



OEBB

Preferred Provider Organization
(PPO)

Plan 7 A

Effective Date October 1, 2008



Member handbooks and other services are available at www.odscompanies.com.

Insurance products provided by ODS Health Plan, Inc.

Welcome

We are pleased that you have chosen ODS as your Preferred Provider Organization (PPO) plan. This Member Handbook is designed to provide you with important information about your Plan's benefits, limitations and procedures.

We hope that you find this Member Handbook helpful. If you have any questions about the handbook please call the ODS Medical Customer Service Department at 503-265-2909 in the Portland area or toll free at 1-866-923-0409. For questions related to the pharmacy benefit, please call the Pharmacy Drug Benefit Customer Service at 503-265-2911 or 1-866-923-0411. You may also visit our website at www.odscompanies.com to access your myODS account.

During your first appointment, tell your medical provider that you have medical benefits through ODS. You will need to provide your subscriber identification number and ODS Group number. These numbers are located on your I.D. card.

Thanks for choosing ODS as your healthcare plan!

Medical Customer Service Department

Portland	503-265-2909
Toll-Free	1-866-923-0409
TDD/TTY	1-800-433-6313
	(for the hearing and speech impaired)
En Español	503-265-2961
Llamado Gratis	1-888-786-7461

Pharmacy Drug Benefit Customer Service

Portland	503-265-2911
Toll-Free	1-866-923-0411
TDD/TTY	1-800-433-6313
	(for the hearing and speech impaired)

Service Authorization

Portland	503-243-4496
Toll-Free	1-800-258-2037
TDD/TTY	1-800-433-6313
	(for the hearing and speech impaired)

ODS reserves the right to monitor telephone conversations and e-mail communications between its employees and its customers for legitimate business purposes as determined by ODS. The monitoring is to ensure the quality and accuracy of the service provided by employees of ODS to their customers.

Please note: This handbook may be changed or replaced at any time, by OEBC or ODS, without the consent of any enrollee. All plan provisions are governed by OEBC's policy with ODS. This handbook may not contain every plan provision.

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General Plan Information

1. **Plan Name:**
OEBB Benefit Plan
2. **Plan Sponsor:**
Oregon Educators Benefit Board
1225 Ferry Street SE
Salem, Oregon 97301
(503) 378-3329
3. **Employer Identification Number:** 41-2246536
4. **Agent for Legal Process:** The Plan Sponsor named above.
5. **Type of Plan:** Employee Medical Benefit Plan.
6. **Plan Year:** October 1st through September 30th.
7. **Plan Administrator:** The Plan Sponsor is the administrator of the Plan.
8. **Funding Medium and Type of Plan Administration:** Benefits are provided under a group insurance policy entered into between OEBB and ODS Health Plan, Inc. Claims for benefits are sent to ODS. ODS, not OEBB, is responsible for paying claims.

The Plan is funded by employer and/or employee contributions. The amount of total contributions is determined by the use of sound actuarial and underwriting methods. The portion an employee pays toward the total contribution is determined by OEBB or the Participating District.
9. **Provider of Benefits:** Benefits are provided in accordance with a policy of insurance between ODS Health Plan, Inc. and Oregon Educators Benefit Board.

Summary of Benefits

This section summarizes your medical plan benefits. The details of the actual benefits and the conditions, limitations and exclusions of the Plan are contained in the sections that follow. In-Network Benefits are those delivered by in-network physicians and providers; Out-of-Network Benefits are those delivered by out-of-network physicians and providers.

By using the services offered by your Network, you will receive quality healthcare and will have a higher level of benefits (See Network Definition on page 16 for the Network available to you). You may choose an in-network physician or provider from the In-Network medical directory, which is available on the ODS website at www.odskompanies.com under "Provider Search", or by contacting the ODS Customer Service Department to request a paper copy.

Note: Benefits are paid on a Plan Year beginning October 1st of each year and ending September 30th of the following year.

