

**Skamania County PUD
Employee Benefits
Booklet**

CONTENTS

INTRODUCTION	1
PLAN EFFECTIVE DATE	1
SCHEDULE OF BENEFITS.....	1
General Terms Under Which Benefits Are Provided	4
All benefits are subject to the	4
Physician Services	4
Hospital Inpatient Services	6
Emergency Room / Outpatient Services	6
Maternity Benefits	7
Medical Care Outside the Service Area.....	7
Other Services	7
Exclusions and Limitations.....	11
Definitions	14
Eligibility	20
Enrollment and Effective Date	20
Pre-existing Conditions Exclusion Period.	21
VISION CARE BENEFIT.....	22
DENTAL COVERAGE	22
THE BENEFITS.....	23
Preventive Services	23
Basic Services	23
Major Services	23
MAXIMUM BENEFIT PER YEAR	23
THE DEDUCTIBLE	23
Family Deductible Limit.....	24
Covered Dental Expenses	24
EXPENSES WE DO NOT COVER.....	24
TABLE OF DENTAL SERVICES AS LISTED IN THE ADA cdt CODE OF PROCEDURES	25
ORTHODONTIC COVERAGE.....	26
WHAT IS ORTHODONTIC COVERAGE?.....	26
THE BENEFITS.....	26
COVERED ORTHODONTIC EXPENSES	27
EXPENSES WE DO NOT COVER.....	27
Coordination of Benefits	27

Subrogation.....	28
APPEAL OF A CLAIM DENIAL – ALL CLAIMS.....	29
CUSTOMER SERVICE DIRECTORY	30

INTRODUCTION

Skamania County PUD offers an excellent benefit package covering a broad range of services for injury and illness.

This plan provides coverage for employees and dependents enrolled with Skamania County PUD.

The plan allows you a wide choice of network providers through the First Choice Health Network and Providence Preferred Network who have agreed to accept the “reasonable amount” as payment for services to employees.

In this brochure, Skamania County PUD is referred to as the “Company”, First Choice Health Network or Providence Preferred Network are collectively referred to as the “Network”, Pacific Underwriters is referred to as the “Administrator” and the PURMS Self-Insurance Fund is referred to as the “Fund”.

The PURMS Self-Insurance Agreement has several terms and conditions which may affect the procedures outlined in this booklet. A copy of the agreement is available at the Company or Administrator’s office.

PLAN EFFECTIVE DATE

The Plan Effective Date is April 1, 2000. Modified as of May 1st, 2003

SCHEDULE OF BENEFITS

	Network	Non Network
Max Cal. Yr. Out of Pocket	\$1,250 per person \$2,500 per Family	\$2,500 per person \$5,000 per Family
Lifetime Max per Person	Unlimited	\$2,000,000
Outpatient Services		
Physicians office-home visits	\$10 Copay per visit per person paid to the Physician's office at time of visit for all services provided on same day	30% coinsurance
Services of a Chiropractor	\$10 Copay per visit per person limited to 6 visits per year unless certified as necessary by a physician.	30% coinsurance limited to 6 visits per year unless certified as necessary by a physician.
Birth control devices (IUD & depo-provera)	\$10 Copay	30% coinsurance
Ultrasound / EKG / X-ray/and similar diagnostic services	No Charge	30% coinsurance
Preventive care	\$10 Copay per visit	30% coinsurance
Antigen Admin. Including serum	\$3 per injection	30% coinsurance
Hospital Outpatient Services – SURGERY & Procedures	\$50 Copay per surgery	30% coinsurance
Hospital Outpatient Services - Emergency room	\$20 Copay per admission Waived if admitted	\$50 Copay per admission Waived if admitted

Mental health care and Outpatient Alcohol/drug treatment - Limited to lesser of 26 visits or \$5,000 per 24 months. MUST call mental health provider for authorization prior to visit for mental health, alcoholism, and drug abuse. \$10,000 lifetime limit	\$10 Copay per visit	30% coinsurance
Outpatient rehabilitation services - Physical, speech, occupational and respiratory therapy combined (limit 60 visits per cal. Year)	\$10 Copay per visit	30% coinsurance
Neurodevelopment therapy for children - 6 & under limited to a maximum of \$2,500 per cal yr per person	\$10 Copay per visit	30% coinsurance
Outpatient cardiac rehab. Services - limited to 36 visits cal yr	\$10 Copay per visit	30% coinsurance
Mental health care - limited to 20 visits per cal yr. MUST call mental health provider for authorization prior to visit for mental health, alcoholism, and drug abuse	\$10 Copay per visit	50% coinsurance
Inpatient Services -	\$250 Copay per admission per person	\$250 Copay per admission per person
Semi-Private room Private room (if medically necessary)	100% after Copay	30% coinsurance
Intensive and coronary care unit (if medically necessary)	100% after Copay	30% coinsurance
Physician & surgeon services, anesthesia, nursing care, & related services	100% after Copay	30% coinsurance
Mental health care - limited to 10 day per cal yr.	100% after Copay	50% coinsurance
Inpatient alcohol & drug treatment (limited to \$5,000 in a 24-month period for combined inpatient & outpatient services – Limit \$10,000 lifetime max, Inpatient / outpatient combined	100% after Copay	30% coinsurance
Other Services		
Ambulance - ground	100% if emergent, 50% if not	100% if emergent, 50% if not
Ambulance - air	100% if emergent, 50% if not	100% if emergent, 50% if not
Medical care at urgent care facility	\$20 Copay per visit	30% coinsurance

Diabetic Rehab & risk services and supplies	20% coinsurance	30% coinsurance
Ostomy supplies	20% coinsurance	30% coinsurance
Durable medical equipment & external prostheses -limit \$5,000 per cal yr	20% coinsurance	50% coinsurance
<u>Organ & tissue transplants - see comprehensive medical benefit section of this booklet for specific coverage \$1,000,000 lifetime max benefit</u>	Applicable co-payment – see inpatient & outpatient services	50% coinsurance
Skilled nursing facility services - limited to 90 days per cal year	\$10 Copay per day up to a maximum of \$250.	30% coinsurance
Home Health care services - limited to 60 visits per cal year	\$10 Copay per day up to a maximum of \$250.	30% coinsurance
Hospice care services - limited to 180 days per lifetime	\$10 Copay per day up to a maximum of \$250.	30% coinsurance
Vision benefits		
One refraction during any 24 month period if between 18-47 yrs old	\$10 per refraction	\$10 per refraction
One refraction during any 12 month period if under 18 or over 47 yrs old	\$10 per refraction	\$10 per refraction
Hardware		
Any two year period	\$300	\$300
Lasik	\$1,000 per surgery (eye)	
Limitations and exclusions: non-prescription glasses, prescription and non-prescription sunglasses when not medically necessary , and services on products not specifically listed above. Other provisions, limitations and exclusions of the insured's booklet of insurance may also apply.		
Prescription drug benefit - must use a participating pharmacy		
Generic prescription	\$6 Copay	\$6 Copay
Brand name (when no generic is available)	\$10 Copay	\$10 Copay
Brand name (when generic is available)	\$15 Copay	\$15 Copay
Mail order prescription - generic drug	\$10 Copay for up to a 90 day supply	\$10 Copay
Mail order prescription - name brand / when no generic is available	\$15 Copay for up to a 90 day supply	\$15 Copay

Mail order prescription - name brand / when generic is available	\$20 Copay for up to a 90 day supply	\$20 Copay
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General Terms Under Which Benefits Are Provided

Employees are entitled to receive the benefits set forth in this Benefit Schedule from the Company subject to the following conditions:

All benefits are subject to the

- 1) Exclusions and Limitations section beginning on page 11, including payment of any applicable Co-payments identified in the attached Co-payment Schedule.
- 2) All benefits are covered only if Medically Necessary.

