East West Fusion LLC

Frontline 5500

1036949
HOW TO CONTACT US

Please call or write Our Customer Service staff for help with the following:

- Questions about the benefits of Your Plan;
- Questions about Your Claims;
- Questions or complaints about care or Services You receive; and
- Change of address or other personal information.

<table>
<thead>
<tr>
<th>Customer Service - 1-800-596-3440</th>
</tr>
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<tbody>
<tr>
<td><strong>Mailing Address</strong></td>
</tr>
<tr>
<td>Bend</td>
</tr>
<tr>
<td>LifeWise Health Plan of Oregon</td>
</tr>
<tr>
<td>P O Box 7709</td>
</tr>
<tr>
<td>Bend, OR 97708-7709</td>
</tr>
<tr>
<td>Portland</td>
</tr>
<tr>
<td>LifeWise Health Plan of Oregon</td>
</tr>
<tr>
<td>2020 SW Fourth Avenue, Suite 1000</td>
</tr>
<tr>
<td>Portland, OR 97201</td>
</tr>
</tbody>
</table>

You'll find answers to most of Your questions about Your Plan in this benefit booklet. You can also explore Our Web site at www.lifewiseor.com anytime You want to:

- Learn more about how to use Your Plan;
- Locate a health care provider near You;
- Gain knowledge about diseases, illnesses, medications, treatment, nutrition, fitness and many other health topics.
- You can also call Our Customer Service staff at the numbers listed above. We are happy to answer Your questions and appreciate any comments You want to share.

**Employer/Group Name**          East West Fusion LLC
**Effective Date**               January 1, 2016
**Employer/Group Number**        1036949
**Plan**                         Frontline 5500
**INTRODUCTION**

This Benefit Booklet is for Members enrolled in this Plan. This Benefit Booklet describes the benefits of Your Plan and replaces any other Benefit Booklet You may have received.

The benefits, limitations, exclusions and other coverage provisions described on the following pages are subject to the terms and conditions of the Master Group Contract (Contract) We have issued to the Employer/Group. The Employer/Group is the firm, corporation or partnership that contracts with Us. This Benefit Booklet is a part of the complete Contract, which is on file in the Employer/Group’s office.

This Plan will comply with the 2010 federal health care reform law, called the Affordable Care Act of 2010 (see “Definition”). 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 them even if they are not stated in this Benefit Booklet or if they conflict with statements made in this booklet.

**Translation Services**

LifeWise has an additional service available to assist any of Our non-English speaking Members. We have the assistance of the language translation services. If You require translation services, please contact Us at the number listed in the front of this Benefit Booklet and ask for an interpreter. The Customer Services area will be able to guide You through the service.

**HOW TO USE THIS BENEFIT BOOKLET**

We realize that using a health-care plan can seem complicated, so We have prepared this Benefit Booklet to help You understand how to get the most out of Your benefits. Please familiarize Yourself with the Table of Contents, which lists sections that answer many frequently asked questions.

Each section in this Benefit Booklet contains important information as outlined below:

- **How To Contact Us** – Our Web site address, phone numbers, mailing addresses and other contact information conveniently located inside the front cover.
- **Summary of Covered Services** – Lists Lifetime Maximum Benefit Limit, Deductible amounts, Benefit Exclusion Periods and Copayment/Coinsurance amounts You must pay for Covered Services.
- **Maximum Allowable Amount Disclosure Notice** – Describes how We determine the Maximum Allowable Amount for Covered Services.
- **Important Plan Information** – Describes Deductibles, Out-of-Pocket Limits, Pre-Existing Condition Provisions, and Benefit Exclusions and provides details about how these provisions apply to Your Plan.
- **How To Reduce Your Costs With LifeWise Preferred Providers** - Describes how the providers You receive Services from affect Your Plan benefits and how to reduce Your out-of-pocket costs.
- **How To Obtain Services** – Provides Emergency Services and Continuity of Care information.
- **What Are My Benefits** – Describes what is covered under Your Plan.
- **What Is Not Covered** – Lists Services that are limited or not covered by Your Plan.
- **How To File A Claim** – Provides instructions to submit a claim.
- **Your Ideas, Questions, Complaints And Appeals** – Describes Our complaint and appeal processes.
- **What If I Have Other Coverage** – Describes how benefits are paid when You have other health coverage in addition to this Plan.
- **Third Party Liability (Subrogation)** – Describes what You must do when a third party is responsible for an injury or illness.
- **Who Is Eligible For Coverage** – Describes the eligibility requirements for Your Plan.
- **When My Coverage Ends** – Describes when coverage terminates.
- **My Rights Under COBRA** – Includes a brief Summary of Your COBRA rights.
- **How To Continue Coverage** - Describes how You can continue coverage after Your group coverage terminates.
- **Portability Plans** – Provides information about Oregon Portability plans.
- **Plan Notices And Disclosures** - Lists required state and federal notices and disclosures.
- **My Rights Under ERISA** - Includes a brief Summary of rights under ERISA.
- **General Information About My Plan** – Lists general information about how Your Plan is administered.
- **Definition Of Terms** – Lists the terms that have specific meanings under this Plan. Example: The terms You and Your refer to Members enrolled under this Plan. The terms We, Us and Our refer to LifeWise Health Plan of Oregon.
SMALL GROUP NON-GRANDFATHERED
TRANSITIONAL/GRANDMOTHERED PLANS
DIALYSIS ENDORSEMENT

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 basis. No term, condition or limitation of the Contract is changed or altered except as expressly provided herein.

This Endorsement makes important changes to Your Plan. The revisions described in this Endorsement are required and apply to this Plan upon your Employer/Group’s renewal.

In the 2015 Small Group Non-Grandfathered Extension Plans Omnibus Endorsement, a Dialysis Services benefit was added. That benefit is revised to:

**Dialysis Services**
This plan covers dialysis Services You get in an office visit, at a facility or at home. Benefits are provided for professional Services, facility charges, and any supplies, drugs or solutions used for dialysis.

If You receive dialysis Services due to a diagnosis of end stage renal disease. You may be eligible to enroll in Medicare. If You enroll in Medicare, this Plan will coordinate benefits per Medicare rules. Generally, this Plan will be the primary payer for 30 months, and Medicare will be the primary payer after 30 months.

For information about Medicare enrollment, contact Medicare at 1-800-MEDICARE or log onto their website at [www.medicare.gov].

In the 2015 Small Group Non-Grandfathered Extension Plans Omnibus Endorsement, the Maximum Allowable Amount Disclosure Notice was revised. This provision is now revised to:

**MAXIMUM ALLOWABLE AMOUNT**
This Plan provides benefits based on the Maximum Allowable Amount for Covered Services. The Maximum Allowable Amount is described below.

**Non-Emergency Services**
**Preferred Providers**
The Maximum Allowable Amount is the fee that LifeWise has negotiated with its Preferred Providers for Covered Services.

**Non-Preferred Providers**
The Maximum Allowable Amount is the lesser of the following:
- The provider’s billed charge
- No less than 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (CMS). LifeWise will use the fee schedules from CMS in setting the allowed amount.

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 allowed amount will be the lesser of the amount that CMS would reimburse for similar Services or the non-preferred provider’s billed charges.
SMALL GROUP NON-GRANDFATHERED TRANSITIONAL/GRANDMOTHERED PLANS

OMNIBUS ENDORSEMENT

EFFECTIVE JANUARY 1, 2016

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 basis. No term, condition or limitation of the Contract is changed or altered except as expressly provided herein.

This Endorsement makes changes to Your Plan to comply with new laws. If Congress, federal regulators, or the courts make further changes or clarifications regarding the requirements of the new laws, this Plan will comply with those requirements even if they are not specifically stated in Your Benefit Booklet or all Endorsements.

PRE-EXISTING CONDITION

The Pre-Existing Condition Provision listed in the Important Plan Information and Definitions sections of the Benefit Booklet and any references to a Pre-Existing Condition Provision are removed.

OUTPATIENT PRESCRIPTION DRUGS

Certain prescription drugs may be provided for up to a 90-day supply when dispensing and coverage requirements are met. Additionally, some contraceptives may be allowed up to a 12-month supply.

The Summary of Covered Services is amended to indicate that certain retail prescription drugs are allowed up to a 90-day supply of covered medication when requirements have been met and some contraceptives may be allowed up to a 12-month supply. Additionally, you will pay one copayment for each 30-day supply dispensed at a retail pharmacy.
SMALL GROUP NON-GRANDFATHERED EXTENSION PLANS
OMNIBUS ENDORSEMENT

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 basis. No term, condition or limitation of the Contract is changed or altered except as expressly provided herein.

This Endorsement makes changes to Your Plan to comply with new laws. If Congress, federal regulators, or the courts make further changes or clarifications regarding the requirements of the new laws, this Plan will comply with those requirements even if they are not specifically stated in Your Benefit Booklet or all Endorsements.

Please Note: The titles, shown in bold, represent the provision included in Your Benefit Booklet.

The Summary of Services is revised to include diabetic supplies for pregnant women and colon health screenings with no cost share when Services are received from a Preferred Provider.

