates
Services and supplies you or your enrolled dependent receives while in the custody of any state or federal law enforcement authorities or while in jail or prison.

Expenses Incurred Before Coverage Begins Or After Coverage Ends
Services and supplies incurred before enrollment under the plan or after enrollment under the plan. The only exception is that when you or your enrolled dependent is in the hospital on the day the coverage ends, we will continue to provide benefits for that hospitalization until you or your enrolled dependent’s discharge from the hospital or your or your enrolled dependent’s benefits have been exhausted, whichever comes first.

Services Provided By A Member Of Your Immediate Family

Treatment Not Medically Necessary
Services and supplies that are not medically necessary for the treatment of an illness or injury (except as may be specifically provided)

Growth Hormones
Growth hormone conditions other than growth hormone deficiency in children, failure in children secondary to chronic renal insufficiency prior to transplant, or for the promotion of wound healing in patients with severe, active burns while hospitalized. Growth hormone for the treatment of these listed conditions is covered when our medical policy criteria are met.

Surgery to Alter Refractive Character Of The Eye
Surgical procedures which alter the refractive character of the eye, including, but not limited to, radial keratotomy, myopic keratomileusis, and other surgical procedures of the refractive keratoplasty type, the purpose of which is
to cure or reduce myopia or astigmatism. Additionally, reversals or revisions of surgical procedures which alter the refractive character of the eye and complications of all of these procedures are excluded.

Massage or Massage Therapy

**Massage or Massage Therapy** means scientific manipulation of the soft tissues of the body for the purpose of normalizing those tissues and consists of manual techniques that include applying fixed or movable pressure, holding, and/or causing movement of or to the body.

**Cosmetic/Reconstructive Services And Supplies**

Services and supplies (including medications) rendered for **cosmetic** or **reconstructive** purposes, including complications resulting from **cosmetic** or **reconstructive** surgery except as follows:

- if the surgery is performed to correct a functional disorder or as the result of an accidental **injury**;
- if the surgery is performed for correction of congenital anomalies in children under age 18,
- if the surgery is related to breast **reconstruction** following a mastectomy necessary because of **illness** or **injury** in accordance with the Women’s Health And Cancer Rights benefit; or
- if the surgery is performed to reduce breast size and the following conditions are met:
  a) a history of the diagnosis and treatment of breast related shoulder and back pain must be documented within the medical record of your or your enrolled dependent’s professional provider for an extended period,
  b) obesity (weigh more than 20 percent above lean body weight), must be corrected, if it is present, before breast reduction surgery will be preauthorized; and
  c) breast tissue, equal to or greater than 500 grams, must be removed from each breast.

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

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

**Orthognathic Surgery**

Services and supplies 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 by **us** since birth).

**Paraphilia**

Services and supplies to diagnose, rule out, or treat paraphilia as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

**Gender Identity Disorders**

Services and supplies to diagnose, rule out, or treat gender identity disorders (including sex change procedures) as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders. However, treatment of children under age 19 for such diagnoses may be covered and should be **preauthorized**.

**Benefits Not Stated**

Services and supplies not specifically described as benefits in the **contract**.

**Impotence Medications**

Any medication therapy for the treatment of impotence regardless of cause.

**Routine Services and Supplies**

Services and supplies that in general do not involve treatment of an **illness** or **injury**. These include:

- routine physical examinations, except as may be specifically covered in the **contract** and except for routine annual Pap smear and breast mammographies according to the guidelines of the American Cancer Society;
- eye examinations, except as may be specifically covered in the contract, including eye exercises;
- the fitting, provision, or replacement of eyeglasses except as specifically covered in the **contract**;
- treatment for corns and calluses, removal of nails (except complete removal), and other routine foot care;
- the fitting, provision, or replacement of hearing aids, including implantable hearing aids and the surgical procedure to implant them except as specifically covered in the contract;
- telephone consultations, missed appointments, completion of claim forms, or completion of reports requested by us in order to process claims;
- self-help or training programs, including, but not limited to, those to stop smoking, control weight, or provide general fitness;
- programs that teach a person how to use durable medical equipment or how to care for a family member;
- instruction programs, including, but not limited to, those to learn to self-administer medications or nutrition, except as specifically covered in the contract under the Outpatient Diabetic Instruction benefit;
- appliances, or equipment primarily for comfort, convenience, cosmetics, environmental control, or education, such as air conditioners, humidifiers, air filters, whirlpools, heat lamps, or tanning lights; and
- private duty nursing, including ongoing hourly shift care in the home, or personal items such as telephones, televisions, and guest meals in a hospital or skilled nursing facility.