Physician Services

Medically Necessary Physician services are covered as follows:

- 1) Preventive and Health Maintenance Services.
 - a) Newborn and Pediatric Care. Except as provided in Maternity Benefits starting on page 7 routine new born care and treatment of illness or injury of the newborn are covered from the moment of birth and beyond the first 31 days of life, provided the child is enrolled within 31 days after the date of birth. Pediatric care including immunizations, injections, and routine medical attention, is covered. Sick childcare is covered as any other medical condition regardless of age.
 - b) Physical Examinations. Scheduled Physical Examinations, are covered according to the following schedule:

i. Pediatric (under age 19)

Infant (age under 2 years)	8 well baby exams first 24 months
Early childhood (3-5 years)	One exam every year
Late childhood (6-12 years) Male Child	One exam every 2 years
Late childhood (6-10 years) Female Child	One exam every 2 years
Adolescent female (11-18 years)	One exam every year
Adolescent male (13-18 years)	One exam every year

ii. Adult age groups

19– 40	One exam every 18 months
41 and over	One exam every 12 months

- iii. Women. Yearly breast and pelvic exam, PAP test, and at the Provider’s discretion, blood chemistry profile, CBC, hematocrit and urinalysis, are covered. Screening and diagnostic mammography are covered with the following guidelines:

Age 35-39	One baseline mammogram
Age 40-49	Once every 24 months
Age 50 and over	Annually

Additional mammograms and PAP test are covered as Medically Necessary for enrollees at high risk.

- c) Vision and Hearing Services are covered as follows:
 - i) Eye Exams. Eye examinations to determine the need for vision correction are covered under
 - ii) VISION CARE BENEFIT on page 22.
 - iii) Upon Written Referral, medical treatment for special eye problems is covered.
 - iv) Hearing Exams. Upon Written Referral, hearing tests in support of a diagnosis are covered. Hearing aids and other corrective appliances are covered up to \$500 annually.
- d) Family Planning. Counseling and assessment for birth control are covered. Diaphragms, intrauterine devices, and Depo Provera are covered when provided in the doctor's office.
- e) Immunizations and injections are covered as follows:
 - i) Immunizations and injections routinely administered or those, which become necessary due to a specific local threat of disease, are covered.
- 2) Administration of treatment compounds, solutions and medications for allergy care is covered.
- 3) Diagnostic Services. Diagnostic services, including radiology (X-ray), pathology, laboratory tests, and other imagining and diagnostic services are covered.
- 4) Routine Office Visits. An Insured's routine office visits, including routine diagnostic examination and treatment of illness or injury, are covered.
- 5) Mental Health. Outpatient mental health visits are covered to applicable benefit limits as set forth on page 9 paragraph 10).
- 6) Chemical Dependency Treatment.
- 7) Chemical dependency means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to common problems on a recurring basis. For purposes of this Agreement, chemical dependency does not include addiction to or dependency on tobacco, tobacco products or foods.
- 8) Diagnosis and medical treatment for chemical dependency, including outpatient detoxification, are covered to applicable benefit limits set forth on page 10 paragraph 0.
- 9) In all cases, Physicians shall determine the presence of chemical dependency and the modality of treatment that best serves the interest of the Insured. No coverage shall be provided for educational programs to which drivers are referred by the judicial system or for volunteer mutual support groups.

- 10) **Physician Services While Hospitalized.** The services of Physicians during a covered hospitalization, including services of specialists, surgeons, assistant surgeons, anesthesiologist, and other appropriate medical personnel, are covered.
- 11) **Home Visits.**
- 12) **Outpatient Surgery.** Surgical procedures performed in the office are covered. Outpatient surgical procedures performed in other facilities are covered.

Hospital Inpatient Services

Medically Necessary Hospital inpatient services are covered as follows:

- 1) **Hospital Inpatient Services.** Inpatient services are covered only
 - a) upon Written Referral; or
 - b) as Emergency Medical Care.
- 2) **Maternity Hospitalization.** Refer to Page 7.
- 3) **Inpatient Mental Health.** Inpatient mental health care is covered to the applicable benefit limits set forth beginning on page 9.
- 4) **Chemical Dependency Treatment.** Inpatient chemical dependency treatment at a participating hospital or facility is covered to the applicable benefit limits set forth beginning on page 10.
- 5) **Emergency Room/Transfer.** Emergency room Co-payments are waived when the Insured is admitted to a Hospital as an inpatient directly through that Hospital's emergency room.
- 6) **Reconstructive Breast Surgery.** Reconstructive breast surgery following a mastectomy which resulted from disease, illness or injury, all stages of one reconstructive breast reduction on the non diseased breast to make it equal in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed, and prostheses and treatment of physical complications of the mastectomy, are covered.
- 7) **Reduction mamoplasty** deemed medically necessary for the long-term health.

Emergency Room / Outpatient Services

Medically Necessary emergency room treatment and other outpatient services are covered as follows:

- 1) **Emergency room treatment,** including but not limited to diagnostic, laboratory, and radiological services, is covered only for Emergency Medical care and not merely for the convenience of the Insured.
- 2) **Outpatient Surgery.** Other than outpatient surgery performed by the doctor in the office, outpatient surgery is covered only
 - (1) upon Written Referral; or
 - (2) as Emergency Medical Care.

- 3) **Outpatient Service.** Upon Written Referral, outpatient services, including but not limited to diagnostic services, preventative / wellness treatments and procedures, treatment services, rehabilitation services in accordance with page 8 paragraph 5), x-ray and other imaging services, are covered. Outpatient services may be provided in a non-hospital based health care facility or at a Hospital.
- 4) **Urgent Care.** When an Insured receives Urgent Care a claim must be submitted to the Administrator within 90 days from the date the care was rendered or as soon as medically possible. The claim must contain sufficient information to establish the Medically Necessary and urgent nature of the care.

Maternity Benefits:

Medically Necessary maternity care is covered as follows:

- 1) **Availability.** Maternity benefits are available for the Insured or Insured's spouse only.
- 2) **Prenatal and Postnatal Care.** Prenatal and postnatal care is covered.
- 3) **Hospital Room and Board.** Hospital room and board is covered.
- 4) **Delivery and Nursing Care.** Delivery services and facilities and nursing care are covered in a Hospital only.
- 5) **Woman's Health Provider Services.** Obstetrical services are covered when provided by a Primary Care or Women's Health Provider.

Medical Care Outside the Service Area

Only Medically Necessary Urgent Care and Emergency Medical Care are covered outside the Service Area. Except for maternity care and complications described on page 12, Medically Necessary Urgent Care and Emergency Medical Care provided outside the Service Area are covered as provided under the Schedule of Benefits for Network Providers:

- 1) **Physician Direction.** Urgent Care and Emergency Medical Care must be provided under the order and direction of a Physician.

Other Services

Other Medically Necessary services will be covered as follows:

- 1) **Home Health Care.** Upon Written Referral, Home Health Care for Skilled Nursing Services is covered in the home or place of residence of the Insured, which is not a Skilled Nursing Facility. Daily coverage is limited to what PURMS would pay a participating Skilled Nursing Facility for 24-hour Skilled Nursing Services. The maximum benefit is 60 days per year. PURMS may utilize an exclusive Provider of Home Health Care.
- 2) **Medical Emergency Ambulance Transport.** Licensed ground ambulance services are covered in the event of an Emergency Medical Condition. Licensed air ambulance services are covered at 100% if emergent, 50% if not.
- 3) **Skilled Nursing Care.** Skilled Nursing Service in a participating Skilled Nursing Facility is covered upon Written Referral, but limited to a maximum of 60 days per Year.

