LANE COMMUNITY COLLEGE

Group No.: B202
PREFERRED 80+150 VAR
Effective: July 1, 2006

09-21-2006

48824

PacificSource
HEALTH PLANS

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

Using this Handbook

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

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

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

PacificSource Customer Service Department
phone (541) 684-5582 or (888) 977-9299
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Web site
www.pacificsource.com

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MEDICAL BENEFIT SUMMARY PREFERRED 80+150 VAR

POLICY INFORMATION

Group Name: LANE COMMUNITY COLLEGE
Group Number: B202
Plan Name: PREFERRED 80+150 VAR

EMPLOYEE ELIGIBILITY REQUIREMENTS

Minimum Hour Requirement: PER EMPLOYER POLICY
Waiting Period for New Employees: 1ST OF THE MONTH FOLLOWING DATE OF HIRE

SCHEDULE OF BENEFITS

Maximum Lifetime Benefit $2,000,000

Annual Deductible

Participating Providers ..... $150 per person / $300 per family per calendar year
Nonparticipating Providers ..... $300 per person / $600 per family per calendar year
The deductible is an amount of covered medical expenses the member pays each calendar year before the plan's benefits begin. Deductible expense is not applied to the out-of-pocket limit. The deductible applies to all services and supplies except those marked with a bullet(•).

Out-Of-Pocket Limit

Participating Providers ..... $1,000 per person / $2,000 per family per calendar year
Nonparticipating Providers ..... $1,500 per person / $3,000 per family per calendar year
Only participating provider expense applies to the participating provider out-of-pocket limit and only nonparticipating provider expense applies to the nonparticipating out-of-pocket limit. Once the participating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges for participating and network not available providers for the rest of that calendar year. Once the nonparticipating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges for nonparticipating providers for the rest of that calendar year. Deductibles, benefits paid in full, the out-of-pocket expense for transplants performed at non-participating transplant facilities, penalties for failure the obtain preauthorization for services requiring preauthorization, and nonparticipating provider charges in excess of the PacificSource fee allowance do not accumulate toward the out-of-pocket limit. Nonparticipating provider charges in excess of the PacificSource allowable fee will continue to be the member's responsibility even after the out-of-pocket limit is met.

SERVICE:	PARTICIPATING PROVIDER/ NETWORK NOT AVAILABLE BENEFIT:	NONPARTICIPATING PROVIDER BENEFIT:
PREVENTIVE CARE		
• Well Baby Care	100% after $10 copay	Not covered
• Routine Physicals	100% after $10 copay	Not covered
• Routine Gynecological Exams	100% after $10 copay	60%
• Children's Vision and Hearing Exams	100%	Not covered
• Immunizations	100%	Not covered
PROFESSIONAL SERVICES		
• Office and Home Visits	100% after $10 copay	60%
• Urgent Care Center Visits	100% after $10 copay	60%
Surgery	80%	60%
HOSPITAL SERVICES		
Inpatient Room and Board	80%	60%
Inpatient Rehabilitative Care	80%	60%
Skilled Nursing Facility Care	80%	60%
OUTPATIENT SERVICES		
Outpatient Surgery	80%	60%
CT Scans and MRIs	80%	60%

* **In true medical emergencies, nonparticipating providers are paid at the participating provider level.**

• **Not subject to the annual deductible.**

SERVICE:	PARTICIPATING PROVIDER/ NETWORK NOT AVAILABLE BENEFIT:	NONPARTICIPATING PROVIDER BENEFIT:
Diagnostic / Therapeutic Radiology & Lab	80%	60%
*• Emergency Room Visits	80% after $100 copay per visit	60% after $100 copay per visit
MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES		
• Office Visits	100% after $10 copay	60%
Inpatient Care	80%	60%
Residential Programs	80%	60%
OTHER COVERED SERVICES		
Physical Therapy	80%	60%
Allergy Injections	80%	60%
Ambulance, Ground	80%	80%
Ambulance, Air	80%	80%
Durable Medical Equipment	80%	60%
Home Health Care	80%	50%
TMJ Services ($3,000 lifetime max)	80%	60%
Hearing Aid ($800 max every 3 years)	80%	60%
Infertility Services	50%	50%
Chiropractic Care (24 visit annual max)	80%	80%
Alternative Care (24 visit annual max)	80%	80%

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

* **In true medical emergencies, nonparticipating providers are paid at the participating provider level.**

• **Not subject to the annual deductible.**

Your plan's alternative care benefit allows you to receive treatment from the licensed alternative care providers listed below for diagnosis and treatment of illness or injury. Refer to the Medical Benefit Summary for your copayment and/or coinsurance information. PacificSource contracts with a network of alternative care providers, so you can reduce your out-of-pocket expense by using one of the Participating Providers. For a listing of participating alternative care providers in your area, please refer to your plan's Participating Provider directory, visit our Web site (www.pacificsource.com), or call our Customer Service Department.

Covered Services

- Services of a licensed naturopath for diagnosis and treatment of illness or injury.
- Acupuncture services of a licensed acupuncturist or physician for diagnosis and treatment of illness or injury.
- Services of a licensed massage therapist.

The combined benefit for all treatments, services, and supplies provided or ordered by an alternative care provider is limited to 24 visits per person per calendar year. That amount includes, but is not limited to, covered charges for any laboratory services, x-rays, radiology, and durable medical equipment provided by or ordered by an alternative care provider.

Excluded Services

- Any service or supply excluded or not otherwise covered by the policy.
- Drugs, homeopathic medicines, or homeopathic supplies furnished by an alternative care provider.
- Services of an alternative care provider for pregnancy or childbirth.

Your plan's chiropractic care benefit allows you to receive treatment from licensed chiropractors for medically necessary diagnosis and treatment of illness or injury. Refer to the Medical Benefit Summary for your copayment and/or coinsurance information.

PacificSource contracts with a network of chiropractors, so you can reduce your out-of-pocket expense by using one of the Participating Providers. For a listing of participating chiropractors in your area, please refer to your plan's Participating Provider directory, visit our Web site (www.pacificsource.com), or call our Customer Service Department.

Covered Services

This plan pays for covered charges for chiropractic manipulation, massage therapy, and any laboratory services, x-rays, radiology, and durable medical equipment provided by or ordered by a chiropractor.

Maximum Benefit

The combined benefit for all treatments, services, and supplies provided or ordered by a chiropractor is limited to 24 visits per person per calendar year.

Excluded Services

- Any service or supply excluded or not otherwise covered by the policy.
- Drugs, homeopathic medicines, or homeopathic supplies furnished by a chiropractor.
- Services of a chiropractor for pregnancy or childbirth.

BENEFIT SUMMARY PHARMACY SUMMARY

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

COPAYMENTS

Each time a covered pharmaceutical is dispensed, you are responsible for a copayment. Copayments under your plan are as follows:

From a participating Caremark® retail pharmacy using the PacificSource Pharmacy Program (see below):	Tier 1: Generic	Tier 2: Preferred	Tier 3: Non-preferred
Up to 34-day supply:	$20 or 20% whichever is greater	$20 or 20% whichever is greater	$20 or 20% whichever is greater
From Walgreens Mail Service:			
Up to a 90-day supply:	$20	$20	$20
From a participating Caremark® pharmacy without using the PacificSource Pharmacy Program (see below) or from a nonparticipating pharmacy:	$20 or 20%, whichever is greater, up to the contracted allowance		

WHAT HAPPENS WHEN A BRAND NAME DRUG IS SELECTED

Unless your doctor requires the use of a brand name drug, your prescription may automatically be filled with a generic drug when available and permissible by Oregon law. If you receive a brand name drug when a generic is available, you must pay the brand name drug's copay plus the difference in cost between the brand name drug and its generic equivalent.

PRESCRIPTION DRUG OUT-OF-POCKET LIMIT

The copayment for prescription drugs obtained from a participating pharmacy is waived at participating pharmacies during the remainder of a calendar year in which the member has satisfied a Prescription Drug Out-of-Pocket Limit of $750. The limit applies separately to each family member. Claims must be submitted by the participating pharmacy electronically. Differential between brand name and generic drugs, and drugs obtained at a nonparticipating pharmacy do not apply toward the Prescription Drug Out-of-Pocket Limit.

USING THE PACIFICSOURCE PHARMACY PROGRAM

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

To use the PacificSource pharmacy program, you must show the Caremark® plan number on your PacificSource ID card at the participating pharmacy to receive your plan's highest benefit level. When obtaining prescription drugs at a participating Caremark® retail pharmacy, the PacificSource pharmacy program can only be accessed through the pharmacy plan number printed on your PacificSource ID card. That plan number -- V154-9593 -- allows the pharmacy to collect the appropriate copayment from you and bill PacificSource electronically for the balance. When you use your PacificSource ID card at participating pharmacies, the pharmacy will charge you the lesser of your copayment or the pharmacy's discounted drug cost plus service fee. For example, if your copayment is $10 and the drug's discounted cost plus service fee is only $7.50, a participating pharmacy will only charge you $7.50.

If you do not present your PacificSource ID card at the time of purchase, or if you use a nonparticipating pharmacy, you will need to file a claim for reimbursement and your benefits will be reduced. To submit a claim, send PacificSource your pharmacy receipt, your group name and number, your name and member ID number, and the patient's name and relationship to you. We will reimburse you up to the contract allowance minus the retail copayment above.

Mail Order Service

Mail order prescription service is also available through your plan for most prescription drugs. If you take a medication on a regular basis, Walgreens Mail Service is a convenient way to order prescriptions and have them delivered directly to your home. There's no shipping or handling charge. For more information, please see the Walgreens Mail Service brochure available from your plan administrator or PacificSource, or on the For Members area of our Web site, www.pacificsource.com.

OTHER COVERED PHARMACEUTICALS

Supplies covered under the pharmacy plan are in place of, not in addition to, those same covered supplies under the medical plan

Contraceptives

- Oral Contraceptives
- Depo Provera or Lunelle injections, Ortho Evra Transdermal Patch, NuvaRing Vaginal Contraceptive Ring, or Preven. Your plan's Tier 1, Tier 2, or Tier 3 copayment will apply depending on the specific item purchased.
- Diaphragm or cervical caps are available. Your plan's Tier 1, Tier 2, or Tier 3 copayment will apply depending on the specific item purchased.

Diabetic Supplies

- Insulin and diabetic syringes are available. Your plan's Tier 1, Tier 2, or Tier 3 copayment will apply depending on the specific item purchased.
- Lancets and test strips are available. Your plan's Tier 1, Tier 2, or Tier 3 copayment will apply depending on the specific item purchased.
- Glucagon recovery kits are available for your plan's Tier 2 copayment. You may purchase up to two kits at one time, but no more than four kits in any calendar year (unless preauthorized by PacificSource)
- Glucostix and glucose monitoring devices are not covered under this pharmacy benefit, but are covered under your medical plan's durable medical equipment benefit

Bee Sting Kits

Anaphylactic recovery kits (for people with severe allergic reactions to bee stings) are available for your plan's Tier 2 copayment. You may purchase up to two kits at one time, but no more than four kits in any calendar year (unless otherwise preauthorized by PacificSource).

Caremark® Speciality Pharmacy

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

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

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

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

LIMITATIONS AND EXCLUSIONS

- This plan only covers drugs prescribed by a licensed physician (or other licensed practitioner eligible for reimbursement under your plan) prescribing within the scope of his or her professional license, except for:
  - Over-the-counter drugs or other drugs that federal law does not prohibit dispensing without a prescription (even if a prescription is required under state law)
  - Drugs for any condition excluded under the health plan. That includes treatments for obesity or weight loss, smoking cessation drugs, experimental drugs, and drugs available without a prescription (even if a prescription is provided).
  - Immunizations (although certain immunizations are covered under your health plan's preventive care benefit - please refer to your Member Benefit Summary)
  - Viagra and other drugs and devices to treat impotency
  - Drugs used as a preventive measure against hazards of travel
- Certain drugs require preauthorization by PacificSource in order to be covered. An up-to-date list of drugs requiring preauthorization is available on the For Members area of our Web site, www.pacificsource.com
- Quantities for any drug filled or refilled are limited to no more than a 34-day supply when purchased at retail pharmacy or a 90-day supply when purchased through mail order pharmacy service.