	<u>In-Network Benefits</u>	<u>Out-Of- Network Benefits</u>
Plan Year Deductible per Enrollee		\$500
Maximum Plan Year Family Aggregate Deductible		\$1,500
Per Person Out-of-Pocket Maximum (does not include deductible)	\$2,000	\$4,000
Lifetime Maximum for all Benefits (Includes in-network and out-of-network benefits)		\$2,000,000

BENEFITS

CO-PAYMENT (Amount You Pay)

	In-Network	Out-Of-Network
Hospital - Inpatient Care		
Acute Care	20%	40%
Skilled Nursing Facility Care	20%	40%
Ambulatory Services		
Outpatient Surgery and Invasive Diagnostic Procedures (Facility Charges) These services require authorization	20%	40%
Diagnostic X-ray and Lab	20%	40%
Therapeutic X-ray	20%	40%
Imaging Procedures	20%	40%
Kidney Dialysis	20%	40%
Rehabilitation		
Inpatient Rehabilitation	20%	40%
Outpatient Rehabilitation	20%	40%
Professional Services		
Preventive Healthcare		
Periodic Health Exams	No co-payment, deductible waived	40%

BENEFITS**CO-PAYMENT**
(Amount You Pay)

	In-Network	Out-Of-Network
Routine Diagnostic X-ray & Lab	No co-payment, deductible waived	40%
Immunizations	No co-payment, deductible waived	40%
Women's Annual Exam & Pap Tests	No co-payment, deductible waived	40%
Routine Mammogram	No co-payment, deductible waived	40%
Prostate Rectal Exam	No co-payment, deductible waived	40%
Prostate Specific Antigen (PSA) Test	No co-payment, deductible waived	40%
Colonoscopy	No co-payment, deductible waived	40%
Cardiovascular Screening	No co-payment, deductible waived	40%
Hearing Evaluation	No co-payment, deductible waived	40%
Outpatient Diabetic Instruction	20%	40%
Home and Office Visits	20%	40%
Therapeutic Injections	20%	40%
Physician Hospital Visits	20%	40%
Surgery	20%	40%
Chiropractic, naturopathic & acupuncturist care (up to a \$2,500 Plan Year maximum, see page 27 for complete details)	20%	40%
Emergency Care		
Urgent Care Centers		
Urgent care office visit	20%	20%
Diagnostic X-ray and lab	20%	40%
Emergency Room Facility (co-pay waived if covered hospitalization immediately follows emergency room use)	\$100 per visit, then 20%	\$100 per visit, then 20%
Ambulance Transportation	20%	20%
Other Services		
Maternity		
	Treated same as any other condition.	Treated same as any other condition.
Hospice Care	20%	40%
Home Healthcare	20%	40%

BENEFITS**CO-PAYMENT**
(Amount You Pay)

	In-Network	Out-Of-Network
Infusion Therapy		
Home Infusion	20%	40%
Outpatient Infusion	20%	40%
Outpatient Durable Medical Equipment	20%	40%
Supplies and Appliances	20%	40%
Disposable Supplies (provided in a physicians office)	20%	40%
Prescription Drugs (up to an out-of-pocket maximum of \$1,000 per Plan year)		
In-Network Pharmacy		
Generic	\$5 per prescription	\$5 per prescription
Preferred Brand Name	20%	20%
Non-Preferred Brand Name	50%	50%
Mail Order Pharmacy		
Generic	\$10 per prescription	\$10 per prescription
Preferred Brand Name	20%	20%
Non-Preferred Brand Name	50%	50%
Mental Health and Chemical Dependency		
Inpatient	20%	40%
Residential, Day Treatment or Partial Hospitalization	20%	40%
Outpatient	20%	40%

COVERED EXPENSES

To the extent medically necessary, covered expenses include the following:

A. Hospital - Inpatient Care

- Daily hospital room allowance, not to exceed the average daily semi-private rate of the hospital.
- Other hospital services.

Type of Care	Maximum Number of Days Per Plan Year
Medical/Surgical	Unlimited
Rehabilitative	30
Intensive Care Unit	Unlimited

B. Hospital - Outpatient Care

- Emergency room treatment
- Outpatient surgery
- Pre-admission testing

C. Skilled Nursing Facility

Daily room allowance, not to exceed the semi-private room rate nor more than 60 days per plan year, plus other medically necessary services.

D. Ambulatory Services

Facility charges for outpatient surgery, diagnostic x-ray and lab, therapeutic x-ray, and specified imaging (such as MRI, CT, CAT and PET scans).

E. Physician or Professional Provider

Services of a physician or professional provider who meets the definitions in this Plan.

F. Maternity

Services and supplies.

G. Ambulance

Transportation to the nearest facility that has the capability to provide the necessary treatment. See page 28 for a complete benefit description

H. Supplies, Appliances and Medications

Items that relate directly to the treatment of an illness or injury are covered. Wheelchairs (including scooters) and related expenses are subject to a maximum of \$5,000 per plan year (see page 32 for more details).