- 4) Hospice Care. Upon Written Referral for terminally ill Employees, hospice care is covered to the extent that the Home Health Care and Skilled Nursing Service benefits described in paragraphs 1) and 3) of this section have not been fully utilized. Daily coverage is limited to what the Company would pay a participating Skilled Nursing Facility for 24-hour Skilled Nursing Services. In no event shall the total number of days covered for Home Health Care, Skilled Nursing Services and hospice care combined exceed 120 days per Year.
- 5) Therapy. Upon Written Referral, short-term Hospital-based or outpatient rehabilitation services and physical therapy which are expected to significantly improve the condition of an Insured within 60 days are covered. The maximum benefit is 60 consecutive days from the onset of treatment, including both inpatient and outpatient services, per illness or injury.
- 6) Health Education Services. Instruction in the appropriate use of health services and the contribution each Insured can make to the maintenance of his or her own health is covered up to the limits set forth in this Section. Health education services shall include instruction in personal health care measures and information about services, including recommendations on generally accepted medical standards for use and frequency of such service. Diabetes self-management education classes are covered as medically indicated. PURMS will cover up to \$50 for each health education class, up to a total of \$150 annually. "Class" for this purpose is defined as covering a standalone project or series of related subjects. Diabetes self-management classes and cardiac rehabilitation classes will be covered at up to \$150 per class with a Written Referral, if Medically Necessary. Written Referrals are not required for other types of health education classes.
 - a) The total benefit under this Section is not to exceed \$500 annually, whether through one diabetes self-management class or through multiple health education classes. Qualifying classes include: diabetes management, prenatal/child birthing, cardiac rehabilitation, exercise, health heart, first aid/CPR, weight management, stress management, and smoking cessation.
- 7) Organ and Tissue Transplants. No benefits shall be provided for services related to any organ or tissue transplant until the affected Insured has been covered under this Agreement for a period of 12 consecutive months, whether or not the transplant is required as the result of a Pre-existing Condition or an emergency. Upon receipt of a booklet of Creditable Coverage, the transplant exclusion period will be reduced by the length of Creditable Coverage under other Health Benefit Plans that are not preceded by a break in coverage of 63 days or more. Credit for Creditable Coverage will be applied if the excluded service was covered under the prior coverage. The transplant exclusion period does not apply to a newborn or newly adopted child with Creditable Coverage since birth or adoption.
 - a) Subject to a \$1,000,000 lifetime maximum for all transplant services, the following organ and tissue transplants are covered: kidney transplants; cornea transplants; heart transplants; liver transplants; lung transplants; heart-lung transplants; concurrent kidney-pancreas transplants for uremic insulin-dependent diabetics; artificial pump as a bridge to cardiac transplants; and autologous or allogeneic bone marrow transplants, stem cell rescue or hematopoietic support (all referred to herein as transplants) only for aplastic anemia, leukemia, hereditary severe combined immunodeficiency disease or Wiskott-Aldrich Syndrome, neuroblastoma, Hodgkins and non-Hodgkins lymphoma and for malignant tumors (including breast cancer) when necessary to support high dose

- chemotherapy. Services, supplies and pharmaceuticals required in connection with a) evaluation of an Insured as a transplant candidate, b) tissue typing, c) a covered transplant procedure, d) scheduled follow-up care, e) anti-rejection drugs, and transportation and living expenses in connection with those services when PURMS requires the Insured to receive care from a Specialty Care Center outside the Service Area if the services are available from another provider within the Service Area are covered only within the lifetime maximum. Organ or bone marrow search, selection, transportation and storage costs are not covered.
- b) When the recipient of a covered transplant is an Insured, donor costs directly relating to surgical removal of the organ from the donor, as well as the costs of treating complications directly resulting from the surgery, will also be paid under the limits of this benefit, provide that the donor is not eligible for coverage under any other health care plan or government funding program.
 - c) The \$1,000,000 lifetime maximum includes all amounts paid on behalf of an Insured by the Company or by any other health insurer or entity providing group health care benefits for any organ or tissue transplant and supporting services.
 - d) The Company reserves the right to direct care to designated Specialty Care Center which are more cost effective and provide high quality care for the patient. Specialty Care Center may be located anywhere in the United States, so the Insured may be required to travel outside the Service Area for care.
- 8) Durable Medical Equipment. Durable Medical Equipment, including the initial rental or purchase and repair but excluding replacement, is covered at 80%.
- 9) Medical Supplies. Diabetic and ostomy supplies are covered. All other non-durable medical supplies are excluded
- a) Diabetic supplies dispensed in accordance with any formulary adopted by PURMS, including syringes, injection aids, blood glucose monitors and test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories, insulin infusion devices, and foot care appliances for prevention of complications associated with diabetes, are covered at 80%. Insulin, glucagons emergency kits and prescriptive oral agents are excluded, unless covered under a Supplemental Prescription Benefit Schedule. Diabetic glucometers, insulin pumps, infusion pumps and supplies are covered.
 - b) Ostomy supplies dispensed in accordance with any formulary adopted by PURMS are covered at 80%. Covered supplies include flanges, pouches, irrigators, irrigator sleeves and drains, closed-end pouches, stoma caps, belts, convex inserts, drain tube adapters, drainable pouch clamps, medical adhesive, replacement filters, security tape, and skin barriers. The following are not covered; wound care products; incontinence products; generic multi-use products; reusables.
- 10) Mental Health Benefits. Benefits for treatment of Mental Disorders, or for treatment of both Mental Disorders and Chemical Dependency, as provided up to the following service limits during any 12-consecutive-month period.

	Adults	Under Age 18
Inpatient	10 days	11 days
Residential/day	19 days	19 days
Outpatient	26 visits	26 visits

This policy will never provide less than the minimum benefits required by state and federal laws.

- 11) Chemical Dependency (Alcohol & Drugs) Benefits. Chemical dependency benefits are provided only upon Written Referral. Maximum benefits for specific inpatient, residential, or outpatient treatment are limited as follows: Provided for one series only, no repeat treatments. No cure, no employment.

Outpatient	In a 24 month period	Up to \$1,500 for adults Up to \$2,000 for children under 18
Inpatient	In a 24 month period	Up to \$4,500 for adults Up to \$4,000 for children under 18
Residential/Day Care	In a 24 month period	Up to \$3,500 for adults Up to \$3,000 for children under 18

Note: There is a \$1,500 floating chemical dependency benefit for children under 18 which may be utilized for either inpatient or residential/day care services.

This policy will never provide less than the minimum benefits required by state and federal laws.

- 12) Nonprescription Elemental Enteral Formula. Nonprescription elemental enteral formula for home use is covered if the formula is Medically Necessary for the treatment of severe intestinal malabsorption, and a Physician has issued a written order for the formula, and the formula comprises the sole source or an essential source, of nutrition.
- 13) Inborn Errors of Metabolism. Treatment and medical foods are covered for inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist. Coverage includes diagnosis, monitoring and controlling the disorders by nutritional and medical assessment. "Medical foods" are defined as those formulated to be consumed or administered enterally under the supervision of a physician that are specifically processed or formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts, that are for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained therein or have other specific nutrient requirements as established by medical evaluation and that are essential to optimize growth, health and metabolic homeostasis.
- 14) Case Management. The Company will have the right to authorize benefits for services and supplies excluded or not specifically covered under this Agreement as a substitute for other, possibly more costly, covered services or supplies. Such alternative benefits shall be

determined by the Company, in advance, in cooperation with the Insured and will only be covered upon Written Referral. The decision on the course of treatment shall remain up to the Insured and the Insured's Provider. The Company's decision in any specific instance to authorize benefits that would not otherwise be covered under this Agreement shall not commit the Company to cover the same or similar benefits for the same or any other Insured in other instances. By authorizing alternative benefits, the Company shall not waive its right to enforce all terms, limitations and exclusions of this Agreement.

- 15) Diagnosis and treatment of dependant children for learning disorders, psychosocial problems, speech delay, conceptual handicap and developmental delay or dyslexia.

Exclusions and Limitations

Benefits provided by this Agreement may be revoked or modified from time to time and year to year. No Insured acquires a vested right to continue to receive a benefit as set forth in this Agreement on or after the effective date of any revocation or change to such benefit. An Insured's right is to receive only such benefits as are expressly provided for and in effect on the date of each treatment. Employees are entitled to receive benefits subject to the exclusions and limitation as stated in any provision of this Agreement. Benefits are available only as Medically Necessary.

All benefits, exclusions and limitations set forth in the attached Benefit Schedules are incorporated here by this reference.

Written notice of claim for treatment of accident or sickness more than twelve month after the date of service will be denied.

Any care deemed not Medically Necessary.

