LIFEWISE | HEALTH PLAN OF OREGON

# Important Notice About This Sample Benefit Booklet

**Please note:** This is not a complete benefit booklet.

This is a SAMPLE used solely as a model of our standard benefit booklet and may not contain all of the terms and conditions of the group plan you may select. This document does not grant or entitle you to any right or benefit named or implied herein.

Endorsements are included in this sample and are located in the front behind the Table of Contents. Endorsements modify the terms and conditions of the plan.

You can locate specific sections of the sample provisions by clicking on the item listed in the Table of Contents.

If you have questions about this information please contact Customer Service.

# TABLE OF CONTENTS

# GROUP OMNIBUS ENDORSEMENT 0110

**Applies to LifeWise Health Plan of Oregon Group Policy Series:**

LWO 2005 LAT.SG (Rev 08-2008)
LWO 2005 LAT.LG (Rev 08-2008)
LWO 2005 LAT.SG (Rev 08-2009)
LWO 2005 LAT.LG (Rev 11-2009)

**This Endorsement revises the Contract between the Employer/Group and LifeWise Health Plan of Oregon. All Covered Services are subject to the specific conditions, durational limitations and all applicable maximums of the Contract on a Maximum Allowable Amount/Usual, Customary and Reasonable basis. No term, condition or limitation of the Contract is changed or altered except as expressly provided herein.**

**The changes described in this Endorsement become effective the later of the effective date of Your Contract or the date the Endorsement is added to Your Contract.**

## *The following is added to The Summary Of Benefits:*

| SUMMARY OF SERVICES | BENEFITS FOR COVERED SERVICES RECEIVED FROM PREFERRED PROVIDERS | BENEFITS FOR COVERED SERVICES RECEIVED FROM NON-PREFERRED PROVIDERS |
|---|---|---|
| **Tobacco Use Cessation Programs**<br>Subject to a Benefit Maximum Limit of $500 per Calendar Year. | 100% to the Benefit Maximum Limit and does not apply to the Coinsurance Maximum. | Not Covered. |
| **Hearing Exam and Aids** | | |
| • **Hearing Exam**<br>Subject to a Benefit Maximum Limit of $50 per Calendar Year. | 100% to the Benefit Maximum Limit after a $20 Copayment per visit and does not apply to the Coinsurance Maximum. | 100% to the Benefit Maximum Limit after a $20 Copayment per visit and does not apply to the Coinsurance Maximum. |
| • **Hearing Aids**<br>Subject to a Benefit Maximum Limit of $4,000 every 48 consecutive months for dependent children up to the limiting age. | 80% after the Deductible is satisfied, to the Coinsurance Maximum. | 80% after the Deductible is satisfied, to the Coinsurance Maximum. |

## *The following is added to What Are My Benefits:*

***Telemedicine Services benefit listed under Qualified Practitioner Services is deleted and replaced by the following:***

12. Benefits are provided for Medically Necessary Telemedicine Services delivered through two-way video communication. Covered Services include the professional fees for consultations, office visits, individual psychotherapy and pharmacologic management for telecommunication between a Qualified Practitioner and a Member. There are special limitations that apply to this benefit, please refer to What Is Not Covered section for additional information.

***The Community Wellness Benefits benefit listed under Other Covered Services is deleted and replaced by the following:***

Benefits are included for Community Wellness Benefits as shown on the Summary of Benefits when provided by a Hospital that is a Preferred Provider. Wellness topics usually include matters such as maternity fitness and education, newborn care and parenting skills, nutrition and healthy heart exercises or CPR skills. You may contact the provider directly to determine what specific wellness-related classes they offer.

Covered Services include:

- Wellness-related classes; and
- Printed material required for the class.

After You have completed the class, please provide Us with proof of payment and a completed Community Wellness Reimbursement Form for Us to review for benefit payment consideration. The Community Wellness Reimbursement Form may be obtained from Your Employer or Our Customer Service Department.

***A Tobacco Use Cessation Program benefit is added under Other Covered Services:***

**Tobacco Use Cessation Programs**

Benefits are included for Tobacco Use Cessation Programs as shown on the Summary of Benefits when provided by a Hospital that is a Preferred Provider. Covered Services include programs recommended by a physician that follow the United States Public Health Service guidelines for tobacco use cessation.

After You have completed a program, please provide Us with proof of payment and a completed Reimbursement Form for Us to review for benefit payment consideration. The Reimbursement Form may be obtained from Your Employer or Our Customer Service Department.

***A Hearing Exam and Hearing Aid benefit is added under Other Covered Services:***

**Hearing Exam and Aids**

Benefits for hearing exams and aids are provided as shown on the Summary of Benefits. Covered Services include the following:

**Hearing Exam**

- Examination of the inner and exterior ear;
- Observation and evaluation of hearing;
- Case history and recommendations; and
- Hearing testing services including the use of calibrated equipment.

**Hearing Aids**

Hearing aid benefits are available to enrolled dependent children only. Covered Services include:

- Hearing aids;
- Ear molds; and
- Attachments or accessory for the instrument or device, except batteries or cords.

***The Outpatient Prescription Drugs benefit for smoking cessation drugs is deleted and replaced by the following:***

- Prescription tobacco use cessation drugs up to a Benefit Maximum Limit of $500 per Member per Calendar Year.

## *The following is added to What Is Not Covered:*

***The exclusion for Telemedicine Services is deleted and replaced with the following:***

56. Telemedicine Services except as described under What Are My Benefits. Telemedicine Covered Services do not include telephone calls, facsimile machines and electronic mail systems (text message without visualization of the patient) or health services that are available to the patient in person;

***The following exclusion is added:***

59. Benefits are not provided for Qualified Clinical Trial Services including the drug, device or service being tested; items or services required solely for the provision of the drug, device or service being tested in the clinical trial; items or services required solely for the clinically appropriate monitoring of the drug, device or service being tested in the clinical trial; items or services required solely for the prevention, diagnosis or treatment of complications arising from the provision of the drug, device or service being tested in the clinical trial; items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; items or services provided by a clinical trial sponsor free of charge to any participant in the clinical trial; or items or services that are not covered by Us if provided outside the clinical trial.

## *The following is added to Definition Of Terms:*

**Qualified Clinical Trials**

A Qualifying Clinical Trial is a clinical trial that is funded and supported by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs.

The Qualified Clinical Trial must be conducted as an investigational new drug application, an investigational device exemption or a biologics license application subject to approval by the United States Food and Drug Administration (FDA). Also, a Qualified Clinical Trial is exempt by federal law from the requirements to submit an investigational new drug application to the FDA.

We encourage You or Your provider to call Customer Service to answer any coverage questions you may have regarding benefits. You or Your provider can call Us at the number listed on Your LifeWise ID Card.

# GROUP HEALTH CARE REFORM ENDORSEMENT
# NON-GRANDFATHERED PLANS

This Endorsement makes important changes to the Employer/Group Contract issued by LifeWise Health Plan of Oregon to Your Employer/Group. These revisions are required by the federal Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Act of 2010 (collectively referred to as the "Affordable Care Act"). If Congress, federal or state regulators, or the courts make further changes or clarifications regarding the Affordable Care Act and its implementing regulations, this Plan will comply with those requirements even if they are not specifically stated in this Endorsement.

This Endorsement takes effect on Your Plan effective date or first renewal date that falls on or after September 23, 2010.

Your Plan includes a Grievance and Appeals process as outlined under the What If I Have A Question, Grievance Or Appeal section of Your Benefit Booklet. The grievance and appeals process will comply with any new requirements as necessary under federal laws and regulations. For information regarding Your appeal rights, contact Our Customer Service at 800-777-1502 or on Our Web site at **www.lifewiseor.com**.

If you have questions about your appeal rights, please contact us directly. We can provide assistance in filing an appeal.

The titles, shown in bold, represent the provision included in Your Contract. They are displayed in the order in which they appear in Your Benefit Booklet.

## LIFETIME MAXIMUM BENEFIT

The overall Plan Lifetime Maximum Benefit listed on the Summary Of Benefits is deleted and any references to the Lifetime Maximum Benefit are removed from the Benefit Booklet.

Your Plan now includes an Annual Plan Maximum.

The maximum amount of benefits available to any one Member is $2,000,000 per calendar year. This Annual Plan Maximum applies to all benefits provided under this Plan. The Annual Plan Maximum renews each January 1.

Dollar Benefit Maximum Limits Removed From Specific Benefits

If Your Plan includes dollar Benefit Maximum Limits on the specific benefits shown below, the dollar Benefit Maximum Limits are removed. These Services accrue to the Annual Plan Maximum.

- Human Organ Transplants. Donor costs are subject to a Benefit Maximum Limit of $75,000 per transplant and transportation and lodging are subject to a Benefit Maximum Limit of $7,500 per transplant.
- Outpatient Rehabilitation Services. Benefits for Covered Services are limited to 45 visits per Calendar Year.
- Preventive Services; and
- Tobacco Use Cessation Programs and drugs

**Please Note:** Other maximums on units of care, such as day and visit maximums, remain unchanged.

## PRE-EXISTING CONDITION PROVISION

The Pre-existing Condition Provision listed in the Important Plan Information and Definitions sections of the Benefit Booklet are revised to remove the Pre-existing condition waiting period for Members under 19 years of age.

This Plan's Pre-Existing Condition Provision applies to Members age 19 and older.

## PREVENTIVE SERVICES

The Preventive Services provision listed on the ***Summary of Benefits*** and as described under ***What Are My Benefits*** is revised as required by federal regulation as stated below. Preventive Covered Services accrue to the Annual Plan Maximum.

Benefits for Covered preventive Services are provided as follows:

- Preferred Providers: Covered in full up to the Maximum Allowable Amount.
- Non-Preferred Providers: Benefits are provided based on the Services received as shown on the Summary of

Benefits under Benefits For Covered Services Received From Non-Preferred Providers.

Preventive Covered Services include:

- Evidence-based preventive services including, but not limited to screening for high blood pressure, high cholesterol, breast cancer, cervical cancer, colorectal cancer, osteoporosis and diabetes,
- Immunizations and vaccinations; and;
- Infant, child and adolescent preventive care and screening services.

A detailed list of covered preventive services and schedules listing who should receive preventive services and how often the services should be provided are available on our Web site at **www.lifewiseor.com** or by contacting Us at the number listed in the front of Your Benefit Booklet.

## DEPENDENT COVERAGE TO AGE 26

Eligibility requirements have changed for dependent children, please see the Who Is Eligible For Coverage section of Your Benefit Booklet. Insurers are prohibited from defining an adult child in any terms other than the relationship between the child and the Eligible Employee and maximum age. The Eligible child provision has been revised to remove any reference to financial dependency, marital or employment status and the maximum age is increased to 26.

If an Eligible Employee has a child under age 26 who meets the requirements as an eligible child and who lost health coverage sponsored by the Employer/Group or was not eligible for such coverage, that child can now enroll in this Plan. An eligible child who enrolled in COBRA coverage can now also enroll.

A one-time 30-day special enrollment period will be held for this purpose. When the Eligible Employee is eligible but not enrolled in any of the Employer/Group's plans or is enrolled in a different plan sponsored by the Employer/Group, the employee can also enroll in this Plan during the 30-day special enrollment period in order to cover the dependent.

We must receive a completed enrollment application within the 30-day special enrollment period. The coverage will become effective on the first day of the Employer/Group's effective date beginning on or after September 23, 2010. If We do not receive the enrollment application within the special enrollment period, the adult child will be considered a Late Enrollee, as described in Enrollment Provisions For Late And Special Enrollees section for Late Enrollees.

## PATIENT PROTECTIONS

This Plan does not require the use or selection of a primary care provider or require referrals for specialty care. Members may self-refer to providers, including OB/GYNs and pediatricians to receive care. You do not need a referral from LifeWise or from any other person (including a primary care provider) to obtain access to these providers. The health care professional and You may be required to comply with certain procedures, including Prior Authorization, for specific Services as shown in the Prior Authorization section of Your Benefit Booklet.

Emergency Care Services are provided without Prior Authorization requirements. Emergency Care Services are provided as shown on the Summary Of Benefits and the Emergency Care Services section of Your Benefit Booklet. You are responsible for applicable Deductibles, Copayments and Coinsurance, and any charges in excess of the Maximum Allowable Amount for Services received from Non-Preferred Providers.

# LIFEWISE HEALTH PLAN OF OREGON GROUP CONTRACT APPEALS ENDORSEMENT

**Applies to LifeWise Health Plan of Oregon Group Contract Numbers:**

LWO 2005 LAT.LG (Rev 11-2009) policy series

LWO 2005 LAT.SG (Rev 08-2009) policy series

**This Endorsement revises the Group Contract between the Group and LifeWise Health Plan of Oregon. The changes described in this Endorsement become effective on July 1, 2011.**

**In compliance with new administrative rules enacted by the Oregon Insurance Division, We have revised and replaced the What If I Have A Question, Grievance Or Appeal provision with the following:**

## YOUR IDEAS, QUESTIONS, COMPLAINTS AND APPEALS

As a LifeWise Member, You have the right to offer Your ideas, ask questions, voice complaints and request a formal appeal to reconsider decisions We have made. Our goal is to listen to Your concerns and improve our service to You.

If You need an interpreter to help with oral translation services, please call Us. Customer Service will be able to guide You through the service.

### WHEN YOU HAVE IDEAS

We would like to hear from You. If You have an idea, suggestion, or opinion, please let Us know. You can contact Us at the addresses and telephone numbers found on the front cover of this Benefit Booklet.

### WHEN YOU HAVE QUESTIONS

You can call Us when You have questions about a benefit or coverage decision, the quality or availability of a health care service or Our service. We can quickly and informally correct errors, clarify benefits, or take steps to improve our service.

We suggest that You call Your provider of care when You have questions about the health care services they provide.

### WHEN YOU HAVE A GRIEVANCE

You or Your authorized representative can write to Us when You have a grievance. Grievance means:

- A complaint in writing about;
  - The availability, delivery or quality of health care services;
  - Claims payment, handling or reimbursement for a health care service that is not disputing an adverse benefit determination; or
  - Concerns about Your health plan or Us.

  We will review Your complaint and notify You of the outcome as soon as possible, but no later than 30 days.
- A written request for an internal appeal or external review;
- An oral or written request for an expedited appeal or expedited external review.

Grievances for an internal appeal and external review are described below under *When You Have An Appeal* and *When Am I Eligible For External Review*.

### WHEN YOU DISAGREE WITH A PAYMENT OR BENEFIT DECISION

If We declined to provide benefits in whole or in part, and You disagree with that decision, You have the right to request that We review that adverse benefit determination through a formal, internal appeals process.

This plan's appeals process will comply with any requirements as necessary under state and federal laws and regulations.

**What is an adverse benefit determination?**

An adverse benefit determination means a denial, reduction, or termination of a health care item or services, or a failure or refusal to provide or to make payment, in whole or in part for a health care item or services based on:

- Denial or eligibility for or termination of enrollment in a health benefit plan;
- Rescission of coverage or cancellation of a policy or certificate. A rescission of coverage means a retro-active termination or cancellation of coverage due to acts of fraud or intentional misrepresentation of material fact;
- A preexisting condition exclusion, source or injury exclusion, network exclusion, or other limitation on otherwise covered benefits;
- A determination that a benefit is experimental, investigational, or not medically necessary, effective or appropriate.
- A determination that a course or plan of treatment is an active course of treatment for purposes of Continuity of Care as described under the *How To Obtain Services* section of Your Policy.

## WHEN YOU HAVE AN INTERNAL APPEAL

After You are notified of an adverse benefit determination, You can request an appeal. Your plan includes two levels of appeals. Your Level I appeal will be reviewed by individuals who were not involved in the initial adverse benefit determination. If the adverse benefit determination involved medical judgment, the review will be provided by a health care provider. They will review all of the information relevant to Your appeal and will provide a written determination. If You are not satisfied with the decision, You may request a Level II appeal.

Your Level II appeal will be reviewed by a panel that includes individuals who were not involved in the Level I appeal. If the adverse benefit determination involved medical judgment, a health care provider will be included in the panel. You may participate in the Level II panel meeting by phone to present evidence and testimony. Please contact Us for additional information about this process.

Once the Level II review is complete, We will provide You with a written determination. If You are not satisfied with the final internal appeal decision, You may be eligible to request an External Review, as described below.

**Who may file an internal appeal?**

You or Your authorized representative, someone You have named to act on Your behalf/ an individual who by law or by consent may act on Your behalf, may file an appeal. To appoint an authorized representative, You must sign an authorization form and mail or fax the signed form to the address or phone number listed below. This release provides Us with the authorization for this person to appeal on Your behalf and allows Our release of information, if any, to them.

Please call Us for an Authorization For Appeals form. You can also obtain a copy of this form on Our website at www.lifewiseor.com.

**How do I file an internal appeal?**

You or Your authorized representative may file an appeal by writing to Us at the address listed below. We must receive Your appeal request as follows:

- For a Level I internal appeal, within 180 calendar days of the date You are notified of an adverse benefit determination.
- For a Level II internal appeal, within 60 calendar days of the date You are notified of the Level I determination.

You must submit Your appeal request in writing to:

LifeWise Health Plan of Oregon
Attn: Appeals Department, MS 123
P.O. Box 91102
Seattle, WA 98111-9202

Or, You may fax Your request to:

Appeals Department
(425) 918-5592

If You need help filing an appeal, or would like a copy of the appeals process, please call Customer Service at the number listed in the back of this Benefit Booklet. You can also get a description of the appeals process by visiting

Our web page at www.lifewiseor.com.

We will acknowledge Our receipt of Your request in writing within 7 days.

**What if my situation is clinically urgent?**

If Your provider believes that situation is clinically urgent under law, Your appeal will be conducted on an expedited basis. A clinically urgent situation means one in which Your health may be in serious jeopardy or, in the opinion of Your physician, You may experience pain that cannot be adequately controlled while You wait for a decision on Your appeal. You may request an expedited internal appeal by calling Customer Service at the number listed on the front cover of this Benefit Booklet.

If Your situation is clinically urgent, You may also request an expedited external review at the same time You request an expedited internal appeal.

**Can I provide additional information for my internal appeal?**

You may supply additional information to support Your appeal at the time You file an appeal or at a later date by mailing or faxing to the address and fax number listed above. Please provide Us with this information as soon possible.

**Can I request copies of information relevant to my internal appeal?**

You can request copies of information relevant to the adverse benefit determination. We will provide this information as well as any new or additional information We considered, relied upon or generated in connection to Your appeal as soon as possible and free of charge. You will have the opportunity to review this information and respond to Us before We make Our decision.

**What happens next?**

We will review Your appeal and provide You with a written decision as stated below:

- Expedited appeals, as soon as possible, but no later than 72 hours after We received Your request. We will call, fax or email and will follow up with a decision in writing.
- Adverse benefit determinations made prior to You receiving services; 15 days of the date We received Your request
- All other appeals, within 30 days of the date We received Your request.

If We uphold Our initial decision, You will be provided information about Your right to a Level II internal appeal or Your right to an External Review at the end of the internal appeals process.

**Appeals Regarding Ongoing Care**

If You appeal a decision to change, reduce or end coverage of ongoing care for a previously approved course of treatment because the service or level of service is no longer medically necessary or appropriate, We will suspend our denial of benefits during the internal appeal period. Our provision of benefits for services received during the internal appeal period does not, and should not be construed to, reverse our denial. If our decision is upheld, You must repay Us all amounts that We paid for such services. You will also be responsible for any difference between our allowable charge and the provider's billed charge.

## WHEN AM I ELIGIBLE FOR EXTERNAL REVIEW?

If You are not satisfied with the final internal adverse benefit determination based on Medical Necessity, Experimental or Investigational, appropriate health care setting or level of care, and Continuity of Care, You may have the right to have Our decision reviewed by an Independent Review Organization (IRO). An IRO is an independent organization of medical reviewers who are contracted by the Oregon Insurance Division (OID) and who are qualified to review medical and other relevant information. There is no cost to You for an external review.

We will send You an External Review Request form at the end of the internal appeal process notifying You of Your rights to an external review. We must receive Your written request for an external review within 180 calendar days of the date You received the final internal adverse benefit determination. Your request must include a signed waiver granting the IRO access to medical records and other materials that are relevant to Your request.

You can request an expedited external review when Your provider believes that Your situation is clinically urgent under law. You can also request an expedited review for adverse benefit determinations regarding mastectomy

related services. Please call Customer Service at the number listed on the front cover of the Benefit Booklet to request an expedited external review.

We will notify the OID of Your request for an external review. The OID will notify You and Us of the IRO appointed to Your external review. The IRO will let You, Your authorized representative and/or Your attending physician know where additional information may be submitted directly to the IRO and when the information must be provided. We will forward Your medical records and other relevant materials for Your external review to the IRO. We will also provide the IRO with any additional information they request that is reasonably available to Us.

You can also request an external review by contacting the OID. Their contact information is listed below under *Other Resources For Help*.

**How will I know when the IRO has completed the external review?**

The IRO will review Your request and provide You and Us with a written decision as stated below:

- Expedited external review, as soon as possible, but no later than 72 hours after receiving the request. The IRO will notify You and Us immediately by phone, e-mail or fax and will follow up with a written decision by mail.
- All other external review, within 30 calendar days of the IRO's receipt of Your request.

**What happens next?**

LifeWise is bound by the decision made by the IRO. If the IRO overturned the final internal adverse benefit determination, We will implement their decision in a timely manner.

If the IRO upheld Our decision, there is no further review available under this Plan's internal appeals or external review process. However, You may have other remedies available under State or Federal law, such as filing a lawsuit.

## OTHER RESOURCES TO HELP YOU

If You have questions about understanding a denial of a claim or Your appeal rights, You may contact LifeWise Customer Service for assistance at the number listed on the front cover of Your Benefit Booklet. If You are not satisfied with Our decision or need help filing an appeal, You can also contact the OID at any time during this process.

If Your plan is governed by the Federal Retirement Income Security Act of 1974 (ERISA), You can contact the Employee Benefits Security Administration of the U.S. Department of Labor.

Oregon Insurance Division, Consumer Protection Unit

PO Box 14480

Salem, OR 97309-0405

Call: 503-947-7984 or the toll free message line at 1-888-877-4894

Email: mailto:cp.ins@state.or.us

On line: www.insurance.oregon.gov/consumer/consumer.html

Employee Benefits Security Administration (EBSA)

1-866-444-EBSA (3272).

**All other provisions of the group plans remain unchanged. This Endorsement forms a part of the Group Contract between the Group and LifeWise Health Plan of Oregon. It should be kept with Your Benefit Booklet for future reference.**

# MAXIMUM ALLOWABLE AMOUNT DISCLOSURE NOTICE

Your Plan provides benefits based upon the Maximum Allowable Amount for Covered Services.

The Maximum Allowable Amount is determined as follows:

**Preferred Providers:**

The fee that LifeWise has negotiated with its Preferred Providers for the Covered Service performed.

**Non-Preferred Providers:**

When You receive Services from a Non-Preferred Provider, providers who don't have a contract with LifeWise, the Maximum Allowable Amount is based on the following:

**For Covered Services Received Within The Service Area** The Maximum Allowable Amount will be no more than the fee that LifeWise has negotiated with its Preferred Providers for the same or similar Covered Services.

**For Covered Services Received Outside The Service Area** The Maximum Allowable Amount will be no more than the lower of the following:

- No less than 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (CMS). LifeWise will use data and fee schedules from CMS in setting the Maximum Allowable Amount; or
- The provider's billed charge.

In the event CMS does not have a fee for a given service, We will request additional information from Your provider. We will evaluate this information to determine the amount that CMS would reimburse for similar services. The Maximum Allowable Amount will be the lesser of that amount or the provider's billed charges.

You will be responsible for charges received from Non-Preferred Providers in excess of the Maximum Allowable Amount (the difference between what We allow for the Covered Service and the provider's actual charge) and for Your normal share of the claims costs.

If You have questions about the information included in this notice, please call LifeWise at the number listed on Your LifeWise ID Card.

# IMPORTANT PLAN INFORMATION

**Deductible**

Individual Deductible

Your Plan includes an Individual Deductible for Services received from Preferred Providers and a separate Individual Deductible for Services received from Non-Preferred Providers as stated on the Summary of Benefits. Individual Deductible means the amount You must pay for Covered Services in a Calendar Year before We begin to provide certain benefits to You.

Family Deductible

Your Plan includes a Family Deductible for Services received from Preferred Providers and a separate Family Deductible for Services received from Non-Preferred Providers as stated on the Summary of Benefits. Family Deductible means the aggregate amount a Family must pay for Covered Services in a Calendar Year before We begin to provide certain benefits to Your family. Once the Family Deductible is met, any remaining Individual Deductibles will be waived for that Calendar Year.