- PacificSource may limit the dispensing quantity through the consideration of medical necessity, generally accepted standards of medical practice, and review of medical literature and governmental approval status.

- For drugs purchased at nonparticipating pharmacies or at participating pharmacies without using the PacificSource pharmacy program, reimbursement is limited to an allowable fee. That fee is the wholesale acquisition cost of the medication plus 20%.
- Your share of the cost for prescription drugs does not apply to your medical plan's deductible or out-of-pocket limit. Prescription drug copayments are your responsibility even if the medical plan's out-of-pocket limit is satisfied.
- Prescription drug benefits are subject to your plan's coordination of benefits provision. (For more information, see Claims Payment-Coordination of Benefits section)

BENEFIT SUMMARY VISION SUMMARY

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

BENEFIT PERIOD

Eye Exam: Once every calendar year
Lenses: One pair every calendar year
Frames: One every 2 calendar years
Contact Lenses: Once every calendar year

	SERVICE/SUPPLY	BENEFIT
	Eye Exam	
	Participating Providers	100%
	Nonparticipating Providers	$64.50
	Network Not Available	100% of UCR
*	**Lenses (maximum per pair)**	
»	Single Vision	$105
»	Bifocal	$130
»	Trifocal	$150
»	Lenticular	$236
	Progressive	$116
*	**Frames**	$125
*	**Contacts (in place of glasses)**	$230

* Participating Providers discount these services.

» Participating Providers accept these benefit amounts as payment in full.

The amounts listed above are the maximum benefits available for all vision exams, lenses, and frames furnished during any benefit period. If charges for a service or supply are less than the amount allowed, the benefit will be equal to the actual charge. If only one lens is supplied, the allowance for the lens is 50 percent of the lens allowance shown above.

This plan does not cover:

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

- Services or supplies received before this plan's coverage begins or after it ends.
- Tint
- Medical or surgical treatment of the eye

Important information about your vision benefits

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

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

We hope this information helps clarify your vision benefits. If you or your provider have any questions about your benefits, please call PacificSource Customer Service at (541) 684-5582 from Eugene-Springfield or (888) 977-9299 from other areas.

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Life Events

A Guide to Your Health Benefits During Major Life Changes

Major life events nearly always affect your health insurance coverage in one way or another. Knowing what to expect, and what is required of you, can relieve stress and help you avoid surprises. We've taken several examples of life events—getting married, divorced or separated; having or adopting a baby; sending a child to college; undergoing surgery; and moving—and pulled together the relevant information for you. The following pages are designed to answer your questions and give you valuable information regarding your health plan benefits.

MARRIAGE

Changing your name or address

So that we may continue providing the best possible service, we ask that you notify us as soon as possible when you legally change your name or move to a new address. To report a name or address change, contact our Membership Service Department by phone at (541) 684-5583 or toll-free at (866) 999-5583, or by e-mail at membership@pacificsource.com.

You may also complete an employee address or name change form, available from your group administrator. The form may be returned to your plan administrator, or mailed directly to PacificSource at PO Box 7068, Eugene OR 97401.

Adding a spouse or dependent child to your coverage

If you marry, you may add your new spouse and any newly eligible dependent children to your coverage during the 31-day initial enrollment period after the marriage. PacificSource must receive an enrollment application and additional premium during the initial enrollment period. For enrollment materials and premium information, please contact your plan administrator. Coverage for your new family members will then begin on the day of the marriage.

Please note: If your spouse enrolls after the initial enrollment period, he or she will be subject to an enrollment waiting period (For more information, see the Becoming Covered - Enrolling After the Initial Enrollment Period - Late Enrollment section)

For more information about enrolling your spouse or dependent children, please see Becoming Covered–Enrolling During the Initial Enrollment Period.

Further information

If you have questions about your health coverage related to getting married, you are welcome to contact our Membership Services Department by phone at (541) 684-5583 or toll-free at (866) 999-5583, or by e-mail at membership@pacificsource.com.

Continued on next page.

DIVORCE

If you divorce and your spouse is covered under your health plan, his or her coverage will end on the last day of the month in which the divorce decree or legal separation is final. Child custody circumstances may also affect your children's healthcare coverage. Keep in mind, however, that your family members may have the right to continue this plan's coverage for a limited time under federal or state laws. For more details, please see the Continuation of Coverage section.

Further Information

If you have questions about your health coverage related to divorce or separation, you are welcome to contact our Membership Services Department by phone at (541) 684-5583 or toll-free at (866) 999-5583, or by e-mail at membership@pacificsource.com.

HAVING OR ADOPTING A BABY

"Baby Benefits" prenatal program

Prenatal care is vital to the health of your new baby. That's why PacificSource offers Baby Benefits, a free prenatal program that includes educational materials, 24-hour access to a nurse consultant, and risk assessment. For more information, call toll-free at (800) 421-1918.

Coverage and costs

Pregnancy is treated like any other health condition, so maternity benefits are determined by the specific services rendered.

- **Prenatal visits and delivery:** Combined into one charge, then paid under your plan's Professional Services–Surgery benefit
- **Bloodwork, urinalysis, other lab services, and ultrasound:** Paid under your plan's Outpatient Services–Diagnostic & Therapeutic Radiology and Lab benefit
- **Hospital stay:** Paid under your plan's Hospital Services–Inpatient Room and Board benefit

These benefits apply to normal pregnancies; complications may alter your coverage and costs. Please refer to your Member Benefit Summary on page A to determine your financial responsibility.

How to enroll your newborn

Your newborn child is eligible to enroll on the day he or she is born. To enroll your child, an enrollment form and additional premium (if any is required) must be submitted to PacificSource within 31 days of your newborn's date of birth. Coverage will become effective from the date of birth For enrollment materials and premium information, please contact your plan administrator.

Newborn Care

Healthcare services for your newborn include the initial practitioner exam, circumcision, and specialist services for medical complications. Well baby care benefits can be found in the Preventive Care Services section of this handbook. Your Member Benefit Summary on page A explains your share of the expenses.

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Continued on next page.

Adopted Children

When a child is placed in your home for adoption, the child is eligible for enrollment under this plan during the 31-day initial enrollment period after placement. Placement means you have assumed financial responsibility for the support and care of the child in anticipation of adoption. To add the child to your coverage, you must complete and submit an enrollment application listing the child as your dependent, along with any premium due. Legal documentation from the court or child placement agency is also required. For more information, please see Becoming Covered–Enrolling During the Initial Enrollment Period.

Q&A

Is pregnancy considered a pre-existing condition?

No. Under employer-sponsored health plans, pregnancy is not subject to any waiting periods or reduced benefit periods for pre-existing conditions. Coverage begins as soon as your plan benefits begin.

Does PacificSource cover the services of midwives?

Yes, certified nurse midwives (CNMs) are eligible providers.

What if I'm not covered by PacificSource during the entire pregnancy and delivery?

In this case, the combined charges for your prenatal visits and delivery will be prorated based on the time you're under coverage with us.

What if I need maternity care while I'm traveling?

The First Health® Network is a national healthcare PPO network that includes physicians, hospitals, and other outpatient care facilities. PacificSource has a contract in place that makes First Health providers available when you need medical care outside of Oregon, southern Washington, and western Idaho. You will receive your plan's participating provider benefits when you use First Health providers for covered services outside your plan's service area. For more information, please see the Travel Benefits section of this book.

Further Information

If you have questions we have not answered here, you are welcome to contact our Customer Service Department by phone at (541) 684-5582 or toll-free at (888) 977-9299, or by e-mail at cs@pacificsource.com.

SENDING A CHILD TO COLLEGE

Coverage for out-of-state college students

If your child will be attending college outside Oregon, you don't need to worry about what will happen if he or she needs medical attention away from home. Your PacificSource health plan provides benefits to your covered dependents while they are outside the plan's service area.

To save out-of-pocket expense, however, your child should use participating providers available through our contracted national provider network, The First Health® Network. To find a First Health provider near your child's college, call toll-free at (800) 449-9905, or visit www.pacificsource.com and click on Provider Directory, then on The First Health Network.

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Continued on next page.

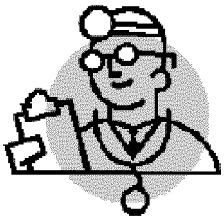
If there are no First Health providers in the area, your plan pays covered expenses based on a usual, customary, and reasonable charge for that area. For more information, please see the Coverage While Traveling section.

Further information

If you have other questions, you are welcome to contact our Membership Services Department by phone at (541) 684-5583 or toll-free at (866) 999-5583, or by e-mail at membership@pacificsource.com.

SURGERY

Coverage and costs



Your health plan covers inpatient or outpatient surgery, as well as physician's office surgery services. The plan may require that you share the cost of these services; please see your Member Benefit Summary on page A for details.

Benefits are based on where the services are performed. For surgeries performed in a physician's office, your plan's Professional Services–Office Visit benefit applies. For surgeries performed in an ambulatory surgery center or outpatient hospital setting, both the Professional Services–Surgery and the Outpatient Services–Outpatient Surgery/Services benefits apply.

For surgeries performed in an inpatient setting (hospital), both the Professional Services–Surgery (surgeon, assistant surgeon, and anesthesiologist), and the Hospital Services–Inpatient Room & Board benefits apply.

Preauthorization

Authorization is required for some covered services when you have surgery. Since authorization requirements may vary by covered service, please check the requirements for each covered service before seeking treatment. For more information, please see the Preauthorization section. Please be aware that our preauthorization list is frequently revised. The most current list is available on our Web site, www.pacificsource.com, in the For Members section.

Further information

If you have questions we have not addressed here, you are welcome to contact our Customer Service Department by phone at (541) 684-5582 or toll-free at (888) 977-9299, or by e-mail at cs@pacificsource.com.

MOVING

Please notify us as soon as possible when you move to a new address so that we may continue providing the best possible service. To report an address change, contact our Membership Service Department by phone at (541) 684-5583 or toll-free at (866) 999-5583, or by e-mail at membership@pacificsource.com.

You may also complete an employee address change form, available from your plan administrator. The form may be returned to your plan administrator, or mailed directly to PacificSource at PO Box 7068, Eugene OR 97401.

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PacificSource Health Plans
PO Box 7068 • Eugene OR 97401-0068 • (541) 686-1242 • (800) 624-6052
www.pacificsource.com

USING THE PROVIDER NETWORK

This section explains how your plan's benefits differ when you use participating and nonparticipating providers. This information is not meant to prevent you from seeking treatment from any provider if you are willing to take increased financial responsibility for the charges incurred.

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

Risk-sharing Arrangements

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

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

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

PARTICIPATING PROVIDERS

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

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

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

NONPARTICIPATING PROVIDERS

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

Allowable Fee

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

PacificSource bases payment to nonparticipating providers on our "allowable fee" for the same services or supplies. We use several sources to determine the allowable fee, depending on the service or supply and the geographical area where it is provided. The allowable fee may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), Concentra Preferred Systems, Ingenix, Inc., other nationally recognized databases, or PacificSource.

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

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

To maximize your plan's benefits, please check with us before receiving care from a nonparticipating provider. Our Customer Service Department can help you locate a participating provider in your area. If there is no participating provider for the service or supply you need, our staff will verify that your plan's Network Not Available benefits apply.

Example of Provider Payment

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

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

When you receive covered services from a participating provider, you are only responsible for the amounts shown on your Member Benefit Summary.

NETWORK NOT AVAILABLE BENEFITS

The term "network not available" is used when a PacificSource member does not have reasonable geographic access to a participating provider for a covered medical service or supply. Reasonable geographic access is determined by PacificSource using specific criteria.