All the following benefits, accommodations, care, services, equipment, medications or supplies are expressly excluded from coverage:

- 1) All services or supplies that exceed any maximum cost or time (days or visits) limitation imposed in this Schedule or any Supplemental Benefit Schedule.
- 2) All services or supplies rendered for any illness, injury, or condition to the extent that benefits are available to the Insured as an insured under the terms of any insurance (except group or individual health insurance) including without limitation automobile medical, personal injury protection, auto-mobile no-fault, automobile insured or underinsured motorist, homeowners or renters, commercial premises or comprehensive general liability insurance coverage. If the Fund pays benefits before any such insurance payments are made, reimbursement must be made out of any subsequent insurance payments made to the Insured and, when applicable, the Fund may recover benefits already paid directly from the insurer.
- 3) Medical, surgical or other health care procedures, treatments, devices, products or services (collectively, "health care services") which are determined by the Administrator to be Experimental or Investigational, and complications directly caused thereby, are expressly excluded from coverage. Health care services will be considered experimental or investigational if there is a preponderance of the qualified medical community which does

not accept the service as proven to be safe and effective in treating a particular illness or condition and in improving the length and quality of life.

- 4) In determining whether health care services are experimental or investigational, the Administrator will evaluate the services with regard to the particular illness or disease involved and will consider factors such as; the demonstrated effectiveness of the services in improving the length and quality of life; the incidence of death and complications associated with the services; alternative methods of treatment; whether the services are provided under continued scientific testing and research and report in current medical and scientific literature concerning such testing and research; the positions of governmental agencies and other institutions (including without limitation Medicare, the Agency for Health Care Policy and Research and the American Medical Association) regarding the experimental or investigational nature of the services; whether the FDA has approved drugs for the use proposed; and the patient's physical, mental and psychological condition.
- 5) Expenses for any condition or complication caused by any procedure, treatment, service, drug, device, product or supply excluded from coverage.
- 6) A private room or services of private or special duty nurses other than as Medically Necessary when an Insured is an inpatient in a Hospital.
- 7) Services of physiologist, homeopaths, naturopaths, massage therapists, rolfers and hypnotherapists, acupuncture, unless ordered by a licensed physician.
- 8) Custodial Care; respite care.
- 9) The replacement of Durable Medical Equipment, whether or not originally acquired while the Insured was covered by this health plan; corrective appliances and artificial aids, braces, all internal and external Prosthetic Devices not specifically identified as covered herein, including temporary prostheses and orthotics; disposable or non-prescription or over-the-counter supplies such as ace bandages, splints, and syringes unless dispensed by a Network Provider and except as provided in **Other Services**, paragraph 9) page 9; exercise and hygiene equipment; support garments; electronic monitors; devices to perform medical tests on blood or other body substances or excretions; devices not exclusively medical in nature including but not limited to sauna baths, spas, elevators, air conditioners or filters; humidifiers or dehumidifiers; equipment that can be used after the medical need is over such as orthopedic chairs and motorized scooters; or modifications to the home or motorized vehicles.
- 10) Cosmetic surgery.
- 11) Augmentation mammoplasty, except as provide in paragraph 6) page 6.
- 12) Preparation and presentation of medical or psychological reports or physical examinations required primarily for the protection and convenience of the Insured or third parties, including, but not limited to, examinations or reports for school events, camps, employment, marriage, trials or hearings, licensing and insurance, unless performed as a Scheduled Physical Examination as described in paragraph 1)b) page 4.
- 13) Payment for care for conditions that state or local law requires be treated in a public facility. All military service connected disabilities.

- 14) Diagnosis and treatment of infertility. Complications caused by treatment for infertility. From a coverage standpoint, infertility-related diagnosis and treatment includes but is not limited to:
- i. Evaluation and/or treatment of an inability to conceive.
 - ii. Evaluation and/or treatment of habitual abortion, including chromosomal analysis.
 - iii. Treatment to maintain a first-trimester pregnancy.
 - iv. Assisted reproductive technologies and artificial insemination.
 - v. Semen analysis, documentation of normal ovulation function (unless done as part of an endocrine evaluation for non-infertility indications), post-coital examination, and testing for patency of fallopian tubes is always considered infertility evaluation.
- 15) Reversal of voluntary surgically induced infertility (sterilization). Procedures, services and supplies related to sex transformation, transsexualism or paraphilias (sexual deviations).
- 16) Diagnosis, treatment and rehabilitation services for obesity and other eating disorders including counseling, educational services, diet supplements, weight loss surgery or complications caused by weight loss surgery. Services for bulimia and anorexia are covered only as mental health benefits.
- 17) All organ and tissue transplants or autologous stem cell rescue not explicitly listed as covered (see page 9.a.). Services for an organ donor or prospective organ donor when the transplant recipient is not an Insured. Organ and bone marrow search, selection, transportation and storage costs. Non-human or artificial organs and the related implantation services. Permanent or temporary implantation of artificial or mechanical devices to replace or assist human organ function until the time of organ transplant, except for dialysis to maintain a kidney and artificial pump bridge to cardiac transplants. High dose chemotherapy which requires the support of a non-covered bone marrow transplant or autologous stem cell rescue. Transplants disapproved by the PURMS Transplant Evaluation Committee. Bone marrow transplantation, stem cell rescue or hematopoietic support for human gene therapy (enzyme deficiencies, severe hemoglobinopathies, primary lysosomal storage disorders). All services in excess of the lifetime maximum benefit or organ and tissue transplants.
- 18) Personal comfort items provided in the home, such as television, telephone, lotions, shampoos, meals, guest meals, housekeeping services, etc.
- 19) Rehabilitation services, physical, speech, and hearing therapy except as provided in paragraph 5) page 8. Speech therapy for developmental or emotional problems.
- 20) Mental Health and Chemical Dependency Services except as provided in paragraph 10) and 11) starting on page 9.
- 21) Medications, surgical treatment or hospitalization for treatment of impotency, penile implants, services, devices, prosthetics or aids related to treatment for any types of sexual dysfunction, congenital or acquired, except those symptoms resulting from prostate cancer and / or treatment.
- 22) Genetic engineering or counseling.

- 23) Recreational or educational therapy; non-medical self-help training.
- 24) Bone bank and eye bank charges.
- 25) Counseling or training in connection with family, sexual, marital, or occupational issues.
- 26) Orthoptics, pleoptics, visual analysis, visual therapy and/or training.
- 27) Services for which the Insured would not be liable in the absence of PURMS coverage.
Services rendered by a person who resides in the Insured's home or by an immediate relative of the Insured.
- 28) Any illness, condition or injury occurring in or arising out of the course of employment.
- 29) Court-ordered care, unless determined to be Medically Necessary. Psychiatric therapy as a condition of parole probation or court order.
- 30) Diagnosis, treatment and rehabilitation services for injuries sustained while practicing for or competing in a professional or semi-professional athletic contest.
- 31) Any charges for medical records necessary to determine benefits.
- 32) Hair analysis.
- 33) Services or supplies for any illness, injury or condition caused in whole or in part by or related to the use of a motor vehicle by the Insured when test show the Insured had a blood alcohol level in excess of that permitted to legally operate a motor vehicle under the laws of the state in which the accident occurred.
- 34) Medical Services provided outside the Service Area for maternity care and complications for a pregnant Insured and, in the event of delivery, the newborn, during the 31-day period prior to the expected date of delivery or at any time after the Insured has been notified that she is at high risk of complications.
- 35) Routine foot care, including treatment for corns, calluses and cutting of nails.
- 36) Growth hormone therapy.

Definitions

The following terms, when used in this Agreement, are defined as follows:

- 1) "Anniversary Date" means an anniversary of the Effective Date as identified on the Signature Sheet of this Agreement.
- 2) "Appeal" or "Grievance" means a written request submitted by or on behalf of an Insured for reconsideration of a decision regarding (a) availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (b) claims payment, handling or reimbursement for health care services; or (c) matters pertaining to the contractual relationship with the Plan.
- 3) "Benefit Schedule" means the attached exhibits identified as the Co-payment Schedule or other Benefit Schedule(s) which set forth the medical, hospital and other benefits provided by PURMS.
- 4) "Coinsurance" means the percentage portion of a Provider's Usual, Customary and Reasonable charge to be paid by Employees directly to Providers.