Any charges for Covered Services from a Preferred Provider or Non-Preferred Provider incurred by You or Your family during the last three (3) months of the Calendar Year that are used to satisfy all or part of the Deductible for that Calendar Year will be used to credit all or part of the Deductible for the following Calendar Year.

**Coinsurance Maximum**

Individual Coinsurance Maximum

Your Plan includes a Coinsurance Maximum for Covered Services received from Preferred Providers and a separate Coinsurance Maximum for Covered Services received from Non-Preferred Providers as stated on the Summary of Benefits. The Coinsurance Maximum is the amount of Coinsurance You must pay each Calendar Year. After the Deductibles, if the Coinsurance Maximums have been satisfied, benefits for Covered Services will be provided at 100% of the Maximum Allowable Amount for the remainder of that Calendar Year, subject to the benefit maximums and the Lifetime Maximum Benefit.

Expenses that do not apply to Your Coinsurance Maximum include:

- Copayments;
- Deductibles;
- Charges in excess of the Maximum Allowable Amount;
- Services in excess of any Benefit Maximum Limit or Durational Limit;
- Services not covered by this Plan;
- Any Covered Services as shown on the Summary of Benefits or on a Supplemental Benefit as not applicable to the Coinsurance Maximum;
- Prior Authorization Penalty.

There is no Family Coinsurance Maximum for Covered Services.

**Pre-Existing Condition Provision**

This Plan has a Pre-Existing Condition Provision and does not provide benefits for Services for any Pre-Existing Condition for a Member until the earlier of the following dates:

- Six months following the Member's Effective Date Of Coverage;
- Twelve months following the start of any required group Eligibility Waiting Period.

Your Creditable Coverage will be used to reduce the duration of the Pre-Existing Condition Provision if Your Creditable Coverage:

- Is still in effect on the date You enroll in this Plan; or
- Terminated within 63 days of the date You enroll in this Plan.

Any waiting period under this Contract will not count as a break in the period of Creditable Coverage.

**Benefit Exclusion Periods**

Some Services under this Plan have a Benefit Exclusion Period that must be satisfied before We will consider the Service eligible as a Covered Service. That means these Services will not be covered until You have satisfied the Benefit Exclusion Period. The Benefit Exclusion Period starts on Your Enrollment Date. Creditable Coverage will

be used to reduce the duration of the Benefit Exclusion Period if Your Creditable coverage is in effect on the date You enroll in this Plan or terminated within 63 days of the date You enroll in this Plan. After You have satisfied the Benefit Exclusion Period, these Services may be eligible as a Covered Service, subject to specific conditions, Durational Limits, and all applicable maximums of the Plan. Please refer to Your Summary of Benefits for details about specific Benefit Exclusion Periods included in this Plan.

# HOW TO REDUCE YOUR COSTS WITH LIFEWISE PREFERRED PROVIDERS

This Plan is a PPO Plan. This means that Your Plan provides You the flexibility to receive Covered Services from providers of Your choice without referrals. You have access to one of the many providers included in Our network of Preferred Providers for Covered Services included in Your Plan. You also have access to Qualified Practitioners, facilities, emergency rooms, surgical centers, equipment vendors or pharmacies providing Covered Services throughout the United States and wherever You may travel. Throughout this section You will find important information on how to control Your out-of-pocket costs and how the providers You see for Covered Services can affect Your Plan benefits.

**Availability of Covered Services**
**Please Note:** Not all Covered Services are available from all Preferred Providers and providers may be reimbursed at different benefit levels. Your Summary of Benefits lists the benefits that are available from Preferred Providers and Non-Preferred Providers and the benefit level allowed for the Covered Services they provide.

Your level of benefits depends on the provider who provides You with Covered Services. You will always get the highest level of benefits and have the lowest out-of-pocket costs when You receive Covered Services from a Preferred Provider.

The Covered Services listed below are only available from a Preferred Provider as shown on the Summary of Benefits.

- Preventive Care
- Human Organ Transplants
- Alternative Health Care Services
- Community Wellness

**Preferred Providers**
Preferred Providers are networks of Hospitals, Qualified Practitioners and other providers that We contract with to provide Medical Services at a negotiated fee. We have Preferred Providers in all categories of Services, such as laboratory and x-ray specialists; and medical specialties such as obstetricians.

You benefit in two ways when You receive Covered Services from a Preferred Provider. Your medical bills will be reimbursed at a higher percentage (the Preferred Provider benefit level), and Our Preferred Providers will not charge more than the Maximum Allowable Amount. This means that Your portion of the charges for Covered Services will be lower.

Please remember that Covered Services must be provided by a Preferred Provider to be eligible for the higher benefit level.

**Non-Preferred Providers**
Non-Preferred Providers are providers that do not have a contract with LifeWise. Your medical bills will be reimbursed at the lower percentage (the Non-Preferred Provider) benefit level and the provider may bill You for charges above the Maximum Allowable Amount. This means that Your out-of-pocket costs will be higher because Your benefit level is lower and You will be responsible for any charges over the Maximum Allowable Amount.

**Using Preferred Providers**
Here is an example of how using a Preferred Provider can reduce Your costs. The following comparison is based on a PPO Plan with a Deductible that has been satisfied. For this example, You were admitted to a Hospital for a 2-day maternity stay. You receive the following bills for the Covered Services:

1. $7,500 for the billed Hospital charges; and
2. $5,500 for the billed physician's professional charges.

The amount eligible for benefits is the Maximum Allowable Amount. For these Covered Services, the Maximum Allowable Amount is:

- $5,000 for the Hospital charges; and
- $4,000 for the physician's professional charges.

| | Hospital Charges - $7,500 | | Physician Charges - $5,500 | |
|---|---|---|---|---|
| **Preferred Providers** | The 80% benefit level is available, based on Our Maximum Allowable Amount of $5,000. | | Professional fees for prenatal, delivery and post natal care charges are subject to the 80% benefit level based on Our Maximum Allowable Amount of $4,000. | |
| | LifeWise Pays: | $4,000 | LifeWise Pays: | $3,200 |
| | ($5,000 x 80%) | | ($4,000 x 80%) | |
| | You Pay: | $1,000 | You Pay: | $800 |
| | ($5,000 X 20%) | | ($4,000 x 20%) | |
| **Non-Preferred Providers** | The 50% benefit level is available, based on Our Maximum Allowable Amount of $5,000. | | Professional fees for prenatal, delivery and post natal care charges are subject to the 50% benefit level, based on Our Maximum Allowable Amount of $4,000. | |
| | LifeWise Pays: | $2,500 | LifeWise Pays: | $2,000 |
| | ($5,000 x 50%) | | ($4,000 x 50%) | |
| | You Pay: | $5,000 | You Pay: | $3,500 |
| | (Your Coinsurance of $2,500 and the $2,500 charge in excess of the Maximum Allowable Amount) | | (Your Coinsurance of $2,000 and the $1,500 charge in excess of the Maximum Allowable Amount) | |

Using this example, if You receive Covered Services from Preferred Providers, Your out-of-pocket expenses would be less ($1,800) because the benefit level is higher (80%) and You are not responsible for any charges in excess of the Maximum Allowable Amount.

Your out-of-pocket expenses would be the highest ($8,500) if You receive Covered Services from Non-Preferred Providers because the benefit level is lower (50%) and You are responsible for the charges in excess of the Maximum Allowable Amount.

**How To Select A LifeWise Preferred Provider**

We have a Provider Directory that lists Our network of Preferred Providers. These providers are listed by geographical area, specialty and in alphabetical order to help You select a provider that is right for You. We update this directory regularly but, it is subject to change. We suggest that You call Us for current information and to verify that Your provider, their office location or provider group is included in the LifeWise network of Preferred Providers before You obtain Services.

The LifeWise Provider Directory is available any time on Our Web site at www.lifewiseor.com. You may also request a copy of Our Provider Directory by calling Us or by mailing the Provider Directory request card included with Your member packet. Our Customer Service number is located in the front of this Benefit Booklet or on the back of Your LifeWise ID Card.

# HOW TO OBTAIN SERVICES

Please take the time to read Your Plan Benefit Booklet. It will provide You with information to help You make the best choices for You. For example, You'll learn what Services LifeWise will cover before You receive Services and the level of benefits available for Covered Services. You or Your provider can call Us with questions about Your Covered Services and ask Us to review a recommended treatment plan to make sure the proposed Services are eligible for benefits before You receive Services. You can contact Us at the number listed in the front of this Benefit Booklet.

Your Plan Benefit Booklet describes Your medical benefits. Your medical benefits include inpatient or outpatient treatments and tests received from Qualified Practitioners and Qualified Treatment Facilities. The What Are My Benefits section of this Benefit Booklet describes Your benefits, also known as Covered Services.

The What Is Not Covered section of this Benefit Booklet describes what is not covered by this Plan. In some instances, Your provider may recommend a treatment that is not a Covered Service under this Plan. You can still obtain the recommended treatment and You will be responsible for the full cost of the Services.

The benefits for Covered Services are payable based on Our Maximum Allowable Amount. When You receive Covered Services from Non-Preferred Providers You will be responsible for the charges in excess of this amount. Please refer to How To Reduce Your Costs With Preferred Providers and the Maximum Allowable Amount Disclosure for information regarding Your out-of-pocket costs and the Maximum Allowable Amount.

## CARE OUTSIDE THE SERVICE AREA

LifeWise members have access to a nationwide network of providers when outside the Service Area. Dependents that are outside the Service Area (such as a student attending school) can also access these providers. When You seek care from these providers, covered Services are provided at the Preferred Provider benefit level. These providers will not charge You for amounts over Our Maximum Allowable Amount, and they will submit claims directly to Us.

The availability of these providers may vary by location. Please contact Customer Service at the numbers listed in the front of this Benefit Booklet or on Your LifeWise ID Card for more information on accessing care when outside the Service Area.

## CONTINUITY OF CARE

Continuity of Care means that You are in an active treatment plan and receiving Covered Services from a Preferred Provider while insured under this Plan and the Preferred Provider ends his/her contract with LifeWise. This means Your provider becomes a Non-Preferred Provider.

We will notify You, if it is reasonably known to Us that You are under an active treatment plan with a Preferred Provider, no later than the 10th day after the date on which Your Preferred Provider's contract with LifeWise terminates. If LifeWise learns after the termination date of Your Preferred Provider's contract with LifeWise, that You were in an active treatment plan, We will notify You no later than the 10th day after We become aware this fact. In order to obtain Continuity of Care, You must request Continuity of Care from Us.

If You would like Us to consider Your request to continue receiving services at the Preferred Provider benefit level, please call or send Your request to:

LifeWise
Care Management
Utilization Review
P.O. Box 7709
Bend, Oregon 97708
1-800-722-3372
Fax (541)-318-2305

Continuity of Care is subject to specific regulatory requirements. You may be eligible to continue Your treatment plan with this provider for a limited period of time at the Preferred Provider's benefit level if the treatment is Medically Necessary and You and this provider agree that it is desirable to maintain Continuity of Care.

We will not provide Continuity of Care when You discontinue Your coverage or when the contractual relationship between the individual provider and Us terminates and the provider:

- Will not accept the reimbursement rate applicable at the time the provider contract terminates;
- Retired;
- Died;
- No longer holds an active license;
- Relocates out of the Service Area;
- Goes on sabbatical;
- Is prevented from continuing to care for patients because of other circumstances; or
- Terminates the contractual relationship in accordance with provisions of contract relating to quality of care and exhausts his/her contractual appeal rights.

Duration of Continuity of Care

If You are eligible for Continuity of Care, You will receive Continuity of Care until the earlier of:

- The day following the date You complete the active course of treatment entitling You to Continuity of Care; or
- The 120th day after We notify You that Our contractual relationship with the Preferred Provider terminated; or the date on which We receive or approve Your request for Continuity of Care, whichever is earlier.
- If You are pregnant, and become eligible for Continuity of Care after commencement of the second trimester of the pregnancy, You will receive Continuity of Care until the later of:
    1. The 45th day after the birth; or
    2. As long as You continue under an active course of treatment, but no later than the 120th day after We notify You of the termination of Our contractual relationship with the Preferred Provider, or the date on which We receive or approve Your request for Continuity of Care, whichever is earlier.

When Continuity of Care terminates, You may continue to receive services from this same Provider, however, We will pay for Covered Services at the Non-Preferred Provider benefit level, subject to the Maximum Allowable Amount. Please refer to How To Reduce Your Costs With LifeWise Preferred Providers for an illustration about benefit payments.

If We deny Your request for Continuity of Care, You may request an appeal of the denial. Please refer to the section titled "What If I Have A Question, Grievance, or Appeal" as outlined in Your Contract.

## BENEFIT LEVEL EXCEPTIONS FOR NON-EMERGENT CARE

Your Plan provides You the freedom to select Your provider for many of the Plan's Covered Services. Our network of Preferred Providers is a broad panel of Preferred Providers that contract with LifeWise to provide the full scope of Your Plan's Covered Services and Your, and Your attending physician's direction. However, there may be times when You see a Non-Preferred Provider for a Covered Service that is reimbursed at a lower benefit level. In the circumstances outlined below, You may be eligible to receive the highest level of benefits when You received Services from one of these providers.

Your attending physician may recommend that non-emergent care be obtained from a Non-Preferred Provider at Your Plan's highest level of benefits. Your attending physician must request a benefit level exception, in advance and in writing, documenting that this provider possesses unique skills which are required to adequately care for You. In addition, Your attending physician must provide information that the requested care is not available from any of Our Preferred Providers.

If Your special circumstances meet Our criteria, We will grant Your attending physician's request to provide coverage at the highest level of benefits for those Covered Services. However, if We determine that requested Covered Services are available from a Preferred Provider, the Covered Services will be subject to the Non-Preferred Provider benefit level.

## EMERGENCY CARE SERVICES

Benefits for Emergency Care Services are provided when Your medical condition meets medical criteria for an Emergency Medical Condition. Covered Services include Services provided by Preferred Providers and Non-Preferred Providers and Services received in or out of the Service Area. Benefits will be provided at the Preferred Provider benefit level as shown on the Summary of Benefits when You receive Covered Services at a Hospital (inpatient or Emergency Room) or at an Urgent Care Center and when the choice of provider is beyond Your control. Emergency Care Services received from Non-Preferred Providers are subject to the Maximum Allowable Amount as described in the Maximum Allowable Amount Disclosure notice included in Your Benefit Booklet.

You will continue to receive Emergency Care Covered Services at the higher benefit level for the first 24 hours following the onset of the Emergency Medical Condition or until We determine You can be discharged from the Hospital or can be safely transferred to the care of a Preferred Provider. After this time period, benefits for Your Covered Services will be based upon whether You receive Covered Services from a Preferred Provider or a Non-Preferred Provider.

Members are responsible for the Deductible (if applicable), Coinsurance and/or Copayments and any charges in excess of the Maximum Allowable Amount when Services are received from Non-Preferred Providers. Covered Services are payable as shown on Your Summary of Benefits and are subject to all other benefit maximums and terms of the Contract. Please see What Are My Benefits for details.

Covered Services for an Emergency Medical Condition include the Emergency Medical Screening Exam consisting of the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition. Some examples are:

- Heart attack
- Stroke
- Poisoning

- Loss of Consciousness
- Serious burn
- Acute abdominal pain
- Severe chest pain
- Severe pain
- Bleeding that does not stop

If an emergency situation should occur, You should take immediate action and seek prompt medical care. You should call 911, or the emergency number listed in the local telephone directory or go to the nearest Hospital emergency department. If possible, contact Your attending physician first and follow their instructions.

## PRIOR AUTHORIZATION, UTILIZATION REVIEW AND CASE MANAGEMENT

We recommend many Services be reviewed for medical necessity prior to Services being provided. If Services are not reviewed prior to being rendered, they will be reviewed for medical necessity when a claim is received. We encourage You or Your provider to call Customer Service to answer any coverage questions You may have regarding benefits. You or Your provider can call Us at the number listed on Your LifeWise ID Card.

### Prior Authorization

Some Services and supplies covered under this Plan must be Prior Authorized. Prior Authorization is required for services received from Preferred and Non-Preferred providers. This means that You must receive authorization in writing from Us before You receive the Services. If an emergency exists that prevents You from obtaining Prior Authorization, We must be notified within 48 hours, following the onset of treatment, or as soon as reasonably possible, to continue coverage of the Services.

### How To Obtain A Prior Authorization

It is Your responsibility to make sure that a Prior Authorization is received. You or Your provider can call Us at the number listed on Your LifeWise ID Card to request a Prior Authorization. You will be directed to Our Care Management department who will guide You through this process.

Nothing in this provision will be construed to cover a hospitalization or Service that is not Medically Necessary or otherwise not covered as described elsewhere in this Benefit Booklet. If Your proposed treatment plan is determined at any time, either partially or totally, not to be an eligible Covered Service under the terms of this Contract, benefits will only be provided for Services that are deemed to be eligible.

### What Happens If You Don't Receive A Prior Authorization

If You don't receive Prior Authorization when required, You will be subject to a penalty. The penalty is 50% of the Maximum Allowable Amount for Covered Services, up to a maximum of $500 per occurrence. The penalty will be applied towards the Services that require Prior Authorization. The penalty does not apply to emergency admissions and does not accrue to the Deductibles or Coinsurance Maximums.

### Services That Require Prior Authorization:

- **Inpatient Admissions:**

  Inpatient admissions for both surgical and non-surgical acute rehab; Skilled Nursing Facility; Inpatient Hospice; Inpatient Rehab Facility; Obstetric (OB) related medical stays (OB complications, excludes routine maternity-48 hours and cesarean sections-96 hours); Ill newborn; and All mental or nervous conditions and chemical dependency care including residential and partial hospitalization treatment programs
- **Non-emergent Ambulance Services**
- **Human Organ Transplants (except cornea and skin)**
- **Outpatient Imaging:**

  Computed Tomography Scans (CT); Nuclear Cardiology; Magnetic Resonance Imaging (MRI); and Magnetic Resonance Angiography (MRA)
- **Outpatient Services and Procedures:**

  Back / Spine procedures – Kyphoplasty, Vertebroplasty, and Lumbar Fusion; Hyperbaric Oxygen Therapy; Proton Beam Therapy; Cochlear Implantation; Automated Cardio-Defibrillator Device (AICD); Gamma Knife Surgery; Uvulopalatopharyngoplasty (Somnoplasty/Uvulectomy and Laser assisted (LAUP)); and Steriotactic Radiosurgery
- **Home Medical Equipment, Prosthetis and Orthotics (purchase, repair or total rental over $500)**
- **Physican Administered "Biotech Drugs" / Medical Injectables:**

  Amevive (Alefacept), Avastin (Bevacizumab), Botox (Botulinum Toxin type A&B), CamPath (Alemtuzumab), Euflexxa (Hylauronan), Erbitux (Cetuximab), Flolan (Epoprosenol Sodium), Gleevec (Imatinib), Growth Factor Receptor Inhibitors, Growth Hormone (all brands), Herceptin (Trastuzumab), Hyalgan (Sodium Hyluronate), Immune Globulin (IVIG all brands), Iressa (Gefitinib), Increlex (Mecasermin), Mylotarg (Gemtuzumab Ozogamicin), Nexavar (Sorafenib), Oncology Clinical Trials, Orencia (Abatacept),

Recombinant Human Insulin-like Growth Factor 1, Recominant Platelet-derived Growth Factor – wound healing, Rituxan (Rituximab), Remicade (Infliximab), Revlimid (Lenalidomide), Sprycel (Desatinib), Supartz (Sodium Hyluronate), Synagis (Palivizumab), Synvisc (Hylan G-F 20), Sutent (Sunitinib), Tarceva (Erlotinib), Tasigna (Nilotinib), Vectibix (Panitumumab), and Xolair (Omalizumab)

You can locate a detailed list of by visiting Our web page at www.lifewiseor.com or by contacting Customer Service at the number listed on Your LifeWise ID Card.

**Utilization Review**
LifeWise has developed guidelines and clinical criteria used to make Medical Necessity determinations for some medical procedures and outpatient services, Hospital admissions and length of stay assignments. The criteria is reviewed annually and updated as necessary to ensure Our determinations are consistent with documented medical practice standards. The use of criteria follows national and regional norms. Additionally, We involve practicing community physicians in the review and development of Our internal criteria. You or Your provider may request the criteria used to review, and make the Medical Necessity determination for, a particular condition or procedure. To obtain the information, please send Your request to:

LifeWise
Care Management
Utilization Review
P.O. Box 7709
Bend, OR 97708
800-777-1502
Fax 541-318-2305

LifeWise reserves the right to deny payment for Services that are judged not to be Medically Necessary or that are Experimental/Investigational as determined by LifeWise. A decision by LifeWise following this review may be appealed in the manner described in the "What If I have A Complaint, Grievance, Or Appeal" section of Your Benefit Booklet. When there is more than one alternative available, coverage will be provided for the least costly among medically appropriate alternatives.

**Case Management**
Case Management works cooperatively with You and Your physician to consider effective alternatives to hospitalization and other high cost care. Working together We can make more efficient use of Your Plan's benefits. The decision to provide benefits for these alternatives is within Our sole discretion. Your participation in a treatment plan through Case Management is voluntary. If We agree, You or Your legal representative, Your physician and other providers participating in the treatment plan will be required to sign written agreements. These agreements will set forth the terms under which benefits will be provided.

Case Management is subject to the terms set forth in the signed written agreements. We may utilize Your Contract benefits as specified in the signed agreements, but the agreements are not to be construed as a waiver of Our right to administer Your contract in strict accordance with its terms in other situations. All parties have the right to re-evaluate or terminate the Case Management agreement at any time, at their sole discretion. Case Management termination must be provided in writing to all parties. Your remaining benefits under this Plan would be available to You at that time.

# WHAT ARE MY BENEFITS

This section of Your Benefit Booklet describes Services that will be considered Covered Service(s). Covered Service means a Medically Necessary Service, that is provided to You when You are covered for that benefit under this Benefit Booklet up to the Maximum Allowable Amount and as shown on Your Summary of Benefits. Benefits are subject to:

- The Copayment, if applicable;
- The Deductible, if applicable;
- Any Coinsurance percentage, if applicable; and
- Any Benefit Maximum Limit or Durational Limit.

Services must be provided by a Qualified Practitioner or a Qualified Treatment Facility to be eligible for benefits as described on the Summary of Benefits. Please refer to How To Reduce Your Costs With LifeWise Preferred Providers and How To Obtain Services sections for additional information.

Prior Authorization is required for inpatient admissions, transplants, outpatient imaging, outpatient services and procedures, Home Medical Equipment (HME), Prosthetics and Orthotics and physician administered "biotech drugs" / medical injectables. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.

All terms, provisions, limitations and exclusions described in the Benefit Booklet are applicable to Covered Services.

If You have any questions regarding Your benefits and how to use them, call Your Customer Service Representative.

## PHYSICIAN AND PROVIDER SERVICES

**Qualified Practitioner Services**
Benefits for the treatment of Illness or Accidental Injury from Your Qualified Practitioner include the Covered Services listed below and are provided as shown on Summary of Benefits. Qualified Practitioner Covered Services do not include Services provided by chiropractors, acupuncturists or naturopaths. Please refer to the Alternative Health Care Supplemental Benefit for information regarding these Covered Services.

Covered Services include the following:

1. Home and office visits, including covered physician and other provider evaluation and management services for examination and diagnosis of an illness or injury.
2. Inpatient or outpatient Hospital visits
3. Therapeutic injections administered at the physician's office, allergy testing and allergy injections, including serums, needles and syringes.
4. Consultations.
5. Diagnostic Services, including administration and interpretation.

   Some examples of what's covered are:

   - Diagnostic imaging and scans (including x-rays and EKGs)
   - Screening tests for prostate, cervical and colorectal cancer
   - Laboratory services
   - Pathology tests

   Preventive Diagnostic Services are defined as laboratory and imaging Services done for preventive or screening purposes, based on the U.S. Preventive Services Task Force (USPSTF) guidelines. (These guidelines are available at www.lifewiseor.com or by contacting Us.) Examples are cholesterol screening, home colon cancer test, colorectal cancer screening and pap smears.

   When covered outpatient diagnostic services are billed by an outpatient facility or emergency room and received in combination with other hospital or emergency services, benefits are provided under the Hospital Outpatient or Emergency Room Services benefits.