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

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

COVERAGE WHILE TRAVELING

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

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

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

Nonemergency Care While Traveling

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

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

Emergency Services While Traveling

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

FINDING PARTICIPATING PROVIDER INFORMATION

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

- By asking your healthcare provider if he or she is a participating provider for PacificSource Preferred plans.
- On the PacificSource Web site, www.pacificsource.com. Simply click on "Provider Directory" and you can easily look up participating providers or print your own customized directory.
- By contacting the PacificSource Customer Service Department. Our staff can answer your questions about specific providers. If you'd like a complete provider directory for your plan, just ask--we'll be glad to mail you a directory free of charge.
- By calling The First Health® Network at (800) 449-9905 if you live outside the area covered by the PacificSource provider network.

BECOMING COVERED

ELIGIBILITY

Employees

Your employer decides the minimum number of hours employees must work each week to be eligible for health insurance benefits. Your employer may also require new employees to satisfy a probationary waiting period before they are eligible for benefits. Your employer's eligibility requirements are shown on your Member Benefit Summary. All employees who meet those requirements are eligible for coverage.

Family Members

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

- Your legal spouse or qualified domestic partner.
- Your, your spouse's, or your qualified domestic partner's unmarried dependent children under age 25.
- Your, your spouse's, or your qualified domestic partner's unmarried children age 25 or over who are mentally or physically disabled. To qualify as dependents, they must have been continuously unable to support themselves since age 25 because of a mental or physical disability. PacificSource requires documentation of the disability from the child's physician, and will review the case before authorizing coverage.

"Dependent children" means any natural, step, and adopted children you or your qualified domestic partner are legally obligated to support or contribute support for. Children placed for adoption include foster children. The foster child must be living with the member with the intent that the child will be adopted.

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

ENROLLING DURING THE INITIAL ENROLLMENT PERIOD

The "initial enrollment period" is the 31-day period beginning on the date a person is first eligible for enrollment in this plan. Everyone who becomes eligible for coverage has an initial enrollment period.

When you satisfy your employer's probationary waiting period and become eligible to enroll in this plan, you and your eligible family members must enroll within the initial enrollment period. If you miss your initial enrollment period, you may be subject to a waiting period. (For more information, see "Special Enrollment Periods" and "Late Enrollment" under the Enrolling After the Initial Enrollment Period section.) To enroll, you must complete and sign an enrollment application, which is available from your employer. The application must include complete information on yourself and your enrolling family members. Return the application to your employer, and your employer will send it to PacificSource.

Coverage for you and your enrolling family members begins on the day after you satisfy your employer's probationary waiting period. The probationary waiting period is shown on your Member Benefit Summary. Coverage will only begin if PacificSource receives your enrollment application and premium with your employer's premium payment for that month.

Newborns

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

- If additional premium is required, then the baby's eligibility for enrollment will end 31 days after birth if PacificSource has not received an enrollment application and premium.
- If no additional premium is required, then the baby's eligibility continues as long as you are covered. However, PacificSource cannot enroll the child and pay benefits until we receive an enrollment application listing the child as your dependent.

Adopted Children

When a child is placed in your home for adoption, the child is eligible for enrollment under this plan during the 31-day initial enrollment period after placement. "Placement" means you, your spouse, or your qualified domestic partner have assumed financial responsibility for the support and care of the child in anticipation of adoption. To add the child to your coverage, you must complete and submit an enrollment application listing the child as your dependent.

- If additional premium is required, then the child's eligibility for enrollment will end 31 days after placement if PacificSource has not received an enrollment application and premium.
- If no additional premium is required, then the child's eligibility continues as long as you are covered. However, PacificSource cannot enroll the child and pay benefits until we receive an enrollment application listing the child as your dependent.

Family Members Acquired by Marriage

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

Qualified Medical Child Support Orders

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

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

Domestic Partners

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

- You are both eighteen years of age or older;
- You are not related to each other by blood closer than would bar marriage in Oregon or the state where you live and have permanent residence;

- You have jointly shared the same permanent residence for at least six months immediately preceding the date of your enrollment application and intend to continue to do so indefinitely;
- You have joint financial accounts and are responsible for each other's common welfare, including basic living expenses;
- You share an exclusive domestic partnership and have no other domestic partner;
- Neither of you has a legally binding marriage nor has had another domestic partner within the last six months;
- You were both mentally competent when your domestic partnership began, and remain mentally competent;
- You and your partner are bound by and subject to all provisions of the health plan and any additional provisions of the domestic partnership endorsement;
- Your enrollment could be terminated if your Affidavit of Domestic Partnership or your enrollment application contains falsified information. A damages claim for losses sustained by the health plan could occur due to such falsification;
- You must meet all the requirements as well as any applicable requirements of the underlying health plan and the domestic partner endorsement. Coverage will terminate if you fail to meet any requirement;
- You both agree to notify your employer in writing within 31 days of any change which would cause you or your partner to fail to meet any requirements of your Affidavit of Domestic Partnership, the underlying health plan, or the domestic partnership provision of this policy.

Children of domestic partners. Your enrolled domestic partner's children are eligible on the same terms and conditions as your dependent children.

Eligible partners. Your qualified domestic partner may enroll by submitting an enrollment application and a completed and notarized Domestic Partnership Affidavit that has been signed by both you and your partner to your employer. The enrollment application must be received by PacificSource within 31 days of the your initial eligibility period or within 31 days of your domestic partner first becoming eligible according to the criteria set forth in the Eligibility section of the policy.

If enrollment is not accomplished within the time frames set forth above and the domestic partnership has existed for at least six months, your partner will be considered a late enrollee and will be subject to policy provisions for late enrollment. Late enrollment provisions will not apply if your partner qualifies for enrollment under other provisions of the Enrollment section of the policy.

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

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

Portability. Your domestic partner and their children have the same rights to individual portability coverage as dependents of other enrolled employees.

Continuation coverage. Your domestic partner and their children may not continue this policy's coverage under state or federal (COBRA) continuation laws independent of you.

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD

Returning to Work after a Layoff

If you are laid off and then rehired by your employer, you will have to satisfy another probationary waiting period.

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

Returning to Work after a Leave of Absence

If you are granted a non-FMLA leave of absence by your employer, you may continue coverage for up to 12 months (24 months for full-time faculty). Premiums must be paid through your employer in order to maintain coverage during a leave of absence.

If you return to work after an employer-approved leave of absence after this extended coverage period expires, or if you elected not to extend your coverage or pay the premium for extended coverage, you will have to satisfy another probationary waiting period. Your health coverage will resume the first of the month following the day you return to work and again meet your employer's minimum hour requirements. If your family members were covered before your leave of absence, they can resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment application within the 31-day initial enrollment period following your return to work.

Returning to Work after Family Medical Leave

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

Special Enrollment Periods

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

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

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

- Special Enrollment Rule #1

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

- Special Enrollment Rule #2

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

Late Enrollment

An otherwise eligible employee or dependent that does not enroll during the initial enrollment period, or as provided for in the special enrollment provisions above is a "late enrollee." A "late enrollee" may enroll in this plan by submitting an enrollment application to your employer during an open enrollment period designated by your employer just prior to the policy's anniversary date. When you enroll during the open enrollment period, enrollment becomes effective on the policy's anniversary date.

TERMINATING COVERAGE

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

Divorced Spouses

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

Dependent Children

When your enrolled child no longer qualifies as a dependent, coverage will end on the last day of that month. Please see the Eligibility section of this handbook for information on when your dependent child is eligible beyond age 24. The Continuation and Individual Portability Policy sections include information on other coverage options for those who no longer qualify for coverage.

Certificates of Creditable Coverage

A certificate of creditable coverage is used to verify the dates of your prior health plan coverage when you apply for coverage under a new policy. These certificates are issued by health insurers whenever a plan participant's coverage ends. After your or your dependent's coverage under this plan ends, you will receive a certificate of creditable coverage by mail. We have an automated process that generates and mails these certificates whenever coverage ends. We will send a separate certificate for any dependent with an effective or termination date that differs from yours. For questions or requests regarding certificates of creditable coverage, you are welcome to contact our Membership Services Department at (541) 684-5583 or (866) 999-5583.

CONTINUATION OF INSURANCE

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

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

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

USERRA CONTINUATION

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

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

The following requirements apply to USERRA continuation:

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

SURVIVING OR DIVORCED SPOUSES

If you die or divorce, and your spouse is 55 or older, your spouse may be able to continue coverage until eligible for Medicare or other coverage. Dependent children are subject to the group policy's age and other eligibility requirements. Some restrictions and guidelines apply; please see your employer for specific details.

COBRA CONTINUATION

If your employer group is not an association group, church, or branch of a local or federal government, you have continuation rights under federal COBRA continuation laws. Local governments also have similar continuation rights under the Public Health Service Act.

COBRA Eligibility

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

Qualifying Event	Continuation Period
Employee's termination of employment or reduction in hours	Employee, spouse, and children may continue for up to 18 months[1]
Employee's divorce	Spouse and children may continue for up to 36 Months[2]
Employee's eligibility for Medicare benefits if it causes a loss of coverage	Spouse and children may continue for up to 36 months
Employee's death	Spouse and children may continue for up to 36 months[2]
Child no longer qualifies as a dependent	Child may continue for up to 36 months[2]

[1] *If the employee or covered dependent is determined disabled by the Social Security Administration within the first 60 days of COBRA coverage, all qualified beneficiaries may continue coverage for up to 29 months.*

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

If your dependents were not covered prior to your qualifying event, they may enroll in the continuation coverage while you are on continuation. They will be subject to the same rules that apply to active employees, including the late enrollment waiting period.

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

Your domestic partner and their children may not continue this policy's coverage under state or federal (COBRA) continuation laws independent of you. Please see the Domestic Partner section of this handbook for more information.

When Continuation Coverage Ends

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

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

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

Type of Coverage

Under COBRA, you may continue any coverage you had before the qualifying event. If your employer provides both medical and dental coverage and you were enrolled in both, you may continue both medical and dental. If your employer provides only one type of coverage, or if you were enrolled in only one type of coverage, you may continue only that coverage.

COBRA continuation benefits are always the same as your employer's current benefits. Your employer has the right to change the benefits of its health plan or eliminate the plan entirely. If that happens, any changes to the group health plan will also apply to everyone enrolled in continuation coverage.

Your Responsibilities and Deadlines

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

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

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

Continuation Premium

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

CONTINUATION WHEN YOU RETIRE

If you retire, you and your insured dependents are eligible to continue coverage subject to the following:

- You must apply for continued coverage within sixty (60) days after retirement.
- You must have been continuously covered under your employer's health insurance plan for at least 24 months.
- You must be receiving benefits for PERS (Public Employee Retirement System) or from a similar retirement plan offered by your employer.
- You must meet all of the retirement requirements set forth in your employment agreement with your employer.
- You may add a new spouse or other dependent after retirement if family coverage is available. A completed enrollment application must be submitted within 31 days of the date of marriage, birth, or adoption. If you do not add your new spouse or other dependent when they are first eligible, they will be subject to the late enrollment provisions of this policy.

Your continuation coverage will end when any one of the following occurs:

- When full premium is not paid or when your coverage is voluntarily terminated, your coverage will end on the last day of the month for which premium was paid.
- When you become eligible for federal Medicare coverage or turn 65 years of age, coverage will end on the last day of the month preceding Medicare eligibility or following your 65th birthday.
- When the regular group policy is terminated, your coverage will end on the date of termination.

Your dependent's continuation coverage will end when any one of the following occurs:

- When full premium for your dependent is not paid or when your dependent's coverage is voluntarily terminated by you or your dependent, coverage will end on the last day of the month for which premium was paid.
- When your spouse becomes eligible for federal Medicare coverage or turns 65 years of age, coverage will end on the last day of the month preceding Medicare eligibility or following your spouse's 65th birthday.
- When your dependent is divorced from you, your dependent's coverage will end on the last day of the month of the divorce.
- When your dependent child marries, reaches the maximum dependent age, or is otherwise no longer considered a dependent under the group plan, his or her coverage will end on the last day of the month of their eligibility. Continuation of coverage may be available under COBRA continuation (see Continuation of Coverage provisions).
- When the regular group policy is terminated, your dependent's coverage will end on the date of termination.

Labor Unions

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

INDIVIDUAL PORTABILITY POLICY

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

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

You are not eligible to purchase a portability policy if you are eligible for this or any other plan provided by your employer, or are covered under another health plan, or are eligible for Medicare. For information on PacificSource individual portability policies, contact our Individual Sales Department at (541) 684-5585 or (877) 657-9797.