Treatment For Obesity Or Weight Control
Surgery or treatment (including any later complications), even if you or your enrolled dependent has other medical conditions related to or caused by obesity. Specifically excluded are; gastric stapling or bypass procedures, weight loss programs, counseling, hypnosis, biofeedback, neurolinguistic programming, guided imagery, and other forms of relaxation training as well as subliminal suggestion used to modify eating behavior.

Acupuncture, except as specifically covered in the contract.

Orthopedic Shoes
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.

Family Planning
Services and supplies for family planning (except sterilization), artificial insemination, in vitro fertilization, diagnosis, or surgery to correct voluntary sterilization.

Dental Examinations And Treatments
Except as specifically described as covered in any dental care benefit in this benefits booklet. For the purposes of this exclusion, the term dental examinations and treatments means services and supplies provided to prevent, diagnose, or treat diseases or conditions of the teeth and supporting tissues or structures, including, but not limited to, services and supplies rendered:
- to repair defects which have developed because of tooth loss;
- to restore the ability to chew; or
- to control bruxism.

Physical Exercise Programs
Even though they may be prescribed for a specific condition.

Custodial Care
Includes routine nursing care and rest cures, and hospitalization for environmental change.

Mental Retardation/Learning Disabilities/Autism
Mental retardation/learning disabilities and autism for enrollees age seven years or older.

Services Required By State Law As A Condition Of Maintaining A Valid Driver’s License
Diversion Education programs, however diversion treatment or other court mandates for DUII may be covered but are subject to certain exclusions and regular copayments or coinsurance.

Personality Disorders
Services and supplies for the treatment of a well established pattern of behavior causing significant impairment in social or occupational functioning.
Behavior Modification
Psychological enrichment or self-help programs for mentally healthy individuals, including assertiveness training, image therapy, sensory movement groups, marathon group therapy, and sensitivity training.

Counseling Or Treatment In The Absence Of Illness
Includes individual or family counseling or treatment for marital, social, behavioral, family, occupational, or religious problems; or treatment of normal transitional response to stress.

Charges Over Amount Allowed
Any charge for services and supplies over the amount allowed according to the terms of the contract.
Benefits under this Plan shall be paid only if the Plan Administrator decides within the terms of the Plan and to the extent of its fullest legally allowed discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must complete the following as applicable to your particular Claim:

1. Obtain a Claim form (an itemized billing may be submitted in lieu of a claim form) from the Claims Administrator or the Plan Administrator.

2. Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

3. Have the Physician or Dentist complete the provider’s portion of the form.

4. For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
   - Name of Plan
   - Employee’s name
   - Name of patient
   - Name, address, telephone number of the provider of care
   - Diagnosis
   - Type of services rendered, with diagnosis and/or procedure codes
   - Date of services
   - Charges

5. Send the above to the Claims Administrator at this address:
   Covenant Administrators
   PO Box 105738
   Atlanta, Georgia 30348
   678-258-8000

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 365 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claims.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the Claim. If not, more information may be requested from the claimant. Where applicable, the Plan reserves the right to have a Plan Participant seek a second medical opinion. The Claims Administrator will provide assistance in filing a written claim upon request to the address and telephone number above.

CLAIMS PROCEDURE

Note: The following procedures are valid for claims submitted on or after January 1, 2003.

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the
time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

**Urgent Care Claim**

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

- Notification to claimant of benefit determination: 72 hours
- Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:
  - Notification to claimant, orally or in writing: 24 hours
  - Response by claimant, orally or in writing: 48 hours
  - Benefit determination, orally or in writing: 48 hours
- Ongoing courses of treatment, notification of:
  - Reduction or termination before the end of treatment: 72 hours
  - Determination as to extending course of treatment: 24 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

**Pre-Service Claim**

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims under the term "prior authorization" or "precertification."

In the case of a Pre-Service Claim, the following timetable applies:

- Notification to claimant of benefit determination: 15 days
- Extension due to matters beyond the control of the Plan: 15 days
- Insufficient information on the Claim:
  - Notification of: 15 days
  - Response by claimant: 45 days
  - Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim: 5 days
- Ongoing courses of treatment:
  - Reduction or termination before the end of the treatment: 15 days
  - Request to extend course of treatment: 15 days
Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

- Notification to claimant of benefit determination: 30 days
- Extension due to matters beyond the control of the Plan: 15 days
- Insufficient information on the Claim:
  - Notification of: 15 days
  - Response by claimant: 45 days
- Review of adverse benefit determination: 30 days per benefit appeal

Notice to claimant of adverse benefit determinations

Except with Urgent Care Claims, when the notification may be orally followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

1. The specific reason or reasons for the adverse determination.
2. Reference to the specific Plan provisions on which the determination was based.
3. A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
4. A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."
6. If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.
7. If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Grievance Procedures

If participants in the OICEBT have concerns regarding a decision, action or statement from a health care provider or health care facility, the OICEBT encourages the participant to discuss that issue with the particular provider or facility. If the participant remains dissatisfied, the participant may file a grievance or appeal. A grievance, as used in this section, is a written expression of dissatisfaction. The OICEBT will provide a written acknowledgment of the participant's complaint or grievance within 7 calendar days from receipt.