I. Transplants

The Plan will pay for covered donor costs up to a maximum of \$25,000 per transplant. Services and supplies incurred during a transplant period, including donor costs, are included in computing the Plan's \$2,000,000 lifetime maximum benefit. Complications resulting from a transplant are subject to the Plan's \$2,000,000 lifetime maximum benefit.

J. Residential Mental Health Treatment Program (includes Day Treatment and Partial Hospitalization Programs)

All-inclusive per diem charge for room, (if overnight program), and treatment services by a treatment program that meets the definitions in this Plan.

K. Residential Chemical Dependency Treatment Program (includes Day Treatment and Partial Hospitalization Programs)

All-inclusive per diem charge for room, (if overnight program), and treatment services by a treatment program that meets the definitions in this Plan.

L. Chemical Dependency Detoxification Program

All-inclusive per diem charge for room and treatment services by a program that meets the definitions in this Plan.

M. Chemical Dependency Outpatient Treatment Program

Assessment and treatment services by a treatment program that meets the definitions in this Plan.

DEDUCTIBLES

This Plan has a plan year deductible. The deductible is the amount of covered expenses that are paid by an enrollee before benefits are payable by the Plan. The amount of the deductible is shown in the Summary of Benefits. Covered services, whether performed in-network or out-of-network, accumulate toward the plan year deductible. The deductible applies separately to each enrollee, but

no family will be required to satisfy more than the total family deductible as shown in the Summary of Benefits, no matter how many enrollees are in the family. After the deductible has been satisfied, benefits will be paid according to the schedule of benefits. Expenses applied towards the plan year deductible do not apply toward the out-of-pocket maximum.

Fixed dollar co-payments, prescription drug out-of-pocket expenses, and disallowed charges do not apply toward the plan year deductible.

Covered expenses incurred in the last three months of a plan year and applied toward the plan year deductible will be applied to the plan year deductible for the following plan year, when no benefits (subject to deductible) were paid out during the current plan year.

PLAN YEAR MAXIMUM OUT-OF-POCKET COST

After you or your enrolled dependents have met a \$2,000 per person plan year out-of-pocket maximum (\$4,000 per person plan year out-of-pocket maximum for services rendered out-of-network), the Plan will pay 100% of covered services for the remainder of the plan year. Services accumulated toward the in-network out-of-pocket maximum can be used to satisfy both the in-network and the out-of-network out-of-pocket maximum. Services accumulated toward the out-of-network out-of-pocket maximum cannot be used to satisfy the in-network out-of-pocket maximum.

You are responsible to pay for the following costs (they do not accrue toward your out-of-pocket maximum and you must pay for them even after your out-of-pocket maximum is met):

- The emergency room facility co-payment;
- The out-of-pocket expenses for prescription drugs;
- The out-of-pocket expenses for transplants performed at out-of-network transplant facilities;
- The service authorization cost containment penalty; and
- Disallowed charges.

MAXIMUM LIFETIME BENEFIT

Benefits for covered expenses of in-network and out-of-network physicians and providers accrue toward an aggregate \$2,000,000 lifetime maximum benefit for each enrollee. An enrollee's aggregate lifetime maximum accrues under all OEBB medical plans regardless of when or under which plan the claims were paid.

PAYMENT

Expenses allowed by ODS are based upon the contracted fees for services rendered by in-network physicians and providers and the maximum plan allowance for services of out-of-network physicians and providers. The maximum plan allowance for out-of-network physicians and providers is established, reviewed, and updated by a national database. Please see the Summary of Benefits on page 2 for further details.

Except for co-payments, deductibles, and policy benefit limitations, in-network physicians and providers agree to look solely to ODS, if it is the paying insurer, for compensation of covered services provided to you. Nothing in this paragraph shall prohibit a physician or provider and you from entering into an agreement for payment by you for medical services that are not covered by the Plan.

RESTORATION

If you or one of your enrolled dependents receive benefits from this Plan during the plan year, the amount paid, up to \$25,000 will automatically be restored the following October 1st to your available lifetime maximum benefit.

HOW WE COORDINATE BENEFITS WITH MEDICARE

This Plan coordinates benefits with Medicare Part A or B as allowed under federal government rules and regulations (see also page 71).

EMERGENCY CARE

You and your enrolled dependents are covered for emergency services worldwide. If you believe you have a medical emergency you should call 9-1-1 or seek care from the nearest appropriate physician or provider, such as a physician's office or clinic, urgent care facility or emergency room. See Emergency Care in the Benefit Description section of your handbook for more information about this benefit.