<table>
<thead>
<tr>
<th>SUMMARY OF SERVICES</th>
<th>BENEFITS FOR COVERED SERVICES RECEIVED FROM PREFERRED PROVIDERS</th>
<th>BENEFITS FOR COVERED SERVICES RECEIVED FROM NON-PREFERRED PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/Provider Services</td>
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<tr>
<td>Preventive Care Preventive Services are covered as designated in the federal guidelines. Please refer to What Are My Benefits for details. Services include:</td>
<td></td>
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<tr>
<td>• Wellness Exams</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td>• Immunizations (including seasonal immunizations provided by Your attending physician)</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td>• Seasonal Immunizations and certain other immunizations provided at a pharmacy or other seasonal immunization center</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>• Diabetic supplies for pregnant women</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>• Colon Health Screenings</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
</tbody>
</table>

The Summary of Services is revised for Air Ambulance. The Benefit Maximum Limit of $3,000 per Calendar Year has been removed.
<table>
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<tr>
<th>SUMMARY OF SERVICES</th>
<th>BENEFITS FOR COVERED SERVICES RECEIVED FROM PREFERRED PROVIDERS</th>
<th>BENEFITS FOR COVERED SERVICES RECEIVED FROM NON-PREFERRED PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Covered Services</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
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</tbody>
</table>

Emergency Medical Transportation – Ambulance
- Ground Ambulance
- Air ambulance

In the What Are My Benefits section under the Preventive Services section, the following is added to the Covered Services section:
- Diabetic Supplies for Pregnant Women from conception to six weeks postpartum;
- Colon Health Screenings includes exams, colonoscopy, sigmoidoscopy, double contrast barium enemas, removal of polyps in the colon and fecal occult blood tests

The Maximum Allowable Amount Disclosure notice included in Your Benefit Booklet is revised to:

**MAXIMUM ALLOWABLE AMOUNT**

This Plan provides benefits based on the Maximum Allowable Amount for Covered Services. The Maximum Allowable Amount is described below.

**Non-Emergency Services**

**Preferred Providers**

The Maximum Allowable Amount is the fee that LifeWise has negotiated with its Preferred Providers for Covered Services.

**Non-Preferred Providers**

The Maximum Allowable Amount is the lesser of the following:
- The provider’s billed charge
- No less than 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (CMS). LifeWise will use fee schedules from CMS in setting the allowed amount.
- For dialysis and related Services due to End-Stage Renal Disease, the Maximum Allowable Amount will not be less than a comparable provider that has a contracting agreement with Us and no more than 90% of billed charges. If You are entitled/eligible for Medicare due to ESRD, the Maximum Allowable Amount is 100% of the fee schedule determined by the Centers of Medicare and Medicaid Services (Medicare).

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.

**Emergency Services**

Consistent with the requirements of the Affordable Care Act (federal health care reform) the Maximum Allowable Amount will be the greater of the following:
- The median amount in-network providers have agreed to accept for the same Services
- The amount Medicare would allow for the same Services
- The amount calculated by the same method the Plan uses to determine payment to Out-of-Network Providers

In addition to Your deductible, Copayments and Coinsurance, You will be responsible for charges received from Out-of-Network Providers above the allowed amount.
If you have questions about this information, please call us at the number listed on your LifeWise ID card.

In the **How To Obtain Services** section, the **Prior Authorization, Utilization Review, Case Management and Disease Management** provision has been removed and is replaced. Also, in this same section, the **Benefit Advisory** provision has been removed.

**SERVICES THAT REQUIRE PRIOR AUTHORIZATION**

Your coverage for some Services depends on whether the Service is approved by Us before you receive it. This process is called Prior Authorization.

A planned Service is reviewed to make sure it is medically necessary and eligible for coverage under this Plan. We will let you know in writing if the Service is authorized. We will also let you know if the Service is not authorized and the reasons why. If you disagree with the decision, you can request an appeal.

See the **Your Ideas, Questions, Complaints and Appeals** section or call us.

There are three situations where Prior Authorization is required:

- Before you receive certain medical Services or Prescription Drugs
- Before you schedule a planned admission to certain Inpatient facilities
- When you want to receive the higher benefit level for Services you received from a Preferred Provider

**How to Ask for Prior Authorization**

This Plan has a specific list of Services that must have Prior Authorization with any provider. Before you receive Services, we suggest that you review the list of Services requiring Prior Authorization. You can get a detailed list of medical Services requiring Prior Authorization by calling Customer Service at the number on the back of your ID card or on our website at www.lifewiseor.com.

**Services From Preferred Providers:** It is your Preferred Provider’s responsibility to get Prior Authorization. Your Preferred Provider can call us at the number listed on your ID card to request a Prior Authorization.

**Services From Non-Preferred Providers:** It is your responsibility to get Prior Authorization for any of the Services on the Prior Authorization list when you see a Non-Preferred Provider. You or your Non-Preferred Provider can call us at the number listed on your ID card to request a Prior Authorization.

**Responding to Prior Authorizations**

We will respond to a request for Prior Authorization within 2 business days of receipt of all information necessary to make a decision. If your situation is clinically urgent (meaning that your life or health would be put in serious jeopardy if you did not receive treatment right away), you may request an expedited review. Expedited reviews are responded to as soon as possible, but no later than 48 hours after we get all information necessary to make a decision. We will provide our decision in writing.

The Prior Authorization will be binding to us when related to eligibility and obtained no more than five business days before the date of Service. Our Prior Authorization will be valid for 30 calendar days for benefit coverage and Medical Necessity determinations. This 30-day period is subject to your continued coverage under the Plan. If you do not receive the Services within that time, you will have to ask us for another Prior Authorization.

**Services that must be Prior Authorized**

The following are types of Services that require Prior Authorization. You can see the detailed list on our website www.lifewiseor.com or you can call Customer Service.

**The following types of Services require Prior Authorization:**

- Planned Inpatient admission into Hospitals, Skilled Nursing Facilities, and rehabilitation facilities
- Non-emergency ground, air, or ambulance transport
- Transplant and donor Services
- Injectable medications You get in a healthcare provider’s office
- Prosthetics and Orthotics other than foot Orthotics or orthopedic shoes
- Reconstructive surgery
- Home Medical Equipment (HME) costing $500 or more
- Selected surgical, medical therapeutic, and diagnostic procedures
- Outpatient advanced imaging, such as MRI, CT and echocardiograms
- Some Outpatient Services. See the detailed list on Our website at www.lifewiseor.com
- Certain Prescription Drugs. See the Pharmacy section on Our website at www.lifewiseor.com
- Pediatric Orthodontia

In the What Are My Benefits section under the Other Covered Services section, the Outpatient Chemotherapy / Infusion Therapy benefit has been revised to include prescribed oral anti-cancer medications used for off-label use. The Outpatient Prescription Drug section has also been revised.

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, including prescribed oral anti-cancer medications used for off-label use. 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.

The Outpatient Prescription Drugs benefit has been revised to exclude prescribed oral anti-cancer medication.

- Off-label use of FDA-approved drugs. Off-Label oral chemotherapy Prescription Drugs are not covered under this benefit. See Outpatient Chemotherapy / Infusion Therapy.

In the What Are My Benefits section under the Other Covered Services section, the following is added:

Dialysis Services

This Plan covers dialysis Services You get in an office visit or at a facility. Benefits are provided for professional Services; facility charges; and any supplies, drugs, solutions used for dialysis.

When You have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or kidney transplant) You may be eligible for Medicare. If eligible, it is important to enroll in Medicare as soon as possible. If You are enrolled in Medicare, this Plan will pay first on Your dialysis claims for the first 30 months and Medicare will pay second. After the 30th month, generally Medicare will pay first and this Plan will pay any remaining Medicare cost shares.

Benefits will continue to be paid at the cost share level applied to other benefits in the same category for Members who are not eligible / entitled for Medicare.

In the What Are My Benefits section under the Other Covered Services section, the following is revised:

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. 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; physical and occupational therapy provided for treatment of a mental condition including autism spectrum disorders, 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. Services also include screening and treatment after a conviction of driving under the influence of intoxicants.

In the What Is Not Covered section the following exclusions in the have been revised:
Cosmetic Services

This Plan does not cover Services and supplies for Cosmetic Services, including but not limited to:

- Services performed to reshape normal structures of the body in order to improve or alter Your appearance and self-esteem and not primarily to restore an impaired function of the body
- Genital surgery for the purpose of changing genital appearance
- Breast mastectomy or augmentation with or without chest reconstruction for the purpose of changing breast appearance

Reconstructive surgery resulting from an Accidental Injury, infection or other Illness may be a Covered Service. Reconstructive breast surgery resulting from a mastectomy or lumpectomy as a result of treatment of cancer may be a Covered Service. Please see the Outpatient Surgery Services and Mastectomy and Breast Reconstruction headings for these Covered Services in the Covered Services section.

Gender Transformations

Gender reassignment surgery Services regardless of age.

Mental Or Nervous Conditions And Chemical Dependency Care Services

- Prescription Drugs. These are covered under Prescription Drug benefit.
- Mental retardation as identified and defined in the current Diagnostic and Statistical Manual (DSM)
- Learning disorders identified and defined in the current DSM
- Noncompliance with treatment; partner relational problem; physical abuse of adult; parent-child relational problem; neglect of child; physical abuse of child, sexual abuse of child, sibling relational problem, relational problem related to a mental disorder or general medical condition; occupational problem; academic problem; acculturation problem; relational problem not otherwise specified; bereavement; physical abuse of adult (if by person other than partner); sexual abuse of adult (if by person other than partner); borderline intellectual functioning; phase of life problem; religious or spiritual problem; malingering; adult antisocial behavior; child or adolescent antisocial behavior; no diagnosis on Axis II; no diagnosis or condition on axis I. The exclusion does not apply to Members age 5 and Younger for Parent child relational problem, Neglect of child, and Bereavement.
- Paraphilias identified and defined in the current DSM
- Institutional care, except that Services are covered when provided for an Illness or injury treated in an acute care Hospital
- Dementia
- Sleep disorders. See Diagnostic Lab, X-ray and Imaging.
- EEG biofeedback or neurofeedback
- Family and marriage counseling or therapy, except when it is Medically Necessary to treat Your mental condition
- Therapeutic or group homes, foster homes, nursing homes boarding homes or schools and child welfare facilities
- Outward bound, wilderness, camping or tall ship programs or activities
- Phone Services, unless they are done in a crisis or when the Member cannot get out of bed for medical reasons. See Telemedicine Services for phone that use real time video or audio.
- Mental health tests that are not used to assess a covered mental condition or plan treatment. This Plan does not cover tests to decide legal competence or for school or job placement.
- Support groups, such as Alanon or Alcoholics Anonymous
- Services that are not Medically Necessary. This is true even if a court orders them or You must get them to avoid being tried, sentenced or losing the right to drive.
- Sober living homes, such as halfway houses
- Addiction to foods
- Caffeine dependence
In the **What Is Not Covered** section, the exclusion for **Electronic Consultations** section has been removed.