Appeals and Grievance Process

First Step—Filing a Grievance or Claim
There are three internal steps to the appeals and grievance process. The first level of review is filing a grievance or claim. You must file your grievance or claim within 180 days of the claim denial or other action giving rise to the grievance or claim by writing the Claims Administrator a letter, filling out a grievance or claim form, or by contacting the Claims Administrator by telephone. Within seven calendar days of receiving a grievance, the Claims Administrator will send you or your representative an acknowledgement letter outlining your issues as well as advising you of your rights. Within 30 calendar days, you or your representative will receive a written decision from the Claims Administrator. However, if more extensive review is needed, the Claims Administrator will notify you of the delay within the initial 30-day period and the decision will come within 45 days.

Second Step—Filing First Appeal

If you remain dissatisfied after the initial grievance or claims review, you have the right to file an appeal verbally or in writing within 180 days of receiving a response from the Claims Administrator. Within seven calendar days of receiving the appeal, you or your representative will be sent an acknowledgment letter. Your issue will be reviewed by someone not previously involved in your case. For clinical issues, a practitioner that specializes in your medical condition or procedure will be involved in the review of your appeal. A panel or representatives will evaluate your case and your appeal coordinator will notify you or your representative of the decision in writing.

The written decision will be sent:
- for appeals of preservice (preauthorization) claims, within 14 calendar days of the Claims Administrator receiving your appeal;
- for appeals of postservice claims denied as investigational, within 30 calendar or 20 working days of the claims administrator receiving your appeal; or
- for appeals of all other postservice claims, within 30 calendar days of the claims administrator receiving your appeal.

Third Step—Voluntary Appeal (May Include External Review)

The third and final level of internal appeal may be filed verbally or in writing within 180 days of the latest decision. If you decide to proceed with the voluntary third step in the appeals process, your internal review appeal will be determined by us by an appeal panel comprised of reviewers not previously involved in your case. Within seven calendar days of receipt, we will send you or your representative an acknowledgement letter. Your appeal coordinator will notify you or your representative in writing of the decision within 30 days of our receiving your appeal.

This final internal appeal, which is voluntary on your part, 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 you and we have mutually agreed to waive that requirement.

External Review — By applying to us, to obtain an independent and external review your request for external review will forwarded to the Department of Consumer and Business Services (DCBS).

The IRO will review your external review request based upon:
- an adverse determination based on medical necessity (cosmetic or nonparticipating provider services, for example);
- and adverse determination for treatment determined as experimental or investigational; or
- for purposes of continuity of care (no interruption of an active course of treatment).

You should know that in order to have the appeal decided by an IRO, you or your enrolled dependent must:
- sign a waiver granting the independent review organization access to medical records; and
- have exhausted all other appeals and grievance opportunities under this contract unless, with your consent, we waive this requirement.

The IRO is assigned by the DCBS and is not connected with us in any way. You are not responsible for the costs of the independent review.

A written response to your appeal will be sent to your or your representative within 20 days of the IRO receiving the appeal. We are not bound by the decision made by the IRO. However, the Trust may nevertheless follow the decision of the IRO. If the Trust does not follow the decision of the IRO, you may file suit.
against the Trust. Please refer to the Claims Procedures within this document for further information regarding appeals.

If you want more information regarding external review, please contact Covenant Administrators at 678-258-8000 or 800-680-8728.

**Expedited Procedure**

In the event you or your physician reasonably believes that a utilization management decision is clinically urgent and that application of the regular appeal timeframes to the review of our denial of preauthorization of a service could jeopardize your live, health, or ability to regain maximum function, you or your representative may request an Expedited Appeal. Expedited Appeal also is available if a physician with knowledge of your medical condition concludes that application of the regular appeal timeframes to the review of our denial of preauthorization of a service would subject you to severe pain that cannot be adequately managed without the disputed service. The appeal request must be made verbally or in writing within 80 days after you receive notice of the initial written preauthorization denial, should state the need for a decision on an expedited basis, and must include documentation necessary for the appeal decision. The appeal request, including any additional information or comments, must be made to the appeal coordinator. However, if the appeal issue doesn’t meet the expedited criteria, the appeal will be handled through the standard appeal process. If the appeal issue meets the expedited criteria, a verbal notice of the decision will be provided to you or your representative no later than one working day or seventy-two hours of receipt of the request. A written notice will be provided to you or your representative no later than one working day or seventy-two hours of receipt of the request. A written notice will be provided within one working day of the verbal notification. If you are not satisfied with that decision, you may ask for an expedited, second level appeal similar to the Second Step appeal process described above.