COVERED EXPENSES

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

Some medically necessary services and supplies may be excluded from coverage under this plan. Be sure you read and understand the Benefit Limitations and Exclusions section

of this book, including the section on Preauthorization. If you ever have a question about your plan benefits, contact the PacificSource Customer Service Department.

Medical Necessity

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

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

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

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

Your Annual Deductible

Deductible Carryover. Covered expenses incurred in October, November, or December may be applied toward satisfying the deductible of the following year. This provision applies only when the deductible is not met nor any benefits subject to deductible are not paid in the year the charges are incurred.

Your Annual Out-of-Pocket Limit

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

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

- Prescription drugs
- Charges over the allowable fee for services of nonparticipating providers
- Incurred charges that exceed amounts allowed under this plan
- Charges applied to deductible, if applicable to your plan
- Copayments, if applicable to your plan
- The out-of-pocket expense for transplants performed at non-participating transplant facilities
- Penalties for failure the obtain preauthorization for services requiring preauthorization

Prescription drug benefits are not affected by the out-of-pocket or stoploss limit. You will still be responsible for that copayment or coinsurance payment even after the out-of-pocket or stoploss limit is reached. (Also see Member Benefit Summary for any specific limitations).

PLAN BENEFITS

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

PREVENTIVE CARE SERVICES

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

- **Routine physicals** for everyone over two years old according to the following schedule:
  - Ages 2 - 6: One exam per year
  - Ages 7 - 18: One exam every two years
  - Ages 19 - 34: One exam every four years
  - Ages 35 - 59: One exam every two years
  - Ages 60 and over: One exam every year

  Routine physical exams may include routine lab work and other diagnostic testing procedures ordered by your practitioner in connection with the exam.
- One **routine eye exam and hearing exam** in any 24-month period for dependent children through age 18.
- One **routine gynecological exam** each calendar year for women of any age. Exams may include Pap smear, pelvic exam, breast exam, blood pressure check, and weight check. Exams may also include an annual mammogram for women 35 and over, or as recommended by a physician for women with a high-risk condition. Covered lab services are limited to occult blood, urinalysis, and complete blood count.
- **Colorectal cancer screening** exams and lab work for everyone 50 and over, or as recommended by a physician for people with a high risk condition, as follows:
  - One fecal occult blood test annually
  - One flexible sigmoidoscopy every five years
  - One colonoscopy every ten years
  - One double contrast barium enema every five years
- One **prostate cancer screening** every two years for men 50 and over, or as recommended by a physician for men at high risk or with a family medical history of prostate cancer. Exams may include digital rectal examination and prostate-specific antigen test.
- **Well baby care**, including any appropriate lab services, as follows:
  - One in-hospital exam at birth
  - Six more exams during the first year of life
  - Two exams during the second year of life

- **Immunizations**, limited to the following:
  - Diphtheria, pertussis, and tetanus (DPT) vaccines
  - Polio vaccine
  - Measles, mumps, and rubella (MMR) vaccines
  - Hemophilus influenza B vaccine
  - Hepatitis A vaccine for the following members:
    - Children ages 12 months through 18 years
    - Adults over age 18 only if there is a history of Hepatitis C
  - Hepatitis B vaccine
  - Pneumococcal vaccine for all children through age 2, and for those at high risk through age 4
  - Varicella vaccine (chicken pox)
  - Influenza vaccine for the following members:
    - Children 6 month through 23 months
    - Children 24 months through 18 years as recommended by their physician
    - Adults - subject to limitations
  - Meningococcal vaccine

PROFESSIONAL SERVICES

This plan covers the following professional services when medically necessary:

- Services of a **physician** (M.D. or D.O.) for diagnosis or treatment of illness or injury
- Services of a licensed **physician assistant** under the supervision of a physician
- Services of a certified **surgical assistant, surgical technician, or registered nurse** (R.N.) when providing medically necessary services as a surgical first assistant during a covered surgery
- Services of a **nurse practitioner**, including certified registered nurse anesthetist (C.R.N.A.) and certified nurse midwife (C.N.M.), for medically necessary diagnosis or treatment of illness or injury
- **Urgent care services** provided by a physician. “Urgent care” means services for an unforeseen illness or injury that requires treatment within 24 hours to prevent serious deterioration of a patient’s health. Urgent conditions are normally less severe than medical emergencies. Examples of conditions that could need urgent care are sprains and strains, vomiting, cuts, and severe headaches.

- Physical or occupational therapy provided by a licensed **physical therapist, occupational therapist, speech therapist, or physician.** Services must be prescribed in writing by a licensed physician, dentist, podiatrist, nurse practitioner, or physician assistant. The prescription must include site, modality, duration, and frequency of treatment. Total covered expenses for physical, occupational, and speech therapy combined is limited to a combined maximum of 30 visits per calendar year. For treatment required following head or spinal cord injury, or for treatment of a cerebral vascular accident (stroke), the limit may be increased to 60 days per calendar year. Coverage of additional visits requires preauthorization, and will only be considered for active, rehabilitative, goal-specific programs to restore or compensate for lost function for acute conditions. Functional capacity evaluations, work hardening, vocational rehabilitation, driving evaluations and training programs, community reintegration, and motion analysis are not covered services.

  Services for speech therapy require preauthorization by PacificSource, and will only be allowed when needed to correct stuttering, hearing loss, peripheral speech mechanism problems, and deficits due to neurological disease or injury. Speech therapy for developmental language and phonological disorders is only considered medically necessary for patients at least 2 ½ years old who are unable to communicate basic needs. The plan does not cover speech therapy for learning disorders or oral/facial motor therapy for strengthening and coordination of speech-producing muscles and structures.

- Services of a physician or a licensed certified nurse midwife for **pregnancy**. Services are subject to the same payment amounts, conditions, and limitations that apply to similar expenses for illness

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

- **Routine nursery care** of a newborn while the mother is hospitalized and eligible for pregnancy-related benefits under this plan.
- Services of a licensed audiologist for medically necessary **audiological (hearing) tests**.
- Services of a dentist or physician to treat **injury of the jaw or natural teeth**. Services must be provided within 18 months of the injury.
- Services of a dentist or physician for **orthognathic (jaw) surgery** as follows:
  - When medically necessary to repair an accidental injury. Services must be provided within one year after the accident.
  - For removal of a malignancy, including reconstruction of the jaw within one year after that surgery
- Services of a board-certified or board-eligible **genetic counselor** when referred by a physician or nurse practitioner for evaluation of genetic disease.
- Treatment of **temporomandibular joint syndrome (TMJ)** for medical reasons only. All TMJ-related services, including but not limited to diagnostic and surgical procedures, must be preauthorized. Services are covered only when medically necessary due to a history of advanced pathologic process (arthritic degeneration) or in the case of severe acute trauma. Benefits for the treatment of TMJ and all related services are limited to a maximum lifetime benefit of $3,000.

HOSPITAL AND SKILLED NURSING FACILITY SERVICES

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

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

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

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

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

Services of a **skilled nursing facility** are covered for up to 100 days per calendar year when preauthorized by PacificSource. Confinement for dementia, mental illness, or custodial care is not covered.

Inpatient rehabilitation is covered up to a maximum of 30 days of rehabilitative care in a calendar year. For treatment required following head or spinal cord injury, or for treatment of a cerebral vascular accident (stroke), the limit may be increased to 60 days per calendar year. Services must be preauthorized by PacificSource.

OUTPATIENT SERVICES

This plan covers the following outpatient care services:

- Diagnostic **CT scans and MRIs**. When services are provided as part of a covered emergency room visit, your plan's emergency room benefit applies. In all other situations and settings, the benefit shown on your Member Benefit Summary for Outpatient Services - CT Scans and MRIs applies.
- Diagnostic **radiology and laboratory procedures** provided or ordered by a physician, nurse practitioner, alternative care practitioner, or physician assistant. These services may be performed or provided by laboratories, radiology facilities, hospitals, and physicians, including services in conjunction with office visits.

- **Emergency room services**. The emergency room copayment shown on your Member Benefit Summary covers medical screening and any diagnostic tests needed for emergency care, such as radiology, laboratory work, CT scans, and MRIs. The copayment does not cover further treatment provided on referral from the emergency room.

  Emergency room charges for services, supplies, or conditions excluded from coverage under this plan are not eligible for payment. Please see the Benefit Limitations and Exclusions section of this handbook.

- **Surgery** and other outpatient services. Benefits are based on the setting where services are performed.
  - For surgeries or outpatient services performed in a physician's office, the benefit shown on your Member Benefit Summary for Professional Services - Office Visit applies.
  - For surgeries or outpatient services performed in an ambulatory surgery center or outpatient hospital setting, both the benefits shown on your Member Benefit Summary for Professional Services - Surgery and the Outpatient Services - Outpatient Surgery/Services apply.

- Therapeutic **radiology services, chemotherapy, and renal dialysis** provided or ordered by a physician

EMERGENCY SERVICES

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

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

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

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

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

MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

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

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

- Licensed medical or osteopathic physicians (M.D. or D.O.), including psychiatrists, licensed psychologists (Ph.D.) and psychology associates, registered nurse practitioners (N.P.), and licensed clinical social workers (L.C.S.W.)
- Programs licensed by a state mental health division for alcoholism, chemical dependency, or mental disturbance
- Hospitals and other facilities licensed for inpatient or residential treatment of mental health conditions or chemical dependency

Covered Mental Health and Dual Diagnosis Services

This plan covers the following mental health services:

- Assessment and evaluation to make a definitive diagnosis of a mental disorder
- Treatment provided in hospital inpatient facilities, residential programs or facilities, day or partial hospitalization programs, or outpatient services.

Treatment in inpatient and residential settings requires preauthorization by PacificSource.

- Treatment of dual diagnosis. Dual diagnosis means a condition involving both mental health and chemical dependency which requires the simultaneous treatment of both conditions. For dual diagnosis conditions, the facility or program must be accredited for treatment of dual diagnosis, and services must be preauthorized by PacificSource.

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

Adults 18 and older:

Inpatient	16 days
Residential	27 days
Outpatient	36 visits

Children 17 and younger:

Inpatient	17 days
Residential	27 days
Outpatient	36 visits

Covered Chemical Dependency Services

Chemical dependency means the addictive relationship with alcohol or any drug. Chemical dependency is characterized by a physical or psychological relationship, or both, that interferes with the person's social, psychological, or physical adjustment to common problems on a recurring basis.

Chemical dependency does not include addiction to, or dependency on, tobacco or food.

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

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

Adults 18 or older:

Inpatient	14 days
Residential	21 days
Outpatient	32 visits

Children 17 or younger:

Inpatient	32 days
Residential	30 days
Outpatient	42 visits

Preauthorization and Review Requirements

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

Transfer or Extension of Benefits

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

HOME HEALTH AND HOSPICE SERVICES

- This plan covers **home health services** when preauthorized by PacificSource up to a 180 day maximum per calendar year. Covered services include skilled nursing by a R.N. or L.P.N., limited to no more than two visits per day; physical, occupational, and speech therapy; and medical social work services provided by a licensed home health agency, limited to no more than one visit per day. Private duty nursing is not covered.
- **Home infusion services** are covered when preauthorized by PacificSource. This benefit covers parenteral nutrition, medications, and biologicals (other than immunizations) that

cannot be self-administered. Benefits are paid at the percentage shown on your Member Benefit Summary for home health care.

- This plan covers **hospice services** when preauthorized by PacificSource. Hospice services are intended to meet the physical, emotional, and spiritual needs of the patient and family during the final stages of illness and dying, while maintaining the patient in the home setting. Services are intended to supplement the efforts of an unpaid caregiver. Hospice care benefits are limited to a lifetime maximum of $8,000 per member. If the member elects to discontinue hospice care before the benefit maximum is exhausted, the member will forfeit any remaining hospice benefit. Hospice does not provide services of a primary caregiver such as a relative or friend, and private duty nursing is not a covered benefit. Service for short-time hospice inpatient services and supplies are covered for up to 12 days during the period of covered hospice care. PacificSource uses specific criteria to determine eligibility for hospice benefits. For more information, please contact PacificSource Customer Service.
- This plan also covers **respite care** provided to a member who requires continuous assistance up to a maximum of 120 hours every three month when arranged by the attending physician. Preauthorization by PacificSource is required.