The **What If I Have Other Coverage** section under Definitions, the definition of a Plan now includes Individual insurance contracts and subscriber contracts, individual closed panel plans.

For the purposes of Coordination of Benefits (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: individual insurance contracts and subscriber contracts, individual closed panel plans, 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. Group and individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.
  - “Plan” does not 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.

In the **Who Is Eligible For Coverage** section, foster children have been added as an eligible family Dependent. We have replaced the provision with the following:

**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.

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 (including foster children) living permanently in the home of the Eligible Employee
- 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.

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. Proof will not be requested 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.
# TABLE OF CONTENTS

Summary Of Benefits .................................................................................................................................1  
Maximum Allowable Amount Disclosure Notice ....................................................................................10  
Important Plan Information ......................................................................................................................12  
How To Reduce Your Costs With LifeWise Preferred Providers ..........................................................14  
How To Obtain Services ...........................................................................................................................16  
  Prior Authorization, Utilization Review, Case Management And Disease Management ......................18  
What Are My Benefits ...............................................................................................................................19  
  Physician And Provider Services ......................................................................................................19  
  Preventive Services ............................................................................................................................21  
  Men's Routine Prostate Health Screening Exam .................................................................................22  
  Women’s Routine Annual Health Screening Exam .............................................................................22  
  Mastectomy And Breast Reconstruction Services ..............................................................................22  
  Facility Services ..................................................................................................................................22  
  Other Covered Services ......................................................................................................................24  
  Supplemental Benefits ........................................................................................................................28  
What Is Not Covered .................................................................................................................................31  
How To File A Claim .................................................................................................................................37  
Your Ideas, Questions, Complaints And Appeals ...................................................................................38  
What If I Have Other Coverage ..............................................................................................................41  
Third Party Liability .................................................................................................................................43  
Who Is Eligible For Coverage ................................................................................................................45  
When Will My Coverage End ..................................................................................................................49  
My Rights Under COBRA .........................................................................................................................50  
How To Continue Coverage ....................................................................................................................52  
Portability Plans .......................................................................................................................................54  
Plan Notices And Disclosures ...............................................................................................................55  
My Rights Under ERISA ..........................................................................................................................57  
General Information About My Plan .......................................................................................................58  
Definition Of Terms ...............................................................................................................................60
SUMMARY OF BENEFITS

The Summary of Benefits is an outline of Covered Services and the level of benefits available under the Contract. Covered Services are subject to specific conditions, Durational Limits and all applicable maximums of the Contract. Covered Services are subject to the Maximum Allowable Amount. You are responsible for charges in excess of Our Maximum Allowable Amount when You receive Covered Services from a Non-Preferred Provider.

Prior Authorization is required for some Services. Please see the Prior Authorization, Utilization Review, Case Management and Disease Management section of this Benefit Booklet for a list of those Services and the What Are My Benefits section for detailed information.

<table>
<thead>
<tr>
<th>Annual Plan Maximum:</th>
<th>$2,000,000 Per Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organ Transplant Benefit Waiting Period:</td>
<td>12 Months</td>
</tr>
<tr>
<td>Calendar Year Deductibles:</td>
<td></td>
</tr>
<tr>
<td>Preferred Providers</td>
<td></td>
</tr>
<tr>
<td>• Individual</td>
<td>$5,500 Per Member</td>
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<tr>
<td>• Family</td>
<td>$16,500 Per Member</td>
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<td>• Family</td>
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<td>Coinsurance Maximum:</td>
<td></td>
</tr>
<tr>
<td>Preferred Providers</td>
<td>$6,000 Per Member</td>
</tr>
<tr>
<td>Non-preferred Providers</td>
<td>$12,000 Per Member</td>
</tr>
<tr>
<td>This plan does not include a family Coinsurance Maximum</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUMMARY OF SERVICES</th>
<th>BENEFITS FOR COVERED SERVICES RECEIVED FROM PREFERRED PROVIDERS</th>
<th>BENEFITS FOR COVERED SERVICES RECEIVED FROM NON-PREFERRED PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/Provider Services</td>
<td>100% after a $30 Copayment for the first 6 visits during the Calendar Year and does not apply to the Coinsurance Maximum. 50% after the Deductible is satisfied for covered visits in excess of the first 6 Calendar Year Office visit limit, to the Coinsurance Maximum. The $30 Copayment does not apply after first 6 aggregate visits. The Copayment and Deductibles do not apply to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
</tbody>
</table>
| Office Visits | The 6 visit office limit per Calendar Year includes any combination of the following evaluation and management Covered Services:  
  • Home And Office Visits  
  • Consultations  
  • Urgent Care, includes Physician and Facility  
  A separate Copayment or Coinsurance will apply to other Services, including, but not limited to: outpatient lab/x-ray, injections or office surgery. | |
<table>
<thead>
<tr>
<th>SUMMARY OF SERVICES</th>
<th>BENEFITS FOR COVERED SERVICES RECEIVED FROM PREFERRED PROVIDERS</th>
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<tbody>
<tr>
<td>Physician/Provider Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Preventive services are covered as designated in the federal guidelines. Please refer to What Are My Benefits for details. Services include:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wellness Exams</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
</tr>
<tr>
<td></td>
<td>Immunizations (including seasonal immunizations provided by Your attending physician)</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
</tr>
<tr>
<td></td>
<td>Seasonal Immunizations and certain other immunizations provided at a pharmacy or other seasonal immunization center</td>
<td>Not Covered.</td>
</tr>
<tr>
<td>Men's Routine Prostate Health Screening Exam</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Women's Routine Annual Health Screening Exam</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>Prenatal care, delivery and postnatal care provided by Your attending physician.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Allergy Testing &amp; Injections</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Therapeutic Injections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Visits</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
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<td>SUMMARY OF SERVICES</td>
<td>BENEFITS FOR COVERED SERVICES RECEIVED FROM PREFERRED PROVIDERS</td>
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<td>---------------------</td>
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<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Physician/Provider Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are special conditions and limitations regarding these Services. Please refer to What Are My Benefits for details.</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>- Professional Preventive Diagnostic Imaging and Laboratory Services</td>
<td>50% to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>- Other Professional Outpatient Diagnostic Imaging Services</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>- Other Professional Outpatient Diagnostic Laboratory Services</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>- Other Professional high technology Diagnostic Imaging Services</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Office Surgery Services</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Outpatient/Inpatient Surgery Services</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Outpatient/Inpatient Assistant Surgery Services</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Outpatient/Inpatient Anesthesiology Services</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Dialysis, Chemotherapy and Radiation Therapy</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Facility Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Inpatient Facility Services</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Residential treatment programs for Mental or Nervous Conditions are limited to 45 days per Calendar Year.</td>
<td></td>
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</tr>
<tr>
<td>SUMMARY OF SERVICES</td>
<td>BENEFITS FOR COVERED SERVICES RECEIVED FROM PREFERRED PROVIDERS</td>
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</tr>
<tr>
<td>Facility Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility Services</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Hospital Inpatient Rehabilitation Facility Services</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Hospital Outpatient or Ambulatory Surgical Facility Services</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Outpatient IV Therapy Facility Services</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Dialysis Center Facility Services</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td></td>
<td>50% to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td></td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
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</tr>
<tr>
<td></td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td></td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
</tbody>
</table>

There are special conditions and limitations regarding these Services. Please refer to What Are My Benefits for details.