   Prior Authorization is required for some outpatient imaging services. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for a list of those services.
6. Administration of anesthesia.
7. Surgical procedures, including inpatient, outpatient and office surgery, post-operative care and assistant surgeon. In addition:
   - Covered Services include the Services of an assistant surgeon when Medically Necessary, and will not exceed 20% of the Maximum Allowable Amount; and
   - The Covered Service for multiple surgical procedures performed during a single operative session may be reduced or excluded when more than one surgical procedure is performed. This determination is based upon established medically appropriate billing practices and the review of the medical circumstances of Your procedures.
   - Reconstructive Surgery is covered if Medically Necessary Services are required to restore features damaged as a result of an Accidental Injury or Illness or to correct congenital deformity or anomaly. Covered Services include:

     a) Repair of a defect which is the direct result of an Accidental Injury, providing such repair is started within 12 months of the date of the accident.

     b) Repair of a dependent child's congenital anomaly.

     Reconstructive breast surgery in connection with a mastectomy is provided under the Mastectomy and Breast Reconstruction Services benefit.

   Prior Authorization is required for some outpatient services and procedures. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for a list of those services.
8. Maternity care, including prenatal care, delivery and postnatal care. Childbirth and prenatal education classes are not a Covered Service under this benefit. However, these types of classes may be eligible for coverage under the Community Wellness Benefit. Please refer to this benefit for additional information.

   The hospital length of stay for mother and newborn child will not be limited to less than 48 hours for a vaginal delivery or less than 96 hours following a cesarean section in accordance with the Newborn's and Mothers' Health Protection Act of 1996 (NMHPA). This limitation does not apply in any case when the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending physician in consultation with the mother.

   Benefits for a newly born child are provided only

when the child meets the dependent eligibility and enrollment requirements explained under the Eligibility and Enrollment section of Your Benefit Booklet. Benefits are subject to the child's own Deductible and Copayment, and Coinsurance requirements as applicable. Routine nursery care will be payable under the infant's coverage.

Prior Authorization is required for mother and a newborn child if the length of stay is more than 48 hours for a vaginal delivery or more than 96 hours following a cesarean section. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.

9. Family Planning Covered Services include voluntary sterilization (vasectomy and tubal ligation to prevent pregnancy), the exam, insertion of Norplant or an IUD and the device itself, Depo Provera injections necessary to prevent pregnancy and emergency contraception methods (oral or injectable) when furnished by Your provider.

   Benefits for oral contraceptives (birth control pills), cervical caps and diaphragms are provided as described in Prescription Drug Supplemental Benefit.

10. Benefits are provided for Inborn Errors of Metabolism that involves amino acid, carbohydrate and fat metabolism in accordance with state regulatory requirements. Covered Services consist of the diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits and biochemical analysis. Medical foods for treatment of Inborn Errors of Metabolism are provided for under Medical Supplies/Devices.

11. The benefits of this plan provide for outpatient diabetic health education and training services. Benefits are provided as shown on the Summary of Benefits.

12. Benefits are provided for Telemedicine Services when the originating site for the Service is located in a rural health professional shortage area (HPSA) or a non-metropolitan statistical area (MSA) county as defined by Medicare. Covered Services include the professional fees for consultations, office visits, individual psychotherapy and pharmacologic management for telecommunication between a Qualified Practitioner and a Member. There are special limitations that apply to this benefit, please refer to What Is Not Covered for additional information.

13. Benefits for routine colorectal cancer screening examinations and diagnostic laboratory are included and provided as those Covered Services shown on the Summary of Benefits based on the Services received. Covered Services include fecal occult blood tests, flexible sigmoidoscopy, colonoscopy and double contrast barium enemas as recommended by Your attending Physician.

## PREVENTIVE SERVICES

Preventive Covered Services include office visits, and any accompanying diagnostic laboratory and x-ray Services as recommended by Your attending physician, and are provided as those Covered Services shown on the Summary of Benefits. Please see Outpatient Pathology and Lab for diagnostic laboratory and x-ray Covered Services.

Covered Services include the following:

**Physical Examinations And Well-Baby Care**
Benefits are included for the prevention of disease and consist of physical examinations and well-baby care, as shown on the Summary of Benefits.

In order for a child to be eligible for benefits for routine newborn baby care they must be properly enrolled as outlined in the Eligibility and Enrollment section.

**Immunizations and Vaccinations**
Benefits are included for immunizations and vaccinations when ordered or approved by Your attending physician as shown on the Summary of Benefits.

**Seasonal Immunizations**
Benefits for seasonal immunizations are included as shown on the Summary of Benefits. Covered Services include flu shots, flu mist and pneumonia immunizations.

Covered Services do not include Services provided by chiropractors, acupuncturists or naturopaths. Please refer to the Alternative Health Care Supplemental Benefit for information regarding these Covered Services.

## MEN'S ROUTINE PROSTATE HEALTH SCREENINGS

Benefits for routine prostate health screening exams are included annually or more often if recommended by Your attending physician. Covered Services include digital rectal examinations and prostate antigen tests (PSA Tests) as shown on the Summary of Benefits and are separate from the Preventive Services benefit.

Men's routine prostate health screening Covered Services do not include Services provided by chiropractors, acupuncturists or naturopaths. Please refer to the Alternative Health Care Supplemental Benefits for information regarding these Covered Services.

## WOMEN'S ROUTINE HEALTH SCREENINGS

Annual Health Examinations

Benefits for women's routine health screenings are included annually or more often if recommended by Your attending physician. The women's health exam includes a pelvic examination and clinical breast examination that are provided to You in the absence of an Illness or Accidental Injury. Benefits are as listed in the Summary of Benefits and are separate from the Preventive Services benefit.

Mammograms and Pap Smears

Benefits for mammograms and Pap smears are included annually or more often as recommended by Your attending physician. Benefits are provided as shown on the Summary of Benefits and are separate from the Preventive Services benefit.

Women's routine health screenings Covered Services do not include Services provided by chiropractors, acupuncturists or naturopaths. Please refer to the Alternative Health Care Supplemental Benefit for information regarding these Covered Services.

## MASTECTOMY AND BREAST RECONSTRUCTION SERVICES

Benefits are provided for mastectomy necessary due to Illness or Accidental Injury and are provided as those Covered Services shown on the Summary of Benefits. For any Member electing breast reconstruction in connection with a mastectomy, this benefit covers:

- Reconstruction of the breast on which mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Physical complications of all stages of mastectomy, including lymphedemas.

Services are provided in a manner determined in consultation with the attending physician and the patient in accordance with state requirements and federal WHCRA 1998 requirements.

Prior Authorization is required for inpatient admissions for mastectomy and breast reconstruction services. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.

## FACILITY SERVICES

**Hospital, Ambulatory Surgical Facility, Skilled Nursing Facility and Inpatient Rehabilitation Services**

Benefits for these Covered Services are provided as shown on the Summary of Benefits. Benefits are limited to Covered Services provided in the least costly treatment setting which, is Medically Necessary for the individual patient's condition. Some of these Covered Services require Prior Authorization as described below.

**Inpatient Hospital**

Covered Services are included for semi-private room accommodations, coronary care, intensive care, care for mental or nervous conditions and chemical dependency care including residential treatment programs. Other Hospital Covered Services include, but are not limited to; the use of an operating room, anesthesia, dressings, medication including discharge or take-home medications, oxygen, x-ray, and laboratory services during the period of inpatient hospitalization.

Prior Authorization is required for inpatient admissions. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.

**Outpatient Hospital/Ambulatory Surgical Facility**

Covered Services include, but are not limited to, the use of operating room, anesthesia, dressings, medication, including discharge or take-home medication, oxygen, x-ray and laboratory.

Under certain circumstances, benefits for general anesthesia and related facility charges are included for dental procedures as shown on the Summary of Benefits based on the Services received. Covered Services are provided when determined to be Medically Necessary for the following reasons:

- The Member is under age 7 or is disabled physically or developmentally and has a dental condition that cannot be safely and effectively treated in a dental office;
- The Member has a medical condition besides the dental condition needing treatment that the attending provider finds that it would create an undue medical risk if the treatment were not done in a hospital or ambulatory surgical center.

Prior Authorization is required for some outpatient services and procedures. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.

Outpatient hospital/ambulatory surgical facility Covered Services do not include dental procedures.

**Inpatient Rehabilitation Facility**

Inpatient Rehabilitation Therapy Covered Services are provided as shown on the Summary of Benefits and are subject to the Benefit Maximum Limit. Covered Services are included for a semi-private room, plus Services and supplies provided and used while confined in a specialized rehabilitative unit of a Hospital or facility approved by Us. When rehabilitation follows acute care in a continuous

inpatient stay, this benefit starts on the day that the care becomes primarily rehabilitative.

Prior Authorization is required for inpatient rehabilitation services. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.

**Inpatient Mental Or Nervous Conditions And Chemical Dependency Care, Including Residential And Partial Hospitalizations**
Benefits for these Covered Services are provided as shown on the Summary of Benefits. Services must be provided by a Qualified Practitioner or Qualified Treatment Facility who is professionally licensed by the appropriate state agency to diagnose or treat an Accidental Injury or Illness and who provides Covered Services within the scope of that license. Not all providers or Services are Covered Services and will not be eligible for benefits under this Plan.

Prior Authorization is required for inpatient mental health or nervous conditions and chemical dependency care. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.

**Skilled Nursing Facility**
Skilled Nursing Facility Covered Services are provided as shown on the Summary of Benefits and are subject to the Benefit Maximum Limit. Covered Services are included for a semi-private room, plus Services and supplies furnished by and used while confined in a Medicare-approved Skilled Nursing Facility. When Skilled Care follows acute care in a continuous inpatient stay, this benefit starts on the day that the care becomes primarily skilled nursing care.

This benefit is only provided when You are at a point in Your recovery where inpatient Hospital care is no longer Medically Necessary, but Skilled Care in a Skilled Nursing Facility is Medically Necessary. Your attending physician must actively supervise Your care while You are confined in the Skilled Nursing Facility.

Prior Authorization is required for skilled nursing facility services. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.

**Diagnostic Services**
Benefits are included for inpatient and outpatient Diagnostic Services and as shown on the Summary of Benefits. Covered Services include the following:

- Diagnostic and routine imaging and scans (such as x-rays and EKGs)
- Laboratory services
- Pathology tests

**Preventive** Diagnostic Services are defined as laboratory and imaging Services done for preventive or screening purposes, based on the U.S. Preventive Services Task Force (USPSTF) guidelines. (These guidelines are available at **www.lifewiseor.com** or by contacting Us.) Examples are cholesterol screening, home colon cancer test, colorectal cancer screening and pap smears.

Diagnostic procedures, including biopsies, and scope insertion procedures, such as colonoscopy and endoscopy, are considered surgical Services and are not covered under this benefit. Please see Physician Provider Services and Facility Services for the applicable surgery Services benefits.

Prior Authorization is required for some outpatient imaging services. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for a list of those Services.

**Emergency Room Care**
Benefits are included for Emergency Room Care provided in a Hospital emergency room as shown on the Summary of Benefits. Covered Services include the emergency room physician charges, Emergency Medical Screening Exams and stabilization of an Emergency Medical Condition. Please see How to Obtain Services for detailed information about Emergency Care Services.

Diagnostic laboratory, x-ray Services and other Covered Services not provided by the emergency room physician and/or provided outside the emergency room are included as those Covered Services described under Physician/Provider Services and Facility Services.

You must notify Us when You are hospitalized for an Emergency Medical Condition within 48 hours, or as soon as reasonably possible following the onset of treatment.

Covered Services do not include Services for the inappropriate use of an emergency room. This means Services which could be delayed until You can be seen in a Qualified Practitioner's office, for example: routine care including check ups, follow up visits and prescription drug requests; and treatment of minor illnesses such as sore throats.

**Urgent Care Services**
Benefits include Covered Services from an Urgent Care facility and are provided as shown on the Summary of Benefits.

## OTHER COVERED SERVICES

The following are other Covered Services and are provided as shown on the Summary of Benefits

**Accidental Dental Injury**
Benefits are provided for Accidental Dental Injury as

shown on the Summary of Benefits.

Covered Services include the initial medical care to stabilize Emergency Medical Conditions involving pain, bleeding and dental care for teeth and gums when all of the following requirements are met:

- Services are provided for an Accidental Dental Injury to a Sound Natural Tooth that is free from decay and otherwise functionally sound at the time of the Accidental Injury;
- Services are necessitated as a direct result of an Accidental Injury;
- Services are within the scope of the provider's license; and
- The injury is not caused by biting or chewing, even if the injury is caused by foreign objects in food.

**Biofeedback Therapy**
Benefits are included for outpatient biofeedback Services, as shown on the Summary of Benefits subject to the Benefit Maximum Limit. Covered Services consist of biofeedback training by any modality when provided by a Qualified Practitioner for Illness or Accidental Injury.

**Community Wellness Benefits**
Benefits are included for Community Wellness Benefits as shown on the Summary of Benefits when provided by a Hospital that is a Preferred Provider. Wellness topics usually include matters such as maternity fitness and education, newborn care and parenting skills, smoking cessation, nutrition and healthy heart exercises or CPR skills. You may contact the provider directly to determine what specific wellness-related classes they offer.

Covered Services include:

- Wellness-related classes; and
- Printed material required for the class.

After You have completed the class, please provide Us with proof of payment and a completed Community Wellness Reimbursement Form for Us to review for benefit payment consideration. The Community Wellness Reimbursement Form may be obtained from Your Employer or Our Customer Service Department.

**Emergency Medical Transportation - Ambulance Service**
Benefits for ambulance Services are included as shown on the Summary of Benefits. Covered Services include emergency medical transportation to the nearest Hospital that has the facilities to provide the necessary treatment required for the Member's condition and/or the associated medical treatment. Medically Necessary air ambulance transportation is subject to the Benefit Maximum Limit as shown on the Summary of Benefits. All ambulance Services must be supplied by an appropriately licensed provider of service.

Emergency Medical Transportation or Ambulance Service claims will be paid to the provider of the ambulance care and transportation or jointly to the provider and the Member.

Prior Authorization is required for non-emergent ambulance services. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.

**Home Health Care Benefits**
Benefits for home health care Covered Services are covered as shown on the Summary of Benefits.

A Home Health Care Provider must provide Services at Your home under a home health care plan. Nothing in this provision will increase benefits to cover home health care Services that are not otherwise covered under this Plan.

Each visit by a person providing Services under a home health care plan, or evaluating the need for or developing a plan, is considered one home health care visit. Up to 4 consecutive hours in a 24-hour period of home health aide service is considered one home health care visit. A home health aide visit of 4 hours or more is considered one visit for every 4 hours or part thereof.

Home health care will not be reimbursed unless:

1. A Qualified Practitioner certifies that the home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health Agency or certified rehabilitation agency; and
2. We determine the Services to be Medically Necessary and allow as a Covered Service.

If You were hospitalized immediately prior to the commencement of home health care, the Qualified Practitioner who was the primary provider of Services during the hospitalization must also initially approve the home health care plan.

If the above criteria are not met, benefits will not be provided under this Plan for home health care.

**Hospice Care Benefit**
Benefits are included for hospice care as shown on the Summary of Benefits and described below. Benefits for a hospice care program must be provided in a hospice facility or in Your home by a hospice care agency.

Prior Authorization is required for inpatient hospice care. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.

In addition, the following criteria apply to Covered Services for this benefit:

1. We determine the Services to be Medically Necessary;
2. A Qualified Practitioner certifies that You have a terminal Illness with a life expectancy not exceeding six months; and
3. Covered Services provided are reasonable and necessary for the condition and symptoms being treated.

When the criteria are met for coverage of a hospice care program, We will provide benefits for the Covered Services which a certified hospice care program is required to include.

Covered Services include the following:

1. Nursing care provided by or under the supervision of a registered nurse;
2. Medical social services provided by a medical social worker who is working under the direction of a physician; this may include counseling for the purpose of helping You and Your caregivers to adjust to the approaching death;
3. Services provided by a Qualified Practitioner or a physician associated with the hospice program;
4. Short term inpatient care provided in a hospice inpatient unit or other designated hospice bed in a Hospital or Skilled Nursing Facility; this care may be for the purpose of occasional respite for Your caregivers (not to exceed five days), or for pain control and symptom management;
5. Home Medical Equipment, medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal Illness;
6. Home health aide Services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care;
7. Rehabilitation therapies provided for purposes of symptom control or to enable You to maintain activities of daily living and basic functional skills; and
8. Continuous home care during a period of crisis in which You require skilled intervention to achieve palliation or management of acute medical symptoms.

No other Services are covered under the hospice care benefit.

**Medical Foods**

Benefits are provided for Medically Necessary medical foods for supplementation or dietary replacement for the treatment of inborn errors of metabolism. Inborn errors of metabolism include disorders that involve amino acid, carbohydrate and fat metabolism for which medically standard methods of diagnosis, treatment and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Medical foods are defined as foods that are formulated to be consumed or administered enterally under strict medical supervision, for the treatment of inborn errors of metabolism including, but not limited to: phenylketonuria (PKU); homocystinuria; citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency.

**Medical Supplies/Devices And Home Medical Equipment (HME)**

Benefits for medical supplies/devices and Home Medical Equipment (HME) are included as shown on the Summary of Benefits. Services must be prescribed by Your attending physician. However, the fact that You have a physician's prescription for an item does not mean the Service is a Covered Service. Not all supplies, devices or HME are a Covered Service and are subject to the terms and conditions as described within this section and the Benefit Booklet. Documentation must be provided to Us which includes the prescription stating the diagnosis, the reason the service is required and an estimate of the duration of its need.

The reasonable cost of repairing an item is covered as long as this cost does not exceed the purchase of a new piece of equipment or device. Items that are replaced due to loss or negligence are not covered. Items that are replaced due to the availability of a newer or more efficient model are not covered unless We determine otherwise. Repair or replacement is covered if due to normal growth processes or to a change in Your physical condition due to Illness or Accidental Injury.

<u>Medical Supplies/Devices</u>

Benefits are provided for medical supplies or devices which are described below and as shown on the Summary of Benefits.

1. Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.

   Covered Services include shoe inserts, insoles, arch supports, heel wedges and lifts and orthopedic shoes, the fitting and follow up exam, as required as a result of surgery, congenital defect or diabetes. These covered Services are covered as shown on the Summary of Benefits and are limited to $200 per Calendar Year and accrue to the Medical Supplies Benefit Maximum Limit, if any.
2. Covered Services include non routine vision hardware for certain medical conditions; corneal

ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjorgren's disease, congenital cataract, corneal abrasion and keratoconus.

3. Rental of an oxygen unit used in the home for Members.
4. Medically Necessary supplies as ordered by Your attending physician including, but not limited to ostomy supplies, non-prescription elemental enteral formula for home use, needles and syringes, blood glucose monitor, insulin pump (including accessories), and insulin infusion devices.

   Covered Services for insulin and prescribed needles/syringes, Insulin administration supplies (Insulin Pens), disposable diabetic testing supplies, glucagon emergency kits, and allergy emergency kits are provided only as described under the Prescription Drug Supplemental Benefit.
5. Medical devices surgically implanted in a body cavity to replace or aid the function of an internal organ.

Home Medical Equipment (HME)

Benefits are provided for HME as shown on the Summary of Benefits. Covered Services may include such items as a non-motorized wheelchair, Hospital bed, ventilator, or other Hospital-type equipment when determined to be Medically Necessary as determined by Us. Home Medical Equipment is defined as mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an Illness or Accidental Injury. It is of no use in the absence of Illness or Accidental Injury.

Prior Authorization is required for medical supplies/devices and home medical equipment purchased, repaired or rental over $500. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.

**Prosthetic And Orthotic Devices**

Benefits are provided for prosthetic and orthotic devices as shown on the Summary of Benefits. They must be medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and not solely for comfort or convenience.

Covered Services include prosthetic devices such as an artificial limb; external breast prosthesis following mastectomy; artificial eye, or maxillofacial prosthetic devices. Also covered are orthotic devices, supports or braces applied to an existing portion of the body for weak or ineffective joints or muscles. Maxillofacial prosthetic devices must be Medically Necessary for the restoration and management of head and facial structures that cannot be replaced by living tissue, are defective due to disease, trauma, or developmental deformity to control or eliminate infection and pain and restore facial configuration and function.

Prior Authorization is required for prosthetic and orthotic devices purchased or repaired over $500. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.

**Outpatient Chemotherapy / Infusion Therapy**

Outpatient chemotherapy and infusion therapy Covered Services are included as shown on the Summary of Benefits. Covered Services include outpatient professional Services, supplies, solutions, drugs, and prescribed oral anti-cancer medications. Drugs and supplies used in conjunction with chemotherapy/infusion therapy provided to You at an outpatient facility or Hospital are covered only under this benefit. Please contact Our Customer Service Department for additional information regarding these medications.

Outpatient Chemotherapy/Infusion Therapy Covered Services do not include outpatient Prescription Drugs. Please refer to the Prescription Drug Supplemental Benefit listed in this section of Your Benefit Booklet for these Covered Services, except as stated above.

Prior Authorization is required for physician administered "biotech drugs" / medical injectables. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.

**Outpatient Rehabilitation Therapy**

Benefits are included for outpatient rehabilitation for physical (including osteopathic manipulative therapy), occupational, speech, cardiac and pulmonary therapy and the related testing as shown on the Summary of Benefits.

Covered Services are provided when these Services are included as part of a written plan of treatment prescribed by a physician:

- Services provided to restore fully developed skills that were lost or impaired due to injury or illness; and
- Services provided to treat Members diagnosed with a Pervasive Developmental Disorder through age 17. Covered Services do not include Services provided to Members age 18 and older.

Hospital-sponsored wellness types of classes may be eligible for coverage under the Community Wellness Benefit. Please refer to the Community Wellness Benefit for additional information.

**Outpatient Mental or Nervous Conditions And Chemical Dependency Therapy**

Benefits for Mental or Nervous Conditions and

Chemical Dependency include outpatient visits for individual, family and group therapy and diagnostic evaluation. Benefits are limited to Covered Services provided in the least costly treatment setting which are Medically Necessary for the individual patient's condition. Covered Services must be provided by a Qualified Practitioner who is professionally licensed by the appropriate state agency to diagnose or treat an Accidental Injury or Illness and who provides Covered Services within the scope of that license.

Covered Services include outpatient visits and professional Services for individual, family and group therapy; diagnostic evaluation; inpatient facility services including, but not limited to medications including discharge or take-home medications; x-ray and laboratory Services during the period of inpatient hospitalization; residential treatment programs; and outpatient Prescription Drugs as described under What Are My Benefits in Your Benefit Booklet.

**Human Organ Transplants**
Benefits for human organ transplants are Covered Services to the extent shown on the Summary of Benefits, subject to a lifetime Benefit Maximum Limit. This benefit covers medical Services only if provided by a LifeWise "Approved Transplant Center." An approved transplant center is a hospital or other provider that's developed expertise in performing solid organ transplants, or bone marrow or stem cell reinfusion, and is approved by Us. Please call Us as soon as You learn You need an organ or bone marrow transplant.

This benefit is available after 12 months of consecutive coverage under this Contract. Your Creditable Coverage will be used to reduce the organ transplant Benefit Exclusion Period if Your Creditable Coverage is in effect on Your enrollment date in this Plan or terminated no more than 63 days prior to Your enrollment date in this Plan.

We will waive the transplant Benefit Exclusion Period if the transplant is needed as a direct result of:

- A congenital disease or anomaly of a child who has been covered through Us since birth; or
- A congenital disease or anomaly of a child who has been covered through Us since placement for adoption with the Eligible Employee.

Prior Authorization is required for human organ transplant services. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.

Covered Services consist of all phases of treatment:

- Evaluation;
- Pre-transplant care;
- Transplant and any donor Covered Services;
- Outpatient Prescription Drugs as described under the Prescription Drug Supplemental Benefit; and
- Follow-up treatment.

Of the transplant lifetime Benefit Maximum Limit, a maximum of $75,000 of Covered Services incurred by a live donor are covered under this benefit as though the donor's expense is the expense of the Member when both of the following apply:

- Recipient is a LifeWise Member, and
- Services are not provided by any other plan.

Human organ transplants must not be experimental or investigational, based on the criteria stated in the definition of "Experimental/Investigational." Cornea transplantation or skin grafts are not considered an organ transplant and are covered as surgery, subject to the terms and conditions of Your Benefit Booklet.

Covered Human Organ Transplants include the following:

- Kidney; heart; lung; heart-double lung; pancreas; simultaneous pancreas with kidney; and liver transplants; and
- Allogenic bone marrow and autologous bone marrow transplants (stem cell transplant).