TRANSPLANT SERVICES

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

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

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

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

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

This plan only covers transplants of human body organs and tissues. Transplants of artificial or animal organs and tissues are not covered. Travel and living expenses are not covered for the recipient's family members or the donor.

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

Payment of Transplant Benefits

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

If transplant services are available through a contracted transplantation facility but are not performed at a contracted facility, you are responsible for satisfying any deductibles or copayments shown on your Member Benefit Summary. This plan then pays 60 percent of the billed amount. The out-of-pocket expense for transplants performed at non-participating transplant facilities does not apply toward your plans out-of-pocket limit. Services of nonparticipating medical professionals are paid at the nonparticipating provider percentages shown on the Member Benefit Summary.

OTHER COVERED SERVICES, SUPPLIES, AND TREATMENTS

- This plan covers services of a state certified **ambulance** when private transportation is inappropriate because a medical condition requires paramedic support. Benefits are provided for emergency ambulance service to the nearest facility able to treat the condition. The cost of ground ambulance service is covered for up to 300 miles per calendar year. Air ambulance service is covered, but only when ground ambulance is medically or physically inappropriate.
- This plan covers **biofeedback** to treat migraine headaches or urinary incontinence when provided by an otherwise eligible practitioner. Benefits are limited to a lifetime maximum of 10 sessions.
- This plan covers **blood transfusions**, including the cost of blood or blood plasma.
- This plan covers removal, repair, or replacement of an internal **breast prosthesis** due to a contracture or rupture, but only when the original prosthesis was for a medically necessary mastectomy. Preauthorization by PacificSource is required, and eligibility for benefits is subject to PacificSource's criteria. PacificSource may require a signed loan receipt/subrogation agreement before providing coverage for this benefit. Please contact PacificSource Customer Service for more information.
- **Breast reconstruction** with or without prosthesis, including reconstruction of the opposite breast to achieve cosmetic symmetry, is covered after a medically necessary mastectomy.
- This plan covers **cardiac rehabilitation** as follows:
  - Phase I (inpatient) services are covered under inpatient hospital benefits.
  - Phase II (short-term outpatient) services are covered at the percentages on your Member Benefit Summary for outpatient hospital benefits. Preauthorization by PacificSource is required, and benefits are limited to a lifetime maximum of $1,000.
  - Phase III (long-term outpatient) services are not covered.
- This plan covers IUD, Norplant, diaphragm, and cervical cap **contraceptive devices** along with their insertion or removal. Contraceptive devices that can be obtained over the counter or without a prescription, such as condoms, contraceptive sponges, female condoms, and spermicides are not covered.

- This plan covers **corneal transplants**. Preauthorization is not required.
- In the following situations, this plan covers one attempt at **cosmetic or reconstructive surgery:**
  - When necessary to correct a functional disorder
  - When necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury
  - When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery

  Cosmetic or reconstructive surgery must take place within 18 months after the injury, surgery, scar, or defect first occurred. Preauthorization by PacificSource is required for all cosmetic and reconstructive surgeries covered by this plan. For information on breast reconstruction, see “breast prosthesis” and “breast reconstruction” in this section.
- This plan provides coverage for certain **diabetic supplies and training** as follows:
  - Diabetic supplies other than insulin and syringes (such as lancets, test strips, and glucostix) are covered at the amount shown on your Member Benefit Summary for durable medical equipment. You may purchase those supplies from any retail outlet and send your receipts to PacificSource, along with your name, group number, and member ID number. We will process the claim and mail you a reimbursement check.
  - Diabetic insulin and syringes are covered, if your plan includes prescription coverage. Lancets and test strips are also available under that prescription benefit in lieu of those covered supplies under the medical plan.
  - The plan covers one diabetes self-management education program at the time of diagnosis, and up to three hours of education per year if there is a significant change in your condition or its treatment. To be covered, the training must be provided by an accredited diabetes education program, or by a physician, registered nurse, nurse practitioner, certified diabetes educator, or licensed dietitian with expertise in diabetes.
- This plan covers **dietary or nutritional counseling** provided by a registered dietitian under certain circumstances. It is covered under the diabetic education benefit, or for management of inborn errors of metabolism (excluding obesity), or for management of anorexia nervosa or bulimia nervosa (to a lifetime maximum of five visits)
- This plan covers **durable medical equipment** prescribed exclusively to treat medical conditions. Covered equipment includes crutches, wheelchairs, orthopedic braces, home glucose meters, equipment for administering oxygen, and non-power assisted prosthetic limbs and eyes. Durable medical equipment must be prescribed by a licensed M.D., D.O., N.P., P.A., D.D.S., D.M.D., or D.P.M. to be covered. This plan does not cover equipment commonly used for nonmedical purposes, for physical or occupational therapy, or prescribed primarily for comfort. Please see "Excluded Services - Equipment and Devices" in the Benefit Limitations and Exclusions section for information on items not covered.

  This benefit covers the cost of either purchase or rental of the equipment for the period needed, whichever is less. Repair or replacement of equipment is also covered when necessary. If the cost of the purchase, rental, repair, or replacement is over $500, preauthorization by PacificSource is required.

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

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

- This plan covers nonprescription **elemental enteral formula** ordered by a physician for home use. Formula is covered when needed to treat severe intestinal malabsorption. Coverage is provided at the amount shown on your Member Benefit Summary for durable medical equipment.
- This plan covers routine **foot care** for patients with diabetes mellitus.
- This plan covers medically necessary **foot orthotics** , including related charges for the evaluation and casting, once every two years. Foot orthotics must be custom made or fitted and prescribed by a licensed physician or podiatrist to be covered.
- **Hearing aids** are covered up to a maximum of $800 every three years.
- **Hospitalization for dental procedures** is covered when the patient has another serious medical condition that may complicate the dental procedure, such as serious blood disease, unstable diabetes, or severe cardiovascular disease. Coverage requires preauthorization by PacificSource, and only charges for the facility, anesthesiologist, and assistant physician are covered. Hospitalization because of the patient's apprehension or convenience is not covered.
- **Injectable drugs and biologicals** administered by a physician are covered when medically necessary for diagnosis or treatment of illness or injury. This benefit does not include immunizations (see Preventive Care Services in this section) or drugs or biologicals that can be self-administered or are dispensed to a patient.
- This plan covers **maxillofacial prosthetic services** when prescribed by a physician as necessary to restore and manage head and facial structures. Coverage is provided only when head and facial structures cannot be replaced with living tissue, and are defective because of disease, trauma, or birth and developmental deformities. To be covered, treatment must be necessary to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing. Coverage is limited to the least costly clinically appropriate treatment, as determined by the physician. Cosmetic procedures and procedures to improve on the normal range of functions are not covered. Dentures, and artificial larynx are also not covered.
- This plan covers treatment for inborn errors of **metabolism** involving amino acid, carbohydrate, and fat metabolism for which widely accepted standards of care exist for diagnosis, treatment, and monitoring. Nutritional supplies are covered at the amount shown on your Member Benefit Summary for durable medical equipment.
- For **pediatric dental care** requiring general anesthesia, this plan covers the facility charges of a hospital or ambulatory surgery center. Benefits are limited to a lifetime maximum of $1,000, and preauthorization by PacificSource is required.
- Outpatient **pulmonary rehabilitation** programs are covered for patients with severe chronic lung disease that interferes with normal daily activities despite optimal medication management. Benefits are limited to a lifetime maximum of $1,000, and a physician's prescription and preauthorization by PacificSource are required.

- Medically necessary treatment for **sleep apnea and other sleeping disorders** is covered when preauthorized by PacificSource. Coverage of oral devices is limited to a lifetime maximum benefit of $500, including charges for consultation, fitting, adjustment, follow-up care, and the appliance. The appliance must be prescribed by a physician specializing in evaluation and treatment of obstructive sleep apnea, and the condition must meet criteria for obstructive sleep apnea.
- **Sleep studies** are covered when ordered by a pulmonologist, neurologist, otolaryngologist, or certified sleep medicine specialist, and when performed at a certified sleep laboratory.
- This plan covers **tubal ligation and vasectomy** procedures once the exclusion period has been satisfied (see Exclusion Periods in the following section).
- **Infertility services** are covered when medically necessary subject to a 50 percent copayment. In vitro fertilization and procedures determined to be experimental or investigational in nature are not covered (see Excluded Services section).

BENEFIT LIMITATIONS AND EXCLUSIONS

Least Costly Setting for Services

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

Maximum Lifetime Benefit

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

Your lifetime maximum benefit is like an account, and it works like this:

- Each time we pay benefits for your care, we deduct that amount from your lifetime maximum benefit account.
- If you were insured under another PacificSource policy before this plan, the amount we paid for your care under that policy is subtracted from your lifetime maximum account under this plan.
- For each calendar year you are covered, we add an amount back into your lifetime maximum account. If your covered expenses for the year totaled $25,000 or less, then on January 1 we restore the full amount of your covered expenses for the previous year. If your covered expenses for the year were over $25,000, then we restore $25,000 to your account.

EXCLUDED SERVICES

A Note About Optional Benefits

If your employer provides coverage for optional benefits such as prescription drugs, vision services, chiropractic care, or alternative care, you'll find those Member Benefit Summaries in this handbook. If your employer provides optional benefits for an exclusion listed below, then the exclusion does not apply to the extent that coverage exists under the optional benefit. For example, if your employer provides optional chiropractic coverage, then the exclusion for chiropractic care listed below under "Types of Treatment" does not apply to you.

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

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

- Biofeedback other than for migraine headaches or urinary incontinence, which is limited to 10 sessions
- Chelation therapy, unless preauthorized by PacificSource for certain medical conditions or heavy metal toxicities
- Day care or custodial care, including help with daily activities such as walking, getting in or out of bed, bathing, dressing, eating, and preparing meals
- Dental examinations and treatment, which means any services or supplies to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures
- Family planning services and supplies other than sterilization
- Fitness or exercise programs and health or fitness club memberships
- Foot care (routine), unless you are being treated for diabetes mellitus. Routine foot care includes services and supplies for corns and calluses, toenail conditions other than infection, and hypertrophy or hyperplasia of the skin of the feet
- Genetic (DNA) testing, except for tests identified by PacificSource as medically necessary for the diagnosis and standard treatment of specific diseases
- Homeopathic treatment
- Infertility - Services or supplies to diagnose, prevent, or treat, impotency, frigidity, or sexual dysfunction
- Instructional or educational programs, except diabetes self-management programs
- Jaw - Services or supplies for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants, or improving placement of dentures
- Massage, massage therapy, or neuromuscular re-education, even as part of a physical therapy program
- Motion analysis, including physician review
- Myeloablative high dose chemotherapy, except when the related transplant is covered
- Obesity (including all categories) or weight control treatment or surgery, even if there are other medical reasons for you to control your weight. Food supplementation programs, behavior modification and self-help programs, and other services and supplies for weight loss are also excluded from coverage.
- Osteopathic manipulation, except for treatment of disorders of the musculoskeletal system

- Physical or eye exams required for administrative purposes, such as participation in athletics, admission to school, or employment
- Physical or occupational therapy for developmental delays and disorders, sensory integration disorders, motor skills disorders, or learning disorders
- Private nursing service
- Programs that teach a person to use medical equipment, care for family members, or self-administer drugs or nutrition (except for the diabetic education benefit)
- Screening tests, imaging, and exams solely for screening, and not associated with a specific diagnosis, sign of disease, or abnormality on prior testing (except as allowed under the preventive care benefit). Also excluded are total body CT imaging, CT colonography, and bone density testing.
- Self-help or training programs
- Smoking cessation aids or treatment to modify tobacco use or promote general fitness
- Snoring - Services or supplies for the diagnosis or treatment of snoring or upper airway resistance disorders, including somnoplasty
- Speech therapy for developmental language disorders, phonological disorders, and learning disorders, and facial motor therapy for strengthening and coordination of speech-producing muscles and structures
- Vocational rehabilitation, functional capacity evaluations, work hardening programs, community reintegration services, and driving evaluations and training