- Outpatient Preventive Diagnostic Imaging and Laboratory Services
- Other Diagnostic Imaging Services
- Other Diagnostic Laboratory Services
- Other high technology Diagnostic Imaging Services
  High technology imaging includes advanced imaging such as CT Scans, Nuclear Cardiology, MRI and MRA, and high technology ultrasounds.
<table>
<thead>
<tr>
<th>SUMMARY OF SERVICES</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Care</td>
<td>$250 Copayment, then 50% after the Deductible is satisfied, per visit to the Coinsurance Maximum. Copayment does not apply to the Coinsurance Maximum.</td>
<td>$250 Copayment, then 50% after the Deductible is satisfied, per visit to the Coinsurance Maximum. Copayment does not apply to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Other Covered Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidental Dental Injury</td>
<td>100% to the Benefit Maximum Limit and does not apply to the Coinsurance Maximum.</td>
<td>100% to the Benefit Maximum Limit and does not apply to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Biofeedback Therapy</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Community Wellness</td>
<td>100% to the Benefit Maximum Limit and does not apply to the Coinsurance Maximum.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td>Contraceptive Management</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Health Education Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diabetes Education and Training</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>• Other Health Education Services</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td>• Please refer to What Are My Benefits for details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Therapy Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diabetic-related Nutritional Therapy</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>• Non-Diabetic Nutritional Therapy</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>SUMMARY OF SERVICES</td>
<td>BENEFITS FOR COVERED SERVICES RECEIVED FROM PREFERRED PROVIDERS</td>
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</tr>
<tr>
<td>---------------------</td>
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</tr>
<tr>
<td>Other Covered Services</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Emergency Medical Transportation – Ambulance • Ground Ambulance • Air ambulance subject to a Benefit Maximum Limit of $3,000 per Calendar Year.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Home Health Care Subject to a Benefit Maximum Limit of 30 visits per Calendar Year.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Medical Foods Limited to Medically Necessary medical foods for supplementation or dietary replacement for the treatment of inborn errors of metabolism.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Medical Supplies/Devices and Home Medical Equipment Shoe inserts and orthopedic shoes are subject to a Benefit Maximum Limit of $200 per Calendar Year. There are special conditions and limitations regarding these Services. Please refer to What Are My Benefits for details. • Supplies and devices include: casts, braces, supportive devices, surgically implanted devices, and non-motorized wheelchairs • Breast pumps (standard electric and rental of hospital grade)</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Prosthetic And Orthotic Devices</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>SUMMARY OF SERVICES</td>
<td>BENEFITS FOR COVERED SERVICES RECEIVED FROM PREFERRED PROVIDERS</td>
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<tr>
<td>---------------------</td>
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</tr>
<tr>
<td>Other Covered Services</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Outpatient Chemotherapy and Infusion Therapy</td>
<td>Includes prescribed oral anti-cancer medications.</td>
<td></td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td>Subject to a Benefit Maximum Limit of 20 visits per Calendar Year.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Outpatient Therapy for the treatment of Mental or Nervous Conditions and Chemical Dependency Care</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Human Organ Transplants</td>
<td>Benefits are provided based on the covered Services received.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td>Tobacco Use Cessation Programs</td>
<td>100% and does not apply to the Coinsurance Maximum.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td>Hearing Exam and Aids</td>
<td>100% to the Benefit Maximum Limit after a $20 Copayment per visit and does not apply to the Coinsurance Maximum.</td>
<td>100% to the Benefit Maximum Limit after a $20 Copayment per visit and does not apply to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Hearing Exam</td>
<td>Subject to a Benefit Maximum Limit of $50 per Calendar Year</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Limited to Members up to age 18 and enrolled dependents up to age 26. Benefits are subject to a $5,000 Benefit Maximum Limit once every 48 months.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
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</tr>
<tr>
<td>Supplemental Benefits</td>
<td>100% after a $30 Copayment per visit and does not apply to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Alternative Health Care Services Subject to a Benefit Maximum Limit of $2,500 per Calendar Year.</td>
<td>100% after a $30 Copayment per visit and does not apply to the Coinsurance Maximum.</td>
<td>50% after the Deductible is satisfied, to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>Routine Vision Care</td>
<td>100% after a $20 Copayment and does not apply to the Coinsurance Maximum.</td>
<td>100% after a $20 Copayment and does not apply to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>• Routine Exams Subject to a Benefit Maximum Limit of one exam per Calendar Year.</td>
<td>100% to the Benefit Maximum Limit and does not apply to the Coinsurance Maximum.</td>
<td>100% to the Benefit Maximum Limit and does not apply to the Coinsurance Maximum.</td>
</tr>
<tr>
<td>• Corrective Vision Hardware Subject to a Benefit Maximum Limit of $200 per Calendar Year.</td>
<td>100% to the Benefit Maximum Limit and does not apply to the Coinsurance Maximum.</td>
<td>100% to the Benefit Maximum Limit and does not apply to the Coinsurance Maximum.</td>
</tr>
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</tr>
<tr>
<td><strong>Supplemental Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Prescription Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail Pharmacy</td>
<td>Generic Limited to a 30-day supply of covered medication. 100% after a $25 Copayment. Copayments and Coinsurance do not apply to the Coinsurance Maximum.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td>Prescriptions-by-Mail</td>
<td>Generic Limited to a 90-day supply of covered medication. 100% after a $62 Copayment. Copayments and Coinsurance do not apply to the medical Coinsurance Maximum.</td>
<td>Not Covered.</td>
</tr>
<tr>
<td>Specialty Pharmacy</td>
<td>Limited to a 30-day supply of covered medication. 100% after a $25 Copayment. Copayments and Coinsurance do not apply to the medical Coinsurance Maximum.</td>
<td>Not Covered.</td>
</tr>
</tbody>
</table>
MAXIMUM ALLOWABLE AMOUNT DISCLOSURE

Your Plan provides benefits based upon the Maximum Allowable Amount for Covered Services. The Maximum Allowable Amount is determined as described below:

**Non-Emergency Services**

**PREFERRED PROVIDERS**

The Maximum Allowable Amount is the fee that LifeWise hasnegotiated with its Preferred Providers for Covered Services.

**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**

- **Professional Providers**
  The allowable charge is derived from LifeWise’s standard fee schedule used for negotiations with contracted physicians. This standard fee schedule is developed using Medicare Relative Value Units (RVUs) multiplied by a conversion factor. For some services, our allowable charge is a percentage of Medicare’s allowable or the Average Wholesale Price. The conversion factor and the percentage of Medicare incorporate information including, but not limited to, trends in Medicare RVUs, geographic differences in provider costs, and overall medical price inflation.

- **Services from Ambulatory Surgical Centers**
  The allowable charge is based on the weighted average of rates that we have negotiated with our contracted ambulatory surgical centers.

- **Services from Hospitals (Acute Facilities)**
  The allowable charge is the equivalent, on a weighted average basis, to similar services received from contracted hospitals. In making this determination, we review claims experience from our contracted hospitals. As charges, services, and patients severities vary from hospital to hospital, we apply a “case mix and severity” adjustment to neutralize these differences, using weights which have been developed for this purpose. These weights are from external independent sources.

- **Services from Skilled Nursing Facilities, Extended Care Facilities, Birthing centers, Kidney Dialysis Centers, Rehabilitation facilities, and others Sub-Acute Facilities**
  The allowable charge is the lesser of our standard fee schedule for contracting facilities of that type, a percentage of the billed charge or on the weighted average of rates we have negotiated contracting providers of the same type.

**For Covered Services Received Outside The Service Area**

The Maximum Allowable Amount will be the lesser of the following:

- The provider’s billed charge; or,
- 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.

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.

**Emergency Services**

Consistent with the requirements of the Affordable Care Act (federal health care reform) the Maximum Allowable Amount will be the greater of the following:

- The median amount Preferred Providers have agreed to accept for the same services;
- The amount Medicare would allow for the same services;
- The amount calculated by the same method the plan uses to determine payment to out of non-preferred
In addition to Your Deductible, Copayments and Coinsurance, You will be responsible for charges received from Non-Preferred Providers in excess of the Maximum Allowable Amount.

If You have questions about this information, please call Us at the number listed on Your LifeWise ID Card.
IMPORTANT PLAN INFORMATION

Deductibles

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. Copayments do not apply to the Individual Deductible as shown on the Summary of Benefits.

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. Copayments do not apply to the Family Deductible as shown on the Summary of Benefits.

This Plan does not include Deductible carryover credit for the following Calendar Year.

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. You will still be required to pay any Copayments required by Your Plan.

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 limit.

Pre-Existing Condition Provision
This Plan has a Pre-Existing Condition Provision for Members age 19 and older and does not provide benefits for Services for any Pre-Existing Condition for a Member age 19 and older until the earlier of the following dates:
- Six months following the Member’s Effective Date Of Coverage; or
- Ten 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
- Is 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 the Service can be 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 the 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. The Summary of Benefits lists the benefits that are available from 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
- Tobacco Use Cessation Programs
- Other Health Education Services

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 and not only requested or referred by a Preferred Provider to be eligible for the higher, Preferred Provider 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:

- $7,500 for the billed Hospital charges; and
- $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.
<table>
<thead>
<tr>
<th></th>
<th>Hospital Charges - $7,500</th>
<th>Physician Charges - $5,500</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred Providers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The 80% benefit level is available, based on the Maximum Allowable Amount of $5,000.</td>
<td></td>
<td>Professional fees for pre-natal, delivery and post-natal care charges are subject to 80% benefit level and based on the Maximum Allowable Amount of $4,000.</td>
</tr>
<tr>
<td>Plan Pays:</td>
<td>$4,000</td>
<td>Plan Pays: $3,200</td>
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<tr>
<td>($5,000 x 80%)</td>
<td></td>
<td>($4,000 x 80%)</td>
</tr>
<tr>
<td>You Pay:</td>
<td>$1,000</td>
<td>You Pay: $800</td>
</tr>
<tr>
<td><strong>Non-Preferred Providers</strong></td>
<td></td>
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</tr>
<tr>
<td>The 50% benefit level is available based on the Maximum Allowable Amount of $5,000.</td>
<td></td>
<td>Professional fees for pre-natal, delivery and post-natal care charges are subject to the 50% benefit level, based on the Maximum Allowable Amount of $4,000.</td>
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<tr>
<td>Plan Pays:</td>
<td>$2,500</td>
<td>Plan Pays: $2,000</td>
</tr>
<tr>
<td>($5,000 x 50%)</td>
<td></td>
<td>($4,000 x 50%)</td>
</tr>
<tr>
<td>You Pay:</td>
<td>$5,000</td>
<td>You Pay: $3,500</td>
</tr>
<tr>
<td>(Your Coinsurance of $2,500 and the $2,500 charge in excess of the Maximum Allowable Amount.)</td>
<td></td>
<td>(Your Coinsurance of $2,000 and the $1,500 charge in excess of the Maximum Allowable Amount.)</td>
</tr>
</tbody>
</table>

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 are 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 this 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 the 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 the 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's benefit level, please call or send Your request to:

LifeWise
Care Management
Utilization Review
P.O. Box 7709
Bend, OR 97708
1-800-722-3372
Fax 1-800-843-1114

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 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:

- The 45th day after the birth; or
- 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 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 benefit level subject to the Maximum Allowable Amount. Please refer to How To Reduce Your Costs with 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 Your Ideas, Questions, Complaints And Appeals for information on how to submit a Grievance review request.