- 5) “Contract Year” means the 12-month period between the Group Effective Date of the Agreement and the first Anniversary Date and successive 12-month periods beginning on each Anniversary Date thereafter. “Year” or “Determination Year” means calendar year unless the Signature Sheet specifies use of a Contract Year as the Determination Year.
- 6) “Copayment” means the cash amount stated in the Schedule of Benefits to be paid by Employees directly to Providers for services, which qualify as Plan Authorized Benefits.
- 7) “Creditable Coverage” means prior health care coverage under a group or individual health benefit plan, Medicare, Medicaid, military-sponsored health care, a medical care program of the Indian Health Services or of a tribal organization, a state health benefits risk pool, a Federal Employee’s Health Benefit Plan (FEHBP), a public health plan, or a health benefit plan under the Peach Corps Act, except coverage consisting solely of coverage of benefits for which credit is not required under applicable law. Coverage is Creditable only if there has not been a gap in coverage exceeding 62 days.
- 8) “Custodial Care” means care that does not require the continuing services of skilled medical or allied health professionals or that is designed primarily to assist an Insured in activities of daily living, whether provided in an institution or in the home. Custodial Care includes but is not limited to medical care and services which can reasonably be provided to an Insured by a medically non-licensed individual such as a parent, spouse, child or other resident of the home, help in walking, getting in and out of bed, bathing, dressing, use of the toilet or commode, feeding, preparation of special diets, and supervision of medications that are ordinarily self-administered.
- 9) “Dependent” means any Insured of Insured’s immediate family who is one of the following:
 - a) The spouse of the Insured.
 - b) An unmarried child of the Insured under the age of 19 for who the Insured provides over half of the total support or who is the subject of qualified medical child support order requiring the Insured to provide health coverage for the child.
 - c) An unmarried child of the Insured of less than 24 years of age who is a full-time student (which means a minimum of 12 credit hours per quarter or semester for three quarters or two semesters during an academic year) in an educational or vocational institution and for whom the Insured provides over half of the total support or who is the subject of a qualified medical child support order requiring the Insured to provide health coverage for the child. Proof of full-time student status may be required at any time.
 - i) “Child” means a natural child of the Insured, an adopted child of the Insured or a stepchild of the Insured (during the marriage of the Insured and the natural parent), but does not include foster children, wards, or children who are the subject of an Assignment of Parental Rights, even if decreed by a court. “Child” also does not include children of Dependents unless the Insured is a court-appointed guardian. Provided, however, that a child who is placed with an Insured for the purposes of adoption shall be considered a Dependent of the Insured. Coverage of any Dependent child of an Insured shall not be terminated by the child’s attaining the relevant limiting age (19 or 24) if the child is and continues to be Disabled and is not eligible to be covered under any government program except Medicaid. Proof of disability must be furnished annually.

- 10) “Dependent Coverage” means coverage provided to a Dependent.
- 11) “Disabled” means, in the case of an adult person an individual who by reason of developmental disability, injury or illness is totally unable to perform the usual tasks in the work he/she was performing at the time of the developmental disability, injury or illness and is wholly unable to perform in any physical or mental capacity in his/her current occupation or is wholly unable to engage in the normal activities of a person of the same age and sex. A Dependent will be considered disabled when, by reason of injury or illness, he/she is wholly unable to engage in the normal activities of a person of the same age and sex.
- 12) “Durable Medical Equipment” means equipment (a) which can withstand repeated use; (b) the only function of which is for treatment of a medical condition or for improvement of function related to the medical condition; (c) which is of no use in the absence of the medical condition; (d) which is appropriate for home use.
- 13) “Effective Date” means of the date of this Agreement as stated on the Signature Sheet. The date coverage is effective for individual Insureds and Dependents is described herein.
- 14) “Eligible Employee” means any Commissioner, officer, manager, or employee of the District, the officers, managers, and employees of subsidiary or affiliated corporations (if the District is a corporation), and the individual proprietors, partner and employees of individuals and firms, the business of which is controlled by the District, by stock ownership, contract or otherwise. To qualify as an Employee, an individual must work a minimum of 17.5 hour per week at the business of the Employer and otherwise have a bona fide employee/employer relationship with the District. The term excludes individuals who work on a temporary or substitute basis. Individuals who are engaged as independent contractors are not considered ‘Eligible Employees’.
- 15) “Emergency Medical Care” means the following services rendered in the diagnosis and treatment of an Emergency Medical Condition of an Insured:
- a) Services of Participating or Nonparticipating Providers consisting of an Emergency Medical Screening Exam and Stabilization of the Emergency Medical Condition; or
 - b) Services of Nonparticipating Providers consisting of those health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required for the Stabilization of an Insured, if a prudent layperson possessing an average knowledge of health and medicine would reasonably believe that the time required to go to a Network Provider would place the health of the Insured (or a fetus in the case of a pregnant Insured) in serious jeopardy. Claims for Emergency Medical Care by Nonparticipating Providers shall be limited to 80% of the Usual, Customary and Reasonable rates in the geographic area in which the Medical Services are provided. Maternity and newborn services may be subject to limitations on out-of-area coverage.
- (1) All claims for Emergency Medical Care must be accompanied by sufficient documentation to establish the Emergency Medical Condition.
- 16) “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 an Insured (or a fetus in the case of a pregnant Insured) in serious jeopardy.

- 17) "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.
- 18) "Enrollment" or "Enroll" or "Enrolled" means the completion and signing of the necessary PURMS enrollment forms by or on behalf of an eligible person and acceptance by PURMS.
- 19) "Enrollment Date" means the effective date of coverage or the first day of the Group Insured's probationary period, if any, whichever is earlier.
- 20) "Experimental" or "Investigational" means services which a preponderance of the medical community does not accept as proven to be safe and effective in treating a particular illness or condition and in improving the length and quality of life. In determining whether health care services are experimental or investigational, PURMS will evaluate the services with regard to the particular illness or disease involved and will consider factors such as: the demonstrated effectiveness of the services in improving the length and quality of life; the incidence of death and complications associated with the services; alternative methods of treatment; whether the services are provided under an experimental or investigational protocol or study; whether the services are under continued scientific testing and research and report in current medical and scientific literature concerning such testing and research; the positions of governmental agencies and other institutions (including without limitation Medicare, the Agency for Health Care Policy and Research and the American Medical Association) regarding the experimental or investigational nature of the services; whether the FDA has approved drugs for the use proposed; and the patient's physical, mental and psychological condition.
- 21) "Health Benefit Plan" means any Hospital expense, medical expense or Hospital or medical expense policy or booklet, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the Federal Employee Retirement Income Security Act of 1974, as amended.
- 22) "Home Health Care" means a program of care provided by a public agency or private organization or a subdivision of such an agency or organization, which; (a) is primarily engaged in providing Skilled Nursing Services in homes or places of residence of its patients; (b) is licensed according to applicable laws of the State of Washington and of the locality in which it is located or provides services; and (c) has a written agreement with PURMS as an agency or organization to provide Home Health Care to Employees under this Agreement.
- 23) "Hospice" means a program provided by a public agency or private organization that is primarily engaged in providing services to terminally ill persons. The Hospice and its employees must be licensed in accordance with applicable state and local laws and certified by Medicare.
- 24) "Hospice Care" is care provided by a Hospice and designed to provide medical and supporting care to the terminally ill and their families. Hospice Care is designed to be provided primarily in the patient's home.
- 25) "Hospital" means an institution which is either:

- a. An institution which is primarily engaged in providing, on an inpatient basis, medical care and treatment for sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be located on its premises, under the supervision of a staff of Physicians and with 24 hour-a-day nursing services; or
 - b. An institution not meeting all the requirements of (a) above, but which is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations or pursuant to Title XVIII of the Social Security act as amended.
 - 1. In no event shall the term “Hospital” include a convalescent nursing home or any institution or part thereof which is used principally as a convalescent facility, rest facility, or nursing facility.
- 26) “Hospital Services” means those Medically Necessary services for inpatients and outpatients, which are generally and customarily, provided by acute care general Hospitals, and which are prescribed, directed, or authorized by a Physician in accordance with this Agreement. “Hospital Services” shall also include Medically Necessary services rendered in the emergency room and/or the outpatient department of any Hospital.
- 27) “Infertility” means the failure of a couple during normal childbearing years to achieve conception after one or more years of regular sexual intercourse without practicing contraceptive measures. Sexual dysfunction that prevents successful intercourse may also be considered infertility.
- 28) “Insured” or “PURMS Insured” or “Enrollee” means any Insured or Dependent who satisfies all of the requirements of this Agreement, who has been enrolled by PURMS and for whom the current monthly assessment has been received by PURMS.
- 29) “Medical Director” means a Medical Director of PURMS or his or her designee. A decision of the Medical Director, which substantially affects an Insured, and will be made in the exercise of the Medical Director’s reasonable judgment, subject to all of the terms and conditions of this Agreement.
- 30) “Medical Services” means (except as expressly limited or excluded by this Agreement) those Medically Necessary health care services, which are performed, prescribed or directed by a Physician.
- 31) “Medically Necessary” means any health care service or supply for prevention, diagnosis, or treatment which is not excluded or limited by this Agreement and which is:
- i. Consistent with the illness, injury or condition of the Insured;
 - ii. Not primarily for the convenience, appearance or recreation of the Insured;
 - iii. In accordance with approved and generally accepted medical or surgical practice prevailing in the geographic locality where and when the service or supply is ordered;
 - iv. Is ordered by a Licensed Physician;
 - v. The most appropriate of the alternative levels of service or supply that is adequate and available.
- 32) “Nonparticipating Provider” means any Provider who is not a Network Provider at the time services are rendered to an Insured.