**How to Contact Us**

If you have any questions about the grievance and appeal process outlined here, you may contact:

- Covenant Administrators
- PO Box 105738
- Atlanta, GA 30348
- 678-258-8000
- 800-680-8728

**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, OR 97310
- or call: 503-947-7984
- or E-mail: http://www.cbs.state.or.us/external/ins/

Please note that your enrolled dependents also have the right to grievance and appeal as described here.
CONTINUITY OF CARE

Continuity of Care Procedures

As used in this Plan, "continuity of care" means the feature of the Plan under which an enrollee who is receiving care from an individual provider is entitled to continue with care with the individual provider for a limited period of time after the medical services contract terminates.

An enrollee is entitled to continuity of care if:

- A medical services contract or other contract for an individual provider’s services is terminated;
- The provider no longer participates in the provider network; and
- The Plan does not cover services when services are provided to enrollees by the individual provider or covers services at a benefit level below the benefit level specified in the plan for out-of-network providers.

In order to obtain continuity of care, an enrollee must request continuity of care from the Plan through written notice to the Plan Administrator.

An enrollee of the Plan is entitled to continuity of care when the following conditions are met:

- The enrollee is undergoing an active course of treatment that is medically necessary and, by agreement of the individual provider and the enrollee, it is desirable to maintain continuity of care; and
- The contractual relationship between the individual provider and the Plan has ended, except:
  - The contractual relationship between the individual provider and the Plan has ended because the individual provider:
    - Has retired;
    - Has died;
    - No longer holds an active license;
    - Has relocated out of the service area;
    - Has gone on sabbatical; or
    - Is prevented from continuing to care for patients because of other circumstances; or
  - The contractual relationship has terminated in accordance with provisions of the medical services contract relating to quality of care and all contractual appeal rights of the individual provider have been exhausted.

The Plan will not provide continuity of care if the enrollee leaves the Plan.

An enrollee who is entitled to continuity of care shall receive the care until the earlier of the following dates:

- The day following the date on which the active course of treatment entitling the enrollee to continuity of care is completed; or
- The 120th day after the date of notification by the insurer to the enrollee of the termination of the contractual relationship with the individual provider.

An enrollee who is undergoing care for a pregnancy and who becomes entitled to continuity of care after commencement of the second trimester of the pregnancy shall receive the care until the later of the following dates:

- The 45th day after the birth; or
- As long as the enrollee continues under an active course of treatment, but not later than the 120th day after the date of notification by the insurer to the enrollee of the termination of the contractual relationship with the individual provider.

The Plan shall give written notice of the termination of the contractual relationship between the Plan and the individual provider and of the right to obtain continuity of care to those enrollees that the Plan knows or reasonably should know are under the care of the individual provider. The notice may be given prior to the date the Plan terminates the individual provider’s participation in the provider network; but not later than the 120th day after the date of notification by the insurer to the enrollee of the termination of the contractual relationship with the individual provider.
on which the termination of the contractual relationship with the individual provider takes effect only if the Plan gives notice in a good faith belief that the termination will take effect as stated in the notice. In any event, the notice shall be given to those enrollees not later than the 10th day after the date on which the termination of the contractual relationship with the individual provider takes effect. If the Plan first learns the identity of an affected enrollee after the date of termination of the contractual relationship with the individual provider or after the date on which the Plan gave notice to the other affected enrollees, then the Plan shall give a notice of termination to the affected enrollee not later than the 10th day after learning that enrollee’s identity.

For the purpose of notifying an enrollee:

- The date of notification by the Plan is the earlier of the date on which the enrollee receives the notice or the date on which the Plan receives or approves the request for continuity of care.
- If an individual provider belongs to a provider group, the provider group may deliver the notice if the Plan agrees that the provider group may do so and if the notice clearly provides the information that the plan is required to provide to the enrollee.