COVERAGE OUTSIDE THE SERVICE AREA FOR DEPENDENT CHILDREN

When an enrolled dependent child under age 19 (26 if meeting the requirements to qualify as a dependent as described on page 53) resides outside the service area, we will extend plan benefits for treatment of an illness or injury, preventive healthcare (including routine physicals and immunizations) and maternity services, as if the care were rendered by in-network physicians or providers, subject to the following limitations:

- All non-emergency hospital confinements must be authorized;
- Services will be paid at the in-network benefit level if provided within a 30-mile radius of the dependent child's residence or at the closest appropriate facility;
- Services will be paid at the out-of-network benefit level if such services are provided outside the 30-mile radius of the dependent child's residence;
- Fees charged by out-of-area physicians and providers of care will be reimbursed at the maximum plan allowance for those services.

Note:

Your Participating District may offer other dependent coverage limitations due to a collective bargaining or district policy. Check with your Participating District for dependent coverage limitations.

Cost Containment

This Plan contains the following special cost containment provisions which may affect how benefits are paid.

SERVICE AUTHORIZATION REQUIREMENTS

A. Pre-admission Authorization for Hospitalization and Residential Programs

All non-emergency hospital confinements that are scheduled in advance, and admission to any residential treatment program, must be authorized in order for maximum plan benefits to be payable. ODS will authorize medically necessary lengths of stay, based upon the medical condition. Additional hospital or residential days are covered only upon medical evidence of need.

Authorization for emergency hospital admissions must be obtained by calling ODS within 48 hours of the emergency hospital admission (or as soon as reasonably possible).

Please Note:

If an enrollee fails to obtain pre-admission authorization for inpatient or residential (includes overnight residential, day treatment, or partial hospitalization) stays, a co-payment penalty of 50%, up to a maximum deduction of \$2,500 per occurrence, will be applied to covered charges before regular plan benefits are computed. You will be responsible for payment of any charges not covered because of non-compliance with pre-admission authorization requirements. The co-payment penalty does not apply toward the Plan's deductible or out-of-pocket maximum. This penalty will not apply in the case of an emergency admission.

Pre-admission authorization involves the following steps:

- When your physician or professional provider suggests that you be admitted to the hospital or a residential program, or have a non-emergency surgery, ask that he/she contact ODS for service authorization.
- Your physician or professional provider or his or her office staff either calls ODS or submits a service authorization form.
- ODS will either approve the admission, ask for additional information and/or request that you get a second opinion. ODS may also specify that you receive care on an outpatient basis only.
- If admission is approved, ODS will assign the expected length of stay and an appropriate time of admission (such as the morning of or the night before a scheduled surgery.)
- The hospital, physician or professional provider, and the patient are notified of the outcome of the service authorization process by letter.

To obtain pre-admission authorization by phone, contact ODS at 503-243-4496 (in Portland) or 1-800-258-2037 (toll-free, outside of Portland).

To obtain pre-admission authorization for mental health or chemical dependency services, call ODS Behavioral Health at 503-382-5323 or toll-free at 1-877-796-3223.

B. Ambulatory Surgery

Certain diagnostic and therapeutic procedures can be performed without an inpatient admission or overnight stay in a hospital. Some outpatient or ambulatory services also require authorization. Service authorization must also be obtained for any inpatient admission or overnight stay for a service that is commonly performed on an outpatient basis. Any covered benefit will be based on the cost of the most appropriate setting for the procedure.

Authorization involves the following steps:

- When your physician suggests that you have a non-emergency surgery, ask that he/she contact ODS for service authorization.
- Your physician or his or her office staff either calls ODS or submits a service authorization form.
- ODS will either approve the surgery, ask for additional information and/or request that you get a second opinion.
- The hospital, physician and patient are notified of the outcome of the service authorization process by letter.

C. Outpatient Services

The Plan requires prior service authorization for many outpatient services. **Failure to obtain required service authorizations may result in denial of benefits or payment at the out-of-network benefit level.**

D. Mandatory Second Surgical Opinion

ODS may require an independent consultation to confirm that non-emergency surgery is medically necessary. This Plan pays the full cost of the second opinion with any deductible waived.

Please Note:

If an enrollee chooses not to participate in the mandatory second surgical opinion program or decides to have surgery when it is not recommended by the consulting surgeon, a co-payment penalty of 50%, up to a maximum deduction of \$2,500 per occurrence, will be applied to covered charges before regular plan benefits are computed. You will be responsible for payment of any charges not covered because of non-compliance. The co-payment penalty does not apply toward the Plan's deductible or out-of-pocket maximum.