The following organ transplant Covered Services apply to the transplant maximum benefit as stated above:

- All Covered Services related to the transplant surgery before the actual surgery.
- All resultant Covered Services related to the transplant after the surgery. The term "resultant Covered Service" includes, but is not limited to, medical Services, medical supplies, inpatient drugs, diagnostic modalities, prosthesis and therapy.
- Treatment of conditions resulting from the transplant.
- The reasonable and necessary donor costs.
- Of the transplant lifetime Benefit Maximum Limit, a maximum of $7,500 per transplant is allowed for reasonable and necessary transportation and living expenses of the Member and one companion, not to exceed three (3) months. Meals and personal care items are not covered.

## SUPPLEMENTAL BENEFITS

Supplemental Benefits are attached to and made a part of Your Contract. All Covered Services are subject to the specific conditions, Durational Limits and all applicable Benefit Maximum Limits included in the Contract on a Maximum Allowable Amount basis.

Supplemental Benefits are effective the latter of the effective date of this Contract or the date the benefits

are added to Your Contract.

**Alternative Health Care**
Benefits for outpatient Alternative Health Care Covered Services are provided as stated on the Summary of Benefits subject to the Benefit Maximum Limit when Services are:

- Received by a Preferred Provider who is a licensed chiropractic physician, a licensed naturopath physician or a licensed acupuncturist who provides Services within the scope of his or her license; and Covered Services are determined to be Medically Necessary and are not otherwise excluded by this Supplemental Benefit or Contract.

Naturopathic Services
Naturopathic Covered Services include preventive care or Medically Necessary treatment of an Illness or Accidental Injury including but not limited to: manual manipulation, physical modalities, minor office procedures and common diagnostic procedures consistent with naturopathic practice. X-rays and lab ordered by the physician are covered as outpatient x-ray and lab services as shown on the Summary of Benefits. This benefit does not cover hair analysis, or legend or non-legend drugs or medicines, except Vitamin B-12 intramuscular injections as indicated for a Vitamin B-12 deficiency.

Acupuncture Services
Acupuncture Covered Services are limited to Medically Necessary acupuncture, electro-acupuncture, cupping, moxibustion, extravasation and Gus Sha/Tui Na.

Chiropractic Services
Chiropractic Covered Services are limited to an initial evaluation visit for each diagnosis or injury, chiropractic treatment such as manipulation for neuromusculoskeletal disorders. Related diagnostic laboratory or x-rays Services consistent with Current Procedural Terminology (CPT) guidelines are covered as outpatient x-ray and lab services as shown on the Summary of Benefits.

Chiropractic Covered Services do not include Services provided for examinations, and/or treatment of strictly non-neuromusculoskeletal disorders.

Massage Therapy Services
Massage Therapy Covered Services are provided when prescribed by Your attending physician or naturopathic physician or chiropractor. Covered Services are limited to an initial evaluation visit for each diagnosis or injury and Medically Necessary treatment such as external manipulation or pressure of soft tissue for therapeutic purposes (massage therapy).

**Routine Vision Care**
Benefits for Routine Vision Care Covered Services are provided as shown on the Summary of Benefits.

Covered Services include the following:

Routine Vision Exam
Covered Services include the vision analysis by an Ophthalmologist or an Optometrist. A vision analysis may consist of external and ophthalmoscopic examination, determination of best corrected visual acuity, determination of the refractive state, gross visual fields, basic sensorimotor examination, and glaucoma screening.

Corrective Vision Hardware
Covered Services include those provided by an Optician or Optometrist when prescribed by an Ophthalmologist or Optometrist. Corrective eyewear benefits include:

- Lenses
- Frames
- Contact Lenses

**Outpatient Prescription Drugs**
Benefits for Outpatient Prescription Drugs are provided as shown on the Summary of Benefits when dispensed by a Preferred Provider pharmacy for use outside a medical facility.

Covered Services include the following:

- FDA-approved drugs, which by federal law, require a prescription. These are known as "legend drugs;"
- Off-label use of FDA approved drugs as defined in Definition of Terms;
- Drugs dispensed by a Qualified Practitioner at a rural health clinic for an urgent medical condition if there is no pharmacy within 15 miles of the clinic or if dispensed outside of the normal business hours of any pharmacy within 15 miles of the clinic. For the purposes of this benefit, urgent medical condition means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems;
- Selected compounded Medications where at least one ingredient is a covered prescription drug;
- Vitamins, which by federal law require a prescription;
- Glucagon and allergy emergency kits;
- Injectable diabetic drugs, including needles/syringes for use with diabetic drugs, diabetic drug administration supplies (Diabetic Drug Pens) and disposable diabetic testing supplies;
- Injectable prescription medications for self-administration;
- Prescribed needles and syringes;

- Medications, drugs or hormones to stimulate growth only when determined by Us to meet medical criteria;
- Prescription oral contraceptives, diaphragms and cervical caps; and
- Prescription smoking cessation drugs up to a Benefit Maximum Limit of $250 per Member per Calendar Year.

Covered Services do not include prescribed oral anti-cancer medications. Please see the Chemotherapy/Infusion Therapy benefit for those Covered Services.

Prior Authorization is required for physician administered "biotech drugs" / medical injectables, including growth hormones. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.

Using Your LifeWise ID Card

It is very important that You show Your LifeWise ID Card at the time You purchase a covered medication from a Preferred Provider Pharmacy.

When You show Your LifeWise ID Card at a Preferred Provider Pharmacy, the Preferred Provider Pharmacy will not charge You more than the Allowable Charge and will submit claims on Your behalf. This means that You will be responsible for Your Copayment or Coinsurance.

If You do not show Your LifeWise ID Card at a Preferred Provider Pharmacy, You will be required to pay the full retail price for the covered medication and submit a claim to Us for reimbursement. In addition to the Copayment or Coinsurance, You will be responsible for all costs above the Allowable Charge.

Under certain circumstances, You will not be required to pay charges in excess of the Allowable Charge when You do not use Your LifeWise ID Card. If You purchase a covered medication at a Preferred Provider Pharmacy within 30 days of Your Effective Date of Coverage or the date Your Prescription Drug benefit is changed, You will be responsible for only the Copayment or Coinsurance amount.

Please call Us at the number listed in the front of Your Benefit Booklet with any questions about this benefit or to request a new LifeWise ID Card.

If You need a list of preferred retail pharmacies, please call Us at the number listed in the front of Your Benefit Booklet. You can also call the toll-free Pharmacy Locator Line number listed on the back of Your LifeWise ID Card.

Allowable Charge

The allowable Charge is the amount agreed upon by the Pharmacy Benefit Manager and the Preferred Provider Pharmacies for prescription drugs that are covered by this Plan. Your liability for any applicable Deductibles, Coinsurance, Copayments, and amounts applied toward Benefit Maximum Limits will be calculated on the basis of the Allowable Charge.

Clinical Pharmacy Management

In accordance with established pharmacy practice standards, We may limit benefits to a specific dispensed days' supply, drug or drug dosage appropriate for a usual course of treatment. We may also limit benefits for certain drugs to specific diagnoses or pharmacies or require prescriptions to be obtained from an appropriate medical specialist.

In making this determination, We take into consideration medically necessary criteria, the recommendations of the manufacturer, the circumstances of the individual case, U.S. food and Drug Administration Guidelines, published medical literature and standard reference compendia.

Prescription Drug Volume Discount Program

Your prescription drug benefit program includes per claim rebates that are received by LifeWise from its pharmacy benefit manager. These rebates are taken into account in setting subscription charges or are credited to administrative charges otherwise payable to Us by Your group plan and are not reflected in Your cost share. The allowable charge that Your payment is based upon for prescription drugs is higher than the price We pay Our pharmacy benefit manager for those prescriptions. LifeWise either retains the difference and applies it to the cost of LifeWise operations and the prescription drug benefit program or credits the difference to subscription rates for the subsequent benefit year. If Your prescription drug benefit includes a copayment, coinsurance calculated on a percentage basis, or a deductible, the amount You pay and Your account calculations are based on the allowable charge.

Coordination of Benefits

Prescription Drugs benefits are subject to the Coordination of Benefits Provisions as described under What If I Have Other Coverage. If this Plan is Your secondary coverage, You will be required to submit Your pharmacy receipts for reimbursement. Please refer to Prescription Drug Claims as described under How To File A Claim for details. If You need help with this process, please call Customer Service at the number listed in the front of Your Benefit Booklet.

Dispensing Limits

Retail Pharmacy

Benefits are provided for up to a 30-day supply of covered medication unless the drug maker's packaging limits the supply in some other way. Dispensing of up to a 90-day supply is allowed when the drug maker's packaging does not allow for a lesser amount or as described under Specialty

Pharmacy. However, a separate Copayment or Coinsurance amount will apply for each 30-day supply of covered medication or the cost of the drug if that cost does not exceed the cost of the Copayment or Coinsurance Amount. We will apply a single Copayment or Coinsurance amount to insulin and needles and syringes when dispensed at the same time. A separate Copayment or Coinsurance amount will apply in all other circumstances.

Prescriptions By Mail
Benefits are provided for up to a 90-day supply of covered medication. A separate Copayment or Coinsurance amount will apply for each 90-day supply of covered medication.

Generic Drugs
When available, a generic drug will be dispensed in place of a brand name drug. In the event a generic equivalent is not manufactured, the applicable brand name Copay or Coinsurance will apply. If You request a brand name drug when a generic equivalent is available You will be required to pay the difference in price between the brand name drug and the generic equivalent, in addition to paying the applicable brand name Copayment/Coinsurance.

How to Submit a Claim
Please refer to How To File A Claim for detailed claim information.

Preferred Drug List
This benefit uses a list of preferred drugs, which is reviewed and updated from time to time. This preferred drug list includes medications to treat most medical conditions, including all FDA-approved generic drugs, and many brand name drugs. Drugs not on the preferred list are covered under Your benefit, but at the highest Copayment/Coinsurance as shown on the Summary of Benefits.

Please call Customer Service at the phone number listed in the front of Your Benefit Booklet to inquire about whether a drug is included on Our preferred list, or to receive a copy of the list.

Preferred Provider Pharmacy
Preferred Provider Pharmacy means a pharmacy that has a contract with the Pharmacy Benefit Manager.

Refills
Benefits for refills will be provided only when the enrollee has used three-fourths (75%) of the current supply. The seventy-five percent (75%) is calculated based on the number of units and days supply dispensed on the last refill.

Specialty Pharmacy
Benefits for specialty drugs are only available when purchased through one of Our Specialty Pharmacies. Benefits are provided for a 30-day supply of covered specialty Drugs as stated on the Summary of Benefits.

Specialty drugs are drugs used to treat complex or rare conditions that require special handling, storage, administration or patient monitoring. They are high cost, often self-administered injectable drugs for the treatment of conditions such as rheumatoid arthritis, hepatitis or multiple sclerosis. We have contracted with specific specialty pharmacies that specialize in the delivery and clinical management of specialty drugs. These pharmacies will work with You and Your health care provider to arrange ordering and delivery of these drugs.

Please visit Our web page at **www.lifewiseor.com** for additional information about specialty drugs included under this benefit and how to locate a Specialty Pharmacy or contact Customer Service at the number provided in the front of Your Benefit Booklet.

Prior Authorization is required for physician administered “biotech drugs” / medical injectables. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.

Tablet Splitting Program
Prescription Drugs that are easily split and available in appropriate strengths for splitting may be eligible for Our Tablet Splitting program. We will determine which drugs are eligible and not all Prescription Drugs will qualify for this program. Accessing these Services through Your retail and mail order benefits may reduce Your out-of-pocket expenses for these Prescription Drugs.

Participation in this program is voluntary. Please contact Customer Service at the number listed in the front of Your Benefit Booklet for more information about this program, to receive a list of the drugs that are eligible and how You can participate.

## WHAT IS NOT COVERED

In addition to those Services listed as not Covered under What Are My Benefits, the following are specifically excluded from coverage under this Contract.

1. Services determined by LifeWise not to be Medically Necessary for diagnosis and treatment of an Accidental Injury or Illness;
2. Services not directly related to an Illness or Accidental Injury, in excess of the preventive Care Benefit, including but not limited to routine physical examination and vaccinations for insurance, licensing, traveling or obtaining a passport and recreation programs. All Services related to a Preventive Care Benefit must be provided by a Preferred Provider;
3. Services not directly related to an Illness or Accidental Injury, in excess of the Men’s Routine

Prostate Health Screenings Covered Services;

4. Services not directly related to an Illness or Accidental Injury, in excess of the Women's Routine Health Screenings Covered Services;
5. Any Service which is an Experimental/Investigational procedure;
6. Services:
   - Which are not Covered Services;
   - Which are provided for a Pre-Existing Condition and are subject to the Pre-Existing Condition Provision as shown on the Summary of Benefits and as described under Important Plan Information and Definition of Terms;
   - Not furnished by a Hospital, Qualified Practitioner or Qualified Treatment Facility, or that are outside the scope of the provider's license or certification, or that are furnished by a provider that is not licensed or certified by the jurisdiction in which the Services or supplies were received;
   - Provided by homeopaths; massage therapists; faith healers; or unlicensed midwives;
   - Provided by licensed acupuncturists; naturopathic physicians; chiropractic physicians in excess of the Alternative Care Supplemental Benefit as described under What Are My Benefits and as shown on the Summary of Benefits, including but not limited to:
     - Services provided by Non-Preferred Providers;
     - Routine or preventive care Services provided by Acupuncturists or Chiropractors;
     - Hair analysis;
     - EAV and electronic tests for diagnosis and allergy; Tryptophan load test; Zinc tolerancy test; Loomis 24 hours urine nutrient/enzyme analysis; Darkfield examination for toxicity or parasites; comprehensive digestive stool analysis; urine/saliva PH; Cytotoxic food allergy test; salivary caffeine clearance; Sulfate/creatinine ratio; urinary sodium benzoate; fecal transient & retention time; Melatonin biorhythm challenge; intestinal permeability; and Henshaw test;
     - Services determined by Us or Our authorizing agent not to be a Covered Service;
     - Transportation costs including local ambulance charges;
     - Biofeedback or vocational rehabilitation;
     - Massage therapy in the absence of any other treatment or modality;
     - Vitamins, minerals, nutritional supplements, remedies, or other similar-type products, whether or not prescribed or recommended by Your Alternative Health Care Provider;
     - Legend or non-legend drugs or medicines, except as stated under What Are My Benefits;
     - Educational programs, non-medical self-care, or self-help training or any related diagnostic testing;
     - Chiropractic Services of strictly non-neuromusculoskeletal disorders.
   - For which no charge is made, or for which You would not be required to pay if You did not have this coverage;
   - Provided by or payable under any plan or law through a Government or any political subdivision, unless prohibited by law;
   - Which are not provided;
   - Provided by a person who ordinarily resides in Your home or who is a Member of Your immediate family (parent, Spouse, sibling or child);
   - Provided by You as the treating physician for Your own treatment;
   - Any Hospital, ancillary or other Service performed in association with a Service that is not covered under this Contract; or
   - Complications resulting from a non-Covered Service;
7. Charges in excess of the Maximum Allowable Amount;
8. Hospital, Ambulatory Surgical Facility, Skilled Nursing Facility or Inpatient Rehabilitation Therapy Services for care that is primarily for senile deterioration, mental deficiency; private duty nursing or private room unless prescribed as Medically Necessary; and personal items such as telephone, radio, television and guest meals;
9. Custodial Care;
10. Cosmetic Services. Reconstructive Surgery resulting from an Accidental Injury, infection or other Illness of the involved part is covered. Please refer to What Are My Benefits for additional information;
11. Services, supplies, education or training:
    - Provided under a court order or as a condition of parole or probation;
    - Related to behavioral disorders, marriage, family or sex counseling in the absence of a

Mental Health Illness; or

- Related to personal growth, assertiveness training or consciousness raising, career counseling, and learning disabilities except for attention deficit/hyperactivity disorders;

12. Mental or Nervous Conditions and Chemical Dependency Care Services for:
    - Mental retardation identified by DSM-IV-TR codes 317, 318.0, 318.1, 318.2 and 319;
    - Materials of an institution for mentally retarded individuals, except Services provided while admitted to an acute care Hospital for an Accidental Injury or Illness;
    - Learning disorders identified by DSM-IV-TR codes 315.00, 315.1, 315.2, 315.9;
    - Paraphilias identified by DSM-IV-TR codes 302.4, 302.81, 302.89, 302.2, 302.83, 302.84, 302.82, and 302.9;
    - Gender identity disorders identified by DSM-IV-TR codes 302.85, 302.6, 302.9, for members age 19 and older, including Services for medical conditions and psychological treatment of these disorders;
    - All medical Services provided in preparation for or subsequent to gender reassignment surgery, including, but not limited to the surgery itself, medical counseling and hormone therapy, regardless of age;
    - All medical Services for the treatment of sexual dysfunction, including, but not limited to implants, surgery and prescription drugs, such as Viagra. Psychotherapy and psychological or psychiatric diagnostic evaluation for sexual dysfunction are included as shown on the Summary of Benefits and as stated under Mental or Nervous Condition Covered Services;
    - Court ordered sex offender treatment programs;
    - Educational or correctional services or sheltered living provided by a school or half-way house;
    - Educational or training programs, regardless of diagnosis or symptoms that may be present;
    - V codes V15.81 through V71.09, except that V codes V61.20, V61.21 and V62.82 are included for children age 5 and younger as stated under Mental Or Nervous Conditions Covered Services;
    - Addiction to foods.
13. Community Wellness Services that are provided by Non-Preferred Providers, classes that are not wellness-related classes such as educational or vocational assistance, alcohol diversion as mandated by the judicial system and volunteer mutual support groups.
14. Services or materials of an institution for the developmentally disabled, except while in an acute care Hospital for an Accidental Injury or Illness;
15. Services for the treatment of sexual dysfunction, including, but not limited to implants, surgery and prescription drugs, such as Viagra;
16. Services related to preparation for sex change operations and medical or psychological counseling or hormonal therapy in preparation for, or subsequent to, any such procedure;
17. Services related to family planning, including, but not limited to contraceptive foams, jellies, sponges or condoms; and except as described under What Are My Benefits.

    Services for oral contraceptives, cervical caps and diaphragms are covered as described under the Prescription Drug Supplemental Benefit;
18. Infertility Services or any assisted fertilization techniques including but not limited to in-vitro fertilization, GIFT or ZIFT, and any cost associated with the collection or storage of sperm for artificial insemination by a donor, including donor fees;
19. Reversal of voluntary sterilization;
20. Dental Services including, but not limited to the care of teeth and gums, oral surgery (non-dental or dental), and all procedures involving the teeth; wisdom teeth and areas surrounding the teeth, orthodontics including casts, models, x-rays, photographs, examinations, appliances, braces, retainers and anesthesia, except as shown on the Summary of Benefits and as described under What Are My Benefits;
21. Hospital Services for dental procedures except as described under What Are My Benefits;
22. Jaw augmentation or reduction (orthognathic surgery), except when determined to meet required medical criteria and as required by ORS 743.706;
23. Any Services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders;
24. Outpatient retail or mail order Prescription Drug Services in excess of the Prescription Drug Supplemental Benefit as described under What Are My Benefits and as shown on the Summary of Benefits, including but not limited to:
    - Infertility drugs regardless of their intended use;
    - Vitamins or minerals;
    - Drugs dispensed for use or administration in a

health care facility or provider's office;

- Take home or discharge medications;
- Experimental or Investigational drugs including drugs labeled "Caution--limited by federal law to investigational use;"
- Professional Services including administration or injection of drugs;
- Allergy Serums;
- Prescriptions or refills in excess of the quantity specified by the prescriber, or that are dispensed after one year from the date the prescription was written; and
- Replacement of lost or stolen medication;

25. Over the counter drugs and medicines which may be lawfully obtained over the counter ("OTC") without a prescription, food supplements, herbal, naturopathic or homeopathic medicines or devices, dietaries and any other non-prescription supplements whether or not prescribed or recommended by Your provider;
26. Services for Home Medical Equipment (HME); Medical Supplies/Devices and Prosthetic Devices except as shown on the Summary of Benefits and as described under What Are My Benefits;
27. Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
28. Hair prosthesis, hair transplants or implants and wigs;
29. Physical therapy and rehabilitation Services in excess of the physical therapy and rehabilitation benefits; massage therapy in the absence of any other treatment or modality; rolfing; polarity therapy; growth and cognitive therapies; self directed or seminar type of treatment; charges associated with day or overnight facilities for the purpose of intensive nutrition, exercise, educational, relaxation and similar Services; or other Services otherwise excluded by this Contract; and except as shown on the Summary of Benefits and as described under What Are My Benefits;
30. Pervasive Developmental Disorder Services for Members age 18 or older and in excess of the physical therapy and rehabilitation benefit. This exclusion applies even if You have an Illness or medical condition that might be helped by these Services;
31. Routine foot care, or palliative foot care, including but not limited to hygienic care, removal of corns and calluses or trimming of the toenails, except for Medically Necessary foot care for diabetics;
32. "Telephone visits" by a physician or "environment intervention" or "consultation" by telephone for which a charge is made to the patient. Also, "get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided;
33. Home births, except when provided by a licensed midwife with documentation of physician back up;
34. Any loss contributed to or caused by:
    - War or any act of war, whether declared or not; or
    - Any act of armed conflict, or any conflict involving armed forces of any authority;
35. All Services for bariatric surgery and any resulting complications, including but not limited to Laparoscopic Gastric Bypass, Laparocopic Mini-gastric Bypass, Biliopancreatic Bypass, Fobi Pouch, Vertical Banded Gastroplasty, Laparoscopic Adjustable Gastric Banding;
36. Services for surgical and pharmaceutical treatment of obesity or morbid obesity, and any direct or indirect complications, follow-up services or aftereffects thereof. This exclusion applies to all surgical obesity procedures (inpatient and outpatient) and all obesity drugs and supplements, even if You also have an Illness or Accidental Injury which might be helped by weight loss. Dietary therapy including medically supervised formula weight-loss programs or unsupervised self-managed programs utilizing over-the counter weight loss formulas are not covered;
37. Dietary or nutritional Services except as provided for inborn errors of metabolism and diabetes self management, and as described under What Are My Benefits;
38. Services for convenience, educational or vocational purposes including, but not limited to, videos and books, educational programs to which drivers are referred by the judicial system and volunteer mutual support groups;
39. Services for insoles, arch supports, heel wedges, and lifts. Covered Services for orthotics and orthopedic shoes are described under What Are My Benefits;
40. Transplants, except when determined to meet required medical criteria and as described in under What Are My Benefits;
41. Communications, lodging accommodations and transportation or travel time except when medical

criteria is met as determined by Us and as described under What Are My Benefits;

42. Medications, drugs or hormones to stimulate growth except when determined to meet medical criteria and for the treatment of idiopathic short stature without growth hormone deficiency. Human growth hormone benefits are provided only under the Specialty Pharmacy benefits as shown on the Summary of Benefits and described under the Prescription Drug Supplemental Benefit;

    Prior Authorization is required for physician administered "biotech drugs" / medical injectables. Please see the Prior Authorization, Utilization Review, and Case Management section of this Benefit Booklet for additional information.
43. Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
44. Services which would be eligible for medical payment or expense coverage provided under a motor vehicle insurance Contract, as required by Oregon state mandated minimum personal injury protection (PIP) limits;
45. Services which would be eligible for benefits under the terms of a contract or insurance offering Underinsured Motorists or Uninsured Motorists (UIM) coverage;
46. Services which would be eligible for medical payments under commercial and/or homeowner's medical premises coverage, or other similar type of insurance or contract coverage;
47. Services for any Accidental Injury or Illness that is sustained by a Member that arises out of, or as the result of, any work for wage or profit:

    This exclusion does not apply to the following Eligible Employees of the Employer/Group that are or may be eligible for coverage under any Workers' Compensation Act or similar law when the Employer/Group is given the option to apply for such coverage by such Act or law and the Employer/Group did not apply for this coverage:

    - Sole proprietor, if the Employer/Group is a proprietorship;
    - A partner of the Employer/Group, if the Employer/Group is a partnership; and
    - An executive officer of the Employer/Group, if the Employer/Group is a corporation.
48. Services for routine vision care in excess of the vision benefit including, but not limited to non-prescription, over-the-counter reading or magnification glasses; Medically Necessary ophthalmological Services and/or treatment; and except as shown on the Summary of Benefits and as described under the Routine Vision Care Supplemental Benefit;
49. Services for vision therapy, eye exercise, and any type of training to correct muscular imbalance of the eye (orthoptics) and pleoptics;
50. Any Services to improve the refractive character of the cornea, including the treatment of any results of such treatment. Covered Services for medical supplies related to cataract removal or corneal surgery are covered under Medical Supplies and Devices as described in What Are My Benefits;
51. Travel and occupational immunizations;
52. Home Health Services, except when determined to meet medical criteria. Charges for mileage or travel time to Your home, wage or shift differentials for home health care providers, and supervision of home health care providers are not a Covered Services;
53. Treatment or testing required by a third party or court of law;
54. Services in excess of the Chemotherapy/Infusion Therapy Services including over the counter drugs, solutions, and nutritional supplements; drugs and solutions received while confined in a Hospital or other medical facility; and oral and/or topical prescription drugs; except as shown on the Summary of Benefits and as described under What Are My Benefits;
55. Emergency medical transportation Services provided by unlicensed providers and when determined by Us not to be Medically Necessary;
56. Telemedicine Services except as described under What Are My Benefits. Telemedicine Covered Services do not include telephone calls, facsimile machines and electronic mail systems (text message without visualization of the patient);
57. Services provided for routine hearing care, including hearing examination, diagnostic screening and hearing aids or other devices to improve hearing sharpness;
58. Services in excess of a stated Benefit Maximum Limit, Durational Limit or the Lifetime Benefit Maximum.