The Plan conditions continuity of care upon the requirement that the individual provider adhere to the medical services contract between the provider and the Plan and accept the contractual reimbursement rate applicable at the time of contract termination or, if the contractual reimbursement rate was not based on a fee for service, a rate equivalent to the contractual rate.
COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans — including Medicare — are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or anyone of the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans.
2. OICEBT group plans.
3. Group practice and other group prepayment plans.
4. Federal government plans or programs. This includes Medicare.
5. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
6. No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits up to the Allowable Charge:
   a. The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
   b. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
   c. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those
of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(I) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(II) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(III) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(IV) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(V) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(VI) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.
RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

1. automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

2. must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a Responsible Third Party until after the Covered Person or his authorized legal representative obtains valid Court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental
expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.
CONTINUATION OPTIONS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated nonCOBRA beneficiaries).

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

(i) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(iii) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a Spouse or Dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.
What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(i) The death of a covered Employee.

(ii) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(iii) The divorce or legal separation of a covered Employee from the Employee's Spouse.

(iv) A covered Employee's enrollment in the Medicare program.

(v) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).

(vi) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met. Any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

(i) A Dependent child's ceasing to be a Dependent child under the generally applicable requirements of the Plan.

(ii) The divorce or legal separation of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.
When may a Qualified Beneficiary’s COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(i) The last day of the applicable maximum coverage period.
(ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
(iii) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.
(iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
(v) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
(vi) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
   (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary’s entitlement to the disability extension is no longer disabled, whichever is earlier; or
   (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated nonCOBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual’s relationship to a Qualified Beneficiary, if the Plan’s obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
(ii) In the case of a covered Employee’s enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
   (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
   (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee’s termination of employment or reduction of hours of employment.
(iii) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee’s death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary’s death or the date that is 36 months after the death of the retired covered Employee.
(iv) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
(v) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee’s employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage.

Can a Plan require payment for COBRA continuation coverage? Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer’s behalf, the Employer is allowed until that later date to pay for coverage of similarly situated nonCOBRA beneficiaries for the period.

Notwithstanding the above paragraph, a Plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan’s requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A “reasonable period of time” is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan must, during the 180- day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated nonCOBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

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.
RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Oregon Independent Colleges Employee Benefits Trust is the benefit plan of Oregon Independent Colleges Employee Benefits Trust, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Oregon Independent Colleges Employee Benefits Trust to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Oregon Independent Colleges Employee Benefits Trust shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.
(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
(3) To decide disputes which may arise relative to a Plan Participant's rights.
(4) To prescribe procedures for filing a claim for benefits and to review claim denials.
(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
(6) To appoint a Claims Administrator to pay claims.
(7) To perform all necessary reporting as required by ERISA.
(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
(9) Explain, fully disclose and submit actuarial support for any benefit reimbursement of 50 percent or less.
(10) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary” is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named
fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

ENTIRE CONTRACT

ENTIRE CONTRACT; CHANGES: This policy, including the indorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be indorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CHANGE OF BENEFICIARY

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries or to any other changes in this policy.

CONFIDENTIALITY OF RECORDS AND ENROLLEE INFORMATION

As a Plan, we comply with federal and state laws regarding the confidentiality of medical records and personal information about our members and former members. We've developed policies and procedures to ensure that the collection, use and disclosure of such information complies with the law. Whenever necessary, we obtain patient consent for disclosure of personal information and we give members access to their own information consistent with applicable law. Our policies and practices are designed to facilitate appropriate and effective use of information, internally and externally, to enable us to serve our members and improve the health of our members, our patients and the community. If you would like to receive a copy of our privacy notice, please contact the Plan Administrator.

STATUTE OF LIMITATIONS

TIME LIMIT ON CERTAIN DEFENSES: After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of that period.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or Employer receiving the overpayment will be required to return the
incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

CERTIFICATE OF CREDITABLE COVERAGE

The Employee or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

MEDICAL RECORDS

All participants by acceptance of these benefits shall be deemed to have consented to examination of medical records for utilization review, quality assurance and plan review.

PARTICIPATION IN POLICIES AND PROCEDURES

The Oregon Independent Colleges Employee Benefits Trust recognizes its responsibility to cooperate with Participants, Providers, and anyone associated with the Oregon Independent Colleges Employee Benefits Trust in assuring that the most appropriate and highest quality care and service is provided. You are encouraged to participate in many areas of service and will be consulted frequently about policies, program planning and staff appointments through periodic quality assessment surveys and have the opportunity to voice your opinions, questions or comments at any time to the Oregon Independent Colleges Employee Benefit Trust at 503-299-3401.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

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

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents 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.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.
In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

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

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Plan Participant should contact either the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, at 200 Constitution Avenue, N.W., Washington, DC 20210.