PLAN AMENDMENT #3

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

Effective January 1,2026, the Plan Document is amended as follows, all other language and sections remains the same:

The following language within the Preventive Care Services section has been amended to read as follows, the remainder of the section remains the same:

Weight Reduction or Control Services

This Plan covers medical nutritional therapy and obesity screening for children ages six and older and adults who qualify as obese, as required under the USPSTF recommendations.

Medical nutritional therapy 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.

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

The Dietary or Nutritional Counseling section has been removed.

Medical Nutritional Therapy

This Plan covers medical nutritional therapy for diabetes, inborn errors of metabolism, eating disorders, and obesity if provided by a qualified Provider.

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

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 *Medical Nutritional Therapy* 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.

The *Pre-exposure and Post-exposure Prophylaxis* section has been removed.

The following language within the Cochlear Implants section has been amended to read as follows:

This Plan covers single or bilateral cochlear implants when Medically Necessary, including the fitting, programming and reprogramming, or other Assistive Listening Devices. Cochlear implants will not be subject to the Deductible. The cost of repair and replacement parts are covered if the repair or replacement parts are not under warranty. Contact our Customer Service team for specific coverage requirements.

The following language within the Diabetic Equipment, Supplies, and Training section has been amended to read as follows, the remainder of the section remains the same:

This Plan covers certain diabetic equipment, supplies, and training, as follows:

- Medications and diabetic supplies will be payable under the separate Prescription Drug Benefits section under this Plan.
- Outpatient and self-management training and education for the treatment of diabetes and prediabetes (via National Diabetes Prevention Programs). The training must be provided by a Provider with expertise in diabetes.
- Medically Necessary Telehealth, via two-way electronic communication, provided in connection with the treatment of diabetes.

The following language within the Durable Medical Equipment section has been amended to read as follows, the remainder of the section remains the same:

This Plan covers services and applicable sales tax for Durable Medical Equipment. Durable Medical Equipment must be prescribed.

This Plan covers Prosthetic Devices and Orthotic Devices to restore or maintain the ability to complete activities of daily living, performing physical activities, or essential job-related activities and are not for comfort or convenience, and that maximize the Member's whole body health, including lower and upper limb functions. Repair or replacement of a Prosthetic Device and Orthotic Device is covered when needed due to normal use. This Plan covers maxillofacial prostheses to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing.

The hearing aid benefit within this section has been amended to read as follows, the remainder of this section remains the same:

- Hearing Aids: Hearing Aids, Assistive Listening Devices, and ear molds are provided in accordance with state and federal law. Contact the PacificSource Customer Service team for specific coverage requirements. Benefits are as follows:
    - For Members age 18 and younger, or age 19 to 25 when enrolled in a secondary school or an accredited educational institution, coverage is limited to a maximum benefit of one Hearing Aid per ear every 24 months.

- For Members age 19 and older, or age 19 to 25 not enrolled in a secondary school or an accredited educational institution, coverage is limited to a maximum benefit of one Hearing Aid per ear up to a maximum of $2,500 every 24 months.

The following bullet point within the Benefit Exclusions section are amended to read as follows, the remainder of the section remains the same:

- Obesity or weight reduction control – Surgery or other related services, supplies, food supplementation, or self-help programs provided for obesity, weight reduction control, weight loss, or cosmetic purposes regardless of the medical conditions that may be caused or exacerbated by excess weight, including food supplementation, and self-help programs, except as specified under Weight Reduction or Control Services in the Preventive Care Services section and Obesity Services (Interventions) in the Professional Services section.

The following language within the Prior Authorization section has been amended to read as follows:

Coverage of certain services requires a Benefit Determination by PacificSource, on behalf of the Plan Sponsor, before the services are performed. This process is called prior authorization. PacificSource will utilize the criteria adopted by the Plan Sponsor and, where necessary, will coordinate review with the Plan Sponsor, to render a determination based on the Plan.

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

Your Provider can submit a prior authorization request on your behalf. If your Provider is unable to do so, you may contact PacificSource directly.

They may ask for more details or require a second opinion (provided at no cost to you if requested by PacificSource) before approving coverage. You and/or your Provider are responsible for ensuring PacificSource has all the information needed to make a Benefit Determination.

