# PLAN AMENDMENT #2

| | |
|---|---|
| Client Name: | Deschutes County |
| Group Number: | G0037173 |
| IRS Tax ID Number: | 93-6002292 |
| Plan: | Medical Plan (High Deductible Plan and Standard Plan) |

Prior authorization requirements may be subject to change upon evaluation of new technologies, standards of care and/or clinical recommendations. Please refer to the Prior Authorization section for information on how to search for procedures, and services requiring prior authorization. Additional information regarding services and procedures requiring prior authorization can be found on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Effective January 1, 2025, the Plan Document is amended as follows, all other language and sections remains the same:

**The following language in the Professional Services section has been amended to read as follows, the remainder of the section remains the same:**

***Dietary or Nutritional Counseling***

This Plan covers services for prediabetes education via National Diabetes Prevention Programs, diabetic education, management of inborn errors of metabolism, and management of eating disorders if provided by a qualified Provider or as required under ACA for obesity screening and counseling. Nutritional counseling will also be provided for women 40 to 60 years of age with normal or overweight body mass to maintain weight or limit weight gain to prevent obesity.

- Benefits are limited as follows: Obesity nutritional counseling is limited to 26 visits per Benefit Year combined with the *Obesity Services* (*Interventions*) section.

***Intravenous Immunoglobulin Therapy***

This Plan covers up to three monthly immunomodulatory courses of intravenous immunoglobulin therapy (IVIG) for the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS) when certain conditions are met.

***Obesity Services (Interventions)***

This Plan covers obesity services (interventions) when Plan Sponsor criteria is met. Covered Services include Provider-directed intensive, multicomponent behavioral interventions for weight management for Members age 18 and older with a body mass index (BMI) of 30 kg/m2 or higher. Prior to seeking services for this benefit, contact the PacificSource Customer Service team for eligibility.

- Benefits are limited as follows: Limited to 26 visits per Benefit Year combined with the *Dietary or Nutritional Counseling* section. Bariatric surgery and other gastric restrictive procedures, or the revision of these procedures, and related services are not covered. Medications for weight reduction control and all categories of obesity are not covered.

***Pre-exposure and Post-exposure Prophylaxis***

- This Plan covers pre-exposure prophylaxis (PrEP) for the prevention of HIV infection and post-exposure prophylaxis (PEP) medications after a potential exposure to HIV.

**DURABLE MEDICAL EQUIPMENT**

- **Benefits are limited as follows:**
  - Breast Pumps: Manual and electric breast pumps are covered at no cost share when provided by an In-network Provider, or purchased from a retail outlet, and are limited to once per pregnancy. Hospital-grade breast pump rentals are covered.

**The following language in *Covered Prescription Drugs* within the Prescription Drugs section has been amended to read as follows, the remainder of the section remains the same:**

1. Legend drugs, (those drugs which cannot be purchased without a prescription written by a physician or dentist).

2. Drugs used to treat attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD).

3. Insulin and diabetic supplies.

   Note: Diabetic medications, including insulin, and other diabetic supplies (and when prescribed by a physician) in connection with diabetes management for covered pregnant women will be payable subject to first dollar coverage (i.e., no deductible or copayment will apply) as shown in the Prescription Drug Benefit Summary.

   Preferred insulin will bypass deductible requirement and will be treated as a maintenance medication.

4. Fluoride products.

5. Oral dental rinses requiring a prescription.

6. Migraine therapy.

7. Injectable medications, including Imitrex, bee sting kits, Glucagon, growth hormones, Lupron, and interferons.

8. Acne treatments, including Retin-A, through age 24, and oral isotretinoin (i.e; Claravis).

9. Antibiotics.

10. Hematinics (iron preparations) requiring a prescription.

11. Anabolic steroids.

12. Psychotherapeutic drugs.

13. Alcoholism and chemical dependency medications.

14. AIDS treatments.
15. Immunosuppressant agents.
16. Chemotherapy agents.
17. Laxatives requiring a prescription.
18. Compound medications which include at least one legend drug. (considered non-formulary or non-formulary tier)
19. Syringes and needles.
20. Orally administered anti-cancer medications.