- 33) "Participant" means an individual who is an employee or Insured of the Company and is entitled, in accordance with the Group's established eligibility rules, to participate in the health and welfare plan sponsored by Company. Participant also includes employees of entities that are eligible, in accordance with the Group's eligibility rules, to participate in the health and welfare plan sponsored by Company.
- 34) "Participating Physician: means any Physician who has entered into a contract or other arrangement to provide Medical Services to PURMS Employees with an expectation of receiving payment, other than Co-payments, directly or indirectly from PURMS and whose contract or other arrangement is in effect at the time such services are rendered.
- 35) "Network Provider" means a licensed or certified Physician, health professional, Hospital, home health agency, pharmacy, or other licensed or certified entity or person who has entered into a contract or other arrangement to provide health care services to PURMS Employees with an expectation of receiving payment, other than Co-payments, directly or indirectly from PURMS and such contract or other arrangement is in effect at the time such services are rendered.
- 36) "Physician" means any doctor licensed to practice medicine or osteopathy in Washington or in the state in which medical care is rendered.
- 37) "Pre-existing Condition" means a condition for which medical advice; diagnosis, care or treatment was recommended or received during the six-month period preceding the enrollment date. Pregnancy is not a Pre-existing Condition. Genetic information does not constitute a Pre-existing Condition in the absence of a diagnosis of the condition related to such information.
- 38) "Pre-existing Condition Exclusion Period" means six months, plus the Group Insured's Probationary Period, not to exceed an additional three months, for a new Insured enrolled when first eligible. A new Insured not enrolled when first eligible is a Late Enrollee.
- 39) "Preventative Care" means the same as 'Wellness Care', which includes, but is not limited to, routine physical examinations; gynecological exams, including Pap smear; prostate exams; well child care; necessary diagnostic X-ray and imaging, endoscopic, and laboratory tests; and routine immunizations and vaccinations, and other procedures as ordered by a physician.
- 40) "Prosthetic Devices" means artificial substitutes that are required to replace all or any part of a body organ or extremity.
- 41) "Service Area" means The Dalles, Hood River, White Salmon, Skamania County, Clark County, Portland / Vancouver, and surrounding areas.
- 42) "Signature Sheet" means the Sheet attached to this Agreement and identified as such.
- 43) "Skilled Nursing Facility" has the same meaning as Extended Care Facility in Title XVIII of the Social Security Act and regulations but is limited to those facilities with a contract or other arrangement with PURMS.
- 44) "Skilled Nursing Service" has the same meaning as Extended Care Service in Title XVIII of the Social Security Act and regulations except that it does not include a requirement of prior hospitalization, interpreted as if all Employees were covered under both parts of Title XVIII and applies only to services performed, prescribed, or directed by a Participating Physician.

“Post-Hospital Extended Care Service” has the same meaning as Title XVIII of the Social Security Act and regulations but applies only to services performed, prescribed, or directed by a Participating Physician.

- 45) “Stabilization” means that, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur.
- 46) “Urgent Care” means Medically Necessary Medical Services, other than Emergency Medical Care, which are provided without a Written Referral for an unforeseen acute medical condition that requires the Insured to seek immediate treatment in order to prevent serious deterioration of the Insured’s medical condition when the Insured is unable to contact his or her doctor. Employees should not use Hospital emergency rooms to receive Urgent Care. Coverage for Urgent Care is limited to the lesser of the Usual, Customary and Reasonable rates in the geographic area in which the Medical Services are provided or the contacted rate agreed to by the Urgent Care Center. All claims for Urgent Care must be accompanied by sufficient documentation to establish the medical Necessity and urgent nature of the treatment or services.
- 47) “Usual, Customary, and Reasonable” means the maximum allowable amount for a health care service, determined by the Administrator in its sole and absolute discretion on the basis of the fee usually charged by the Provider and data obtained by the Administrator regarding fees charged by Providers of similar training and experience for the same service within the same geographic area.
- 48) “Women’s Health Provider” means a Network Provider who is an obstetrician or gynecologist, Physician assistant specializing in women’s health advanced registered nurse practitioner specialist in women’s health or a certified nurse midwife, practicing within the applicable lawful scope of practice.

Eligibility

- 1) To be eligible to Enroll as an Insured, a person must, at the time of Enrollment and throughout the term of this Agreement, be a Participant of the Company and live or work in the Service area and must meet the subscriber Group’s eligibility criteria.
- 2) To be eligible to Enroll as a Dependent, a person must be a Dependent of an Insured, live with the Insured or in the Service Area and must meet the Company’s eligibility criteria. Dependent Coverage will terminate when an Insured ceases to be an eligible Dependent.
- 3) A Dependent child of an Insured for whom a qualified medical child support order has been issued by a court of competent jurisdiction may be enrolled even if the child lives outside the Service Area. However, only Urgent Care and Emergency Medical Care are covered outside the Service Area.

Enrollment and Effective Date

- 1) Participants and their Dependents may Enroll by submitting a completed application form within 31 days of the first day of employment, transfer or the first day of eligibility for health Benefits.
- 2) An Insured may Enroll a Dependent during any open Enrollment period, or by obtaining Dependent Coverage within 31 days of acquisition of the Dependent.

- 3) When an Insured acquires a new Dependent, the Insured must make an appropriate written application for Dependent coverage within 31 days of the date the new Dependent first becomes eligible. Dependent Coverage becomes effective upon approval of the Enrollment. Insureds who wish to enroll a new Dependent must provide supporting documentation. When an Insured acquires new Dependents as a result of marriage, birth, or adoption, the Insured and new Dependents may be enrolled by making application. Coverage becomes effective the first day of the month following submission of the application.
- 4) Newborn or Adopted children of an Insured will be automatically covered as Dependents for a period of 31 days from date of birth or adoption. An Insured must submit an appropriate application within 31 days after birth and be accepted by PURMS in order to continue coverage of the newborn beyond the first 31 days of life. Dependent Coverage for children placed with an Insured for the purpose of adoption will be automatically provided for a period of 31 days after placement. A subscriber must submit an appropriate application to PURMS within 31 days. Coverage shall be retroactive to the date of the child's placement with the Insured, not to precede the Insured's Effective Date of the Insured. Dependent Coverage for the Insured's Dependents other than newborn children and children placed for adoption will not be provided under this Section.
- 5) Changes in the enrollment of Participants and their Dependents will be permitted outside of the open Enrollment period when permitted by the terms of Company's health and welfare plan if there is a qualified change in employment or family status and the change in enrollment is consistent with the reason for the change. Qualified status changes include: marriage or divorce; birth or adoption of a child; death of a spouse or dependent; change in the Participant's or spouse's employment status from full-time to part-time or vice versa, or taking or returning from an unpaid leave of absence; loss of a Participant's spouse's job; loss of Dependent eligibility under terms of the plan; and significant changes in health coverage through the Participant's spouse's employer. Except as otherwise provided in this Section, all enrollment changes must be requested within 31 days of the change in status.
- 6) If an Insured is confined as an inpatient in a Hospital on the effective date of this Agreement, and prior coverage terminating immediately before the effective date of this Agreement furnishes benefits for the hospitalization after the termination of prior coverage, then services and benefits will not be covered under this Agreement for that Insured until the Insured is discharge from the Hospital or benefits under the prior coverage are exhausted, whichever is earlier.
- 7) The Company shall require each Insured to disclose to PURMS at the time of Enrollment, at the time of receipt of covered services and supplies, and from time to time as required by PURMS, the existence of any other group insurance coverage Insured may have, the identity of the carrier, and the group through whom the coverage is provided.