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

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

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

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

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

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

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

- Computer or electronic equipment for monitoring asthmatic, diabetic, or similar medical conditions or related data
- Equipment commonly used for nonmedical purposes, or marketed to the general public, or prescribed primarily for comfort, or intended to alter the physical environment. This includes appliances like air conditioners, air purifiers, room humidifiers, heating and cooling pads, home blood pressure monitoring equipment, light boxes, conveyances other than conventional wheelchairs, whirlpool baths, spas, saunas, heat lamps, tanning lights, and pillows. It also includes orthopedic shoes and shoe modifications. Mattresses and mattress pads are only covered when medically necessary to heal pressure sores.
- Equipment used for physical or occupational therapy, or used primarily in athletic or recreational activities. This includes exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal problems.
- Modifications to vehicles or structures to prevent, treat, or accommodate a medical condition
- Personal items such as telephones, televisions, and guest meals during a stay at a hospital or other inpatient facility

Experimental or Investigational Treatment

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

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

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

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

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

Other Items - This plan does not cover the following:

- Services or supplies that are not medically necessary in PacificSource's judgment
- Charges for inpatient stays that began before you were covered by this plan
- Services or supplies received before this plan's coverage began
- Services or supplies received after enrollment in this plan ends. (The only exception is that if this policy is replaced by another group health policy while you are hospitalized, PacificSource will continue paying covered hospital expenses until you are released or your benefits are exhausted, whichever occurs first.)
- Treatment of any illness or injury resulting from an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement authority
- Services or supplies available to you from another source, including those available through a government agency
- Services or supplies with no charge, or which your employer would have paid for if you had applied, or which you are not legally required to pay for. This includes services provided by yourself or an immediate family member.
- Charges that are the responsibility of a third party who may have caused the illness or injury or other insurers covering the incident (such as workers' compensation insurers, automobile insurers, and general liability insurers)
- Services or supplies for which you are not willing to release the medical information PacificSource needs to determine eligibility for payment
- Treatment of any condition caused by a war, armed invasion, or act of aggression, or while serving in the armed forces
- Treatment of any work-related illness or injury, unless your policy provides on-the-job health coverage by endorsement. This includes illness or injury caused by any for-profit activity, whether through employment or self-employment, regardless of the availability of workers' compensation.
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims
- Any amounts in excess of the allowable fee for a given service or supply
- Services of providers who are not eligible for reimbursement under this plan
- Any services or supplies not specifically listed as covered benefits under this plan

EXCLUSION PERIODS

Transplants

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

CREDIT FOR PRIOR COVERAGE

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

Also, your prior coverage must have been a group health plan, COBRA or state continuation coverage, coverage under an individual health policy (including student plans), Medicare, Medicaid, TRICARE, State Children's Health Insurance Program, and coverage through high risk pools and the Peace Corp.

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

Evidence of Prior Creditable Coverage

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

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

PREAUTHORIZATION

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

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

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

If your treatment is not preauthorized, you can still seek treatment, but a coinsurance penalty of 30 percent, up to a maximum of $2,500 per occurence, will be applied to covered charges before regular plan benefits are figured. The penalty does not apply to your annual deductible or out-of-pocket limit. This penalty will not apply in the case of an emergency admission. In addition, you will be held responsible for the expense if it is not medically necessary or is not covered by this plan. Remember, any time you are unsure if an expense will be covered, contact the PacificSource Customer Service Department.

Because of the changing nature of medicine, PacificSource continually reviews new technologies and standards of medical practice. The list of procedures and services requiring preauthorization is therefore subject to revision and update. You'll find the most

current preauthorization list on our Web site, www.pacificsource.com, under "For Members." The list of procedures and services requiring preauthorization includes, but is not limited to, the following:

- **Ambulance transports** (air or ground) between medical facilities, except in emergencies
- CT-scan measurements of **bone density**
- **Breast reconstruction,** including reduction and implants
- Outpatient **cardiac** (Phase II) and **pulmonary rehabilitation**
- **Chelation therapy**
- **Cosmetic and reconstructive procedures** including skin peels, scar revisions, facial plastic procedures or reconstruction, and procedures to remove superficial varicosities or other superficial vascular lesions
- **Durable medical equipment** expense over $500, including purchase, rental, repair, lease, or replacement, or rental for longer than three months
- **Elective medical admissions**, such as preadmission, or admission to a hospital for diagnostic testing or procedures normally done in an outpatient setting , and **transfers to nonparticipating facilities**
- **Elective medical procedures** performed outside the United States
- **Experimental or investigational** procedures or surgeries
- **Extensions** of previously authorized benefits , such as physical or occupational therapy
- **Gamma knife procedures**
- **Genetic (DNA) testing**
- **Home health**, outpatient and home IV infusion , and hospice services, and enteral nutrition supplies
- **Hospitalization for dental procedures** when covered under this plan, including pediatric dental procedures
- **Kidney dialysis**
- **Laparoscopies** of the female reproductive system
- **Mental health and chemical dependency** inpatient or residential treatment, including intensive outpatient mental health treatment
- Multidisciplinary **pain management** and rehabilitation evaluations and programs
- **PET scans**
- **Radiofrequency neurotomy**
- **Rehabilitation** or skilled nursing facility admissions
- Surgical procedures , supplies, and equipment for **sleep apnea and other sleeping disorders**
- **Speech therapy** services
- **Surgeries or procedures** in a hospital or ambulatory center during any exclusion period

- **Transplantation** of organ, bone marrow, and stem cells, including evaluations, related donor services, and HLA tissue typing. Preauthorization is not required for corneal transplants.
- **Varicose vein procedures**

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

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

UTILIZATION REVIEW

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

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

Authorization of Hospital Admissions

When a PacificSource member is admitted to a hospital within the area covered by the PacificSource provider network (see the Using the Provider Network - Coverage While Traveling section), the hospital's admitting clerk calls PacificSource to verify the patient's eligibility and benefits. The clerk gives us information about the patient's diagnosis, procedure, and attending physician. We use that information to create a daily report of all PacificSource members currently admitted to hospitals within our service area. The authorization status of each admission is documented in the report as either pending, approved, or denied, and the patient's related claims are processed accordingly.

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

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

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

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

Extension of Hospital Stays

If a patient's hospital stay extends beyond the assigned length of stay, a Nurse Case Manager contacts the hospital's utilization review coordinator. We obtain current information about the patient's medical progress so we can either extend the length of stay or begin planning for the patient's discharge. The PacificSource Medical Director may review the case to determine if extended hospitalization meets our criteria for coverage.

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

Timeliness

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

Questions About Specific Utilization Review Decisions

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

CLAIMS PAYMENT

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

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

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

All claims should be sent to:

PacificSource
Attn: Claims
PO Box 7068
Eugene OR 97401-0068

Claims Payment Practices

Unless additional information is needed to process your claim, we will make every effort to pay or deny your claim within 30 days of receipt. If a claim cannot be paid within 30 days of receipt because additional information is needed, we will acknowledge receipt of the claim and explain why payment is delayed. If we do not receive the necessary information within 15 days of the delay notice, we will either deny the claim or notify you every 45 days while the claim remains under investigation.

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

Questions About Claims

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

Benefits Paid in Error

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

COORDINATION OF BENEFITS

If you, or your enrolled dependents, are covered by more than one group insurance plan, PacificSource will work with your other insurance carriers to pay up to 100 percent of your covered expenses.

This is called “coordination of benefits.” We do this so you receive the maximum benefits available from all sources for the cost of your care. When benefits are coordinated, one plan pays benefits first (the “primary coverage”) and the other pays based on the remaining balance (the “secondary coverage”). If your primary and/or secondary coverage include a deductible, you will be required to satisfy each of those deductibles before benefits are available. This plan’s rules for coordination of benefits are consistent with the requirements of coordination of benefits provisions in Oregon insurance regulations.

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

- If the other plan does not include “coordination of benefits,” that plan is primary and this plan is secondary.
- If you are covered as an employee on one plan and a dependent on another, your employer’s plan is primary.
- When a child is covered under both parents’ policies and the parents are not separated or divorced, the parent whose birthday falls first in a calendar year has the primary plan.

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

- When a child is covered under both parents' policies and the parents are separated or divorced:
  - If the parent with custody has not remarried, their coverage is primary.
  - If the parent with custody has remarried, the custodial parent's coverage is primary, the stepparent's coverage pays second, and the coverage of the natural parent without custody pays third.
  - If a court order specifies that one parent is responsible for the child's healthcare expenses, the mandated parent's coverage is primary regardless of custody.
- If a plan covers you as an active employee or a dependent of an active employee, that plan is primary. Another plan covering you as inactive, laid off, or retired is secondary.
- If none of these rules apply, the coverage that has been in place longest is primary.

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

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

Coordination with Medicare

- For people who are Medicare-eligible, this plan is usually primary and Medicare is secondary. This rule only applies to active employees and their enrolled dependents .
- *Medicare disabled and end-stage renal disease (ESRD) patients* : The above rule may not apply to disabled people under 65 and ESRD patients enrolled in Medicare. For information on coordination of benefits in those situations, please contact PacificSource.

THIRD PARTY LIABILITY

Third party liability means claims that are the responsibility of someone other than PacificSource. The liable party may be a person, firm, or corporation. Auto accidents and "slip-and-fall" property accidents are examples of common third party liability cases.

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

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

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

- If PacificSource pays any claim determined to be the responsibility of another party, you will hold the right of recovery against the other party in trust for PacificSource.
- PacificSource is entitled to reimbursement for any paid claims if there is a settlement or judgment from the other party. This is so regardless of whether the other party or insurer admits liability or fault.
- You may subtract a proportionate share of the reasonable attorney's fees you incurred from the money you pay back to PacificSource.

- PacificSource may ask you to take action to recover medical expenses we have paid from the responsible party. PacificSource may also assign a representative to do so on your behalf. If there is a recovery, PacificSource will be reimbursed for any expenses or attorney's fees out of that recovery.
- If you receive a third party settlement, that money must be used to pay your related medical expenses incurred both before and after the settlement. If you have ongoing medical expenses after the settlement, PacificSource may deny your related claims until the full settlement (less reasonable attorney's fees) has been used to pay those expenses.
- In a third party liability situation, PacificSource will ask you to agree to the third party liability terms of the group health policy by signing an agreement. PacificSource is not required to pay benefits until that agreement is signed and returned.

Motor Vehicle and Other Accidents

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

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

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

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

This plan does not cover any work-related illness or injury, including those arising from self-employment. This is true regardless of whether workers' compensation benefits are available to you.

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

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

COMPLAINTS, GRIEVANCES, AND APPEALS

Questions, Concerns, or Complaints

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

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

Unresolved Issues

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

GRIEVANCE AND APPEAL PROCEDURES

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

Appealing a Preauthorization Denial

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

How to Submit Grievances or Appeals

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

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

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

SOURCES FOR INFORMATION AND ASSISTANCE

Assistance in Other Languages

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

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

Assistance Outside PacificSource

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

Information Available from PacificSource

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

- A directory of participating healthcare providers under your plan
- Information about our drug formulary
- A copy of our annual report on complaints and appeals
- A description (consistent with risk-sharing information required by the federal Health Care Financing Administration) of any risk-sharing arrangements we have with providers
- A description of our efforts to monitor and improve the quality of health services
- Information about how we check the credentials of our network providers and how you can obtain the names and qualifications of your healthcare providers
- Information about our preauthorization and utilization review procedures

Information Available from the Oregon Insurance Division

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

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

You can request this information by contacting the Oregon Insurance Division, Consumer Protection Unit, 350 Winter Street NE, Room 440-2, Salem, OR 97310, phone (503) 947-7984, Web www.cbs.state.or.us/external/ins/.