- When services are received from an In-network Provider, the Provider is responsible for contacting PacificSource to obtain prior authorization. If your service is denied as not Medically Necessary and your Provider did not obtain prior authorization, the Provider will be held responsible for the denied expense, and they cannot bill you for these charges.

- When services are received from an Out-of-network Provider, the Provider is **not** responsible for contacting PacificSource to obtain prior authorization. If you choose an Out-of-network Provider for services requiring prior authorization, you are responsible for obtaining the prior authorization before receiving services. If prior authorization is not obtained, you may be responsible for the expense if it is later determined not Medically Necessary. If the service is deemed Medically Necessary, out-of-network benefits (which may involve higher out-of-pocket costs) will apply.

Because of the changing nature of care, PacificSource, on behalf of the Plan Sponsor, continually reviews new technologies and standards. Therefore, procedures and services requiring prior authorization are subject to change. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business). The prior authorization search tool is not intended to suggest that all items listed are covered by the benefits in this Plan.

If your treatment does not receive prior authorization, you can still seek treatment, but your Post-Service Claim will be subjected to retrospective authorization. If a treatment requires prior authorization but was not received, the Post-service Claim must be submitted within 60 days of the date of service. If the claim is not submitted within 60 days or if the review determines the expenses were either not covered by this Plan or were not Medically Necessary, you will be held responsible for the expense. Remember, any time you are unsure if an expense will be covered, contact the PacificSource Customer Service team before receiving services.

If more information or a second opinion is needed (at no cost to you if requested by PacificSource), you or your Provider may be asked to supply additional documentation before coverage is approved. You will receive confirmation (via letter, fax, or electronic transmission once PacificSource has made its Benefit Determination. If time is critical, you may be notified by phone, with written follow-up to follow. For more information regarding the timelines for review of Pre-service Review and Post-service Claims, see Benefit and Claim Determinations in the Benefit Determinations and Claims Payment section.

In a medical emergency, services and supplies necessary to determine the nature and extent of an Emergency Medical Condition and to Stabilize the Member are covered without prior authorization requirements. A Hospital or other healthcare facility must notify PacificSource of an emergency admission within two business days of admission.

PacificSource reserves the right to contract with a third party to perform prior authorization procedures on its behalf and such third parties may impose independently developed, evidence-based criteria for making prior authorization determinations. If you have questions about any third party criteria, please contact the PacificSource Customer Service team.

If your Provider's prior authorization request is denied for reasons such as not Medically Necessary or as Experimental, Investigational, or Unproven, your Provider may Appeal on your behalf. You also maintain the right to Appeal PacificSource's decision independently of your Provider.

The following language within the *Active Course of Treatment* under Termination of Provider Contracts section has been amended to read as follows:

If the contract of a Provider who is providing to you an active course of treatment is terminated without cause, you may be able to continue to receive services from the Provider at the in-network benefit level for a limited period of time. The services may be paid at in-network cost sharing until the earliest of the following:

- Treatment is complete;

- 90 days after you were notified that the contract ended ; or
- In the case of pregnancy, the 45th day after the birth or no later than the 120th day after you were notified that the contract ended.

The following language within the *Timelines for Responding to Appeals* under the Complaints, Grievances, and Appeals section has been amended to read as follows:

You will be afforded two levels of Internal Appeal and, if applicable to your case, an External Review. PacificSource will acknowledge receipt of an Appeal no later than seven days after receipt. A written decision in response to the Appeal will be made within 30 days after receiving your request to Appeal.

In addition, if your Appeal qualifies for an expedited response, a decision in response to the Appeal will be completed as soon as possible, but no later than 72 hours of receipt of the request.

The above time frames do not apply if the period is too long to accommodate the clinical urgency of a situation, or if you do not reasonably cooperate, or if circumstances beyond your or our control prevent either party from complying with the time frame. In the case of a delay, the party unable to comply must give notice of delay, including the specific circumstances, to the other party.

The following definition has been added under the Definitions section, the remainder of the section remains the same:

Assistive Listening Devices means devices used with or without Hearing Aids or cochlear implants to improve the ability of a user with hearing loss to hear in various listening situations, such as being located a distance from a speaker, in an environment with competing background noise or in a room with poor acoustics or reverberation.

"Plan Sponsor"
Deschutes County

By: Nick Lelack

Print: Nick Lelack

Title: Deschutes County Administrator

Date: 11-10-2025