## HOW TO FILE A CLAIM

LifeWise Preferred Providers and many Non-Preferred Providers will submit bills to LifeWise directly for Services covered under Your Plan, including physician and facility services, vision services and dental services. If a Non-Preferred Provider is unwilling to bill Us directly or if You are required to pay for the Services at the time You receive them, You must submit a completed claim form or an itemized statement to Us.

**Step 1**
Ask Your provider for an itemized statement at the time You receive services. If You do not have an itemized statement, complete a claim form. A separate statement or claim form is necessary for each patient and each provider. You can order extra claim forms by calling Customer Service at the number listed in the front of this Benefit Booklet.

**Step 2**
Make sure the itemized statement or claim form includes the following information:

- The name of the Enrolled Employee and Member who incurred the expense;
- Identification numbers for both the enrolled employee and the Employer/Group (these are shown on the Member's Membership ID Card);
- Name, address and IRS tax identification number of the provider;
- Information about other insurance coverage;
- Date of onset of the illness or injury;
- The diagnosis code or ICD-9 code;
- Procedure codes (CPT-4, HCPCS or ADA) or descriptive English nomenclature for each Services;
- Dates of Services and itemized charges for each Service received;
- If the Services You received are for the treatment of an accidental injury, You need to include the date, time, location, and a brief description of the accident;

**Step 3**
If You also have other health coverage and the other coverage is primary, You must attach a copy of the "Explanation of Benefits."

If You are also covered by Medicare, and Medicare is primary, You must attach a copy of the "Explanation of Medicare Benefits."

**Step 4**
Check that all required information is complete.

**Step 5**
Mail Your claims to:

LifeWise Health Plan of Oregon
P O Box 7709
Bend, Oregon 97708-7709

## PRESCRIPTION DRUG CLAIMS

**Preferred Provider Pharmacies**
For retail pharmacy purchases at a Preferred Provider Pharmacy, You do not have to send Us a claim form. Just show Your Prescription Drug ID Card to the pharmacist, who will bill Us directly. If You do not show Your ID Card, You will have to pay the full cost of the prescription and submit Your pharmacy receipts attached to a completed prescription drug claim form for reimbursement. Please send the information to the address listed under Direct Reimbursement Claims Instructions included on the drug claim form.

For mail-order pharmacy purchases, You do not have to send Us a claim, but You must follow the instructions on the mail service envelope and submit it to the address printed on the envelope. Please allow up to 14 days for delivery.

It is very important that You use Your LifeWise ID Card at the time You receive Services from a Preferred Provider Pharmacy. Not using Your LifeWise ID Card may increase Your out-of-pocket expenses. Please refer to What Are My Benefits for detailed information.

If You need a supply of claim forms or have any questions about how to submit Your claim, please call Us at the number listed in the front of Your Benefit Booklet. You can also obtain claim forms on Our Web site at **www.lifewiseor.com**.

**Coordination Of Prescription Drug Benefits**
If this Plan is the secondary plan as described under What If I Have Other Coverage, You must submit Your pharmacy receipts attached to a completed claim form for reimbursement. Please send the information to the address listed under Secondary Prescription Claims included on the drug claim form.

**Notice Required For Reimbursement And Payment Of Claims**
At Our option and in accordance with federal and state law, We may pay the benefits of this Plan to the Eligible Employee, provider, other carrier, or other party legally entitled to such payment under federal or state medical child support laws, or jointly to any of these. Such payment will discharge Our obligation to the extent of the amount paid so that We will not be liable to anyone aggrieved by Our choice of payee.

**Timely Payment Of Claim**
You should submit all claims within 365 days of the date You received Services. No payments will be made by Us for claims received more than 365 days after the date of service. Exceptions will be made if We receive documentation of Your legal incapacitation. Payment of all claims will be made within the time limits required by OAR 836-080-0225.

**Claim Procedure For Groups Subject To The Employee Retirement Income Security Act of 1974 (ERISA)**
We will make every effort to review Your claims as quickly as possible. We will send a written notice to You no later than 30 days after We receive Your claim to let You know if Your plan will cover all or part of the claim. If We can not complete the review of Your claim within this time period, We will notify You of a 15-day extension before the 30-day time limit ends. If

We need more information from You or Your provider to complete the review of Your claim, We will ask for that information in Our notice and allow You 45 days to send Us the information. Once We receive the information We need, We will review Your claim and notify You of Our decision within 15 days.

If Your claim is denied, in whole or in part, Our written notice will include:

- The reasons for the denial and a reference to the plan provisions used to decide Your claim;
- A description of any additional information We may need to reconsider Your claim and why the information is needed;
- A statement that You have the right to submit a grievance or appeal; and
- A description of Our Grievance or Appeal processes.

If there were clinical reasons for the denial, You will receive a letter from Us stating these reasons.

At any time, You have the right to appoint someone to pursue the claims on Your behalf. This can be a doctor, lawyer, or a friend or relative. You must notify Us in writing and provide Us with the name, address and telephone number where Your appointee can be reached.

If a claim for benefits is denied or ignored, in whole or in part, or not processed within the time shown in this Benefit Booklet, You may file suit in a state or federal court.

If You are dissatisfied with Our Denial of Your claim You may submit a grievance as outlined under What If I Have A Question, Grievance, Or Appeal.

Some Services and supplies covered under this Plan require Prior Authorization. Please see the Prior Authorization, Utilization Review and Case Management section of this Benefit Booklet for additional information.

## WHAT IF I HAVE A QUESTION, GRIEVANCE OR APPEAL

As a LifeWise Member, You have the right to ask questions and voice complaints or submit a Grievance. Our goal is to listen, resolve Your problems, and improve Our service to You. To provide You an opportunity to resolve problems that may occur, You must follow the following procedures. This resolution procedure fulfills the claim determination appeal requirements established by the Employee Retirement Income Security Act (ERISA) of 1974, as amended, and Oregon state regulations.

**When You Have Questions**
Our Customer Service Team is available to provide information and assistance. They can provide information regarding the status of a claim or how it was processed, if a provider is in Our network, what Your benefits are and other related questions. You may call Us or come by and meet with Us at the address and number shown in the front of this Benefit Booklet. If You have special needs, We can make efforts to accommodate Your requirements. Please contact Us so We may help You with whatever special needs You may have.

**When You Have A Complaint**
A complaint is an expression of dissatisfaction that is about a specific problem encountered by a Member or about a decision by an insurer or an agent acting on behalf of the insurer and that includes a request for action to resolve the problem or change the decision.

You have the right to voice complaints about:

- Availability, delivery or quality of health care services, including a claim for benefits before or after services are rendered;
- Claims payment, handling, or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between a Member and LifeWise.

When You have a complaint, call Our Customer Service Department. We will try to resolve Your complaint at the time You call. If We are not able to immediately resolve Your complaint, We will:

- Gather more information or records when necessary;
- Conduct a review;
- Notify You of the outcome and the reasons for Our decision.

If You disagree with Our complaint resolution, You may submit a Grievance as outlined in this notice. At times, We may ask You to submit Your complaint for review through the grievance procedure as outlined below. If You have questions regarding Our complaint or Grievance process, please contact Us directly. We can provide assistance in filing a Grievance.

Send Your Grievance to:
LifeWise
Grievance Review
P.O. Box 7709
Bend, OR 97708
800-777-1502
Fax 541-318-2337

If You are not satisfied with Our decisions or benefits, You may seek assistance from the Oregon Insurance Division at any time during this process. You may

contact the Oregon Insurance Division by calling (503) 947-7984 or by writing to the Oregon Insurance Division, Consumer Protection Unit, 350 Winter ST. NE, Room 440-2, Salem, OR, 97310 or through the Internet at http://www.cbs.state.or.us/external/ins/.

**When You Submit A Grievance Or Appeal**
If Your complaint is not resolved to Your satisfaction, You may submit a grievance. A grievance is a complaint submitted in writing by or on behalf of a Member.

For claims issues, We must receive Your grievance within 180 days of the date You are notified of an adverse benefit determination. We will acknowledge Our receipt of Your Grievance within seven (7) days.

Our Grievance/Appeal process has three levels of review:

Level I:
LifeWise will evaluate all the information and make a decision. Within 30 days of the date We receive Your Grievance We will advise You in writing of Our decision and the reasons for the decision.

Some grievances may take longer if there are delays beyond Our control. In those cases, an additional 15 days may be needed to resolve Your issue. We will give You or Your authorized representative a notice of delay that includes a specific reason for the delay. These time lines will not apply when:

- The period of time is too long to accommodate the clinical urgency of the situation;
- The Member does not reasonably cooperate; or
- Circumstances beyond the control of a party prevent that party from complying with the standard, but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise.

If You are not satisfied with the outcome of Level I, You may request a review through a Level II Appeal. You should send Us additional information to support Your Appeal. You must make Your request for a Level II Appeal no more than 60 calendar days after the date You receive Our Level I decision.

Level II:
The Level II Appeal will be reviewed by a LifeWise panel that is different from the Level I review. You and/or Your authorized representative may meet with the panel in person or by telephone. You must let Us know within 5 days of receiving notice of the Level II Appeal that You and/or Your authorized representative plan to attend the meeting. If Your notice is received after this time, We will make reasonable accommodation for Your participation at the meeting. The panel will evaluate all the information within 30 days of the date We receive Your request. After the second review is complete, We will advise You in writing of Our decision and the reasons for the decision.

If You are not satisfied with the outcome of Level II Appeal, You may request a final Level III Appeal. You should provide Us with any additional information not previously reviewed to support Your Appeal. You must make Your request for a Level III Appeal no more than 60 calendar days after the date You receive Our Level II decision.

Level III:
The Level III Appeal will be reviewed by a LifeWise panel that is different from the Level II panel and is handled at the Executive Management Level of LifeWise. The panel will evaluate all the information within 30 days of the date We receive Your request. After the final review is complete, We will advise You in writing of Our decision and the reasons for the decision.

**Appeals On Prior Authorization Decisions***
We will respond with a decision within 15 calendar days. In some cases, a 15-day time limit would result in serious jeopardy to Your life, health or ability to regain maximum function, or that would subject You to severe pain that could not be managed without the care requiring Prior Authorization. In these cases, the Prior Authorization appeal is deemed urgent and We will respond as soon as possible, but no more than 72 hours after We receive the request.

***Please Note:** Urgent Prior Authorization Level II appeal requests must contain a contact number where the panel can reach You and/or Your authorized representative if You wish to participate in the Level II appeal review. If a request for an urgent Prior Authorization is deemed not to meet the criteria for an urgent review, You and/or Your authorized representative will be notified that Your request is being handled on a non-urgent basis.

**External Review**
If You are not satisfied with Our final denial of benefits based on Medical Necessity, Experimental/Investigational services, or for Continuity Of Care, You may request an external review by an Independent Review Organization (IRO). You may request an external review by calling Us at the number listed in this section. Your request for an external review must be made within 180 days of the date You receive Our final written decision following the completion of Our Grievance and appeals process. If Your request for an external review is not received within this time period, Your appeal will not be eligible to be reviewed by an IRO. There is no cost to You for an external review.

To be eligible for an IRO review:

- You must sign a waiver granting the IRO access to Your medical records; and

- You must first exhaust Our Plan's internal Grievance procedure, unless We agree to refer the dispute directly to an IRO.

When You request an external review, You agree to provide complete and accurate information to the IRO in a timely manner. You or Your attending physician may also submit additional information to the IRO that is relevant to Your appeal. The additional relevant information must be submitted within seven days of the date of Your request for an IRO review. We will forward all of Your medical records and other relevant materials to the IRO. We will also provide the IRO with any additional information they request that is reasonably available to Us.

We will notify the Oregon Insurance Division of Your request for an external review within two business days. The Oregon Insurance Division will appoint an IRO to review Your appeal and will notify You and Us of the name of the IRO.

Should We reverse Our final denial of benefits prior to the Oregon Insurance Division notice deadline We will let You know of Our decision by the next business day.

We will work with You, the Oregon Insurance Division and the IRO, regarding the information necessary to review Your case within the timelines as mandated by Oregon regulatory requirements and in consideration of Your clinical urgency. The IRO will make a decision within 30 days following Your request for an external review. The IRO will notify You and Us of their decision no later than the fifth day after they make their determination.

**Expedited External Review**
You may request an expedited external review. Your provider must have an established clinical relationship with You and must certify in writing and provide supporting documentation stating the clinical urgency of Your condition. The supporting documentation must establish that the ordinary time period for an external review would seriously jeopardize Your life or health or Your ability to regain maximum function. You or Your attending physician may submit additional information within 24 hours of the assignment of Your appeal to the IRO. The IRO will make a decision within three days following Your request for an expedited external review. The IRO will notify You and Us of their decision immediately by phone, e-mail or fax after they make their determination followed with a written decision by mail.

**External Review Decision**
**Although LifeWise is not legally bound by the decision of the IRO, We will carefully consider the decision in making Our final determination.**

If We do not follow the IRO's decision, You will have the right to bring a legal action against Us, subject to the terms and limitations of applicable state and federal law, including, without limitation, the Employee Retirement Income Security Act (ERISA).

# WHAT IF I HAVE OTHER COVERAGE

## COORDINATING BENEFITS WITH OTHER PLANS

The Coordination of Benefits (COB) provision applies when a member has more than one health Plan.

Certain rules determine which health plan will pay first, this is called the primary plan; the plan that pays after the primary plan is called the secondary plan. The primary plan must pay benefits in accordance with its policy terms and limitations as if You have no other coverage. The secondary plan may reduce the benefits it pays so that the payments from all plans do not exceed 100% of the total Allowable Expense.

## DEFINITIONS

For the purposes of COB:

- A **Plan** is any of the following that provides benefits or services for medical or dental care. If separate contracts are used to provide coordinated coverage for group members, all the contracts are considered parts of the same plan and there is no COB among them. However, if COB rules don't apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB doesn't apply is treated as a separate plan.
    - "Plan" includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
    - "Plan" doesn't include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.
- **This Plan** means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the

contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits. Dental benefits are coordinated only with other plans' dental benefits, while medical benefits are coordinated only with other plans' medical benefits.

- **Primary plan** is a plan that provides benefits as if You had no other coverage.
- **Secondary plan** is a plan that is allowed to reduce its benefits in accordance with COB rules.
- **Allowable Expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any of Your plans. When a plan provides benefits in the form of services, the reasonable cash value of each service is an Allowable Expense and a benefit paid. An amount that is not covered by any of Your plans is not an Allowable Expense.

  Below are some expenses that are not Allowable Expenses:

  - The cost difference between a semi-private and a private hospital room, unless one of the plans covers private rooms.
  - Any amount over the highest of the expense amounts allowed by either the primary plan or the secondary plan. This is true regardless of what method the plans use to set the Allowable Expenses. However, when Medicare is primary to Your other coverage, Medicare's allowable expense must be treated as the highest allowable.
  - Amounts reduced by the primary plan because You did not comply with its Plan provisions.
- **Closed panel plan** is a Plan that provides health care benefits to members primarily in the form of services through a panel of providers that has been contracted with or employed by the Plan, and excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than half of the calendar year, excluding any temporary visitation.

## ORDER OF BENEFIT DETERMINATION RULES

When a member is covered by two or more Plans, the rules for determining the order of benefit payments are listed below. A plan that doesn't include a COB provision that complies with this regulation is always primary unless the provisions of both plans make the complying plan primary. The exception is group coverage that supplements a package of benefits provided by the same group. Such coverage can be excess to the rest of that group's plan. An example is coverage paired with a closed panel plan to provide out-of-network benefits.

The first of the rules below determine which plan is primary. If You have more than one secondary plan, the rules below also determine the order of the secondary plans to each other.

**Non-Dependent or Dependent.** The Plan that doesn't cover You as a dependent is primary to a plan that does. However, if You have Medicare, and federal law makes Medicare secondary to Your dependent coverage and primary to the plan that doesn't cover You as a dependent, then the order is reversed.

**Dependent Children.** Unless a court decree states otherwise, the rules below apply:

- Birthday rule. When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday (month/day) falls earlier in the calendar year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary.
- When the parents are divorced, separated or not living together, whether or not they were ever married:
  - If a court decree makes one parent responsible for the child's health care expenses or coverage, that plan is primary. This rule applies to calendar years starting after the plan is given notice of the court decree.
  - If a court decree assigns one parent primary financial responsibility for the child but doesn't mention responsibility for health care expenses, the plan of the parent with financial responsibility is primary.
  - If a court decree makes both parents responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
  - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the birthday rule determines which plan is primary.
  - If there is no court decree allocating responsibility for the child's expenses or coverage, the rules below apply:

a) The Plan covering the custodial parent, first;

b) The Plan covering the Spouse of the custodial parent, second;

c) The Plan covering the non-custodial parent, third; and then

d) The Plan covering the Spouse of the non-custodial parent, last.

- If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.

**Retired or Laid-off Employee.** The plan that covers You as an active employee (an employee who is neither laid-off nor retired) is primary to a plan covering You as a retired or laid-off employee. The same is true if You are covered as both a dependent of an active employee and a dependent of a retired or laid-off employee.

**Continuation Coverage.** If You have coverage under COBRA or other continuation law, that coverage is secondary to coverage that is not through COBRA or other continuation law.

**Please Note:** The retiree/layoff and continuation rules don't apply when both plans don't have the rule or when the "non-dependent or dependent" rule can decide which of the plans is primary.

**Length of Coverage.** The plan that covered You longer is primary to the plan that didn't cover You as long.

If none of the rules above apply, the plans must share the Allowable Expenses equally. This plan will not pay more that it would have paid had it been the primary plan.

### EFFECT ON THE BENEFITS OF THIS PLAN

The primary plan provides its benefits as if You had no other coverage.

A plan may take into account the benefits of another plan only when it is secondary to that plan. The secondary plan is allowed to reduce its benefits so that the total benefits provided by all plans aren't more than the total Allowable Expenses for that claim. For each claim, the benefits of the primary and secondary plans must total 100% of the highest Allowable Expense allowed for the service or supply by either plan. **However, the secondary plan is never required to pay more than its benefits in the absence of COB**.

The secondary plan must credit to its deductible any amounts it would have credited if it had been primary.

### RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about Your other health care coverage are needed to apply the COB rules. We may get the facts We need for COB from, or give them to, other plans, organizations or persons. We don't need to tell or get the consent of anyone to do this. State regulations require each of Your other plans and each person claiming benefits under this plan to give Us any facts We need for COB.

### RIGHT OF RECOVERY / FACILITY OF PAYMENT

If Your other plan makes payments that this plan should have made, We have the right, at Our discretion, to remit to the other plan the amount We determine is needed to comply with COB. To the extent of such payment, We are fully discharged from liability under this plan. We also have the right to recover any payment over the maximum amount required under COB. We can recover excess payment from anyone to whom or for whom the payment was made or from any other issuers or plans.

### NON–DUPLICATION OF COVERAGE

**Coordination With Medicare**

In all cases, Coordination of Benefits with Medicare will conform with federal statutes and regulations. Medicare means Title XVIII, Parts A and B Social Security Act, as enacted or amended. Medicare eligibility and how We determine Our benefit limits are affected by disability and employment status. Please contact Customer Service at the number listed in the front of Your Benefit Booklet for additional information.

### NOTICE TO COVERED PERSONS

If You are covered by more than one health benefit plan, You should file all Your claims with each plan.

## THIRD PARTY LIABILITY (SUBROGATION)

The following provisions will apply when You have received Services for a condition for which one or more third parties may be responsible. “Third Party” means any person other than You, (the first party to this Contract) and LifeWise (the second party), and includes any insurance carrier providing liability or other coverage potentially available to You. For example, uninsured or underinsured motorist coverage, whether under Your policy or not, is subject to recovery by Us as a third-party recovery. Failure by You to comply with the terms of this section will be a basis for LifeWise to deny any claims for benefits arising from the condition. In addition, You must

execute and deliver to Us or other parties any document requested by Us which may be appropriate to secure the rights and obligations of You and LifeWise under these provisions.

**What Is Third-Party Liability/Subrogation And How Does It Affect You**

Third-party liability refers to claims that are the responsibility of someone besides LifeWise or You. Motor vehicle accidents, workplace accidents, injury or illness, or any other situation involving injury or illness in which You have a basis to bring a lawsuit or to make a claim for compensation against any person or for which You may receive a settlement (for example, food poisoning or an injury from a defective product) are examples of third-party liability. Once it has been established that the third party is responsible to pay and is capable of paying for the expenses for the Services caused by that third party, We will not provide benefits for the Services arising from the condition caused by that third party.

If We make claim payments on Your behalf for which a third party is responsible, We are entitled to be repaid for those payments out of any recovery from the third party. We will request reimbursement from You to the extent the third party does not pay Us directly, and We may request refunds from the medical providers who treated You, in which case those providers will bill You for their Services. "Subrogation" means that We may collect directly from the third party to the extent We have paid on Your behalf for third party liabilities. Because We have paid for Your injuries, We, rather than You, are entitled to recover for those expenses.

We need detailed information from You to accomplish this process. A questionnaire will be sent to You for this information. It should be completed and returned to Our office as soon as possible to minimize any claim review delay. If You have any questions or concerns regarding the questionnaire, please contact Our office. A LifeWise employee who specializes in third-party liability/subrogation can discuss with You what Our procedures are and what You need to do.

**Proceeds Of Settlement Or Recovery**

To the fullest extent permitted by law, We are entitled to the proceeds of any settlement or any judgment that results in a recovery from a third party, whether or not responsibility is accepted or denied by the third party for the condition. We are entitled up to the full value of the benefits provided by Us for the condition, calculated using Our providers' usual charges for such Services, less a percentage of Your counsel's reasonable attorney fees that is equal to the percentage of the total recovery that is payable to Us, whether such benefits are paid by Us before or after the settlement or recovery. For purposes of this paragraph, a total attorney fee in excess of one-third of a total recovery will not be deemed reasonable absent Our prior agreement. Prior to accepting any settlement, You must notify Us in writing of any terms or conditions offered in settlement, and shall notify the third party of Our interest in the settlement established by this provision.

You must cooperate fully with Us in recovering amounts paid by LifeWise. If You seek damages against the third party for the condition and retain an attorney or other agent for representation in the matter, then You must agree to require Your attorney or agent to reimburse LifeWise directly from the settlement or recovery an amount equal to the total amount of benefits paid.

You must execute an authorization for Your attorney or agent to pay LifeWise directly, and cause Your attorney or agent to execute an agreement in a form acceptable to Us, by which Your attorney or agent agrees to reimburse Us directly from the funds of the settlement or recovery. We will withhold benefits for Your condition until a signed copy of this agreement is delivered to Us. The agreement must remain in effect and We will withhold payment of benefits if, at any time, Your authorization or the agreement should be revoked.

We have the right to require You to hold the proceeds of settlement or recovery in trust for the benefit of LifeWise, up to the amount of benefits paid by LifeWise. If We exercise Our right, upon Our notice to You, You must execute an agreement in a form satisfactory to Us to implement the requirement that proceeds of settlement or recovery be held in trust. We will withhold payment of benefits until the agreement is executed and delivered to Us.

**Suspension of Benefits and Reimbursement**

After You have received proceeds of a settlement or recovery from the third party, You are responsible for payment of all medical expenses for the continuing treatment of the illness or injury that LifeWise would otherwise be required to pay under this Contract until all proceeds from the settlement or recovery have been exhausted.