Pre-existing Conditions Exclusion Period.

- 1) All Medical Services necessitated by a Pre-existing Condition will be covered for enrollees who are not Late Enrollees after the Pre-existing Conditions Exclusion Period has been satisfied. The Pre-existing Conditions Exclusion Period begins on the Enrollment Date.
- 2) Except for a Late Enrollee, the Pre-Existing Conditions Exclusion Period ends not later than the first of the following dates:

- a) Six months after the Enrollment Date; or
- b) Either:
 - i) Nine months after the start of the Group Insured's probationary period; or
 - ii) Twelve months after the start of the Group Insured's probationary period in all other groups.
- 3) Late Enrollees are excluded from coverage for 12 months, so this Pre-existing Condition exclusion does not apply.
- 4) Upon receipt of a booklet of Creditable Coverage, the exclusion period will be reduced by the length of prior Creditable Coverage under other Health Benefit Plans that are not preceded by a break in coverage of 62 days or more. This Plan will give enrolling Insured written notice of its determination of any pre-Existing Condition Exclusion Period that applies to an Insured.
- 5) If the Group Insured offers Employees a choice of health coverage under either a federally qualified HMO plan or this Plan, an employee transferring coverage from the HMO plan to this plan during an open enrollment period will not be subject to the exclusion period under this policy.
- 6) The Pre-Existing Conditions Exclusion Period does not apply to a newborn or newly adopted child with Creditable Coverage since birth or adoption.
 - a) Any benefit limitation or other dollar amount that is calculated on an annual basis hereunder shall be calculated on the basis of the calendar year.

VISION CARE BENEFIT

Hardware – Lenses and frames will be provided at 100% up to a maximum of \$300 in any two year period, when prescribed by an approved provider to correct a refractive error (not subject to the stop loss provision). These providers include approved physicians, approved optometrists and approved optical providers. You can take advantage of specially negotiated prices from approved optical providers. Lenses include single vision, bifocal, trifocal, lenticular, contact or aphakic lenses (external lenses requiring a frame and contact lens).

Eye Examinations – In addition to the vision care benefits shown above, you will receive one routine eye examination each calendar year to determine the need for a new or changed prescription for corrective lenses; paid at 100% of the reasonable amount subject to the copay in the Schedule of Benefits when performed by an approved physician, an approved optometrist or an approved optical provider.

Vision care benefits are not subject to the deductible or copay requirements.

DENTAL COVERAGE

Refer to the **General Information About Your Health Care Coverages** Section to see how certain terms used in this Section are defined.

WHAT IS DENTAL COVERAGE?

Under this Coverage, are paid the benefits shown below if a covered person incurs Covered Dental Expenses. These expenses must be incurred while he or she is covered by this Coverage.

“Covered Dental Expenses” include many kinds of expenses you and your family have in connection with dental care. We describe them later on in this Section. But expenses for orthodontic treatment are not considered Covered Dental Expenses under this Coverage. The benefits for this type of treatment are described in the Orthodontic Coverage Section.

Some base rules apply to the Coverage. It is important to understand them:

- 1) All services must be performed by or under the direction of a licensed dentist, dentist or hygienist. A dentist is a person licensed to practice dentistry or perform oral surgery.
- 2) We cover only the services listed in the Table of Dental Services in the next Section.
 - a) We describe these services as Preventive Services, Basic Services, or Major Services. Preventive Services include cleaning and x-rays. Basic Services include oral surgery, periodontics (care of gums), endodontics (root canal therapy) and fillings. Major Services include inlays and crowns (where fillings cannot be used), bridges and dentures.

THE BENEFITS

Preventive Services

Are paid at 80% of the Covered Dental Expenses the insured incurs for Preventive Services, up to the Maximum Benefit Per Year for all Covered Dental Expenses.

Basic Services

After the yearly Deductible for dental services is met, services are paid 80% of the Covered Dental Expenses the insured incurs for Basic Services during the rest of the year, up to the Maximum Benefit Per Year for all Covered Dental Expenses.

Major Services

After the yearly Deductible for dental services is met, services are paid 50% of the Covered Dental Expenses the insured incurs for Major Services during the rest of the year, up to the Maximum Benefit Per Year for all Covered Dental Expenses during the rest of the year.

MAXIMUM BENEFIT PER YEAR

The most we will pay for all Covered Dental Expenses incurred by a covered person in any one year is \$1,500, based on a full year of coverage.

THE DEDUCTIBLE

The Deductible is the amount of Covered Dental Expenses that a covered person must first incur before we start to pay benefits. We do not pay for these expenses under this Coverage. These expenses must be incurred while covered under this Coverage.

The Deductible is \$50 and must be met each year. It applies to both Basic Services and Major Services. But it does not apply to Preventive Services. We apply expenses to the Deductible in the order they are incurred. If both expenses for Basic Services and Major Services are incurred during the same course of treatment, we will apply the expenses from the Basic Services to the Deductible first, and then apply the expenses for Major Services, no matter which came first.

Family Deductible Limit

There is a maximum of 2 Deductibles per family per year. This means that once 2 covered family members have each met their Deductible for a year, every other member of that family will be considered to have met his or her Deductible for the rest of that year.

Covered Dental Expenses

To be a Covered Dental Expense, an expense must be:

- 1) Reasonable and necessary; and
- 2) Listed in the ADA current dental terminology (cdt) codes of dental procedures.

Any expense we list under **Expenses We Do Not Cover** is not a Covered Dental Expense.

EXPENSES WE DO NOT COVER

We do not cover expenses for the following, and none of these expenses will figure in any calculation of benefits. We do not cover any service:

- 1) Received in a facility owned or run by or furnished at the expense of the U.S. Government or one of its agencies. But this does not apply to Covered Expenses furnished by a Veterans Administration hospital for non-service connected disabilities.
- 2) For which the covered person-without this coverage-would not be legally obligated to pay.
- 3) For an injury or a sickness which arises out of or in the course of the covered person's employment or for which he or she is covered by Workers' Compensation or a similar law. But this does not apply to a covered person who is not eligible for coverage under such law.
- 4) Rendered mainly for cosmetic purposes.
- 5) To replace lost or stolen appliances.
- 6) To replace any prosthetic appliance, crown or bridge within 5 years of its last placement.
- 7) Which began before the person was covered under this Coverage.
- 8) To increase vertical dimension or restore occlusion.
- 9) Rendered as an orthodontic services.
- 10) Not listed in the current ADA cdt codes Book of procedures.
- 11) For services furnished by one of these persons: (a) a person who normally lives with the covered person; (b) you or your spouse; or (c) you or your spouse's parent, child, brother or sister.
- 12) For an initial placement of a denture or a fixed bridge, which involves only the specific replacement of one or more natural teeth, which were missing before the person, became covered under this Coverage. But we do cover such a denture or bridge if it also replaces a natural tooth, which is extracted while covered.
- 13) Maxillofacial Prosthetics are not covered. (Codes D5900 – D5999)

TABLE OF DENTAL SERVICES AS LISTED IN THE ADA cdt CODE OF PROCEDURES

PREVENTIVE SERVICES COVERED AT 80%

Diagnostic Procedures

Codes D0100 – D 0999

Preventive Procedures (Not more than once every 6 months)

Codes D 1000 – D1999

BASIC SERVICES COVERED AT 80% AFTER YEARLY DEDUCTABLE IS MET

Restorative

Codes D2000 – D2399: D2910 – D2940

Endodontics

Codes D3000 – D3999

Periodontics

Codes D4000 – D4999

Oral Surgery

Codes D7000 – D7999

Denture Repairs – Complete or Partial

Codes D5510 – D5610

Other Visits, Examinations and Adjunctive General Services

Codes D9000 – D9999

MAJOR SERVICES COVERED AT 50% AFTER YEARLY DEDUCTABLE

Restorative

Codes D2400 – 2799: D2950 – D2999

Prosthodontics: Removable (Note: Expenses Not Covered, section 13)

Codes D5000 – D5899 (Except Denture Repair codes above)

Implant Services

Codes D6000 - D6199

Prosthodontics Fixed

Codes D6200 - D6999

ORTHODONTIC COVERAGE

Refer to the **General Information About Your Health Care Coverages** Section to see how certain terms used in this Section are defined.