**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. However, there may be times when You see a 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 receive Services from one of these providers.

In special circumstances, Your attending physician may recommend that non-emergent care be obtained from a 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 the requested Covered Services are available from a Preferred Provider, the Covered Services will be subject to the benefit level of the provider who provided the Covered Services.

**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 as shown on the Summary of Benefits when You receive Covered Services at a Hospital 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 on who You receive Covered Services from, Preferred Providers or Non-Preferred Providers.

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 the 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, CASE MANAGEMENT AND DISEASE 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

Certain Covered Services provided under this Plan must be Prior Authorized. This means that You must receive approval in writing from Us before You receive these Services from a Preferred or a Non-Preferred Provider. 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. All hospital admissions are subject to review for Medical necessity.

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

Nothing in this provision will increase benefits to cover a Service that is not Medically Necessary or otherwise not covered under this Plan. 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 Policy, benefits will only be provided for Services that are determined to be eligible for benefits.

Penalty For Not Getting 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 does not apply to emergency admissions and does not accrue to the Deductibles or Coinsurance Maximums.

Services That Require Prior Authorization:

The list below includes the categories of Services that require Prior Authorization. You can get a detailed list of Services and procedures that require Prior Authorization on web page at www.lifewiseor.com or by calling Us at the number listed on the back of Your LifeWise ID Card. This list, Prior Authorization and Benefit Advisory List is updated 2 times each year and We suggest that You refer to this list or call Us before You receive these Services.

- Inpatient Confinement/Admissions, surgical and nonsurgical, does not include maternity admissions equal to or less than 48 hours and caesarean sections equal to or less than 96 hours);
- Admission to a skilled Nursing Facility or Rehabilitation Facility
- Inpatient Hospice;
- Inpatient and partial hospital programs for alcohol abuse;
- Elective (non-emergent) ground or air ambulance;
- Transplants (except cornea and skin);
- Outpatient Advanced Imaging;
- Outpatient Services, please see the detailed Prior Authorization List for specific outpatient Services that require Prior Authorization.
- Home Medical Equipment purchase $500 or more;
- Prosthetics And Orthotic Devices $500 or more; and;
- Medical injectables, please see the detailed Prior Authorization list for specific list of medical injectables that require Prior Authorization.

Benefit Advisory

We recommend that certain Services not on the Prior Authorization list be reviewed for Medical Necessity before You receive Services. This is called a Benefit Advisory. A Benefit Advisory is not required, however, if these Services are not reviewed before the date You receive the Services, they will be reviewed when the claim is submitted to Us.

You can get a detailed list of Services that are eligible for a Benefit Advisory on our webpage at www.lifewiseor.com or by calling Us at the number listed on the back page of Your Policy, or on the back
Utilization Review
LifeWise’s Prior Authorization program includes Medically Necessary determinations for selected medical procedures, Hospital admissions and length of stay assignments. LifeWise has developed guidelines and clinical criteria used to make these determinations. 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 Medically Necessary 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
1-800-777-1502
Fax 1-800-843-1114

LifeWise reserves the right to deny payment for Services that are not Medically Necessary or that are Experimental/Investigational. A decision by LifeWise following this review may be appealed in the manner described in the "Your Ideas, Questions, Complaints And Appeals" 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. Your participation in a treatment plan through Case Management is voluntary.

Disease Management
LifeWise’s Disease Management programs are designed to improve health outcomes for members with certain chronic diseases. These programs seek to identify individuals who may benefit from such programs, and achieve the best possible therapeutic outcomes based on an assessment of the patient needs, ongoing monitoring of care, and consultation with your primary care provider. Participation in disease management programs is voluntary. To learn more about the availability of Disease Management programs, contact Customer Service at the number listed on Your LifeWise ID Card.

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 Contract up to the Maximum Allowable Amount and as shown on the 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 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, Case Management, and Disease 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 the 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.
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 laboratory and imaging Services that meet the guidelines for preventive care stated in the Preventive Services benefit. Standard medical cost shares will apply for subsequent covered Services received within the time frames allowed by federal guidelines.
When covered outpatient diagnostic services are billed by an outpatient facility or emergency room and received in combination with other hospital or emergency room 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, Case Management and Disease 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.
   - 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:
     - Repair of a defect which is the direct result of an Accidental Injury;
     - 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 surgical services. Please see the Prior Authorization, Utilization Review, Case Management and Disease 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, Case Management and Disease Management section of this Benefit Booklet for additional information.
9. Contraceptive Management services include office visits and consultations related to contraception, injectable contraceptives and related services, implantable contraceptives (including hormonal implants) and related services, emergency contraception methods (oral and injectable) and sterilization procedures. Covered Services will be
provided as required by federal regulation and as shown under the Contraceptive Management benefit in the Summary of Benefits.

Please note: When sterilization is performed as the secondary procedure, associated services such as anesthesia and facility expenses will be provided as shown under those benefits.

Prescription contraceptives (including emergency contraception) and prescription barrier devices or supplies that are dispensed by a licensed pharmacy are covered under the Prescription Drugs Supplemental benefit. Your normal cost-share is waived for these devices and for generic and single-source brand name birth control drugs when you get them from a Preferred Provider pharmacy. Examples of covered devices are diaphragms and cervical caps.

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 Foods.

The benefits of this Plan provide for outpatient nutritional therapy services to manage Your covered condition. Benefits are provided as shown on the Summary of Benefits.

11. The benefits of this Plan provide for outpatient diabetic health education and training services and other health education Services required by federal regulation. Covered Services include asthma education, pain management, childbirth and newborn parenting and lactation. Benefits are provided as shown on the Summary of Benefits.

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 for additional information.

Benefits are also provided for Medically Necessary Telemedicine Services for diabetes as required by state and federal regulation.

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. Diagnostic scope insertion procedures will be covered under the Surgical Services benefit unless they meet the requirements for preventive services.

When Services meet the federal guidelines for Preventive Services, the Plan will provide benefits for these services as stated in the Diagnostic Services benefit and as shown on the Summary of Benefits. Standard medical cost shares will apply for subsequent Covered Services received within the time frames allowed by federal guidelines.

PREVENTIVE SERVICES

Benefits for evidence-based Preventive Care are provided based on the guidelines set by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA) and as shown on the Summary of Benefits. Benefits are subject to federal guidelines regarding frequency, age and gender.

Covered Services include periodic well visits, including annual comprehensive physical examinations and routine immunizations for symptom-free or disease-free individuals and additional Services for symptom-free or disease-free individuals at increased risk for a particular disease based on the following:

- Evidenced-based preventive items or services with a rating of “A or B” by the USPSTF
- Preventive care and screenings for women as provided for in comprehensive guidelines supported by the HRSA;
- Preventive care and routine prostate health screening for men;
- Immunizations as recommended by the CDC; and
- Evidence-informed Infant, child and adolescent preventive care and screening services provided for in the comprehensive guidelines supported by the HRSA.

When Diagnostic Services meet the federal guidelines for Preventive Services, the Plan will provide benefits for these services as stated in the Diagnostic Services benefit and as shown on the Summary of Benefits.

Not all services recommended by Your attending physician as part of Your routine physical may be covered under the Preventive Care benefits. Additionally, Preventive Care Services that exceed the federal guidelines regarding frequency, age and gender limits may not be covered.
You can get a detailed list of covered preventive services and schedules listing who should receive preventive services and how often the services should be provided by calling Us at 1-800-596-3440 or logging into Your secure account on Our Web page at www.lifewiseor.com. You may also review the federal guidelines at www.uspreventiveservicestaskforce.org/uspsfst/uspsabrecs.htm and www.hrsa.gov/womensguidelines.

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

MEN’S ROUTINE PROSTATE HEALTH SCREENING EXAM
A routine prostate cancer screening exam is covered annually. Covered Services include the digital rectal exam as shown on the Summary of Benefits.

Benefits for Services provided due to illness or injury are provided as shown on the Summary of Benefits based on the Service received. For example: office visits are provided under the Physician and Provider Services benefit and laboratory Services are provided under the Diagnostic Services benefit.

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

WOMEN’S ROUTINE ANNUAL HEALTH SCREENING EXAM
A women’s health exam is covered annually. The women’s health exam includes a pelvic examination and a clinical breast examination provided to You in the absence of an illness or injury. Benefits are as shown on the Summary of Benefits.

Benefits for Services provided due to illness or injury are provided as shown on the Summary of Benefits based on the Service received. For example: office visits are provided under the Physician and Provider Services benefit and laboratory Services are provided under the Diagnostic Services benefit.

Women’s routine health screening Covered Services do not include Services provided by chiropractors or acupuncturists. 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, Case Management and Disease 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, Case Management and Disease 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 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, Case Management and Disease Management section of this Benefit Booklet for additional information.

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 furnished by 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, Case Management and Disease 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 a 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.

Prior Authorization is required for skilled nursing facility services. Please see the Prior Authorization, Utilization Review, Case Management and Disease 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 laboratory and imaging Services that meet the guidelines for preventive care stated in the Preventive Services benefit. Standard medical cost shares will apply for subsequent Covered Services received within the time frames allowed by federal guidelines.