FEEDBACK AND SUGGESTIONS

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

You may send comments or feedback using the "Contact Us" form on our Web site, www.pacificsource.com. You may also write to us at:

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

RIGHTS AND RESPONSIBILITIES

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

Your Rights as a Member:

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

Your Responsibilities as a Member:

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

PRIVACY AND CONFIDENTIALITY

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

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

PLAN ADMINISTRATION

Group Insurance Contract

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

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

Our address is:

PacificSource Health Plans
PO Box 7068
Eugene OR 97401-0068

Plan Funding

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

Plan Changes

The terms, conditions, and benefits of this plan may be changed from time to time. The following people have the authority to accept or approve changes or terminate this plan:

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

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

If changes occur, PacificSource will provide your plan administrator with information to notify you of changes to your plan. Your plan administrator will then communicate any benefit changes to you. Be sure to read and save any communications you receive about your PacificSource coverage.

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

Legal Procedures

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

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

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

Your rights under ERISA

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

Receive information about your plan and benefits.

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

Continue group health plan coverage.

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for transplants under your group health plan, if you have creditable coverage from another plan . You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 6 months (12 months for late enrollees) after your enrollment date in your coverage.

Prudent actions by plan fiduciaries.

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

Enforce your rights

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

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

Assistance with your questions

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

PacificSource
HEALTH PLANS

PACIFICSOURCE HEALTH PLANS NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

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

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

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

We may use and disclose medical information as follows:

Treatment

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

Payment

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

Healthcare Operations

We may use and disclose medical information for regular health plan operations. For example, we may disclose medical information to underwrite your policies, ensure proper billing, engage in case coordination or case management, protect you against fraud, and provide you with excellent customer service.

Business Associates

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

Plan Administration

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

Marketing

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

Individuals Involved in Your Care or Payment for Your Care

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

As Required By Law and For Law Enforcement

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

Public Health and Safety

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

State and Federal Agencies

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

Lawsuits and Disputes

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

Military and National Security

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

Workers' Compensation

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

Information About Health-Related Benefits

We may communicate to you about other services or health-related benefits that may be of interest to you.

Other Uses and Disclosures

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

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding protected health information we maintain about you:

Right to Inspect and Copy

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

Right to Request a Correction

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

Right to an Accounting of Disclosures

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

Right to Request Restrictions

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

Right to Request Confidential Communications

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

Right to Receive a Paper Copy of This Notice

You have the right to ask for a paper copy of this notice at any time, and it will always be available on our Web site at www.pacificsource.com/PDFs/Privacy_Notice.pdf.

If you wish to exercise any of these rights, please contact PacificSource. You will find our contact information in the box at right.

HOW TO REPORT A PROBLEM OR FILE A COMPLAINT

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

CHANGES TO THIS NOTICE

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

You may request that this notice be mailed to you at any time, and it will always be available on our Web site at www.pacificsource.com/PDFs/Privacy_Notice.pdf.

CONTACT INFORMATION

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

PacificSource Health Plans

Contact:	Customer Service Department, PacificSource Health Plans
Office Hours:	Monday through Friday, 8:00 A.M. to 5:00 P.M.
Address:	PO Box 7068; Eugene, OR 97401
Telephone:	(541) 684-5582 or toll-free (888) 977-9299
FAX:	(541) 684-5264
E-mail:	cs@pacificsource.com

Health and Human Services

Contact:	Office for Civil Rights U.S. Department of Health and Human Services
Address:	2201 Sixth Avenue, Suite 900 Seattle, Washington 98121-1831
Telephone:	(206) 615-2287
FAX:	(206) 615-2297
E-mail:	ocrcomplaint@hhs.gov

PacificSource HEALTH PLANS

Discover the Source.

Walgreens Mail Service for Prescription Drugs

Your PacificSource health plan offers mail order prescription service through Walgreens Mail Service in Portland, Oregon. If you take a medication on a regular basis, this mail order service is a convenient way to order prescriptions. Discounted vitamins and herbal supplements are also available through Walgreens.

Why use Walgreens mail order service?

- **Convenience.** Ordering is easy, and your medication is delivered right to your mailbox. The Walgreens pharmacists will even contact your doctor to request more refills when your current maintenance prescriptions expire.
- **Cost savings.** If you're ordering more than a 30-day supply, you may save money on copayments, depending on your benefit plan. (Check your summary of benefits to be sure.) Plus, there's no shipping or handling charge for the service.
- **Quick turn-around.** After your initial order, refills are normally turned around in three to four business days. (More time may be required if the pharmacy needs to contact your doctor prior to filling.)

How can you get started?

Using the service is easy. You can either:

- Complete the online enrollment form on the Walgreens Web site (see sidebar for details).
- Complete a Walgreens order form available from your company's benefits administrator.
- Call Walgreens Customer Service at (800) 304-8070 Monday through Friday between 5:00 A.M. and 7:00 P.M., or Saturday and Sunday between 5:00 A.M. and 2:00 P.M. (PST).

The first time you order, allow at least two weeks for the Walgreens staff to set up your account and ship your medications.

What about refills?

After your initial order through Walgreens, ordering refills is quick and easy. You can order refills:

- Online through the Walgreens Web site (see sidebar for details)
- By calling their automated refill phone line, (800) 797-3345
- By fax to (800) 334-5502
- By mail to Walgreens Mail Service, P.O. Box 5957, Portland, OR 97228-5957

Questions?

For more information, ask your company's benefits administrator for a Walgreens Mail Service brochure and order form. You may also visit their Web site or call Walgreens toll-free at (800) 304-8070 for more information.

Visit Walgreens Mail Service on the Web

One of the easiest ways to use the mail order prescription drug service is by visiting their Web site.

Find a link to Walgreens Mail Service on the PacificSource Web site, ***www.pacificsource.com.*** *Click on "Other Links," then click the "Mail Order Prescription Drug Service" heading on the page.*

PacificSource Health Plans
PO Box 7068 • Eugene OR 97401-0068 • (541) 686-1242 • (800) 624-6052
www.pacificsource.com

PacificSource HEALTH PLANS

Discover the Source.

Healthyroads Amenity Program

Resources for a Healthier Lifestyle

Healthyroads

Through an arrangement with American Specialty Health Networks, Inc. (ASH Networks) and its affiliate Healthyroads, Inc., we bring our members this special amenity program. What is an amenity program? It's a complement to existing healthcare benefits and provides access to separate but related health services, products, and information.

Healthyroads provides a variety of programs offering personalized support, as well as many tools and resources, that can help our members reach their health and fitness goals. PacificSource members can also take advantage of discounts of up to 25 percent on many healthcare services, including chiropractic, massage, and acupuncture, and discounts of up to 40 percent on many health-related products.

What the Healthyroads Web Site Includes

Educational Materials—There's an extensive library of articles written by healthcare experts on health and lifestyle topics. Members can also sign up to receive the Healthyroads monthly newsletter via e-mail.

Health Assessment Tools—Interactive health assessment tools can help members understand their health and set new goals.

Provider Directory and Discounts—Healthyroads' provider directory is a guide to choosing a chiropractor, acupuncturist, or other credentialed complementary care provider. Even if a member's PacificSource health plan does not cover these services, these providers offer discounts of 25 percent off the usual and customary fee or the maximum allowed under the fee schedule, whichever is greater. These providers are part of ASH Networks, which is independent of any PacificSource participating provider network. Many, but not all, PacificSource participating providers are also part of ASH Networks.

Members may use this program as often as they like, don't need a physician referral, and may change providers at any time. However, the program discounts cannot be used in addition to their health plan coverage. In other words, for any single office visit, members may use either their health plan's benefits (if available) or the Healthyroads discount, but not both. Members should check their insurance benefits before using the discount program.

Fitness Club Membership Program—Members can also find fitness clubs through the Healthyroads provider directory. ASH Networks fitness clubs offer a free trial membership and the lowest rate available for the type of membership selected. The Passport Travel Program gives members access to fitness clubs when they're travelling more than 50 miles from home.

Product Discounts—The Healthyroads store offers more than 2,400 health and wellness products at 15 to 40 percent off the suggested retail price.

continued on reverse

Healthyroads for Living

Members can register under the Healthyroads for Living section of the Web site and take advantage of personalized coaching and trackers, as well as a healthy Recipe of the Week and program tips.

Health Trackers—Healthyroads' online trackers can help members monitor their weight, diet and exercise programs, healthy habits, and much more.

Personalized Coaching—PacificSource members are automatically enrolled in Healthyroads for Living at the Affinity membership level and have access to personalized coaching from Healthyroads' registered dietitians, certified personal trainers, and other qualified staff. If members would like more in-depth coaching, they're welcome to join the next membership level for a small monthly fee.

More Information on the Healthyroads Program

For information on the Healthyroads program, visit our Web site at www.pacificsource.com. Click on For Members, then on Health and Wellness. Or call Healthyroads toll-free at (877) 335-2746.

Note: This Healthyroads discount program is not insurance; it is a discount program designed to complement health insurance benefits.

PacificSource HEALTH PLANS

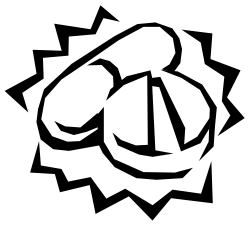
Discover the Source.

Eugene: PO Box 7068 • Eugene OR 97401-0068 • (541) 687-7047 • (877) 657-9797
Bend: PO Box 6837 • Bend OR 97708-6837 • (541) 330-8896 • (888) 877-7996
Medford: PO Box 1027 • Medford OR 97501 • (541) 858-0381 • (800) 899-5866
Portland: PO Box 2129 • Lake Oswego OR 97035 • (503) 699-6561 • (877) 657-9797
Web: www.pacificsource.com

PacificSource HEALTH PLANS

Discover the Source.

Prescription Discount Program



Extra savings

Although there's not a flat percentage discount each time you use the card, you will always get a price reduction on your medications when you use our discount program.

When you have prescription drug coverage included with your health plan, most medications are covered. Of course, there are some exceptions, and in a tough economy, it's sometimes difficult to pay the full price for those excluded prescription drugs. Isn't there some way to save on drugs not covered by the health plan?

PacificSource has created a Prescription Discount Program that does just that—it saves you money on qualifying prescription drugs not covered by your plan.

It's Convenient and Easy to Use!

Your card is accepted at all participating Caremark® pharmacies. Because the program is not an insurance plan, there are no claim forms.

You can use the discount program as often as you like. Just show your PacificSource Member ID card anytime you want to purchase a prescription drug for which you would normally pay the full price.

Questions and Answers

How do I access the discount?

- Present your PacificSource Member ID Card at your pharmacy.
- If the drug is covered under your plan, you pay the appropriate copayment.
- If the drug is not covered under your plan, a discount is automatically taken off the cash price of the prescription, and you pay the discounted price.

How much will I save?

There is NOT a flat percentage discount. Instead, the final discounted price depends on the drug, the drug's manufacturer, and the pharmacy's price on that medication. Rest assured that you will always get a price reduction on that medication when you use our discount program.

Can I use this program with my health plan's prescription drug benefit to save even more?

No, the discount program cannot be used with an insurance benefit or other prescription discount program. If you purchase prescriptions through your spouse's health plan, for example, you won't receive an additional discount with this program. However, if you are purchasing drugs that aren't covered by either of your insurance plans, you may be able to use this discount program to save on those medications.

Continued on reverse

Are there limits on what medications qualify?

The discount does not apply to drugs covered by your health plan. It also does not apply to over-the-counter medications. The program uses IRS guidelines for defining eligible prescriptions. If the drug is allowed as an income tax deduction by the IRS (and is not covered by your health plan), it is eligible for the discount.

Will my pharmacy participate?

This program operates under the same pharmacy network you use for your prescription drug benefit. Just ask an employee at your pharmacy if they participate with Caremark®. Chances are good that they do. All Caremark® pharmacies will honor our discount program.

How is the Prescription Discount Program different from traditional prescription drug insurance?

This program is not insurance; it is a prescription discount program. Think of it like the card at your favorite grocery or wholesale store—when you show your card, you get a price break. It's as simple as that.

Can I use the discount to purchase prescriptions for family members and friends?

The discount program is available to you and any family members enrolled in your health plan's coverage. Prescriptions for people not covered under your health plan are not eligible for the discount.