WHAT IS ORTHODONTIC COVERAGE?

Under this Coverage, we pay the benefits shown below if a covered person incurs Covered Orthodontic Expenses. These expenses must be incurred while he or she is covered under this Coverage. The orthodontic treatment must start after the person has been covered under this Coverage for at least 180 days in a row. This 180 day period does not apply to the person who was covered under our prior Orthodontic plan on the day it ended and who is covered under this Coverage on its effective date.

Some basic rules apply to your orthodontic coverage. It is important to understand them:

- 1) All services must be performed by a licensed dentist / orthodontist. Before any treatment starts, we must receive the following items:
 - a) the class and description of the malocclusion; and
 - b) the charge for the entire course of treatment; and
 - c) the estimated time needed to complete that treatment.

We may also require that the pre-treatment study models be sent to us.

THE BENEFITS

We pay 50% of the total amount of Covered Orthodontic Expenses the covered person incurs for the entire course of treatment. But the most we will pay for a covered person under this Coverage during his or her lifetime is \$1,000.

These benefits are paid in quarterly installments. The number of quarterly payments we make is based on the length of time the dentist estimates it will take to complete the course of treatment. But 2 years is the maximum period of time we will use to determine the number of quarterly payments.

The first installment is due on the date the orthodontic appliances are first put in. The second installment is due 3 months later, and so on, until all installments have been paid.

We will not make a payment unless, on the date it is due, the covered person is:

- still covered under this Coverage; and
- still receiving orthodontic treatment.

COVERED ORTHODONTIC EXPENSES

To be a Covered Orthodontic Expense, an expense must be:

- 1) reasonable and necessary;
- 2) incurred for the diagnosis and treatment of malposed teeth, which starts after the person has been covered under this Coverage for at least 180 days in a row. This 180 day period does not apply to a person who was covered under our prior Orthodontic plan on the day it ended and who is covered under this Coverage in its effective date.

Any expense we list under **Expenses We Do Not Cover** is not a Covered Orthodontic Expense.

EXPENSES WE DO NOT COVER

We do not cover expenses for the following, and none of these expenses will figure in any calculation of benefits. We do not cover any service or treatment:

- 1) Received in a facility owned or run by or furnished at the expense of the U.S. Government or one of its agencies. But this does not apply to Covered Expenses furnished by a Veterans Administration hospital for non-service connected disabilities.
- 2) For which the covered person-without this coverage-would not be legally obligated to pay.
- 3) For which benefits are payable under any other Coverage of this Plan.
- 4) Which began before the person had been covered under this Coverage for at least 180 days in a row. This 180 day period does not apply to the person who was covered under our prior Orthodontic plan on the day it ended and who is covered under this Coverage on its effective date.
 - a) If the person's coverage starts more than 31 days after his or her eligibility date, we will not cover any service or treatment started before the person has been covered under this Coverage for at least 365 days in a row.
- 5) For services furnished by one of these persons: (a) a person who normally lives with the covered person; (b) you or your spouse; or (c) you or your spouse's parent, child, brother or sister.

Coordination of Benefits

You may be covered under more than one health care plan. If so, payment of benefits will be coordinated between the plans so as not to pay more than the actual cost of the services you received. The plan that pays first pays all the expenses allowed under its coverage. Then the other plan pays the remaining allowed expenses.

Some plans do not have a Coordination of Benefits provisions. If your other plan does not have one, that plan will pay its benefits first. Your plan will pay the rest of your covered expenses but not more than would have been paid if you had not had another health care plan.

If your other plan(s) have a Coordination of Benefits provision, benefits will be paid by the plans in the following order:

The plan that covers the patient other than as a dependent shall be exhausted first. However, the other plans shall pay first if the patient is a laid-off or retired employee under this plan, or a dependent thereof.

The Plan that covers the patient as a dependent of a person whose day and month of birth occurs earlier in the calendar year shall be exhausted before the benefits of a plan that covers the patient as a dependent of a person whose day and month of birth occurs later in a calendar year, except that if the other plan does not contain this rule, resulting in conflicting orders of benefits determination, the other plan's provisions shall govern. However, if the patient is a dependent child whose parents are separated or divorced, the following rules shall apply:

If a parent with custody has not remarried, the benefits of the plan of the parent with custody will be exhausted before the plan of the parent without custody.

If a parent with custody has remarried the benefits of the plans that cover the child will be exhausted in the following order:

- a. The plan of the parent with custody.
- b. The plan of the spouse of the parent with custody.
- c. The plan of the parent without custody.
- d. The plan of the spouse of the parent without custody.

Notwithstanding paragraphs a. and b. above, if there is a court decree that established financial responsibility for the health care of the child, the benefits of the plan that covers the child as a dependent of the parent with such financial responsibility shall be exhausted first.

When the above rules do not establish an order of benefit determination, the benefits of a plan that has covered the patient for the longer period of time shall be determined before the benefits of a plan that has covered such patient the shorter period of time. However, for a retired or laid-off employee and his or her dependents covered by this plan, the benefits of this plan will be determined after the benefits of any other plan covering such a person as an active employee or dependent thereof except; if the other plan does not have a provision regarding retired or laid-off employees, resulting in each plan determining its benefits after the other, this plan's provision for retired or laid-off employees shall not apply.

If none of the above rules establishes an order of benefits determination, the benefits of the plan that has covered an employee for the longer period of time shall be determined before the benefits of the plan that has covered an employee for the shorter period of time.

Subrogation

- 1) If you or a covered dependent is injured due to the act or omission of another party who is legally liable, the benefits of this contract will be available, provided you agree to cooperate with the Fund in its subrogation rights and you agree to reimburse the Fund for the amount it has paid if you recover from the party who is liable. Such reimbursement will be limited to the amount collected which is in excess of that necessary to fully compensate you for the total loss sustained.
- 2) The subrogation and indemnity rights of the Fund shall extend to any recovery by a dependent or by a covered employee or personal representative of a patient, if the patient dies.

- 3) When reasonable collection costs and reasonable legal expenses have been incurred in recovering payments which benefit both the covered employee and the Fund, whether incurred in an action for damages or otherwise, there shall be an equitable apportionment of such collection costs and legal expenses.

APPEAL OF A CLAIM DENIAL – ALL CLAIMS

The complete Appeal Procedures are in the Self-Insurance Agreement available at the Company office.

If there are any questions about a claim payment, the Administrator should be contacted. If it is desired to initiate an Appeal Procedure because there is a disagreement with the reasons why the claim was denied, the Administrator should be notified in writing. A request for a review of the claim and examination of any pertinent documents may be made by the claimant or anyone authorized to act on his or her behalf. The reasons why it is believed that the claim should not have been denied, as well as any data, questions or appropriate comments, should be submitted in writing.

The responsibility for full or final determinations of eligibility for benefits; interpretation of terms; determinations of claim; and appeals of claim denied in whole or in part under the Plan rests exclusively with the Administrator (in consultation with the Manager of Skamania PUD).

CUSTOMER SERVICE DIRECTORY

Administrator:

Richard (Dick) Rodruck - 1.800.562.5226

Claims Consultants:

Diane Christensen - 1.800.562.5226

Bambi Harrison – 1.800.562.5226

Coverage Questions:

Diane Christensen - 1.800.562.5226

Bambi Harrison - 1.800.562.5226

Ryan Vanackeren – 1.800.562.5226

Eligibility:

Sue Rhoads - 1.800.562.5226

Ryan Vanackeren – 1.800.562.5226

Bambi Harrison - 1.800.562.5226

Diane Christensen - 1.800.562.5226

Correspondence and Claim Filing Address:

Pacific Underwriters

P.O. Box 66040

Seattle, WA 98166

Telephone for all questions regarding coverage and claims:

1.800.562.5226

Administrator