**The Benefit Exclusions section has been amended to read as follows, the remainder of the section remains the same:**

This Plan does not cover the following:

- Adjunctive Continuous Glucose Monitors (receivers, transmitters, and sensors).
- Bariatric surgery and other gastric restrictive procedures, or the revision or reversals of these procedures.
- Rehabilitation – Functional capacity evaluations, work hardening programs, vocational rehabilitation, community reintegration services, and driving evaluations and driving training programs.
- Services or supplies with no charge, or for which your Employer or the Plan Sponsor has paid, or for which the Member is not legally required to pay, or for which a Provider or facility is not licensed to provide even though the service or supply may otherwise be eligible. This exclusion includes any service provided by the Member, or any licensed professional that is an Immediate Family Member.
- Skin and tissue removal related to cosmetic body contouring procedures.

**The How to File a Claim section under Benefit Determinations and Claims Payment has been amended to read as follows, the remainder of the section remains the same:**

All claims for benefits should be turned in to PacificSource within 90 days of the date of service. If you are unable to submit a claim within 90 days, present the claim with an explanation for consideration for coverage. Claims submitted more than a year following the date of service may be denied as untimely.

**The How to Submit Grievances or Appeals *section under Complaints, Grievances, and Appeals* has been amended to read as follows:**

Grievances and Appeals can be submitted by you or your Authorized Representative. Grievances can be submitted orally or in writing. Appeals must be submitted in writing. Before submitting a Grievance or Appeal, we suggest you contact the PacificSource Customer Service team with your concerns. Issues can often be resolved at this level.

**The following language in the Definitions section has been amended to read as follows, the remainder of the section remains the same:**

**Adjunctive Continuous Glucose Monitor** means a sensor just under the skin that measures the Member's glucose level 24 hours a day. Adjunctive devices are non-therapeutic and require the Member verify their glucose levels with a stand-alone home blood glucose monitor (BGM) to confirm testing results prior to making treatment decisions.

**Appeal** means a written request from a Member or, if authorized by the Member, the Member's Authorized Representative, to change a previous decision made under this Plan concerning:

- Access to healthcare benefits, including an Adverse Benefit Determination made pursuant to utilization management;
- Claims payment, handling, or reimbursement for healthcare services;
- Rescission of the Member's benefit coverage by the Plan Sponsor; and
- Other matters as specifically required by law.

**Grievance** means a written or oral complaint submitted by or on behalf of a Member regarding service delivery issues other than denial of payment for healthcare services or non-provision of healthcare services, including dissatisfaction with health care, waiting time for services, Provider or staff attitude or demeanor, or dissatisfaction with service provided by the carrier.

**Immediate Family Member** means:

- Your Dependents, your parents, your parent's Spouse or Domestic Partner, your siblings, and your half-siblings;
- Your Spouse's or Domestic Partner's parents, siblings, and half-siblings;
- Your Dependent Child's Spouse or Domestic Partner; and
- Any other of your relatives by blood or marriage who shares a residence with you.

**Medically Necessary or Medical Necessity** means those services and supplies that are required for diagnosis or treatment of Illness or Injury and that are:

- Consistent with the symptoms or diagnosis and treatment of the condition;
- Consistent with generally accepted standards of good medical practice in this Plan's state of issuance, or expert consensus Provider opinion published in peer-reviewed medical literature, or the results of clinical outcome trials published in peer-reviewed medical literature;
- As likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any other service or supply, both as to the Illness or Injury involved and the Member's overall health condition;
- Not for the convenience of the Member or a Provider of services or supplies;
- The least costly of the alternative services or supplies that can be safely;

- When referring specifically to infused medications, it further means that they may require administration at a designated location or preferred site of care as outlined in the infusion therapy site of care policy;
- When specifically applied to a Hospital inpatient, it further means that the services or supplies cannot be safely provided in other than a Hospital inpatient setting without adversely affecting the Member's condition or the quality of medical care rendered; and
- When applied to Hospital outpatient services (imaging, infusion, surgery), it further means that the services or supplies can be safely provided in other than a Hospital outpatient setting without adversely affecting the patient's condition or the quality of medical care rendered.