COST EFFECTIVENESS SERVICES

At our sole discretion and under unique and unusual circumstances, ODS may approve benefits for cost effectiveness services, not otherwise covered by the Plan, when doing so is cost-effective and approved by your attending physician and ODS' medical director.

Payment of benefits for cost effectiveness services shall be at the sole discretion of ODS based on our evaluation of the individual case. The fact that we have paid benefits for cost effectiveness services for an enrollee shall not obligate us to pay such benefits for any other enrollee, nor shall it obligate us to pay benefits for continued or additional cost effectiveness services for the same enrollee. All amounts ODS pays for cost effectiveness services under this provision shall be included in computing any benefits, limitations, or co-payments under the Plan.

Care Coordination

CARE COORDINATION

This Plan provides individualized managed care of complex or catastrophic cases. Care Coordinators who are registered nurses (RNs) work directly with you, your family, and your physician(s) to coordinate your healthcare needs.

This Plan will coordinate access to a wide range of services spanning all levels of care depending on the patient's needs. Having an RN Care Coordinator available to coordinate these services ensures improved delivery of healthcare services to you, your family, and your physicians(s).

This Plan's care coordination program is accredited in Case Management by URAC, a national accrediting organization that establishes quality standards for the healthcare industry.

DISEASE MANAGEMENT

This Plan provides education and support to help you manage a chronic disease or medical condition. Health Promotion RNs help you to identify your healthcare goals, self-manage your disease and prevent the development or progression of complications.

Working with a Health Promotion RN can help you follow the medical care plan prescribed by your physician and improve your health status, quality of life and productivity.

This Plan's disease management program is URAC-accredited for Disease Management.

IF CALLING FROM PORTLAND AREA 503-243-3957
OUTSIDE THE PORTLAND AREA 1-800-913-4957

Office Hours – Monday through Friday
7:30 AM to 5:30 PM (Pacific Time)

Definitions

The following are definitions of some important terms used in this Member Handbook.

Affidavit of Dependency means a notarized document that attests that a child meets the criteria in the definition of Dependent Child.

Affidavit of Domestic Partnership means a notarized document that attests the Eligible Employee and one other eligible individual meet the criteria in the definition of Unregistered Domestic Partner.

Ambulatory Care means medical care provided on an outpatient basis. Ambulatory care is given to persons who are not confined to a hospital.

Ancillary Services are support services provided to a patient in the course of care. They include such services as laboratory and radiology.

Authorization or **Authorized** refers to obtaining approval by ODS prior to the date of service. For a complete list of services that require authorization, contact ODS at 503-243-4496, or toll-free at 1-800-258-2037, or visit our website at www.odscompanies.com, and see the Member page. Failure to obtain required service authorization may result in denial of benefits or payment at the out-of-network benefit level.

Authorized Services means services or supplies that have been approved by us.

Chemical Dependency (including alcoholism) means a substance-related disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, (DSM-IV-TR), except for those related to foods, tobacco, or tobacco products.

Chemical Dependency Outpatient Treatment Program means a state-licensed program that provides an organized outpatient course of treatment, with services by appointment, for substance-related disorders.

Claim Determination Period means the plan year or portion thereof commencing October 1 of any calendar year and ending September 30 of the subsequent calendar year.

Condition means a medical condition.

Co-pay or Co-payment means the fixed dollar amounts or percentages of covered expenses to be paid by an enrollee.

Cost Effectiveness Services means services or supplies which are not otherwise benefits of the Plan, but which we believe to be medically necessary and cost effective.

Covered Service is a service or supply that is specifically described as a benefit of this Plan.

Creditable Coverage means prior healthcare coverage as defined in 42 U.S.C. 300 gg as amended and in effect on July 1, 1997, and includes coverage remaining in force at the time the enrollee obtains new coverage. The term creditable coverage means, with respect to an individual, coverage of the individual under any of the following:

- A group health plan;
- Individual insurance coverage including student health plans;

- Medicare Part A and B;
- Medicaid, other than benefits consisting solely of benefits under Section 1928 (pediatric vaccines);
- Tricare (formerly known as CHAMPUS);
- A medical care program of the Indian Health Service or of a tribal organization;
- A State high risk pool;
- Federal Employees Health Benefit Plan (FEHBP);
- A public health plan (as defined in regulations);
- A State Children’s Health Insurance Program (S-CHIP); or
- A health benefits plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Some plans that provide medical care coverage do not qualify as creditable coverage. Such plans are called excepted benefits. The following plans are excepted benefits:

- Coverage only for accident, or disability income insurance, or any combination thereof.
- Coverage issued as a supplement to liability insurance.
- Liability insurance, including general liability insurance and automobile liability insurance.
- Worker’s Compensation or similar insurance.
- Automobile medical payment insurance.
- Credit-only insurance.
- Coverage for on-site medical clinics.
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance.