When outpatient diagnostic services are billed in combination with hospital or emergency services, benefits are provided as shown under Emergency Room and Outpatient Hospital/Ambulatory Surgical Facility benefits.

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, Case Management and Disease 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, subject to the Benefit Maximum Limit. Covered Services include the initial medical care to stabilize Emergency Medical Conditions involving pain and 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, childbirth classes, babysitting skills; back pain prevention; stress management; bicycle safety; healthy heart exercises or adult, child, and infant 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 and/or associated medical treatment to the nearest Hospital that has the facilities to provide the necessary treatment required for the Member's condition. 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, Case Management and Disease 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:

- 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
- 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, Case Management and Disease Management section of this Benefit Booklet for additional information.

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

- We determine the Services to be Medically Necessary;
- A Qualified Practitioner certifies that You have a terminal Illness with a life expectancy not exceeding 6 months; and
- 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:

- Nursing care provided by or under the supervision of a registered nurse;
- 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;
- Services provided by a Qualified Practitioner or a physician associated with the hospice program;
- 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 5 days), or for pain control and symptom management;
- 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;
- 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;
- Rehabilitation therapies provided for purposes of symptom control or to enable You to maintain activities of daily living and basic functional skills; and
- 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 as shown on the Summary of Benefits. 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.

We may authorize benefits for the rental of Medical Supplies/Devices and Home Medical Equipment, but not to exceed the purchase price, when medically necessary. We may also authorize benefits for the initial purchase of covered equipment, in lieu of rental.

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.

**Medical Supplies/Devices**

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

- **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 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 a $200 per Calendar Year.

- **Covered Services include non routine vision hardware for certain medical conditions; corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjogren's disease, congenital cataract, corneal abrasion and keratoconus.**

- **Rental of an oxygen unit used in the home for Members.**

- **Medically Necessary supplies as ordered by Your attending physician including but not limited to ostomy supplies, non-prescription elemental enteral formula for home use, blood glucose monitor, insulin pump (including accessories), and insulin infusion devices.**

  Covered Services for diabetic supplies, including prescribed needles/syringes, Insulin Pen supplies (not including Insulin), disposable diabetic testing supplies and glucagon emergency kits are covered under this benefit. You must pay for these Services at the time of Your purchase and submit Your receipts to Us for reimbursement. Please see How to File A Claim for details.

  Medical Supply Covered Services do not include Insulin and other diabetic drugs are not covered.

- **Covered Services include the purchase of standard electric breast pumps and rental of hospital-grade breast pumps when medically necessary. Purchase of hospital-grade breast pumps is not covered.**

- **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. 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, Case Management and Disease 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, Case Management and Disease 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.

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

Prior Authorization is required for physician administered “biotech drugs” / medical injectables. Please see the Prior Authorization, Utilization Review, Case Management and Disease 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, massage, 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.

**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. 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. 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. 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, Case Management and Disease 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.

A maximum of $75,000 of Covered Services per
transplant 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 are considered organ transplant Covered Services:

- Covered Services related to the transplant surgery before the actual surgery.
- 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.
- A maximum of $7,500 per transplant is allowed for reasonable and necessary transportation and living expenses of the Member (while not confined) and one companion, not to exceed three (3) months. To receive lodging benefits, the transplant recipient must reside more than 50 miles from the approved transplant center, unless medically necessary treatment protocols require the Member to remain closer to the transplant center. Meals and personal care items are not covered.

**Tobacco Use Cessation Programs**

Benefits are included for Tobacco Use Cessation Programs as shown on the Summary of Benefits when provided by 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.

**Hearing Exam and Aids**

**Hearing Exam**

Benefits are provided for hearing exams as shown on the Summary of Benefits subject to the Benefit Maximum Limit. Covered Services include:

- 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**

Benefits are provided for hearing aids as shown on the Summary of Benefits subject to the Benefit Maximum Limit. Hearing Aids are available for all Members up to age 18 and enrolled dependents up to age 26.

Covered Services include:

- Hearing aids;
- Ear molds; and
- Attachments or accessory for the instrument or device

Batteries and cords 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 Provider who provides Services within the scope of his or her license; and
- 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.

When Services meet the federal guidelines for preventive services, the Plan will provide benefits for these Services as stated in the Preventive Services benefit and as shown on the Summary of Benefits. Standard medical cost shares will apply for subsequent covered Services.

**Acupuncture Services**
Acupuncture Covered Services are limited to Medically Necessary acupuncture, electro-acupuncture, cupping, and moxibustion 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.

**Routine Vision Care**
Benefits for routine vision care are provided as shown on the Summary of Benefits.

Covered Services include the following:

**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

**GENERIC OUTPATIENT PRESCRIPTION DRUGS**
A "generic drug" is a prescription drug product approved by the FDA and manufactured and distributed after the brand-name drug patent of the innovator company has expired. Generic drugs are designated as generics by the Pharmacy Benefit Manager.

Benefits for generic outpatient prescription drugs are provided as shown on the Summary of Benefits when dispensed by a licensed pharmacy for use outside a medical facility.

Covered Services include the following:
- Generic FDA-approved drugs, which by federal law, require a prescription;
- Off-label use of generic FDA approved drugs as defined in Definition of Terms;
- Generic 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 the highest cost ingredient is a covered generic prescription drug;
- Vitamins, which by federal law require a prescription and are generic;
- Glucagon emergency kits;
- Generic diabetic drugs;
- Generic injectable prescription medications for self-administration;
- Generic medications, drugs or hormones to stimulate growth only when determined to meet medical criteria;
- Generic prescription oral contraceptives; and
- Generic prescription tobacco use cessation drugs.

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

When Services meet the federal guidelines for preventive services, the Plan will provide benefits for these services as stated in the Preventive Services benefit and as shown on the Summary of Benefits.

Prior Authorization is required for physician administered “biotech drugs” / medical injectables,
including growth hormones. Please see the Prior Authorization, Utilization Review, Case Management and Disease 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 covered generic 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.

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 generic medication and submit a claim to Us for reimbursement. In addition to the Copayment required, You will be responsible for all costs above the Allowable Charge.

**Allowable Charge**

The Allowable Charge is the amount agreed upon by the Pharmacy Benefit Manager and the Participating Pharmacies for prescription drugs that are covered by this Plan. Your liability for any applicable Deductibles, Copayments or Coinsurance 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 these determinations, We take into consideration medical necessity 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 that 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 drug 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 are 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. However, a separate Copayment and/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.

Prescriptions By Mail

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

**Long-term Medications**

Your Plan requires that You use the Prescriptions By Mail program to refill prescriptions for long-term medications. Long-term medications are medications prescribed for the treatment of long-term or chronic conditions such as diabetes, high blood pressure or high cholesterol. When You obtain a long-term medication through a retail Preferred Provider Pharmacy, We will let You know if Your refill medication must be ordered through the Prescriptions By Mail program to be covered under this Plan.

Ordering Your long-term medications through mail order is easy and will save You time and money. To learn about Our Prescriptions By Mail program, please visit Our web site at www.lifewiseor.com or contact Us at the number provided in the front of Your Benefit Booklet.

**Other Prescription Drugs**

If You require or request brand name drugs, You will be responsible for the entire cost of the brand name drug. There is no coverage for non-generic prescription drugs under this benefit.
How to Submit a Claim
Please refer to How To Submit A Claim for detailed claim information.

Generic Drug List
This benefit uses a listing of generic drugs, which is reviewed and updated from time to time. This generic drug list includes all FDA-approved generic drugs. Drugs not on this list are not covered under Your benefit.

Please call Customer Service at the phone number listed in the front of Your Benefit Booklet to inquire about whether a drug is on Our generic drug 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, unless otherwise required by law.

Specialty Pharmacy
Benefits are provided for a 30-day supply of covered generic specialty drugs subject to the Copayment amount as described 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 generic 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, Case Management and Disease Management section of this Benefit Booklet for additional information.

Tablet Splitting Program
Generic 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 generic 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 generic 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 generic 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.

Benefits From Other Sources
Benefits are not available under this Plan when coverage is available through:

- 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.
- Services which would be eligible for benefits under the terms of a contract or insurance offering Underinsured Motorists or Uninsured Motorists (UIM) coverage.
- 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

Benefits That Have Been Exhausted

- Charges in excess of the Maximum Allowable Amount.
- Services in excess of a stated Benefit Maximum Limit or the Annual Plan Maximum.

Community Wellness Services
Community Wellness Services that are not provided by 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.

Cosmetic Services
Services or supplies (including drugs) rendered for cosmetic purposes and plastic surgery, regardless of whether to restore, improve, correct or alter the appearance or shape of the body structure, including any direct or indirect complications and aftereffects thereof. 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.

**Court-Ordered Services**

- Services, supplies, education or training provided under a court order or as a condition of parole or probation (unless Services are required by state or federal law).
- Court-ordered sex offender treatment programs;
- Treatment or testing required by a third party or court of law.

**Custodial Care**

Custodial Care; except as described under the Hospice Care Benefit.

**Dental Services**

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, unless required by law, except as shown on the Summary of Benefits and as described under What Are My Benefits.

Also not covered are hospital Services for dental procedures except as described under What Are My Benefits.

**Developmentally Disabled Services**

Services or materials of an institution for the developmentally disabled, except while in an acute care Hospital for an Accidental Injury or Illness.

**Dietary Or Nutritional Services**

Dietary or nutritional Services except as provided for inborn errors of metabolism and diabetes self management, and as described under What Are My Benefits or as required by federal regulation.

**Drug Or Food Supplements**

Over the counter drugs and medicines which may be lawfully obtained over the counter ("OTC") without a prescription (except as required by federal regulation), 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.