If You continue to receive medical treatment for the condition after obtaining a settlement or recovery from one or more third parties, We are not required to provide coverage for continuing treatment until You prove to Our satisfaction that the total cost of the treatment is more than the amount received in settlement or recovered from the third party, after deducting the cost of obtaining the settlement or recovery. We will only cover the amount by which the total cost of benefits that would otherwise be covered under this Plan, calculated using Our providers usual charges for such services, exceeds the amount received in settlement or recovery from the third party. We are entitled to reimbursement from any settlement

or recovery from any third party even if the total amount of such settlement or recovery does not fully compensate You for other damages, particularly including lost wages or pain and suffering; any settlement arising out of an injury or illness covered by this Plan will be deemed first to compensate You for Your medical expenses, regardless of any allocation of proceeds in any settlement document that We have not approved in advance. In no event shall the amount reimbursed to LifeWise be less than the maximum permitted by law.

**Subrogation**
To the maximum extent permitted by law, We are subrogated to Your rights against any third party who is responsible for the condition, have the right to sue any such third party in Your name, and have a security interest in and lien upon any recovery to the extent of the amount of benefits paid by Us and for Our expenses in obtaining a recovery.

## WHO IS ELIGIBLE FOR COVERAGE

This section outlines who is eligible for coverage, and how and when to enroll Yourself and Your Eligible Family Dependents. Benefits are not available to anyone not enrolled under this Contract. You and Your Employer/Group must provide Us with evidence of eligibility as requested.

**Eligible Employees**
To be an Eligible Employee under this Plan You must:

- Be a permanent employee, sole proprietor, owner, partner, or corporate officer of the Employer/Group who is paid on a regular basis through the payroll system, and reported to Social Security;
- Regularly work the minimum hours required by the Employer/Group Agreement and Employer Provisions; and
- Satisfy any New Employee Waiting Period (Eligibility Waiting Period), if one is required by the Employer/Group Agreement and Employer Provisions; or
- Be a retired employee as stated on the Employer/Group Agreement and Employer Provisions.

On-Call, temporary, substitute and leased employees are not eligible.

**Eligible Family Dependents**
To be an Eligible Family Dependent under this Plan, the family member must be one of the following:

- The Eligible Employee's Legally Recognized Spouse (Spouse) or Domestic Partner; or
- An eligible child under 26 years of age, unmarried, and primarily dependent upon the Eligible Employee for support.

  An eligible child is:

  - A natural offspring of either or both the Eligible Employee, Spouse or Domestic Partner;
  - A legally adopted child of either or both the Eligible Employee, Spouse or Domestic Partner;
  - A child "placed" with the Eligible Employee for the purpose of legal adoption in accordance with state law;
  - A legally placed ward of the Eligible Employee, Spouse or Domestic Partner living permanently in the home of the Eligible Employee; or
  - A grandchild of either or both the Eligible Employee, Spouse or Domestic Partner if the mother or father is an Eligible Family Dependent and enrolled in this Plan.

  An eligible child does not include a foster child. To be an Eligible Family Dependent under this Plan, a grandchild must be an eligible child as outlined above.

  Placement for adoption means the assumption and retention by an Eligible Employee of a legal obligation for total or partial support of a child in anticipation of the adoption of the child (an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption). The child's placement with an Eligible Employee ends upon the termination of such legal obligations.

An Eligible Family Dependent covered as a child under the Plan will remain eligible after age 26 if they are:

- Developmentally disabled or permanently physically handicapped;
- Incapable of self-sustaining employment; and
- Unmarried and primarily dependent upon the Eligible Employee for support.

Within 60 days of the Eligible Family Dependent reaching their 26th birthday, and upon Our request, You must provide satisfactory proof that the above conditions will continuously exist on and after this date. We may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to Us, the child's coverage will not continue beyond the last date of eligibility.

**Enrollment In The Plan**
The Eligible Employee must enroll on forms provided and/or accepted by Us. To obtain coverage, an Eligible Employee must enroll within 31 days after

becoming eligible. Enrollment after this initial time period can be accomplished as outlined in this section under Enrollment Provisions For Late and Special Enrollees.

Eligible Family Dependent enrollment and payment of any necessary additional Premium must occur within 31 days from the date of marriage or date of registered domestic partnership, birth or placement. Enrollment after this initial time period can be accomplished as outlined in this section under Enrollment Provisions For Late And Special Enrollees.

**Newborn Child and Adopted Child Eligibility And Enrollment**
A newborn child of a Member is covered for the first 31 days from the date of birth. Coverage for the newborn child does not continue beyond the first 31 days of birth unless they also meet the definition of an Eligible Family Dependent and the child is properly enrolled.

An adopted child is covered for the first 31 days from the date of placement for the purpose of adoption by the Eligible Employee. Coverage for the adopted child does not continue beyond the first 31 days following placement unless they also meet the definition of an Eligible Family Dependent and the child is properly enrolled.

Enrollment and payment of any necessary additional Premium must occur within 31 days from birth or placement. If the enrollment and payment are not accomplished within this time period, medical Services will not be covered for the child after the initial 31 days. Enrollment after this initial time period can be accomplished as outlined in this section under Enrollment Provisions For Late And Special Enrollees.

**Domestic Partner And Their Dependents Eligibility and Enrollment**
An enrolled Eligible Employee's Domestic Partner who is not a registered domestic partner as defined by Oregon statute is eligible for coverage if requested on Employer/Group Agreement and an Affidavit of Domestic Partnership has been properly executed and accepted by the Employer/Group.

In addition to the requirements as described under Eligible Family Dependents within this section of the Contract, dependents of Domestic Partners must reside within the enrolled employee's household. However, a dependent of a Domestic Partner who is a student or who is under court ordered dependent coverage and qualifies as a dependent of the enrolled Eligible Employee for federal income tax purposes is considered an Eligible Family Dependent and is eligible to enroll in this Plan.

The Domestic Partner must enroll on forms provided and/or accepted by Us. To obtain coverage, the Domestic Partner must enroll within 31 days of the Eligible Employee's initial eligibility or the execution of an Affidavit of Domestic Partnership. If the enrollment form is not submitted within this time period, the Domestic Partner and their dependent children will be considered Late Enrollees. Special provisions applicable to Late Enrollees are outlined in this section of the Benefit Booklet under Enrollment Provisions For Late And Special Enrollees.

**Retired Employee Eligibility And Enrollment**
Retired Eligible Employees and their enrolled Eligible Family Dependents are an eligible class if requested on the Employer/Group Agreement and approved by Us. An Eligible Employee who has satisfied the eligibility requirements as stated in the Employer/Group Agreement and who retires while covered under this Contract is considered eligible for coverage as a retired Eligible Employee on the date of retirement.

Notification of the eligible retired employee's retirement must be submitted to Us by the Employer/Group within 31 days of the date of retirement. If We are not notified within this time period, the retired employee may not enroll in this Plan. Please see How To Continue Coverage for other coverage options.

The Effective Date of Coverage for a retired Eligible Employee is the same as described within this section of the Benefit Booklet, provided We receive notice of the retirement as stated above.

Your benefits under this Plan and Medicare may be affected by Your retirement. If You are a retiree under this Plan and over the age of 65, please call Us to determine how Your benefits may be affected.

**Special Conditions Regarding Eligible Family Dependent Coverage**

1. Eligible Employees may cover their Eligible Family Dependents only if they are also covered and a completed enrollment form requesting dependent coverage is received by Us.
2. If a child becomes an Eligible Employee of the Employer/Group, he or she is no longer an Eligible Family Dependent and must make application as an Eligible Employee.

## EFFECTIVE DATE OF COVERAGE

**Employee Effective Date**
The Effective Date of Coverage provision is stated in the Employer/Group Agreement or another date as requested in writing by the Employer/Group and approved by LifeWise. If You are a late enrollee, as specified within this section, Your Effective Date of Coverage is described under Special Provisions for Late Enrollees.

**Dependent Effective Date**
Each Eligible Family Dependent is eligible for coverage on:

1. The first of the month following the date the Eligible Employee is eligible for coverage, if he or she is an Eligible Family Dependent who may be covered on that date;
2. The first of the month following the date the Eligible Employee is married or is joined in a registered domestic partnership for any Eligible Family Dependents acquired on that date;
3. The date of birth of the natural-born child of the Eligible Employee, Spouse or Domestic Partner;
4. The date the child is placed with the Eligible Employee, Spouse or Domestic Partner for the purpose of adoption;
5. The first of the month following the date of a qualified medical support court or administrative order to provide health coverage for a child of an Eligible Employee, Spouse or Domestic Partner;
6. The first of the month following the date an Affidavit of Domestic Partnership has been properly executed and accepted by the Employer/Group for a Domestic Partner and the Domestic Partner's Eligible Family Dependents.

## ENROLLMENT PROVISIONS FOR LATE AND SPECIAL ENROLLEES

There are special provisions for enrollment in this Plan if You or Your Eligible Family Dependents did not enroll in this Plan when first eligible. When and how You are able to enroll is determined by whether You qualify as a Special or a Late Enrollee as described within this provision.

**Late Enrollees**
A "Late Enrollee" is an individual or family dependent who did not enroll when first eligible for coverage under this Plan and does not qualify as a Special Enrollee. If You or Eligible Family Dependents are Late Enrollees, You or Your Eligible Family Dependents may enroll during the next occurring Annual Group Enrollment Period. Late Enrollees may be subject to a Pre-Existing Condition Provision as shown on the Summary of Benefits. Please refer to Important Plan Information for additional information about Pre-Existing Conditions.

**Special Enrollees**
If an eligible individual qualifies as a Special Enrollee, that person is allowed to enroll in the Plan within specific guidelines as outlined within this provision. You or Your dependent qualifies as a Special Enrollee if:

1. Coverage was declined with this Plan at the time You Were first eligible for coverage because You had coverage under another health plan, Medicaid, Medicare, CHAMPUS, Indian Health Services , Oregon Health Plan or another publicly sponsored or subsidized health plan, and that coverage has since ended; or
2. You apply for coverage during a Special Enrollment Period; or
3. There is a court order that is not more than 30 days old that orders a Spouse or minor child be covered under this Plan; or
4. You are employed by an employer who offers multiple health benefit plans and You elect to enroll with LifeWise in lieu of a different health plan:
   a) On which You have been covered until that time,
   b) During an annual group enrollment period; or
5. You have a change in Your family status due to marriage, birth, adoption or placement for adoption.

If You qualify as a Special Enrollee, You may enroll during a Special Enrollment Period.

**Special Enrollment Periods**
If You or Your dependents qualify as a Special Enrollee, You may enroll in the Plan during the Special Enrollment Period. The Special Enrollment Period has terms and conditions which are specific to the following circumstances. An Eligible Employee must have satisfied the New Employee Waiting Period before they can enroll during a Special Enrollment Period.

**Special Enrollees Who Have Lost Their Other Coverage**
If You have declined enrollment for Yourself or Your Eligible Family Dependents (including Your Spouse) because of other health insurance coverage, You may enroll Yourself or Your Eligible Family Dependents under the terms of this Contract. To do so, You must request enrollment within 30 days after the other coverage ends and each of the following conditions are met:

- The person was covered under a health plan at the time coverage under this Plan was previously offered;
- The person stated in writing that coverage under such group health plan or health insurance coverage was the reason for declining enrollment; but only if We required such a statement and provided the person with notice of such requirement (and the consequences of such requirement) at such time;

And if the other coverage was:

- Under a COBRA Continuation provision and the coverage under such a provision was exhausted.

Failure to pay premium or termination of coverage for cause do not satisfy this requirement; or

- Not under a COBRA Continuation provision and either the coverage was terminated as a result of:

  a) Loss of eligibility for the coverage, including as a result of legal separation; divorce; death; termination of employment; or reduction in the number of hours of employment, children aging out of coverage, the other coverage lifetime maximum benefit is met, or moving out of an HMO service area and there is no other coverage available with the other plan. Failure to pay premium or termination of coverage for cause do not satisfy this requirement; or

  b) The current or former employer contributions towards such coverage Were terminated; and

- The person requests enrollment under this Contract not later than 30 days after the date such other coverage ended.

The coverage will become effective on the first of the month following Our receipt of the enrollment application. If We do not receive the enrollment application within 30 days of the date prior coverage ended, You will be considered a Late Enrollee.

**Special Enrollees Who Have A Change In Family Status**
Individuals who previously declined enrollment in this Plan and have a change in family status may be eligible to enroll in this Plan as a Special Enrollee. Marriage, birth or adoption of a child is considered to be a change in family status. There are specific terms and conditions that must be followed in order to enroll during a Special Enrollment Period. An Eligible Employee may cover their Eligible Family Dependents only if they are also covered. In addition to the eligibility provisions contained in this Contract, the following shall also apply:

The Special Enrollment Period is 30 days and begins on the later of:

- The date dependent coverage is made available under the Plan; or
- The date of the marriage, birth, or adoption or placement for adoption;

Following Our receipt of the enrollment application, the coverage will become effective as follows:

- In the case of marriage, on the first day of the first calendar month following Our receipt of the enrollment request; or on an earlier date as agreed to by Us;
- In the case of a dependent's birth, on the date of such birth; or
- In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

If We do not receive the enrollment application within 30 days of the date of the family status change, You will be considered a Late Enrollee.

**Special Enrollees With Medicaid (Oregon Health Plan) and Children's Health Insurance Program (CHIP) Premium Assistance**
You and Your dependents may have Special Enrollment rights under this Plan if You meet the eligibility requirements described under "Who Is Eligible For Coverage" and:

- You qualify for premium assistance for this Plan from the Oregon Health Plan or CHIP; or
- You no longer qualify for health care coverage under the Oregon Health Plan or CHIP.

If You and/or Your dependents are eligible as outlined above, You qualify for a 60-day Special Enrollment Period. This means that You must request enrollment in this Plan within 60 days of the date You qualify for premium assistance under the Oregon Health Plan or CHIP or lose Your Oregon Health Plan or CHIP coverage.

Coverage under this Plan for the Eligible Employee or Eligible Family Dependent will start on the first of the month following:

- The date the Eligible Employee or Eligible Family Dependents qualify for the Oregon Heath Plan or CHIP premium assistance; or
- The date the Eligible Employee or Eligible Family Dependents lose coverage under the Oregon Health Plan or CHIP.

The Eligible Employee and/or Eligible Family Dependents may be required to provide proof of eligibility from the state for this special enrollment period.

If We do not receive the enrollment application within the 60-day period as outlined above, the applicant will be considered a Late Enrollee.

## CHANGES IN COVERAGE

No rights are vested under this Plan. Its terms, benefits, and limitations may be changed at any time. With one exception, all changes to this Plan will apply, as of the date the change becomes effective to all Members and to eligible Employees and dependents that become covered under this Plan after the date the change becomes effective.

## DISCONTINUANCE AND REPLACEMENT OF GROUP COVERAGE

If a person was covered under the employer's prior group policy or Contract on the date of termination of that group policy or Contract and is eligible for

coverage under this Contract, that person shall be eligible for coverage under this Contract without regard to active status or Hospital confinement.

The following will govern such coverage:

- The minimum level of benefits to be provided by Us shall be the applicable level of benefits of this Contract reduced by any benefits payable by the prior policy or contract. We will provide such coverage until the date on which Your coverage would terminate as described in the Termination of Coverage section. The Discontinuance and Replacement of Group Coverage provision will not apply to an individual who is covered under another contract with similar benefits.
- If You are subject to any Pre-Existing Condition Exclusion Period, credit will be given for time period which was satisfied while You were covered under the prior plan as described under Important Plan Information. If You continue to be subject to a Pre-Existing Condition Exclusion Period, Our benefits payable will be based upon the benefits of the prior plan reduced by any benefits actually paid or payable by the prior plan.
- In applying any Deductibles or benefit exclusion periods of the prior plan, We will credit any applicable Deductibles actually incurred by You and will credit the time period satisfied towards any applicable Benefit Exclusion Periods. This means the Deductible credit shall be given only to the extent the expenses are recognized under the terms of this Plan and are subject to a similar Deductible.
- If You are confined in a facility on Your Effective Date of Coverage with this Plan, and the employer replaces that prior group coverage with this Plan, benefit availability for Services may be affected. If You are hospitalized on the day of termination of a prior policy or contract and are covered under this Plan, Your benefits under the prior plan will affect the benefits of this Plan for that hospitalization until the confinement ends or Hospital benefits under the prior policy or contract are exhausted, whichever is earlier.

### ELIGIBILITY STATUS CHANGES DUE TO LEAVE OF ABSENCE, LAYOFFS AND REDUCTION IN WORK HOURS

An enrolled Eligible Employee on an Employer approved leave of absence, for any reason, may continue to be covered under this Contract as though in active status, at the Employer's option, for a period not to exceed three (3) months. Absences extending beyond this time period will be subject to the provisions outlined under How To Continue Coverage.

An Eligible Employee who has been laid off and rehired within six (6) months shall be covered on the first of the month following their return to work, provided that an Enrollment Application is completed by the Eligible Employee and received by Us within 31 days of returning to work. Please refer to the Pre-Existing Condition Provision under Important Plan Information to determine if the Pre-Existing Condition Provision applies.

An Eligible Employee who lost eligibility due to a reduction in work hours shall be covered on the first of the month following the date the employee regains eligibility provided that an Enrollment Application is completed by the Eligible Employee and received by Us within 31 days of becoming eligible. Please refer to the Pre-Existing Condition Provision under Important Plan Information to determine if the Pre-Existing Condition Provision applies.

For the Eligible Employee, a leave of absence granted under the federal Family and Medical Leave Act of 1993 or the Uniformed Services Employment and Reemployment Rights Act of 1994 is administered in accordance with these Acts and this Contract.

## WHEN WILL MY COVERAGE END

Termination of Coverage will occur on the earliest of the following:

1. The date this Contract terminates;
2. The end of the period for which required Premium was due to Us and not received by Us;
3. For the Eligible Employee, the end of the month following the date he no longer qualifies as an Eligible Employee or terminates employment with the Employer/Group;
4. For the Eligible Employee, the end of the month following the date he fails to pay required Premiums;
5. For the Eligible Employee, the end of the month following the date You fail to be in an eligible class of persons as shown on the Employer/Group Agreement and as described in the Employer/Group Provisions;
6. The end of the month following the date the Eligible Employee requests termination of coverage to be effective for the Eligible Employee or Member;
7. For an Eligible Family Dependent, the date the Eligible Employee's coverage terminates;
8. For an Eligible Family Dependent, the end of the month following the date he or she no longer qualifies as an Eligible Family Dependent;
9. For any benefit, the date the benefit is deleted from this Contract;

10. For You or the Employer/Group, the date We discover any breach of contractual duties, conditions or warranties, as determined by Us;
11. For You or the Employer/Group, the end of the month following the date that the Employer/Group terminates its participation in a multiple employer trust or association;
12. For a Domestic Partner and their enrolled dependents, the end of the month following the date there is a change in one or more of the circumstances as listed on the Affidavit of Domestic Partnership.

We may rescind Your coverage upon the discovery of fraud, material misrepresentation or concealment regarding any terms, conditions or benefits of the Contract.

You and the Employer/Group are responsible to advise Us of any changes in eligibility including the lack of eligibility of a family Member. Coverage will not continue beyond the last date of eligibility regardless of the lack of notice to Us.

**Non-Liability After Termination**

Upon termination of this Contract, We shall have no further liability beyond the effective date of the termination except as stated below. We will provide information to the Employer/Group so they can inform Members of the termination of this Contract. It will be the Employer/Group's responsibility to inform all Members that this Contract has terminated.

If the Employer/Group has immediately replaced this Contract with another insurer's Contract or group policy and a Member is hospitalized at the time of this termination, he or she shall continue to receive benefits for Services he or she received for that hospitalization until discharged from the Hospital or until the limits of coverage under this Contract have been reached, whichever is earlier.

# MY RIGHTS UNDER COBRA

When group coverage is lost because of a "qualifying event" shown below, Federal laws and regulations known as COBRA require the Employer/Group to offer qualified Members an election to continue their group coverage for a limited time. Under COBRA, a qualified Member must apply for COBRA coverage within a certain time period and may also have to pay the premium charges for it.

At the Employer/Group's request, We will provide qualified Members with continued coverage under this Plan when COBRA enrollment and payment requirements are met. But, coverage is provided only to the extent that COBRA requires and is subject to the other terms and limitations of this Plan. Members' rights to this coverage may be affected by the Employer/Group's failure to abide by the terms of its contract with Us. The Employer/Group, not LifeWise, is responsible for all notifications and other duties assigned by COBRA to the "plan administrator" within COBRA time limits.

The following summary of COBRA coverage is taken from COBRA. Member's rights to this coverage and obligations under COBRA automatically change with further amendments of COBRA by Congress or interpretations of COBRA by the courts and federal regulatory agencies.

**Qualifying Events And Length Of Coverage**
Please contact Your Employer/Group immediately when one of the qualifying events highlighted below occurs. The continuation periods listed extend from the date of the qualifying event.

**Please Note:** Enrolled Registered Domestic Partners, Domestic Partners who have provided documentation of a Domestic Partnership and their enrolled dependent children may elect to continue this coverage. However, Domestic Partners do not have all the rights and protections as a Qualified Beneficiary under COBRA as described within this section.

- The Employer/Group must offer the enrolled Employees and enrolled Eligible Family Dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of 1 of 2 qualifying events:

  1. The Employee's work hours are reduced.
  2. The Employee's employment terminates, except for discharge due to actions defined by the Employer/Group as gross misconduct.

  However, if one of the events listed above follows the enrolled Employee's entitlement to Medicare by less than 18 months, the Employer/Group must offer the enrolled Eligible Family Dependents an election to continue coverage for up to 36 months starting from the date of the Medicare entitlement. This happens only if the event would have caused a similar dependent that was not on COBRA coverage to lose coverage under this Plan.
- COBRA coverage can be extended if an enrolled Member who lost coverage due to a reduction in hours or termination of employment, is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all Eligible Family Dependents who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination.
- The Employer/Group must offer the enrolled

Eligible Family Dependents an election to continue coverage for up to 36 consecutive months if their coverage is lost because of 1 of 4 qualifying events:

1. The employee dies;
2. The employee and Spouse legally separate or divorce;
3. The employee becomes entitled to Medicare;
4. An enrolled child no longer qualifies as an Eligible Family Dependent.

In addition, the occurrence of one of these events during the 18-month period described above can extend that period for a continuing dependent. The extended period will end no later than 36 months from the date of the first qualifying event.

- The Employer/Group must offer the retired Eligible Employee and covered Eligible Family Dependents an election to continue their retiree coverage if that coverage is lost because the Employer/Group filed for bankruptcy. COBRA also considers coverage to have been lost due to this qualifying event if the retiree group coverage was substantially eliminated at any time between one year before the bankruptcy proceeding commenced and 1 year after it commenced.

  Under this qualifying event, the retired Eligible Employee may continue coverage for up to the rest of his or her life. The retired Eligible Employee's covered Spouse and children may continue for up to 36 months after the retired Eligible Employee's death or until they lose eligibility as dependents, whichever occurs first. (If the retire Eligible Employee died before the bankruptcy, but his or her Spouse is still covered under this Plan when the bankruptcy filing occurred, that surviving Spouse may continue coverage for up to the rest of his or her life.)

  However, COBRA coverage under this plan will end on the date that the Contract between the Employer/Group and Us is terminated.

**Conditions Of COBRA Coverage**
For COBRA coverage to become effective, all of the requirements below must be met:

**You Must Give Notice Of Some Qualifying Events**
The Plan will offer COBRA coverage only after the Employer/Group receives timely notice that a qualifying event has occurred.

The Eligible Employee or affected Eligible Family Dependent must notify the Employer/Group in the event of a divorce, legal separation, child's loss of eligibility as a dependent, or any second qualifying event which occurs within the 18-month period as described in this section under Qualifying Events and lengths Of Coverage. The Eligible Employee or affected Eligible Family Dependent must also notify the Employer/Group if the Social Security Administration determines that the Eligible Employee or Eligible Family dependent was disabled on any of the first 60 days of COBRA coverage. You also have the right to appoint someone to give the Employer/Group this notice for You.

**If the required notice is not given or is late, the qualified member loses the right to COBRA coverage.**

Except as described below for disability notices, the Eligible Employee or affected Eligible Family Dependent has 60 days in which to give notice to the Employer/Group. The notice period starts on the date shown below.

- For determination of disability, the notice period starts on the later of: 1) the date of the Eligible Employee's termination or reduction in hours; 2) the date a qualified member would lose coverage as a result of one of these events; or 3) the date of the disability determination. Please note: Determinations that a qualified member is disabled must be given to the Employer./Group before the 18-month continuation periods ends. This means that the Eligible Employee or qualified Eligible Family Dependent might not have the full 60 days in which to give the notice. Please include a copy of the determination with Your notice to the Employer/Group.