**Surrogacy Agreement** means an agreement between one or more intended parents and a woman who is not an intended parent in which the woman agrees to become pregnant through assisted reproduction and which provides that each intended parent is a parent of a child conceived under the agreement.

**Prescription Drug Benefit Summary**

Please see attached summary

"Plan Sponsor"
Deschutes County

By: Nick Lelack

Print: Nick Lelack

Title: County Administrator

Date: 12/13/24

**Effective 1/01/2025 the Prescription Drug Benefit Summary has been amended to read as follows:**

## PRESCRIPTION DRUG BENEFIT SUMMARY

### Prescription Drug Benefit Maximum Out-of-Pocket amounts

| Out-of-Pocket Limit | Per Person, Per Calendar Year | Per Family, Per Calendar Year |
|---|---|---|
| **Standard Plan** | $1,200 | $3,600 |
| **High Deductible Plan** | $1,200 | $3,200 |
| Prescription Drug benefit Copayments/Coinsurance will accumulate to the Prescription Drug benefit maximum out-of-pocket amount until the out-of-pocket amount, as shown above, is reached for the calendar year. Then, covered charges for Prescriptions Drug expenses incurred by a covered person will be payable at 100% for the remainder of the calendar year. | | |

**Prescription Drug Copayments/Coinsurance amounts do not apply toward the medical maximum out-of-pocket amount.**

**Accumulators will not be applied on preventative medications or drugs that have generic equivalents unless the enrollee has: (A) Obtained prior authorization from the insurer or pharmacy benefit manager; (B) Complied with a step therapy protocol; or (C) Received approval from the insurer or pharmacy benefit manager through the insurer's or the pharmacy benefit manager's exceptions, appeal or review process.**

**Note: If the covered member's physician prescribes a generic drug, but a brand name drug is purchased, the covered Member must pay the Copayment plus the difference in the generic and brand name cost. These differences may not apply to the out-of-pocket amounts; unless brand name is prescribed out of medical necessity.**

## ONSITE CLINIC – DESCHUTES COUNTY ONSITE CLINIC PHARMACY SERVICES (541) 385-1071

| | Generic Drugs: | Formulary Drugs: | Non-Formulary and Compound Drugs: |
|---|---|---|---|
| **Limited to a 30-day supply:** | | | |
| **Copayment** | $2 Copayment | $20 Copayment | $40 Copayment |
| **Limited to a 90-day supply:** | | | |
| **Copayment** | $4 Copayment | $40 Copayment | $80 Copayment |
| **Note: Prescriptions filled through the Deschutes Onsite Clinic Pharmacy are available for up to a 90-day supply. Mail order maintenance medications are excluded in certain locations. Specialty medications are limited to a 30 day supply.**<br>***Prescriptions for female contraceptives, tobacco cessation drugs or products, and certain vaccines and immunizations are available at no cost to the Covered Person.***<br>***Insulin Copayments will not exceed $35 for a 30 day supply or $105 for a 90 day supply*** | | | |

For additional information regarding the Deschutes Onsite Clinic Pharmacy
Call: 541-385-1071
Or access their website at:
**http://www.deschutes.org/benefits/page/doc-pharmacy**