Custodial Care means care that helps a person conduct such common activities as bathing, eating, dressing or getting in and out of bed. It is care that can be provided by people without medical or paramedical skills. Custodial care also includes care that is primarily for the purpose of separating a patient from others, or for preventing a patient from harming himself or herself.

Dental Care means services or supplies provided to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures, including services or supplies rendered to restore the ability to chew and to repair defects which have developed because of tooth loss.

Dental Implant means a device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement; endosteal (endosseous); eposteal (subperiosteal); transosteal (transosseous).

Dependent means any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.

Domestic Partners see Registered Domestic Partner and Unregistered Domestic Partner.

Durable Medical Equipment is defined in the Supplies, Appliances and Durable Medical Equipment section (see page 31).

Eligible Employee means an:

- Active Employee of a Participating District who is employed on a half-time or greater basis or is in a job-sharing position or meets the definition of an Eligible Employee under an OEBC rule or under a collective bargaining agreement; or a
- Retired Employee who was a previously active Eligible Employee as described on page 54.

Eligibility Waiting Period means the period of employment or membership with the Participating District that a prospective enrollee must complete before coverage begins.

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

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

Emergency Services means those healthcare 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 the patient.

Enroll means to become covered for benefits under a group health plan (that is, when coverage becomes effective) without regard to when the individual may have completed or filed any forms that are required in order to become covered under the Plan. For this purpose, an individual who has health coverage under a group health plan is enrolled in the Plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrolled Dependent means an eligible dependent of an enrolled employee of the Participating District, whose application has been accepted by OEGB and who is enrolled in this Plan.

Enrolled Employee means an employee of the Participating District, who is enrolled in this Plan following acceptance by OEGB of that person's application.

Enrollee means an employee, dependent of the employee or an individual otherwise eligible for a group, individual or Portability health benefit plan who has enrolled for coverage under the terms of this Plan.

Enrollment date means, for new hires and others who enroll when first eligible, the date coverage begins or, if earlier, the first day of the waiting period. For all others, the enrollment date is the date the plan coverage actually begins.

Exclusion Period means a period during which specified treatments or services are excluded from coverage.

Genetic Information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Group Health Plan means any health benefit plan established and maintained by an employer or an employee organization, or both, for the purpose of providing healthcare for its participants or their beneficiaries through insurance, reimbursement or otherwise.

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

Hospice Care is defined in the Hospice Care section on page 29.

Illness means a disease or bodily disorder which results in a covered expense.

Implant means a material inserted or grafted into tissue.

Injury means a personal bodily injury to you or your enrolled dependent caused solely by external, violent and accidental means.

In-Network refers to hospitals, physicians, providers, professionals, chemical dependency treatment programs and facilities that have contracted with us to provide benefits to persons covered under this Plan.

Late Enrollee means an individual who enrolls subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. If you decline coverage for yourself and/or your dependents when initially eligible, you will not be allowed to enroll yourself and or your dependents until the next open enrollment period. (See page 56 for complete details.)

An individual is not a late enrollee if:

- The individual qualifies for special enrollment as described on page 56;
- The individual applies for coverage during an open enrollment period;
- A court has ordered that coverage be provided for a Spouse or minor child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order;
- The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or
- The individual's coverage under Medicaid, Medicare, Tricare (formerly known as CHAMPUS), Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan, has been involuntarily terminated within 63 days prior to applying for coverage in a group health benefit plan.

Maximum Plan Allowance (MPA) is the maximum amount that ODS will reimburse physicians and providers. For an in-network physician/provider, the maximum amount is the amount the provider has agreed to accept for a particular service.

For a service by an out-of-network physician/provider, ODS will process charges for those services as follows: maximum amount is the lesser of the amount payable under any supplemental provider fee arrangements we may have in place and the seventy-fifth (75th) percentile of fees commonly charged for a given procedure in a given area, based on a national database.

If a dollar value is not available in the national database, ODS will consider 75% of the billed charge as the MPA. The remaining 25% over the MPA is the patient's responsibility.

In certain instances, when a dollar value is not available in the database, the claim is reviewed by the ODS Medical Consultant, who determines a comparable code to the one billed. Once a comparable code is established, the claim is processed as described above.

In each of the above situations relating to an out-of-network physician/provider, any amount above the MPA is patient responsibility. Depending upon the plan provisions deductibles and co-payments may apply.