Do purchases accumulate toward my health plan's out-of-pocket maximum or deductible?

No. This discount program is not an insurance plan, so your out-of-pocket costs for purchases do not accumulate toward your health plan's maximums or deductibles.

Questions?

You're welcome to contact our Customer Service Department by phone at (541) 684-5582 or toll-free at (888) 977-9299, or by e-mail at cs@pacificsource.com.

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PacificSource HEALTH PLANS

Discover the Source.

Get *InTouch* with PacificSource

Stay on top of your benefits—from the comfort of home!

At PacificSource, we're committed to providing you with flexible, personalized service. One way we do that is through a members-only area of our Web site called PacificSource InTouch. By logging in with a user name and password, you can access personalized information about your PacificSource coverage 24 hours a day. If you prefer doing business online to phoning a personal representative, you'll appreciate the convenience of InTouch.

Use InTouch to:

- Look up your medical or dental claims information for the past two years
- See how much expense has accumulated towards your plan's deductible, stop-loss, or out-of-pocket maximum
- See how much expense has accumulated towards your PacificSource dental plan's annual maximum benefit
- Track your share of healthcare expenses (deductibles, copayments, etc.) by family member and year
- Track your family's enrollment history and check the coordination of benefits information we have on file
- Check the status of preauthorizations
- Check the status of referrals
- Notify us when your name or address changes
- Select a new PCP

Questions and answers

Can you send my login PIN by e-mail?

Unfortunately, no. To best protect your privacy, your PIN must be sent by U.S. mail.

Can I change my PIN?

Yes, you can change your assigned PIN to another unique PIN if you wish. You'll receive instructions for changing your PIN when you receive your PIN by mail.

What happens if I lose or forget my PIN?

If that happens, you will need to request a new PIN. Privacy regulations prohibit us from reminding you of your PIN.

Can I access my family members' information?

Continued on reverse.

You can access claims information for yourself and your covered dependent children under 18. For confidentiality reasons, your PIN will not allow access to information about a spouse or adult child. Your spouse and children 18 or over may request their own InTouch PINs to access their own coverage information.

Can PacificSource InTouch answer questions about my plan's benefits?

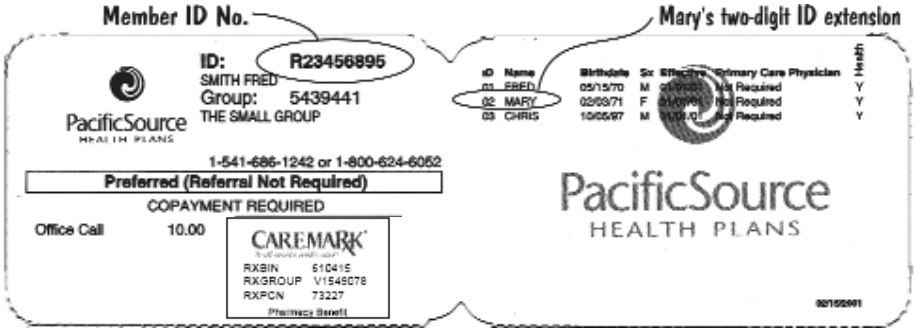
Right now, InTouch is limited to information about your family's claims, medical expenses, and enrollment. We're working on bringing personalized benefit information to the site in the near future. In the meantime, our Customer Service staff is available to answer those questions by phone or e-mail.

Who should I contact if I have technical problems?

If you have any difficulties with PacificSource InTouch, you're welcome to call our Customer Service Department, or use the Contact Us form on our Web site to describe your problem. We'll look into it and follow up with you right away.

Getting started

To start using PacificSource InTouch, simply visit our Web site and register. Browse to www.pacificsource.com, click For Members, click on the InTouch logo, and follow the instructions for new InTouch users. You'll be asked to enter your PacificSource member ID number and a two-digit ID extension, both of which are printed on your PacificSource ID card. The following example shows where to look:



After entering those numbers, click Submit. The next business day, we'll send your PIN and instructions by first class mail.

Ready...set...surf!

If you're already shopping or banking online, then using PacificSource InTouch will be a breeze. Even if you're an Internet rookie, we're sure you'll find InTouch easy to use, and our Customer Service Representatives are happy to help if you get stuck. The next time you're online, give PacificSource InTouch a try—then tell us what you think!

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Baby Benefits: A Free Prenatal Program

Healthy Babies Start With Healthy Pregnancies

There are few things more exciting than having a baby—and few things that cause more concern, whether it's your first pregnancy or your fourth. Above all, you hope for a safe pregnancy and a healthy baby. PacificSource understands these concerns, and is pleased to offer Baby Benefits, a program that helps you take care of your baby even *before* birth.

What are the benefits of the program?

Baby Benefits (formerly called Healthy Beginnings) helps expectant mothers reduce their risk of premature birth. Research indicates that more than half of preterm births may be preventable with appropriate prenatal care.

As a participant, you'll receive a Baby Benefits prenatal information package that includes:

- A book on prenatal care, called *Your Pregnancy Week by Week*
- Educational materials and pamphlets
- A toll-free phone number to reach a Baby Benefits nurse consultant 24 hours a day, 7 days a week during your pregnancy
- A confidential questionnaire to evaluate your risk for premature labor. You and your physician complete the questionnaire and return to Baby Benefits for assessment.
- Completion of the questionnaire makes you eligible to receive a book on childcare once your baby is born.

Who is eligible for Baby Benefits?

All subscribers and partners covered under a PacificSource group or individual health plan are eligible for the program at no charge. The program is completely confidential and participation is voluntary.

How do I register?

Registration is easy. Simply call Baby Benefits toll-free at (800) 828-5891, or visit our Web site, www.pacificsource.com. Click on the For Members link, then click on Baby Benefits. After you register, everything you need to participate will be sent directly to your home.

It is important to sign up in the first three months of pregnancy, or as soon thereafter as possible. The earlier in your pregnancy you register, the sooner the benefits begin for you and your baby!

Questions?

For more information about Baby Benefits, contact our Customer Service Department by phone at (541) 684-5582 or toll-free at (888) 977-9299, or by e-mail at cs@pacificsource.com.

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PacificSource HEALTH PLANS

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Your Healthcare Benefits When Traveling

Avoiding the Away-From-Home-Sick Blues

Ever catch the flu from the cute toddler across the aisle on a plane? Maybe you took up country line dancing on your trip to Nashville, and wound up with a sprain so bad you couldn't get back into your boots?

When you're planning a vacation or business trip, the last thing you need to worry about is what will happen if you need medical attention away from home. Your PacificSource health plan provides benefits when you travel outside the plan's service area. By following a few simple steps, you may save yourself a significant amount of out-of-pocket expense.

The First Health® Network

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

How can I find a First Health provider?

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

- Online: You can look up providers in your area using First Health's online provider directory. To get there, go to our Web site, www.pacificsource.com, click on Provider Directory, then on The First Health Network.
- By phone: Call First Health toll-free at (800) 449-9905. Representatives are available 24 hours a day, seven days a week. They'll help you find a physician, hospital, or other outpatient provider in your area, or tell you if a specific provider or facility participates with First Health. Si habla español—Spanish speaking representatives are available as well.

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

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

Continued on reverse.

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

The First Health Network is growing and adding new providers around the country all the time. If a First Health provider is not available where you are traveling, your plan pays your covered expenses based on a usual, customary, and reasonable charge for that area.

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

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

You may also call First Health yourself at (800) 449-9905 to find out if there is a participating hospital in the area. Then check with your physician to see if he or she has hospital privileges with a participating First Health hospital. Finally, have your physician preauthorize your admission by calling our Health Services Department at (888) 691-8209.

What if I need treatment for a medical emergency?

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

In true medical emergencies, your plan pays benefits at the participating provider level even if you are treated at a nonparticipating hospital.

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

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

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

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

Questions?

No matter where your travels take you, you're welcome to contact our Customer Service Department if you have questions about your plan. Call us toll-free at (888) 977-9299, or e-mail us at cs@pacificsource.com.

PacificSource HEALTH PLANS

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Electronic Participating Provider Directory

Complete, customized provider information is now available online!

PacificSource is pleased to offer an exciting tool that makes it easy to find up-to-date participating provider information whenever you need it: our electronic participating provider directory, part of our Web site at www.pacificsource.com.

Why move directories to the Web?
Some time ago, we phased out our printed provider directories, which were expensive to produce, cumbersome, and quickly out of date. We replaced them with customized directories created on our Web site.

Don't have Internet access?
We realize many people don't have access to the Internet. If that's the case for you, it's no problem. Just complete and mail the attached card, or call our Marketing Department at (541) 687-7047 or toll-free at (877) 657-9797. We'll send you a customized directory within a few days.

What can you do with the electronic provider directory?
If you do have Internet access, we think you'll love our directory. You can use it to:

- Look up a practitioner by name. You can easily see if your doctor is a participating provider or verify your practitioner's street address before your appointment.
- Search for a list of practitioners or facilities in your area. You tell the system what plan you have (check your PacificSource member ID card if you're not sure), what type of care you're looking for, and how far you're willing to travel, and it gives you names, addresses, and phone numbers. You can even get a door-to-door map and driving directions!
- Print your own customized provider directory. You tell the system what plan you have, where you live, and what types of providers to include. Choose the territory your directory covers—you can include all providers statewide, or narrow it down by county or within a distance of your address. The system will create a fully formatted provider directory for you, including a personalized cover. You can view the directory on screen, print it, or save the file on your computer.

Access participating provider information...

On our Web site. Click on "Provider Directory" and you're on your way.

By phone. Just call us and request a provider directory.

By mail. Simply complete the attached postage-paid card, drop it in the mail, and we'll send a customized directory within a week.

Please send me a customized provider directory!

Name:_____

Employer name: LANE COMMUNITY COLLEGE **Group no.:** B202

How would you like to receive your directory? (check one) ☐ **By e-mail** ☐ **By mail**

Your mailing address:_____

City:_____ **State:**_____ **ZIP:**_____ **E-mail:**_____

Phone:(_____)_____ **(In case we need to reach you for more information)**

Your personal directory will list participating providers within a certain distance of your address.

Include providers within *(check one)* ☐ **10** ☐ **25** ☐ **35** ☐ **50** ☐ **100 miles.**

To calculate the distance: ☐ **Use my mailing address (above).** ☐ **Use this address:**

Street:_____

City:_____ **State:**_____ **ZIP:**_____

Thank you! You should receive your directory within a week.

How does it work?

Our online participating provider directory is very easy to use, even for Internet rookies. All you need to get started is your health plan name, which you'll find on your PacificSource member ID card.

For a participating provider search, you'll be guided through a few simple questions to set up your search criteria, then you enter your address. The system searches through thousands of healthcare providers, and displays those closest to your address. You can click a symbol next to a provider's name to get a map and driving directions.

To create and print a customized directory, our system uses Adobe Acrobat Reader, a free, widely-used application that works with your Web browser. If you don't have Acrobat Reader on your computer, our site will help you download it. (This is a one-time process, so once Acrobat is installed you won't have to do it again.) You don't need the Acrobat reader to search for providers or facilities.

What are the advantages of the online system?

- It's up-to-date. The provider data is updated twice a month, so it's always current.
- It's convenient. You can look up a provider or print a directory whenever and wherever you want—from home after midnight, or at the office on your coffee break.
- It's customized—for you, by you. If you're looking for a dermatologist, you don't have to sift through pages of pediatricians, hospitals, and opticians.
- It's localized. You choose the territory you want your listing to cover.

Is the information you enter confidential?

Absolutely. We don't collect any personal information from this site. And you won't be asked for any sensitive or health-related information.

Questions? Our Customer Service Department is here to help.

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

Web Site, Provider Directory, and E-mail Links: **www.pacificsource.com**

NO POSTAGE
NECESSARY
IF MAILED
IN THE
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PACIFICSOURCE HEALTH PLANS
PO BOX 7068
EUGENE OR 97401-9702

What do you think?

We welcome any feedback you have about the directory. Please e-mail us your comments or suggestions using the "Contact Us" form on our Web site.