**Education And Training Services And Supplies**

- Services for convenience, educational or vocational purposes including, but not limited to, videos and books, and volunteer mutual support groups, except as required by federal regulation.
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs.
- Related to behavioral disorders, marriage, family or sex counseling in the absence of a Mental Health Illness.
- Related to personal growth, assertiveness training or consciousness raising, career counseling, and learning disabilities except for attention deficit/hyperactivity disorders.
- 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.

**Electronic Consultations**

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 and 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, unless required by state or federal regulation.

**Emergency Transportation**

Emergency medical transportation Services that are not provided by appropriately licensed providers.

**Experimental Or Investigational Services**

Any Service which is an Experimental/Investigational procedure, based on criteria stated in the definition of "Experimental/Investigational Procedures."

**Family Members Or Volunteers**

- Services or supplies that you furnish to yourself or that are furnished to you by a provider who is an immediate relative. Immediate relative is defined as spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent or spouse of grandchild.
- Services or supplies provided by volunteers, except as specified in the Home and Hospice Care benefit

**Family Planning**

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 Benefit.

Foot Care
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.

Foot Orthotics
Services for insoles, arch supports, heel wedges, and lifts. Covered Services for shoe inserts and orthopedic shoes are described under What Are My Benefits.

Gender Transformations
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.

Hair Loss
Hair prosthesis, hair transplants or implants and wigs.

Hearing Exams, Testing And Hardware
Services provided in excess of the routine hearing benefit and except as shown on the Summary of Benefits and described in the Hearing Exam and Aids benefit under Other Covered Services.

Home Births
Home births, except when provided by a licensed midwife with documentation of physician back up.

Home Health Services
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 Covered Services.

Human Growth Hormone
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 Benefit.

Human Organ Transplant Services
- Transplants, except when determined to meet required medical criteria and as described in under What Are My Benefits.
- Services provided by Non-Preferred Providers.
- Services in excess of the transportation and living expenses Benefit Maximum Limit.

Immunizations
Travel and occupational immunizations, except as required by federal regulation.

Infertility, Assisted Reproduction And Sterilization Reversal
- Testing, diagnosis and treatment of infertility, including procedures, supplies and drugs
- Infertility Services or any assisted reproduction 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.
- Reversal of voluntary sterilization, including any direct or indirect complications thereof

Medical Equipment, Supplies, Devices And Prosthetics
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.

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;
- Services from 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;
- 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; or
- Addiction to foods, unless required by law.
Military And War-Related Conditions

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.

Neurodevelopmental Services

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.

Not Covered By The Plan

- Services not directly related to an Illness or Accidental Injury in excess of the Preventive Care Benefit, Men’s Routine Prostate Health Screening Services or Women’s Routine Health Screening Services, 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.
- 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 in the Definition of Terms section of Your Benefit Booklet.
- 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:
  - Routine or preventive care Services provided by Acupuncturists or Chiropractors;
  - Hair analysis;
  - Electroacupuncture according to Voll (EAV) and electronic tests for diagnosis and allergy; Tryptophan load test; Zinc-tolerance 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 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, except to the extent as outlined under the Emergency Care Services provision in the How To Obtain Services section.

Not Medically Necessary

Services determined not to be Medically Necessary for diagnosis and treatment of an Accidental Injury or Illness.

Obesity Services

- Services for surgical and pharmaceutical treatment of obesity or morbid obesity, and any direct or indirect complications, follow-up services or aftereffects thereof, except to the extent as
outlined under the Emergency Care Services provision in the How To Obtain Services section. (An example of an after effect that would not be covered is removal of excess skin and fat that developed as a result of weight loss surgery or the use of obesity drugs.) 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 unless Services are required by state or federal law.

- All Services for bariatric surgery and any resulting complications, including but not limited to Laparoscopic Gastric Bypass, Laparoscopic Mini-gastric Bypass, Biliopancreatic Bypass, Fobi Pouch, Vertical Banded Gastroplasty, Laparoscopic Adjustable Gastric Banding.

Orthognathic Surgery

Jaw augmentation or reduction (orthognathic surgery), except when determined to meet required medical criteria.

Personal Comfort Or Convenience Items

- Private hospital room charges (unless prescribed as Medically Necessary).

- Personal items such as telephone, radio, television and guest meals.

- 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.

Physical Therapy And Rehabilitation Services

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.

Prescription Drug Services

Outpatient retail or mail order Prescription Drug Services in excess of the Prescription Drug 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

- Replacement of lost or stolen medication

- Brand name drugs

- Long-term medication refills at a retail Preferred Provider Pharmacy. Refills of these drugs are eligible only when ordered through the Prescriptions By Mail program.

Please visit Our web page at www.lifewiseor.com for a complete list of Your plan’s covered prescription drug list and to see the benefit coverage available.

Preventive Services

Charges for services or items that don’t meet the federal guidelines for preventive services described in the Preventive Services benefit, except as shown on the Summary of Benefits and as described as Covered Services under What Are My Benefits, except as required by law. This includes services or items provided more often than as stated in the federal guidelines or to members who are not in the population targeted by the guidelines.

Private Duty Nursing Services

Private duty nursing.

Qualified Clinical Trial Services

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 under this Plan if provided outside the clinical trial.

**Residential Treatment Services**

Residential treatment services that are:

- Therapeutic or group homes; foster homes, nursing homes boarding homes or schools, military academies, and child welfare facilities
- Outward bound, wilderness, camping or tall ship programs or activities
- Telephonic services except for crisis/emergency evaluations, or when the member is temporarily confined to bed for medical reasons; telehealth services that do not utilize real-time video or audio services.
- Mental health evaluations for purposes other than evaluating the presence of or planning treatment for covered mental health disorders, including, but not limited to, custody evaluations, competency evaluation, forensic evaluations, vocational, educational or academic placement evaluations.
- Halfway houses, quarterway houses, recovery houses, and other sober living residences
- Residential treatment programs or facilities that are not units of legally operated hospitals, or that are not state licensed or approved facilities for the provision of residential chemical dependency treatment
- Residential detoxification

**Serious Adverse Events And Never Events**

Members and this Plan are not responsible for payment of services provided by Preferred Providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally-published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. Preferred providers may not bill Members for these Services and Members are held harmless.

Serious Adverse Event means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge.

Never Events means events that should never occur, such as surgery on the wrong patient, a surgery on the wrong body part or wrong surgery.

Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting Us at the number in the front of this Benefit Booklet or on the Centers for Medicare and Medicaid Services (CMS) web page at www.cms.hhs.gov.

**Sexual Dysfunction**

Diagnosis and treatment of sexual dysfunction, regardless of origin or cause, including, but not limited to implants, surgery and prescription drugs, such as Viagra.

**Temporomandibular Joint (TMJ) Disorders**

Any Services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders.

**Travel Expenses**

Communications, lodging accommodations and transportation or travel time except when medical criteria is met and as described under What Are My Benefits.

**Vision Services**

- 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 Vision Supplemental Benefit.
- Services for vision therapy, eye exercise, and any type of training to correct muscular imbalance of the eye (orthoptics) and pleoptics.
- 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.

**Work Related Conditions**

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.

**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. However, 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 LifeWise 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 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 Using Your LifeWise ID Card described under the Prescription Drug Benefit in the section titled “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.

**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.

**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.

**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 cannot 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 needed 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 the Plan's 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 Your Ideas, Questions, Complaints And Appeals.

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

**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 back 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 a health care service;
- 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 I Have An Appeal and When Am I Eligible For External Review.

WHEN YOU DISAGREE WITH A BENEFIT DECISION

If we declined to provide payment or 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 appeal process will comply with any new 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 discontinuation 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 Benefit Booklet.

WHEN YOU HAVE AN APPEAL

After You are notified of an adverse benefit determination, You can request an internal appeal. Your plan includes two levels of internal appeals. Your Level I internal 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 internal 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 in person or 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, 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 above. 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 can mail Your appeal request 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:
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.lifewiser.com.

We will acknowledge Our receipt of Your request in writing within 5 days.

What If My Situation Is Clinically Urgent?
If Your provider believes that Your 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 back 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 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 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.
- Appeals for 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 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 right 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 external review of an adverse benefit determination for mastectomy related services. Please call Customer Service at the number listed in the Benefit Booklet to request an expedited external review.

We will notify the Oregon Insurance Division (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.

The IRO will review Your request and notify You and Us of their 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 Our 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 back page of Your Benefit Booklet. If You are not satisfied with Our decisions and wish to make a complaint 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 toll free message line at 888-877-4894

Email: cp.ins@state.or.us


Employee Benefits Security Administration (EBSA)
1-866-444-EBSA (3272).

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 Oregon state COB regulations 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:
- The Plan covering the custodial parent, first;
- The Plan covering the Spouse of the custodial parent, second;
- The Plan covering the non-custodial parent, third; and then
- 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.

This Plan has the right to appoint a third party to act on its behalf in recovery efforts.

NON–DUPLICATION OF COVERAGE
Coordination With Medicare
In all cases, Coordination of Benefits with Medicare will conform to 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 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
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.

Please note that You do not have to be a citizen of or
live in the United States if You are otherwise eligible
for coverage.

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

• Satisfy any New Employee Waiting Period
  (Eligibility Waiting Period), if one is required by the
  Employer/Group Agreement.

On-Call, temporary, substitute and seasonal
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.
  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. Proof will not be requested 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 an Affidavit of Domestic Partnership has been properly executed and accepted by the Employer/Group.

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 for Late Enrollees are outlined in Your Benefit Booklet under Who Is Eligible For Coverage.