  Note: The Eligible Employee or affected Eligible Family Dependent must also notify the Employer/Group if a qualified member is deemed by the Social Security Administration to no longer be disabled. See When COBRA Coverage Ends.
- For the other event above, the 60-day notice period starts on the later of: 1) the date of the qualifying event, or 2) the date the qualified member would lose coverage as a result of the event.

**Important Note:** The Employer/Group must tell You where to direct Your notice and any other procedures that You must follow. If the Employer/Group informs You of its notice procedures after the notice periods start date above for Your qualifying event, the notice period will not start until the date You are informed by the Employer/Group.

The Group must notify qualified members of their rights under COBRA. If the Group has named a third party as its plan administrator, the plan administrator is responsible to notify members on behalf of the Group. In such cases, the Group has 30 days in which to notify its plan administrator of a subscriber's termination of employment, reduction in hours, death, Medicare entitlement, or loss of retiree coverage because the Group filed for bankruptcy. The plan

administrator then has 14 days after it receives notice of a qualifying event from the Group (or from a qualified member as stated above) in which to notify qualified members of their COBRA rights.

If the Group itself is the plan administrator, it has more than 14 days in which to give notice for certain qualifying events. The Group must furnish the notice required because of a employee's termination of employment, reduction in hours, death, Medicare entitlement, or loss of retiree coverage because the Group filed for bankruptcy no later than 44 days after the later of 1) the date of the qualifying event, or 2) the date coverage would end in the absence of COBRA. For all other qualifying events, the 14-day notice time limit applies.

**You Must Enroll And Pay On Time**

- You must elect COBRA coverage no more than 60 days after the later of 1) the date coverage was to end because of the qualifying event, or 2) the date You were notified of Your right to elect COBRA coverage. You may be eligible for a second COBRA election period if You qualify under section 201 of the Federal Trade Act of 2002. Please contact the Employer/Group or Your bargaining representative for more information if You believe this may apply to You.

  Each qualified member will have an independent right to elect COBRA coverage. Subscribers may elect COBRA coverage on behalf of the Spouses, and parents may elect COBRA coverage on behalf of their children.

  If You are not notified of Your right to elect COBRA coverage within the time limits above, You must elect COBRA coverage no more than 60 days after the date coverage was to end because of the qualifying event in order for COBRA coverage to become effective under this Plan. If You are notified of Your right to elect COBRA coverage within the time limit and You don't elect COBRA coverage within 60 days after the date coverage ends, We will not be obligated to provide COBRA benefits under this Plan. The Employer/Group will assume full financial responsibility for payment of any COBRA benefits to which You may be entitled.
- You must send Your first premium payment to the Employer/Group no more than 45 days after the date You elected COBRA coverage.
- Subsequent premiums must be paid to the Employer/Group and submitted to Us with the Employer/Group's regular monthly billing.

**Adding Family Members**

Eligible Family Dependents may be added after the continuation period begins, but only as allowed under Special Enrollment or Annual Group Enrollment as described under Who Is Eligible For Coverage. With one exception, family members added after COBRA begins are not eligible for further coverage if they later have a qualifying event or if they are determined to be disabled as described in this section under Qualifying Events And Lengths Of Coverage. The exception is that a child born to or placed for adoption with a covered Eligible Employee while the covered Eligible Employee is on COBRA has the same COBRA rights as family members on coverage at the time of the original qualifying event. The child will be covered for the duration of the covered Eligible Employee's initial 18-month COBRA period, unless a second qualifying event occurs which extends the child's coverage. COBRA coverage is subject to all other terms and limitations of this Plan.

**Keep The Employer/Group Informed Of Address Changes**

In order to protect Your rights under COBRA, You should keep the Employer/Group informed of any address changes. It is a good idea to keep a copy, for Your records, of any notices You send to the Employer/Group.

**When COBRA Coverage Ends**

COBRA coverage will end of the last day for which premiums have been paid in the monthly period in which the first of the following occurs:

- The applicable continuation period expires.
- The next monthly premium is not paid when due or within the 30-day COBRA grace period.
- When coverage is extended from 18 to 29 months due to disability (see Qualifying Events and Lengths of Coverage in this section), COBRA coverage beyond 18 months ends if there's a final determination that a qualified member is no longer disabled under the Social Security Act. However, coverage will not end on the date shown above, but on the last day for which premiums have been paid in the first month that begins more than 30 days after the date of the determination. The Eligible Employee or affected Eligible Family Dependents must provide the Employer/Group with a copy of the Social Security Administration's determination within 30 days after the later of: 1) the date of the determination, or 2) the date on which the Eligible Employee or affected Eligible Family Dependents was informed that this notice should be provided and given procedures to follow.
- You become covered under another group health care plan after the date You elect COBRA coverage. However, if the new plan contains an exclusion or limitation for a Pre-Existing condition, coverage does not end for this reason until the exclusion or limitation no longer applies.
- You become entitled to Medicare after the date

You elect COBRA coverage.
(This does not apply to retirees and their dependents who are continuing retiree coverage as a result of a bankruptcy filing.)

- The Employer/Group ceases to offer group health care coverage to any employee;

However, even if one of the events above has not occurred, COBRA coverage under this Plan will end on the date that the Contract between the Employer/Group and Us is terminated.

When COBRA coverage under this plan ends, You may be eligible to apply for a Portability Plan as described in the section of this Benefit Booklet titled Portability Plans.

**If You Have Questions**
Questions about Your Plan or Your rights under COBRA should be addressed to Your Employer/Group. For more information about Your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA Web site at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.

## HOW TO CONTINUE COVERAGE

There are specific requirements, time frames and conditions which must be followed in order to be eligible for continuation of coverage and which are generally outlined below. Please contact Your Employer/Group as soon as possible for details if You think You may qualify for continuation coverage.

At anytime during or at the end of any COBRA or state continuation coverage You are eligible to apply for a Portability Plan as described in this Contract. If You do not continue coverage and obtain a Portability Plan, You waive the right to continue coverage.

### FOR GROUPS WITH 20 OR MORE EMPLOYEES

If You become ineligible You may continue coverage to the extent required by the federal Consolidated Omnibus Budget Reconciliation Act of 1986, (COBRA) as amended, and Oregon state law. You may be eligible to continue coverage on a self-pay basis for 18 or 36 months through COBRA. COBRA is a federal law which requires most employers with 20 or more employees to offer continuation of coverage. How long You may continue coverage on COBRA will depend upon the circumstances which caused You to lose Your coverage on the group plan. Please see My Rights Under COBRA for details.

**Special Notice**
If You are a Member and a surviving, divorced or legally separated Spouse of an enrolled Eligible Employee, and at least 55 years old at the employee's time of death or at the time of the dissolution of a marriage or registered domestic partnership or legal separation, You may be eligible to continue coverage. This state-mandated continuation of coverage will terminate upon the earliest of any of the following:

1. The failure to pay Premiums when due, including any grace period;
2. The date that the Contract is terminated;
3. The date on which the Spouse becomes insured under any other group health plan;
4. The date on which the Spouse remarries and becomes covered under another group health plan; or
5. The date on which the Spouse becomes eligible for federal Medicare coverage.

### FOR GROUPS NOT SUBJECT TO COBRA OR WITH FEWER THAN 20 EMPLOYEES

State mandated continuation of coverage is available to You if You have been covered continuously under this Contract, or a similar predecessor group health plan, during the three month period on the date of termination of employment or membership.

**Who May Be Eligible**
The enrolled Eligible Employee or Spouse may be eligible for continuation of coverage if:

1. Coverage ends because of the termination of employment of the Eligible Employee, or
2. Coverage ends because the Eligible Employee's reduction in work hours, or
3. Coverage ends because of the death, dissolution of marriage or registered domestic partnership, or legal separation.

You must request state continuation coverage in writing and pay premium to Your Employer within 31 days after the date on which You coverage under this Contract would otherwise end.

**Maximum Length Of Coverage**
State continuation of group coverage terminates the earlier of:

1. Nine (9) months after the date on which the enrolled Eligible Employee's coverage under this Contract otherwise would have ended because of termination of employment or membership,
2. Nine (9) months after the start of a leave of absence from which an enrolled Eligible Employee does not return to work;

3. Nonpayment: The end of the month for which You last made timely payment (30 days from the date the Premium is due);
4. Medicare: First of the month in which You become entitled to Medicare benefits;
5. Other Group Coverage: The date You become covered under another group health plan as a covered employee or as a dependent. If Your new plan has a Pre-Existing condition clause, Services that would be denied as Pre-Existing under Your new plan will be covered by Us until the end of the Pre-Existing waiting period. Your coverage under this Contract will terminate at the end of the new plan's pre-existing waiting period; or
6. Remarriage: The date the former Spouse remarries and, because of the remarriage, becomes covered under another group health plan.

### CONTINUATION OF BENEFITS DURING LABOR STRIKE

If Premiums are paid by Your Employer/Group under the terms of a collective bargaining agreement and there is a cessation of work by the Employees due to a strike or lockout, this Contract will continue in effect if the Employer/Group continues to pay the Premium due. The union which represents the Employer/Group is responsible for collecting and paying the Premium by the due date. The amount payable by each Eligible Employee shall be the Premium for the category in which the Eligible Employee belongs plus a maximum of 20% increase to pay the increased cost by Us. Nothing in this paragraph shall be deemed to limit any right We may have in accordance with the terms of this Contract to increase or decrease the Premium.

Coverage under this paragraph shall continue until the first of the following occurs:

1. Less than seventy-five percent (75%) of employees, at the time of cessation of work, continue coverage;
2. Six (6) months after cessation of work;
3. For an individual Eligible Employee and Eligible Family Dependents, the time at which the Eligible Employee takes full-time employment with another employer.

### CONTINUATION OF BENEFITS AFTER INJURY OR ILLNESS COVERED BY WORKER'S COMPENSATION INSURANCE

Coverage under this Contract shall be available to Eligible Employees who are not actively working and are receiving Worker's Compensation insurance payments. Premium payment due will remain the same as if the Eligible Employee was actively at work. This continuation of benefits is administered in accordance with the Coverage Extensions provision and with any state or federal continuation requirements. The Eligible Employee may maintain such coverage until the earlier of:

1. The Eligible Employee takes full-time employment with another employer; or
2. Six (6) months from the date that the payment of Premium is made under this provision.

### COVERAGE EXTENSIONS

Coverage Extensions refer to the extension of full coverage for You and any family Members during which the Contract agrees to pay any portion of Your cost of coverage under the terms of any collective bargaining agreements, Contract, other agreements or Contract provisions. The Coverage Extension follows an event which otherwise would qualify as a Qualifying Event under federal law requiring COBRA continuation coverage. You and Your covered dependents shall continue to be Members during such period, but such period shall be deducted from Your entitlement to COBRA continuation coverage under this Contract to the same extent as federal law gives credit to the Employer/Group against the maximum coverage period under federal law. In the event that You have no entitlement to COBRA continuation coverage remaining at the time the Employer/Group ceases to pay for Your coverage, You and Your covered dependents will be entitled to elect a Portability Plan as if continuation coverage terminated at that time.

## PORTABILITY PLANS

In order to improve the availability and affordability of health benefit plans for individuals leaving coverage under group health benefits plans, Contract reforms have been enacted by ORS 743.760 -.761 and USC 200 gg-431.

If Your medical coverage under this Plan terminates, a Portability Plan is available without Pre-Existing Condition Provisions, waiting periods or other similar limitations on coverage. Portability Plans are new policies and are not a continuation of Your terminated group coverage. Portability Plan benefits differ from those provided under Your group coverage and do not provide vision or dental benefits.

We will automatically send You a Portability Plan Brochure describing the benefits and the rates for each Portability Plan when Your Coverage under this Plan ends. You may obtain additional Portability application forms or additional information about Our Portability Plans by calling a LifeWise Customer Service Representative at 1-800-596-3440 or by writing to Us at PO Box 7709, Bend OR 97708-7709.

**Who Is Eligible For Coverage**
To be eligible for a Portability Plan, You must be covered under this Plan on the date coverage ends and meet the following requirements:

- You must have been covered under one or more Oregon group Health Benefit Plans for at least 180 days and applied for a Portability Plan not later than the 63rd day after termination of this Plan's coverage; or
- You must have been covered for 18 or more months under Creditable Coverage, of which the most recent Creditable Coverage was under a LifeWise group Health Benefit Plan, and apply for a Portability Plan not later than the 63rd day after termination of this Plan's coverage; and
- Termination of Your coverage must have occurred because You no longer meet the eligibility requirements of this Plan; and
- You must be a resident of the state of Oregon.

You are not eligible for a Portability Plan if:

- You are eligible for federal Medicare coverage; or
- You remain eligible for Your prior active group coverage; or
- You are covered under another group plan, policy, or agreement providing benefits for hospital or medical care; or
- Your employer replaces this Plan with another health insurance carrier within 31 days of the termination of this Plan; or
- You are not a resident of the State of Oregon.

**Effective Date and Premium**
To enroll in a Portability Plan, You must submit Your completed application and first month's premium to Us within 63 days after the date Your coverage under this Plan ends. If We do not receive Your application and payment within this required time period, You will not be eligible for a Portability Plan and may not enroll.

Portability Plan coverage will be effective the day following the date coverage ends under this Plan.

# PLAN NOTICES AND DISCLOSURES

The Employer/Group is responsible to determine if it is required to comply with ERISA, HIPAA and other health care related provisions at the time of initial application and renewal of this Contract. The information included in this Benefit Booklet does not relieve the Employer/Group of its responsibility under these laws or acts.

**Creditable Coverage Certificates**
When Your coverage under this Plan terminates, You will receive a Certificate of Creditable Coverage. This Certificate will provide information about Your coverage period under this Plan. When You provide a copy of the certificate to Your new health plan, You may receive credit toward any benefit exclusion periods or Pre-Existing condition waiting periods. You will need a Certificate each time You leave a health plan and enroll in a plan that has a benefit exclusion period for specific benefits or a pre-existing condition waiting period.

We will automatically provide a Certificate of Creditable Coverage to each Member when:

- Coverage under this Plan terminates; and
- When COBRA coverage ends.

If You have not received a Certificate, or have misplaced it, You have the right to request one from Us or Your former Employer within 24 months of the date coverage terminated.

**Groups Subject To Employee Retirement Income Security Act (ERISA)**
If You are a Member of an Employer/Group that is subject to the Employee Retirement Income Security Act (ERISA), You have the right to review documents and records that are relevant to Your claims.

You may also have the right to file suit in a state or federal court when:

- A Grievance is ignored, in whole or in part, or not processed within the time limits as shown in this Benefit Booklet; or
- At the end of the Level II Grievance review.

**LifeWise Annual Summaries**
Copies of Our Annual Summaries are available upon request. If You would like copies of the summaries listed below or have questions about this information, please contact Us at the number listed in the front of this Benefit Booklet. You will be directed to the area which can best answer Your questions.

- LifeWise Annual Summary of Grievance and Appeals
- LifeWise Annual Summary of Provider Network Scope and Adequacy
- LifeWise Annual Summary Of Utilization Review Policies
- LifeWise drug formularies

You may also request a copy of the annual summaries for Grievances and Appeals, Provider Network Scope and Adequacy and Utilization Review Policies from the Department of Consumer and Business Services. You can contact them as follows:

By calling (503) 947-7984 or the toll free message line

at (888) 877-4894;

By writing to the Consumer Protection Unit,
350 Winter Street NE, Room 440-5
Salem, OR 97301-3883; or

Through the Internet at:
http://www.cbs.state.or.us/external/ins; or

By email at: DCBS.INSMAIL@state.or.us.

**LifeWise Privacy Policy and Notification Practices**
We may collect, use, or disclose certain information about You. This "personal information" may include health information, or personal data such as Your address, telephone number or Social Security number. We may receive this information from, or release it to, health-care providers, insurance companies, or other sources.

Your personal information is collected, used or released for conducting routine business operations such as:

- Underwriting and determining Your eligibility for benefits and paying claims;
- Coordinating benefits with other health-care plans;
- Conducting care management, case management, or quality reviews; and
- Fulfilling other legal obligations that are specified under the Contract.

This information may also be collected, used or released as required or permitted by law.

To safeguard Your privacy, We take care to ensure that Your information remains confidential by having a company confidentiality policy and training all employees on Our written confidentiality policy and procedures.

If a disclosure of Your personal information is not related to a routine business function, We will remove anything that could be used to easily identify You, unless We have Your prior consent to release such information.

You have the right to request inspection and/or amendment of records retained by Us that contain Your personal information. Please contact Us at the number listed in the front of this Benefit Booklet and ask a representative to mail a request form to You.

Our detailed Notice of Information Practices is available upon request. You can obtain a copy at Our Web site at www.lifewiseor.com or You can call Us to request a copy be mailed to You. Please call Customer Service at the number listed in the front of this Benefit Booklet or on the back of Your LifeWise ID Card.

**Member Rights and Responsibilities**
We are committed to treating Members in a manner that respects their rights. Our Members have the right to receive information about Our organization, the services We provide, and their rights and responsibilities under Our plan. Members also have the right to receive information about LifeWise providers and participate in decision making about their health care. They also have the right to have a candid discussion with their provider about appropriate or medically necessary treatment options for their condition(s) regardless of the cost of benefit coverage. They have the right to be treated with respect and dignity and to have their privacy recognized. They also have the right to voice Complaints and Grievances about Our organization or the care provided to them.

You are responsible for supplying providers with information necessary for the providers to determine appropriate medical services. You are also responsible for following instructions and guidelines they have agreed upon with their providers and for doing their part to maintain an effective patient/provider relationship.

It is Your responsibility to read and to understand the terms of this Contract. We will have no liability for Your misunderstanding, misinterpretation or lack of knowledge of the terms, provisions and benefits of this Contract. If You have any questions or are unclear about any provision concerning this Plan, please contact Us. We will assist You in understanding and complying with the terms of Your Plan.

**Modification Of The Contract And Notification Of Plan Change**
We may change or amend the Contract as provided in the Employer/Group Provisions section. We will:

- Contact the Employer/Group in writing regarding the change;
- Provide a description of the change and how it affects the Contract; and
- Provide a copy of any pertinent information such as a revised Contract form or Endorsement.

Credit will be applied to Benefit Maximum Limits, Durational Limits, Deductibles and Coinsurance Maximum provisions if the benefits for Covered Services under this Contract are modified, or if Your Employer/Group changes to another LifeWise Contract. However, credit is given only to the extent that these provisions are applicable under the terms of the Contract prior to the modification or change.

Any notice required of Us under this Plan shall be deemed to be sufficient if mailed to the enrolled Eligible Employee at the address appearing on the records of LifeWise. Any notice required of the Employer/Group or You, shall be deemed sufficient if mailed to the principal office of LifeWise Health Plan

of Oregon, P. O. Box 7709, Bend, OR 97708-7709.

**Newborn's and Mother's Health Protection Act**
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, group health plans and health insurance issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the 48 hours (or 96 hours).

**Pre-Existing Condition Provision**
Your Plan may not impose a Pre-Existing Condition Provision to Your benefits before notifying You of the following:

- Your right to demonstrate Creditable Coverage (and any applicable waiting periods);
- Your right to request a certificate from a prior plan or issuer, if necessary; and
- That We will assist in obtaining a certificate from Your prior plan or issuer, if necessary.

Please refer to the sections titled Summary of Benefits and Important Plan Information for details regarding Your Plan's Pre-Existing Condition Provision.

If We determine that Your benefits are subject to a Pre-Existing Condition Provision You will be notified in writing of the following:

- What information We used to make Our determination;
- A written explanation of Our Grievance procedures; and
- Your opportunity to submit additional evidence of Creditable Coverage.

**Provider Credentialing And Recredentialing**
LifeWise Preferred Providers must be credentialed by LifeWise in accordance with LifeWise administrative credentialing policies. You may obtain a copy of Our credentialing policies by calling Us at the number listed in the front of this Benefit Booklet or by writing to LifeWise Health Plan of Oregon at PO Box 7709, Bend, OR 97708-7709.

**Right to Examine Records**
It is specifically understood and agreed that by acceptance of the benefits of this Contract, all Members shall have deemed to have consented to examination of medical records for utilization review, quality assurance and peer review.

**Special Enrollment Rights**
If You are declining enrollment for Yourself or Your dependents (including Your Spouse) because of other health insurance coverage, You may in the future be able to enroll Yourself or Your dependents in this Plan, provided that You request enrollment within 30 days after Your other coverage ends. In addition, if You have a new dependent as a result of marriage, birth, adoption, or placement for adoption, You may be able to enroll Yourself and Your dependents, provided that You request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Please see Who Is Eligible for Coverage for details about Special Enrollment Periods. You may also contact Your employer or Us for additional information.

**Women's Health and Cancer Rights Act of 1998**
Your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related Services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. Please see What Are My Benefits for Covered Services. You may also contact Your employer or Us for additional information.

## MY RIGHTS UNDER ERISA

The Employer/Group may have an employee welfare benefit plan that is subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). If so, this section of the Benefit Booklet describes the enrolled Eligible Employee's rights under ERISA. Please see Your Employer/Group to find out if this Plan is subject to ERISA.

This employee welfare benefit plan is call the "ERISA Plan" in this section. The insured LifeWise Plan described in this Benefit Booklet is part of the ERISA Plan.

When used in this section the term "ERISA Plan" refers to the Employer/Group's employee welfare benefit plan. The "ERISA Plan administrator" is the Employer/Group or an administrator named by the Employer/Group. LifeWise Health Plan of Oregon is not the ERISA plan administrator.

As participants in an employee welfare benefit plan, enrolled Eligible Employees have certain rights and protections. This section of this plan explains those rights.

ERISA provides that all plan participants shall be entitled to:

- Examine without charge, at the ERISA Plan

administrator's office and at other specified locations (such as work sites and union halls), all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements. (Please note that Our Contract with the Employer/Group by itself does not meet all the requirements for an ERISA plan document.) If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to examine a copy of its latest annual report (Form 5500 Series) filed and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreement and updated summary plan descriptions. If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to obtain copies of the latest annual report (Form 5500 Services). The administrator may make a reasonable charge for the copies.
- Receive a summary of the ERISA Plan's annual financial report, if ERISA requires the ERISA Plan to file an annual report. The ERISA Plan administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.
- 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 the summary plan description and the documents governing the plan regarding the rules for Your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for Pre-Existing conditions under Your group health plan, (if this plan has such an exclusionary period) when 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, if 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 the Pre-Existing condition exclusion after Your Enrollment date in the group health plan. Please see the Summary of Benefits for Your Plan's Pre-Existing Condition provisions.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee welfare benefit plan. The people who operate Your ERISA 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. (LifeWise is a fiduciary only with respect to claims processing and payment. However, We do have the discretionary authority to determine eligibility for benefits and to interpret the terms of the portion of the Employer/Group's ERISA Plan that We insure.) 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 welfare benefit or exercising Your rights under ERISA.

If Your claim for a welfare 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.

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 ERISA 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 ERISA 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. In addition, if You disagree with the ERISA Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in federal court.

If it should happen that ERISA Plan fiduciaries misuse the ERISA 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 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 is frivolous.

**Please Note**: Under ERISA, the ERISA Plan administrator is responsible for furnishing each participant and beneficiary with a copy of the summary plan description.

If You have any questions about Your employee welfare benefit plan, You should contact the ERISA 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 ERISA Plan administrator, You should contact either

the:

- Office of the Employee Benefits Security Administration, U.S. Department of Labor, 1111 Third Ave. Suite 860, MIDCOM Tower, Seattle, WA 98101-3212; or
- Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. 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 Employee Benefits Security Administration at 1-866-444-3272.

# GENERAL INFORMATION ABOUT MY PLAN

**Benefit Booklets**
LifeWise will furnish Benefit Booklets to the Employer/Group for delivery to each Eligible Employee. If dependents are enrolled, only one Benefit Booklet will be issued for each family unit.

**Choice of Law**
The laws of the State of Oregon govern the interpretation of this Contract. The laws of the state in which this Contract is executed governs the administration of benefits to Member beneficiaries of this Contract. Oregon law will govern the interpretation of any requirements applicable to Members who are out-of-area or who reside out of the Service Area.

**Conformity With State Statutes**
The Contract is issued and delivered in the State of Oregon and is governed by the laws of the State of Oregon, except to the extent preempted by federal law. In the event any provision of the Contract or any amendment is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the Contract will be administered in conformance with the requirements of such laws and regulations as of their effective date.

**Duplicating Provisions**
If any charge is described as covered under two or more benefit provisions, We will pay only under the provision allowing the greater benefit. This may require Us to make a recalculation based upon both the amounts already paid and the amounts due to be paid. We have no liability for benefits other than those this Contract provides.