Maximum Plan Allowance for prescription benefits is the maximum amount which ODS will reimburse for medications. For an in-network pharmacy, the maximum amount is the contracted fee. For out-of-network pharmacies, the maximum amount is no more than the prevailing pharmacy network fee based on Average Wholesale Price (AWP) determined by First Data Bank minus a percentage discount. AWP is a figure that is reported by commercial publishers of drug pricing data, based on wholesale pricing information provided to them by drug manufacturers. Reimbursement for medications dispensed by physicians and providers other than retail pharmacies, mail-order pharmacies, and specialty pharmacies will be subject to benefit provisions of the Plan and paid based on the lesser of contracted rates, AWP or billed charges.

Medical Condition means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Medical Services Contract means a contract (1) between an insurer and an independent practice association, (2) between an insurer and a provider, (3) between an independent practice association and a provider or organization of providers, (4) between medical or mental health clinics, and (5) between a medical or mental health clinic and a provider to provide medical or mental health services. Medical services contract does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

Medically Necessary means those services and supplies that are required for diagnosis or treatment of illness or injury and which, in the judgment of ODS, are:

- Appropriate and consistent with the symptoms or diagnosis of the enrollee's condition;
- Established as the standard treatment by the medical community in the service area in which they are received;
- Not primarily for the convenience of the enrollee or a physician or provider of services or supplies; and
- The least costly of the alternative supplies or levels of service which can be safely provided to the enrollee. This means, for example, that care rendered in a hospital inpatient setting is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility or by a nurse in the enrollee's home, without harm to the enrollee.

Medically necessary care does not include custodial care.

Please Note:

The fact that a physician or provider prescribes, orders, recommends, or approves a service or supply does not, of itself, make the service medically necessary or a covered service. Refer to the "General Exclusions" section starting on page 38 for further information regarding medical necessity. Also see "Transplants" on page 34.

Mental Health refers to benefits, facilities, programs, levels of care and services related to the assessment and treatment of mental illness, as defined in this Plan.

Mental Health Provider means a board-certified psychiatrist, state-licensed psychologist, state-licensed practicing mental health nurse practitioner, state-licensed clinical social worker, state-licensed psychologist associate, state-licensed professional counselor, state-licensed mental health counselor, or state-licensed marriage and family therapist.

Mental Illness means all disorders listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, (DSM-IV-TR) except for:

- Mental Retardation,
- Learning Disorders,
- Paraphilias,
- Gender Identity Disorders in enrollees age nineteen or older, and
- V-Codes, (this exception does not extend to children 5 years of age or younger for diagnostic codes V61.20, V61.21, and V62.82).

Mental Incapacity, for the purposes of this policy, means intellectual competence usually characterized by an IQ of less than 70.

ODS refers to ODS Health Plan, Inc.

ODS Behavioral Health provides specialty services for managing mental health and chemical dependency benefits to help enrollees access care in the right place, while helping employers to contain costs.

ODS Plus Network is the Preferred Provider Organization (PPO) selected by OEGB for all Active Employees. Retired Employees and COBRA Enrollees who establish residency outside the ODS Plus Network service area may select from the **First Choice Network**, **Idaho Physicians Network (IPN)**, **Health InfoNet (HIN)**, or **Private HealthCare Systems (PHCS)** depending on where they reside. By using an In-Network Physician or Provider, your covered medical expenses will be paid at the higher benefit level.

Oregon Educators Benefit Board (OEGB) means the state agency and program established in the State of Oregon, Department of Administrative Services by Senate Bill 426 and that is overseen by the OEGB Board.

Orthotic Device means a rigid or semi-rigid device supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck.

Out-of-Network refers to hospitals, physicians, providers, professionals, chemical dependency treatment programs and facilities that have not contracted with us to provide benefits to enrollees covered under this Plan. They will be reimbursed at the maximum plan allowance for the service provided.

Outpatient Mental Health Treatment Episode means a sequence of outpatient visits to a single physician or professional provider, with no interval of sixty (60) or more days without a visit.

Outpatient Surgery means surgery that does not require an inpatient admission or overnight stay.

Participant means any employee or former employee who is or may become eligible to receive a benefit under a plan.

Participating District means a common school district, a union high school district, an education service district, or a community college district that participates in Benefit Plans provided by OEGB

Physical Incapacity, for the purposes of this policy, means the inability to pursue an occupation or education because of a physical impairment.

Physician means a doctor of medicine or osteopathy.