Special Conditions Regarding Eligible Family Dependent Coverage
- 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.
- If a child or Spouse 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. It is the first of the month following completion of the new employee Eligibility Waiting Period. 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:
- 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;
- 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;
- The date of birth of the natural-born child of the Eligible Employee, Spouse or Domestic Partner;
- The date the child is placed with the Eligible Employee, Spouse or Domestic Partner for the purpose of adoption;
- The first of the month following the date of a qualified medical child support court order or administrative order to provide health coverage for a child of an Eligible Employee or Eligible Employee's Spouse or Domestic Partner.
- The first of the month following the date an Affidavit of Domestic Partnership has been properly executed and accepted by 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:

- You declined coverage 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
- You apply for coverage during a Special Enrollment Period; or
- There is a court order that is not more than 30 days old orders that a Spouse or minor child be covered under this Plan; or
- 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:
  - On which You have been covered until that time,
  - During an annual group enrollment period; or
- 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 group health coverage, You may enroll Yourself and/or Your Eligible Family Dependents under the terms of this Plan. To do so, You must request enrollment within 30 days after the other coverage ends and each of the following conditions must be 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:
  - Loss of eligibility for the coverage, including legal separation; divorce; death; termination of employment; or reduction in the number of hours of employment, children aging out of coverage, 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
  - The current or former employer contributions towards such coverage were terminated; and
- The person requests enrollment under this Plan 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 Plan, 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 Eligible Family 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 Eligible Family 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 Health Plan or CHIP premium assistance; or
- The date the Eligible Employee or Eligible Family Dependents lose coverage under the Oregon Health Plan or CHIP.

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 Eligible Family 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 nine (9) 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:

- The date this Contract terminates;
- The end of the period for which required Premium was due to Us and not received by Us;
- 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;
- For the Eligible Employee, the end of the month he fails to pay required Premiums;
- For the Eligible Employee, the end of the month following the date he fails to be in an eligible class of persons as shown on the Employer/Group Agreement and as described in the Employer/Group Provisions;
- For the Eligible Employee, the end of the month following the date the Eligible Employee retires;
- The end of the month following the date the Eligible Employee requests termination of coverage to be effective for the Eligible Employee or Member;
- For an Eligible Family Dependent, the date the Eligible Employee’s coverage terminates;
- For an Eligible Family Dependent, the end of the month following the date he or she no longer qualifies as an Eligible Family Dependent;
- For any benefit, the date the benefit is deleted from this Contract;
- For You or the Employer/Group, the date We discover any breach of contractual duties, conditions or warranties, as determined by Us;
- For You or the Employer/Group, the end of the month following the date the Employer/Group terminates its participation in a multiple employer trust or association;
- 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.

- 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:
  - The Employee's work hours are reduced.
  - 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:
  - The employee dies;
  - The employee and Spouse legally separate or divorce;
  - The employee becomes entitled to Medicare;
  - 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.

**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
Employer/Group (or from a qualified member as named a third party as its plan administrator, the plan Group has 30 days in which to notify its plan on behalf of the Employer/Group. In such cases, the administrator is responsible to notify members on their rights under COBRA. If the Employer/Group has the first 60 days of COBRA coverage. You also have a qualified member loses the right to COBRA employment, reduction in hours, death or Medicare entitlement. The plan administrator then has 14 days after it receives notice of a qualifying event from 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 Employer/Group must send notice to 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 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 Employer/Group must notify qualified members of their rights under COBRA. If the Employer/Group has named a third party as its plan administrator, the plan administrator is responsible to notify members on behalf of the Employer/Group. In such cases, the Group has 30 days in which to notify its plan administrator of an Eligible Employee's termination of employment, reduction in hours, death or Medicare entitlement. The plan administrator then has 14 days after it receives notice of a qualifying event from the Employer/Group (or from a qualified member as stated above) in which to notify qualified members of their COBRA rights.

If the Employer/Group itself is the plan administrator, the Employer/Group has more than 14 days in which to give notice for certain qualifying events. The Employer/Group must furnish the notice required because of an Eligible Employee's termination of employment, reduction in hours, death or Medicare entitlement 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. Employees may elect COBRA coverage on behalf of a spouse, 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 on 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.
- The Employer/Group ceases to offer group health care coverage to any employee.
- You become entitled to Medicare after the date You elect COBRA coverage.

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 LifeWise Portability Plan as described under 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 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:

- The failure to pay Premiums when due, including any grace period;
- The date that the Contract is terminated;
- The date on which the Spouse becomes insured under any other group health plan;
- The date on which the Spouse remarries and becomes covered under another group health plan; or
- 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 the Eligible Employee if they have been covered continuously under this Contract, or a similar predecessor group health plan, during the three month period prior to the date of termination of employment or membership.

State mandated continuation of coverage is also available to any enrolled Eligible Family Dependent if they were enrolled in the Plan on the day before the Eligible Employee’s termination of employment or membership.

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

- Coverage ends because of the termination of employment of the Eligible Employee, or
- Coverage ends because the Eligible Employee's reduction in work hours, or
- Coverage ends because of the death, dissolution of marriage or domestic partnership, or legal separation, or
- Coverage ends because the Eligible Employee becomes eligible for Medicare, or
- Coverage ends because the enrolled Eligible Family Dependent no longer qualifies as an Eligible Family Dependent.

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

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

- 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,
- Nine (9) months after the start of a leave of absence from which an enrolled Eligible Employee does not return to work;
- Nonpayment: The end of the month for which You last made timely payment (30 days from the date the Premium is due);
- Medicare: First of the month in which You become entitled to Medicare benefits;
- 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
- 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:

- Less than seventy five percent (75%) of employees, at the time of cessation of work, continue coverage;
- Nine (9) months after cessation of work;
- 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:

- The Eligible Employee takes full-time employment with another employer; or
- Nine (9) 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 Employer/Group 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.

**Continuation Rights**

Enrolled Domestic Partners and/or their enrolled dependents may continue coverage under this Plan as described in Your Benefit Booklet under My Rights Under COBRA and How To Continue Coverage.

**Portability**

We will automatically provide Portability Plan information to the Domestic Partner and/or their enrolled dependents when their coverage ends under this Plan. This information includes a description of Portability Plan benefits and rates for each LifeWise Portability Plan and an application for enrollment. For detailed information please refer to the Portability Plans section of Your Benefit Booklet.

**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 2020 SW 4th Ave., Suite 1000, Portland, OR 97201.

**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. (Genetic information is not collected or used for underwriting or enrollment purposes.);
• Coordinating benefits with other health-care plans;
• Conducting care management, case management, or quality reviews; and
• Fulfiling 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 www.lifewisemr.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 Your 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 Out-of-Pocket Limit 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, 2020 SW 4th Ave., Suite 1000, Portland, OR 97201.

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

LWO 2005 LAT.SG (Rev 01-2013)
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 2020 SW 4th Ave., Suite 1000, Portland, OR 97201.

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 called 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 report.
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, 300 Fifth Ave., Suite 1110, Seattle, WA 98104; or

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.

Compliance With Law
The Employer/Group shall comply fully with all applicable state, federal and local laws and regulations, including notice and disclosure requirements, in carrying out its responsibilities under the Contract. These include, but are not limited to, compliance with the Internal Revenue Code, the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Family and Medical Leave Act of 1993 (FMLA), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, if the Plan provides coverage for retirees, the Employer/Group is also subject to the notice requirements of the Balanced Budget Act of 1997.

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 Master Application, Employer Provisions, 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
The meanings of the terms shown below will apply wherever the term is used in the Plan. 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.

Affordable Care Act
The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

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.

**Annual Plan Maximum**
Annual Plan Maximum means the total benefits paid for each Member enrolled under this Contract. All benefits paid accumulate towards Your Annual Plan Maximum unless otherwise stated in this Contract. The Annual Plan Maximum per Member is shown on the Summary of Benefits and renews each January 1.

**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:
- 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.

**Cost-Share**
The Member's share of the allowable charge for Covered Services. Deductibles, Copayments, and Coinsurance are all types of Cost-Shares. See the Summary of Benefits to find out what the Cost-Share is for the Covered Service provided.

**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 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 included 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 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 specific time period in which benefits are allowed. Durational Limits are listed on 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;

• Result in serious impairment to bodily functions; or

• With respect to a pregnant woman who is having contractions, for which there is inadequate time to affect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the women or the unborn child.

**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:

• Health care items and Services furnished in an emergency department and all ancillary Services routinely available to an emergency department; and

• Further medical examination and treatment as required to stabilize a patient to the extent the examination and treatment are within the capacity of the staff and facilities available at a hospital. Stabilize means to provide medical treatment necessary to ensure that, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during or to result from the transfer of the patient from a facility; and for a pregnant woman in active labor, to perform the delivery.

**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 of 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.

**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 Master Application, Employer Provisions and Benefit Booklet(s), any applicable Supplemental Benefits or Endorsements, and is also referred to as the 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. 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.

**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) for a Member age 19 and older. 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 regulations.

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 the 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."

Prescription Drug Out-of-Pocket Limit
Please refer to Prescription Drug Out-of-Pocket Limit under Important Plan Information.

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 or supply (including medications) is Medically Necessary and is an eligible Covered Service before We authorize the Service.

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, and 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.

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 What Is Not Covered 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 state of Oregon, Alaska and Washington.

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 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.

Small Employer
An employer, including a person, firm, corporation, partnership or association actively engaged in business that, on at least 50 percent (50%) of its working days during the preceding year employed no more than 50 Eligible Employees (those with a normal work week of 17.5 or more hours) and no fewer than two (2) Eligible Employees, the majority of whom are employed within this state.

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