## RETAIL – PRESCRYPTIVE HEALTH (206) 686-9016

### 30 Day Retail Pharmacy Option – Limited to a 34-day supply:

| | Generic Drugs: | Formulary Drugs: | Non-Formulary and Compound Drugs: |
|---|---|---|---|
| **Limited to a 34-day supply:** | | | |
| **Copayment** | $20 Copayment | Greater of 20% Coinsurance or $50 Copayment up to a maximum of $100 | Greater of 20% Coinsurance or $75 Copayment up to a maximum of $125 |
| Note: Insulin Copayments will not exceed $35 for a 30 day supply | | | |

### Retail Pharmacy Option – Diabetes management for covered Pregnant Women (i.e., diabetic medications and supplies):

| | Generic Drugs: | Formulary Drugs: | Non-Formulary and Compound Drugs: |
|---|---|---|---|
| **Limited to a 34-day supply:** | | | |
| **Copayment** | | No Charge | |

### Retail Expense Submitted by Employee:

| | Generic Drugs: | Formulary Drugs: | Non-Formulary and Compound Drugs: |
|---|---|---|---|
| **Limited to a 34-day supply:** | | | |
| **Coinsurance** | | 50% Coinsurance | |
| **Note: If a drug is purchased from an out-of-network pharmacy, or an in-network pharmacy when the covered person's ID card is not used, the covered person will be required to pay 100% at the point of sale, no discount will be given, and the covered person must submit the prescription receipt directly to Prescryptive Health for reimbursement less any applicable Copayment as shown above.** | | | |

## 90 DAY RETAIL (UP TO A 100 DAY SUPPLY) OR MAIL ORDER

## MAIL ORDER – WALMART HOME DELIVERY (800) 273-3455

**WWW.WALMART.COM/HOMEDELIVERY**

## 90 DAY RETAIL OR MAIL ORDER PHARMACY OPTION – LIMITED TO A 100-DAY SUPPLY:

| | Generic Drugs: | Formulary Drugs: | Non-Formulary and Compound Drugs: |
|---|---|---|---|
| **Limited to a 100-day supply:** | | | |
| **Copayment** | $40 Copayment | Greater of 20% Coinsurance or $100 Copayment up to a maximum of $200 | Greater of 20% Coinsurance or $150 Copayment up to a maximum of $300 |

Note: Insulin Copayments will not exceed $105 for a 90 day supply

**Mail Order Pharmacy Option – Diabetes management for covered Pregnant Women (i.e., diabetic medications and supplies):**

| | Generic Drugs: | Formulary Drugs: | Non-Formulary and Compound Drugs: |
|---|---|---|---|
| **Limited to a 100-day supply:** | | | |
| **Copayment** | | No Charge | |

The following will be covered at 100%, no Copayment required:

- Physician-prescribed tobacco cessation products or medications. Limited to a 168-day supply per calendar year of nicotine replacement products (nicotine patch, gum, lozenges) and a 168-day supply per calendar year of physician-prescribed medications (Zyban, Chantix).

- Physician-prescribed contraceptive methods (Food and Drug Administration (FDA) approved) including but not limited to oral contraceptive medications, transdermals, devices (diaphragms, cervical caps), vaginal contraceptives, and injectables. This also includes physician-prescribed over-the- counter (OTC) contraceptives (such as female condoms, spermicides, and sponges); for all covered female members with reproductive capacity.

  Refer to the medical section of this Plan Document, regarding additional coverage for intrauterine devices (IUDs), and implantables.

- Additional Physician-prescribed medications as recommended by the U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations will be covered at 100%, no prescription Copayment, Coinsurance or Deductible will be required, and will only be available when utilizing an in-network pharmacy.

Please note, the USPSTF grades A and B recommendations are subject to change as new medications become available and other recommendations may change. Coverage of new recommended medications will be available following the one (1) year anniversary date of the adoption of the USPSTF grade A and B recommendation.

Refer to the following link for more information regarding USPSTF grade A and B recommendations or contact Prescryptive at (206) 686-9016 for more information regarding which medications are available. Note: Age and/or quantity limitations may apply.

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations

**Additional information on Prescription Drug coverage may be found in the Prescription Drugs section of this Plan Document.**