**Employer/Group As The Agent**
The Employer/Group is the agent of the Members for all purposes under this Contract and not the agent of LifeWise. Any action taken by the Employer/Group will be binding on You.

**Employer/Group Records**
The Employer/Group is responsible for keeping accurate records relating to this Contract. The records must contain all the information We need to administer this Contract. We have the right to request, inspect or audit the Employer/Group's records at any reasonable time during regular business hours.

**Failure To Provide Information Or Providing Incorrect Or Incomplete Information**
The Employer/Group and Members warrant that all information contained in applications, questionnaires, forms, or statements submitted to Us to be true, correct, and complete. If You willfully fail to provide information required to be provided under this Contract or knowingly provide incorrect or incomplete information, then Your rights and those of all other Members of Your family unit may be terminated as described in the Contract.

In addition, if the Employer/Group fails to furnish information as required to be furnished under terms of this Contract, the Employer/Group will indemnify, defend, save and hold harmless LifeWise from any lawsuits, demands, claims, damages or other losses arising from the Employer/Group's failure to inform Us or Members of such required information.

**Integration**
This Contract, consisting of the Employer/Group Provisions, Benefit Booklet(s), Employer/Group Agreement, Supplemental Benefits and Endorsements, embodies the entire Contract of the parties. There are no promises, terms, conditions or obligations other than those contained herein. This Contract plus Endorsements, Supplemental Benefits or amendments, if any, shall supersede all other communications, representations or agreements, either verbal or written, between the parties.

**Interpretation Of Plan**
To the extent this Plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the employer's responsibilities and Our responsibilities include the following:

- The employer is responsible for furnishing summary plan descriptions, annual reports and summary annual reports to plan participants and to the government as required by ERISA.
- The employer and not LifeWise is the "Plan Administrator " as defined in ERISA.
- The employer is responsible for providing all notices regarding continuation. LifeWise is responsible for providing all notices regarding the availability of Portability Plans.
- The employer gives LifeWise, as acting for the "Plan Administrator", the discretionary authority to determine eligibility for benefits under the Plan

and to interpret the terms of the Plan.

**Legal Action**
No legal or equitable action may be brought to recover benefits from this Contract until receipt of a final decision from the LifeWise Grievance Committee. No such action will be brought three years after receipt of the decision of the LifeWise Grievance Committee.

**LifeWise ID Card**
The LifeWise ID Card is issued by LifeWise for Member identification purposes only. It does not confer any right to Services or other benefits under this Contract.

**LifeWise Not Liable For Quality Of Medical Care**
LifeWise is not responsible for the quality of medical care a person receives since all those who provide care do so as independent contractors. We are not liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by You while receiving Services.

**Misstatement Of Age**
If the age of the insured has been misstated, all amounts payable under the Contract is such as the Premium paid would have purchased at the correct age.

**Non-Transferability Of Benefits**
No person other than a Member is entitled to receive benefits under this Contract. Such right to benefits is nontransferable.

**Nonwaiver**
No delay or failure when exercising or enforcing any right under this Contract shall constitute a waiver or relinquishment of that right and no waiver or any default under this Contract shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of this Contract shall be deemed to have been made unless and until such waiver has been reduced to writing and signed by the party waiving the provision.

**Representation Not Warranties**
In the absence of fraud, all statements made by the applicant, Employer/Group or Member shall be considered representations and not warranties. No statement made while applying for insurance will cancel insurance or reduce benefits unless it is in a written document signed by the Employer/Group or insured person. A copy of the document must be given to the person noted.

**Right Of Recovery**
We have the right to recover amounts We paid that exceed the amount for which We are liable. Such amounts may be recovered from the Eligible Employee or any other payee, including a provider. Or, such amounts may be deducted from future benefits of a family Member (even if the original payment was not made on that Member's behalf) when the future benefits would otherwise have been paid directly to the Eligible Employee or to a provider that does not have a contract with Us.

In addition, if the coverage for this Contract is rescinded, We have the right to recover the amount of any claims We paid under this Plan and any administrative costs We incurred to pay those claims from the Eligible Employee or any other payee.

**Severability**
Invalidation of any term or provision herein by judgment or court order shall not affect any other provisions, which shall remain in full force and effect.

**Workers' Compensation Insurance**
This Contract is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation insurance.

## DEFINITION OF TERMS

We will apply the terms and meanings shown below wherever used in the Contract. The masculine includes the feminine and the singular includes the plural.

**Accidental Dental Injury**
Accidental Dental Injury means a dental injury caused by a sudden and unforeseen event at a specific time and place. It does not include injuries caused by biting or chewing.

**Accidental Injury**
Physical harm caused by a sudden and unforeseen event at a specific time and place. It is independent of Illness, except for infection of a cut or wound. It does not include Services provided as a result of over-exertion or muscle strains.

**Ambulatory Surgical Facility**
An Ambulatory Surgical Facility means any licensed public or private establishment that has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery. It does not provide Services or accommodations for patients to stay overnight.

**Annual Group Enrollment**
Annual Group Enrollment means a period of at least 30 days each Contract Year, agreed to by Us and the Employer, during which Eligible Employees are given the opportunity to enroll themselves and/or their Eligible Family Dependents in the Plan for the upcoming Contract Year, subject to the terms and provisions found under Who Is Eligible for Coverage.

There will be an Annual Group Enrollment Period

each Contract Year. The Effective Date of Coverage for new Members who enroll during the Annual Group Enrollment Period is the beginning of the Contract Year for which they enroll.

**Benefit Booklet**
Benefit Booklet describes the benefits, limitations, exclusions, eligibility and other coverage provisions included in this Plan and is part of the Master Group Contract (Contract).

**Benefit Exclusion Period**
Benefit Exclusion Period means a period during which specified treatment or Services are excluded from coverage.

**Benefit Maximum Limit**
Benefit Maximum Limit means the maximum amount of benefits paid by LifeWise for certain Covered Services. Benefit Maximum Limit amounts are listed on the Summary of Benefits.

**Calendar Year**
Calendar Year means a period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on the next December 31 at midnight. Deductibles, Coinsurance Maximums and some benefit maximums are applied on a per Calendar Year basis.

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

Covered Services do not include Services for:

- Addiction to tobacco or tobacco products; and
- Foods.

**Chemical Dependency Center**
Chemical Dependency Center means any facility for the treatment of Chemical Dependency, which is duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license.

**Coinsurance**
Coinsurance means the percentage of the Covered Service that You or LifeWise is responsible to pay.

**Coinsurance Maximum**
Please refer to Coinsurance Maximum included under Important Plan Information.

**Contract Year**
Contract Year means a one-year time period starting from the effective date of the Contract.

**Copayment**
Copayment means the dollar amount or percentage of the Covered Service that You are responsible for paying to a health care provider for a Covered Service.

**Cosmetic Service**
Cosmetic Service means Services performed to reshape normal structures of the body in order to improve Your appearance and self-esteem and not primarily to restore an impaired function of the body.

**Covered Service**
Covered Service means a Medically Necessary Service that is provided to You when You are covered for that benefit under this Plan on a Maximum Allowable Amount basis, up to any benefit maximums and as shown on the Summary of Benefits. A Member must be eligible to receive a Covered Service in order for the Plan to pay for any claim for a Covered Service.

**Creditable Coverage**
Creditable Coverage means prior or ongoing health care coverage as defined in 42 U.S.C. 300gg, as amended and in effect on July 1, 1997. Creditable Coverage includes any group health care coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual health care coverage (including student health plans), Medicare, Medicaid, CHAMPUS, Indian Health Service or tribal organization coverage, state high-risk pool coverage, or a public health plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan as defined in 42 U.S.C. 300gg, in effect on July 1, 1997 and as amended.

**Custodial Care**
Any portion of a Service which, in Our judgment, is provided primarily:

- For ongoing maintenance of the Member's health and not for its therapeutic value in the treatment of an Illness or Accidental Injury.
- To assist the Member in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel.

**Deductible**
Please refer to Deductible under Important Plan Information.

**Domestic Partner**
Domestic Partner means a person who is not a registered domestic partner as defined by Oregon statute and does not qualify as a Legally Recognized Spouse, is at least 18 years of age and who:

- Shares a close personal relationship with the Eligible Employee such that each is responsible for the other's welfare;
- Is the Eligible Employee's sole Domestic Partner;
- Is not married to any person and has not had another Domestic Partner within the prior six months;
- Is not related by blood to the eligible Employee as a first cousin or nearer;
- Shares with the Eligible Employee the same regular and permanent residence, with the current intention of doing so indefinitely;
- Is jointly financially responsible with the eligible Employee for basic living expenses such as food and shelter;
- Is mentally competent to consent to contract when the domestic partnership began; and
- Has provided the Employer/Group any documentation required to establish that a domestic partnership exists.

**Durational Limit**
Durational Limit means the total amount of days or visits allowed for certain benefits and/or the specific time period in which benefits are allowed. Durational Limits are listed in the Summary of Benefits.

**Effective Date of Coverage**
Effective Date of Coverage means the date when Your coverage begins under this Contract. If You re-enroll in this Plan after a lapse in coverage, the date that the coverage begins again will be Your Effective Date of Coverage.

**Eligibility Waiting Period**
Eligibility Waiting Period means the length of time that must pass before an Eligible Employee or dependent is eligible to be covered under a group's health care plan. If an Eligible Employee or dependent enrolls under the "Special Enrollment" provisions of this program or enrolls on a date other than when first eligible to enroll, any period prior to such enrollment is not considered an Eligibility Waiting Period, unless all or part of the initial Eligibility Waiting Period had not been met.

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

**Emergency Medical Screening Exam**
Emergency Medical Screening Exam means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

**Emergency Services**
Emergency Services means those health care items and Services furnished in an emergency department and all ancillary Services routinely available to an emergency department to the extent they are required for the stabilization of a patient.

**Employer/Group**
Employer/Group means the sponsor of this Plan, or any related entity described in the Employer/Group Agreement. To be covered by this Plan, an individual employer must meet the definition of Eligible Employee.

**Endorsement**
Any Endorsement attached hereto and made a part of the Contract that operates to change and supersede any of the terms or conditions set forth in the printed Contract.

**Enrollment Date**
Enrollment Date means the first day of coverage or, if there is an Eligibility Waiting Period, the first day of the Eligibility Waiting Period.

**Experimental/Investigational Procedures**
Experimental/Investigational Procedures mean any services, including a treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply which, as determined by LifeWise, meets one or more or the following criteria:

- A drug or device which cannot be lawfully marketed without the approval of the United States Food and Drug Administration, has not been granted such approval on the date it is furnished;
- The Service is subject to oversight by an Institutional Review Board;
- No Reliable evidence demonstrates that the Service is effective, in clinical diagnosis, evaluation, management or treatment of the condition.
- Reliable evidence shows that the service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy; and
- Evaluation of reliable evidence indicates that additional research is necessary before the Service can be classified as equally or more effective than conventional therapies.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature, scientific results of the provider of care's written protocols, or scientific data from another provider studying the same service.

**Health Benefit Plan**
Health Benefit Plan means any Hospital expense, medical expense or Hospital and medical Contract or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer Welfare arrangement or by any other benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

**Home Medical Equipment**
Home Medical Equipment means mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an Illness or Accidental Injury. It is of no use in the absence of Illness or Accidental Injury.

**Hospital**
Hospital means a medical institution operated in accordance with the laws of the jurisdiction in which the Hospital is located and licensed as a general Hospital. This includes state hospitals (and state approved programs).

The Hospital must, for compensation from its patients and on an inpatient basis, be primarily engaged in providing diagnostic and therapeutic facilities (on the premises or in facilities available to the Hospital on a prearranged basis) for surgical and medical diagnosis, and treatment of injured and sick persons. The service must be provided by or under the supervision of a staff of Physicians, and the institution must continuously provide 24-hour a day nursing service by registered graduate Nurses.

In no event will a "Hospital" be an institution that is run mainly:

- As a rest, nursing, or convalescent home; residential treatment center; or health resort.
- To provide hospice care for terminally ill patients.
- For the care of the elderly.
- For the treatment of chemical dependency or tuberculosis.

**Illness**
Illness means sickness, disease, medical condition, complication of pregnancy, or pregnancy. Any alteration in the body or any of its organs or parts that interrupts or disturbs the performance of vital functions, thereby causing or threatening pain or weakness.

**Legally Recognized Spouse (Spouse)**
A Legally Recognized Spouse means:

- An individual who is married to the Eligible Employee, or
- An individual who is a registered domestic partner of the Eligible Employee as defined by Oregon statute.

**Lifetime Maximum Benefit**
Lifetime Maximum Benefit means the total benefits paid for each Member enrolled under this Contract. All benefits paid accumulate towards Your Lifetime Maximum Benefit unless otherwise stated in this Contract. The Lifetime Maximum Benefit per Member is shown on the Summary of Benefits.

**LifeWise Health Plan Of Oregon**
LifeWise Health Plan of Oregon (LifeWise) is the organization providing benefits for health care Services.

**Master Group Contract**
The Master Group Contract (Contract) consists of the Employer/Group Agreement, Employer Provisions, Benefit Booklet(s), any applicable Endorsements and Underwriting Agreements and is also referred to as Plan.

**Maximum Allowable Amount**
Please refer to the Maximum Allowable Amount Disclosure Notice included in Your Benefit Booklet.

**Medically Necessary**
Those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

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

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

**Member**
Any Eligible Employee or Eligible Family Dependent (also referred to as "You" and "Your") who is properly enrolled in this Plan and is entitled to Services under this Contract. For the purpose of ORS 743.730(13) the term "Member" satisfies the definition of "enrollee".

**Mental or Nervous Conditions**
Mental or Nervous Conditions means all disorders listed in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition, diagnostic codes; and the following V codes: V61.20 (Parent-child relational problems), Diagnostic V61.21 (neglect, physical abuse or sexual abuse of a child) and V62.82 (bereavement) for children age 5 and younger.

Mental or Nervous Conditions do not include:

- Mental Retardation (Diagnostic codes 317, 318.0, 318.1, 318.2, 319);
- Learning Disorders (Diagnostic codes 315.00, 315.1, 315.2, 315.9);
- Paraphilias (Diagnostic codes 302.4, 302.81, 302.89, 302.2, 302.83, 302.84, 302.82, 302.9);
- Gender identity disorders in adults age 19 or older (Diagnostic codes 302.85, 302.6, 302.9);
- V codes V15.81 through V71.09; except V codes V61.20, V61.21 and V62.82 are included as listed above for children age 5 and younger.

**Non-Preferred Provider**
Non-Preferred Provider means a health care provider who has not entered into a contract with LifeWise at the time Covered Services are incurred.

**Off Label Drug Use**
Off Label Use means the prescribed use of a drug which is other than stated in its FDA approved labeling. Off Label Use includes the administration of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by one of the following standard reference compendia:

- The American Hospital Formulary Service-Drug Information;
- The American Medical Association Drug Evaluation;
- The United States Pharmacopoeia-Drug Information; or
- Other authoritative compendia as identified from time to time by the Federal Secretary of health and Human Services or the Insurance Commissioner.
- If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts; or
- The Federal Secretary of Health and Human Services.

**Orthotic**
Orthotic means a support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore or improve function.

**Out-of-Area Member**
An Out-of-Area Member means a Member who does not reside in the Service Area.

**Out-of-Pocket Limit**
Please refer to Out-of-Pocket Limit included under Important Plan Information.

**Pervasive Developmental Disorder**
Pervasive Developmental Disorder means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability or mental retardation.

**Plan**
The benefits, terms, and limitations set forth in this Contract.

**Portability Plans**
Portability Plans are those plans available to a Member whose coverage under this Plan has terminated and as described within the Portability Plans section.

**Pre-Existing Condition**
Pre-Existing Condition means any medical condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the Effective Date of Coverage (or actual enrollment in the Plan if earlier) of the Member. The following conditions are not considered a Pre-Existing Condition:

- Pregnancy;
- Genetic information in the absence of a diagnosis of the condition related to such information; and
- Newborn or an adopted child who obtains coverage under this Plan as described in the Eligibility and Enrollment section of Contract and in compliance with ORS 743.707.

**Preferred Provider**
Preferred Provider means a facility or health care provider or a network of affiliated facilities or providers that have a written contract with LifeWise. Please refer to Your Summary of Benefits for Covered Services and the benefits available from Preferred Providers.

**Premium**
The monthly rates set by Us as consideration for the benefits offered in this Plan.

**Prescription Drug**
Prescription Drugs means any medicinal substance, including biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to

bear the legend: "Caution: Federal law prohibits dispensing without a prescription."

**Prior Authorization**
Prior Authorization means:

- In advance of a proposed Service or supply (including medications) that You or Your Qualified Practitioner request prior approval of coverage from Us, and
- The proposed Services or supply (including medications) is given approval of coverage by Us.

We will determine if a proposed Service of supply (including medications) is Medically Necessary and is an eligible Covered Service before We authorize the Service.

**Qualified Practitioner**
Qualified Practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat an Accidental Injury or Illness and who provides Covered Services within the scope of that license. Not all Qualified Practitioners or the Services that they provide are a Covered Service. Please refer to the Benefits and Limitations and Exclusions section of the Contract for additional information.

**Qualified Treatment Facility**
Qualified Treatment Facility means only a facility, institution, or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license.

**Reconstructive Surgery**
Reconstructive Surgery is surgery

- Which restores features damaged as a result of Accidental Injury or Illness; or
- To correct a congenital deformity or anomaly.

**Service Area**
Service Area means the geographic area as specified in the Employer/Group Agreement.

**Services**
Services mean procedures, surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices or technologies.

**Skilled Care**
Care that is ordered by a physician and, in Our judgment requires the medical knowledge and technical training of a licensed registered nurse.

**Skilled Nursing Facility**
A medical facility providing Services that require the direction of a physician and nursing supervised by a registered nurse, and that is approved by Medicare or would qualify for Medicare approval if so requested.

**Sound Natural Tooth**
Sound Natural Tooth means a tooth that:

- Is organic and formed by the natural development of the body (not manufactured);
- Has not been extensively restored;
- Has not become extensively decayed or involved in periodontal disease; and
- Is not more susceptible to injury than a whole natural tooth.

**Supplemental Benefit**
Any Supplemental Benefit attached hereto and made a part of the Contract that operates to change and supersede any of the terms or conditions set forth in the printed Contract.

**Urgent Care**
Urgent Care means Services which are provided at a medical facility open to the general public, on an extended hour basis, for the primary purpose of treating unscheduled, drop-in patients presenting unforeseen, non-life threatening, minor illnesses and injuries which require immediate attention (such as high fevers, ear, nose and throat infections, minor sprains and lacerations).

**We, Us And Our**
We, Us and Our means LifeWise Health Plan of Oregon.

**You And Your**
You and Your means any Member enrolled in this Plan.

# where to send claims

**CUSTOMER SERVICE:**

800-596-3440

**MAIL YOUR CLAIMS TO:**

LifeWise
P.O. Box 7709
Bend, OR 97708-7709

www.lifewiseor.com

LifeWise

## Discrimination is Against the Law

LifeWise Health Plan of Oregon complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. LifeWise does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

LifeWise:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that LifeWise has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-6396, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentInquiries@LifeWiseHealth.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

## Getting Help in Other Languages

**This Notice has Important Information.** This notice may have important information about your application or coverage through LifeWise Health Plan of Oregon. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-596-3440 (TTY: 800-842-5357).

**አማሪኛ (Amharic):**
ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ LifeWise Health Plan of Oregon ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በእከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያነኙ እና ያለምንም ከፍያ በቋንቋዎ እርዳታ እንዲያነኙ ሙበት አለዎት።በስልክ ቁጥር 800-596-3440 (TTY: 800-842-5357) ይደውሉ።

**العربية (Arabic):**
**يحوي هذا الإشعار معلومات هامة.** قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال LifeWise Health Plan of Oregon. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ800-596-3440 (TTY: 800-842-5357)

**中文 (Chinese):**
**本通知有重要的訊息。**本通知可能有關於您透過 LifeWise Health Plan of Oregon 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-596-3440 (TTY: 800-842-5357)。

**Oromoo (Cushite):**
**Beeksisni kun odeeffannoo barbaachisaa qaba.** Beeksisti kun sagantaa yookan karaa LifeWise Health Plan of Oregon tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-596-3440 (TTY: 800-842-5357) tii bilbilaa.

**Français (French):**
**Cet avis a d'importantes informations.** Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de LifeWise Health Plan of Oregon. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-596-3440 (TTY: 800-842-5357).

**Kreyòl ayisyen (Creole):**
**Avi sila a gen Enfòmasyon Enpòtan ladann**. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè LifeWise Health Plan of Oregon. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-596-3440 (TTY: 800-842-5357).

**Deutsche (German):**
**Diese Benachrichtigung enthält wichtige Informationen.** Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch LifeWise Health Plan of Oregon. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-596-3440 (TTY: 800-842-5357).

**Hmoob (Hmong):**
**Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb.** Tej zaum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm LifeWise Health Plan of Oregon. Tej zaum muaj cov hnub tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-596-3440 (TTY: 800-842-5357).

**Iloko (Ilocano):**
**Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion.** Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti apliksayonyo wenno coverage babaen iti LifeWise Health Plan of Oregon. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-596-3440 (TTY: 800-842-5357).

**Italiano (Italian):**
**Questo avviso contiene informazioni importanti.** Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso LifeWise Health Plan of Oregon. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-596-3440 (TTY: 800-842-5357).

**日本語 (Japanese):**
**この通知には重要な情報が含まれています。**この通知には、LifeWise Health Plan of Oregon の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-596-3440 (TTY: 800-842-5357)までお電話ください。

**한국어 (Korean):**
**본 통지서에는 중요한 정보가 들어 있습니다.** 즉 이 통지서는 귀하의 신청에 관하여 그리고 LifeWise Health Plan of Oregon 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-596-3440 (TTY: 800-842-5357) 로 전화하십시오.

**ລາວ (Lao):**
**ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ**. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ LifeWise Health Plan of Oregon. ອາດຈະມີວັນທີສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-596-3440 (TTY: 800-842-5357).

**ភាសាខ្មែរ (Khmer):**
**សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។** សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ LifeWise Health Plan of Oregon ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព ដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការជានាវ៉ាប់រងសុខភាពរបស់អ្នក ឬជ្រាក់ជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-596-3440 (TTY: 800-842-5357)។

**ਪੰਜਾਬੀ (Punjabi):**
**ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ.** ਇਸ ਨੋਟਿਸ ਵਿਚ LifeWise Health Plan of Oregon ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ਼ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-596-3440 (TTY: 800-842-5357).

**فارسی (Farsi):**
این اعلامیه حاوی اطلاعات مهم میباشد .این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق LifeWise Health Plan of Oregon باشد. به تاریخ های مهم در این اعلامیه توجه نمایید .شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید .شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-596-3440 (کاربران TTY تماس باشماره 800-842-5357) تماس برقرار نمایید.

**Polskie (Polish):**
**To ogłoszenie może zawierać ważne informacje.** To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez LifeWise Health Plan of Oregon. Prosimy zwrócic uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-596-3440 (TTY: 800-842-5357).

**Português (Portuguese):**
**Este aviso contém informações importantes.** Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do LifeWise Health Plan of Oregon. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-596-3440 (TTY: 800-842-5357).

**Română (Romanian):**
**Prezenta notificare conține informații importante.** Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin LifeWise Health Plan of Oregon. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-596-3440 (TTY: 800-842-5357).

**Русский (Russian):**
**Настоящее уведомление содержит важную информацию.** Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через LifeWise Health Plan of Oregon. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-596-3440 (TTY: 800-842-5357).

**Fa'asamoa (Samoan):**
**Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai.** O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, LifeWise Health Plan of Oregon, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'matalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-596-3440 (TTY: 800-842-5357).

**Español (Spanish):**
**Este Aviso contiene información importante.** Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de LifeWise Health Plan of Oregon. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-596-3440 (TTY: 800-842-5357).

**Tagalog (Tagalog):**
**Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon.** Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng LifeWise Health Plan of Oregon. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-596-3440 (TTY: 800-842-5357).

**ไทย (Thai):**
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน LifeWise Health Plan of Oregon และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-596-3440 (TTY: 800-842-5357)

**Український (Ukrainian):**
**Це повідомлення містить важливу інформацію.** Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через LifeWise Health Plan of Oregon. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-596-3440 (TTY: 800-842-5357).

**Tiếng Việt (Vietnamese):**
**Thông báo này cung cấp thông tin quan trọng.** Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình LifeWise Health Plan of Oregon. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-596-3440 (TTY: 800-842-5357).