The **Plan** is the agreement between OEGB and ODS Health Plan, Inc. which contains all the conditions of the Plan. This Member Handbook is a part of the Plan.

Plan Year refers to the twelve month period beginning October 1st and ending September 30th. The separate out-of-pocket maximum for the medical plan and for prescription drug expenses shall be accrued on a plan year basis.

The **Policyholder** means OEGB, for whose members or employees of Participating Districts these medical benefits are being provided.

Professional Provider means any of the following, when providing medically necessary services within the scope of their license. In all cases, the services must be covered under this Plan to be eligible for benefits.

- A podiatrist;
- An acupuncturist;
- A naturopath;
- A chiropractor;
- A dentist (doctor of medical dentistry or doctor of dental surgery), but only for treatment of accidental injury to natural teeth, or for surgery that does not involve repair, removal or replacement of teeth, gums, or supporting tissue;
- A state-licensed psychologist;
- A state-licensed nurse practitioner,
- A state-licensed physician assistant;
- A state-licensed clinical social worker;
- A state-licensed psychologist associate;
- A state-licensed professional counselor;
- A state-licensed marriage and family therapist;
- A state-licensed mental health counselor;
- A clinician providing services under the auspices of a program licensed, approved, established, maintained, contracted with or operated by the Oregon Office of Mental Health & Addiction Services;
- A registered physical, occupational, or speech therapist, but only for rehabilitative services provided upon the written referral of a doctor of medicine or osteopathy;
- A registered nurse or licensed practical nurse, but only for services provided upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill patients;
- A registered nurse first assistant; and
- An optometrist.

The term "professional provider" does not include any class of provider not named above, and no benefits of the Plan will be paid for their services.

Prosthetic Device means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.

Registered Domestic Partner means an individual of the same sex joined with the employee in a partnership that has been registered in Oregon according to the Oregon Family Fairness Act.

Residential Chemical Dependency Treatment Program means a residential program providing an organized full-day or part-day program of treatment for chemical dependency disorders. Services occur in a state-licensed program and facility.

Residential Mental Health Treatment Program means a residential program providing an organized full-day or part-day program of treatment for mental illness. Services occur in a state-licensed program and facility.

Residential Program means a state-licensed program or facility providing an organized full-day or part-day program of treatment. Types of residential programs include an overnight 24-hour day program, a day treatment program, or a partial hospitalization program. Residential program does not include any program that provides less than four hours per day of direct treatment services.

The Plan's **Service Area** is the geographical area where the in-network physicians and providers provide their services.

Service Authorization refers to obtaining approval by ODS prior to the date of service. For a complete list of services that require authorization, contact our Medical Customer Service Department at 503-265-2909, or toll-free at 1-866-923-0409, or visit our website at www.odscompanies.com, and see the Member page. Failure to obtain required service authorization may result in denial of benefits, or payment at the out-of-network benefit level.

Spouse means a person of the opposite sex who is a husband or wife. The definition of Spouse does not include a former Spouse and a former Spouse does not qualify as a dependent.

Unregistered Domestic Partner means an individual of the same or opposite sex who is not married or registered in Oregon under the Oregon Family Fairness Act, and has entered into a partnership that meets the following criteria:

- Both are at least 18 years of age;
- Are responsible for each other's welfare and are each other's sole domestic partners;
- Are not married to anyone and either has not had a Spouse, a Registered Domestic Partner, or another Unregistered Domestic Partner within the prior six months. If previously married, the six-month period starts on the final date of divorce;
- Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;
- Have jointly shared the same regular and permanent residence for at least six months; and
- Are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household. Financial information must be provided if requested.

Urgent Care means the provision of immediate, short-term medical care for minor but urgent medical conditions that do not pose a significant threat to life or health at the time the services are rendered.

Benefit Description

This section describes the benefits under this Plan. The Plan covers services and supplies listed when medically necessary for diagnosis and/or treatment of an illness or injury. Our payment of covered expenses is always limited to the maximum plan allowance for the physician or professional provider.

Many services require service authorization. For a complete list, contact ODS at 503-243-4496, or toll-free at 1-800-258-2037, or visit our website at www.odscompanies.com and see the Member page. **Failure to obtain required service authorizations may result in denial of benefits or payment at the out-of-network benefit level.**

MEMBERSHIP CARD

After enrolling, you and your enrolled dependents will receive identification cards which will include your group and identification numbers. You will need to present your card each time you receive services.

If you lose your identification card, we will issue a replacement. Contact us at 503-265-2909 or toll-free at 1-866-923-0409.

WHEN BENEFITS ARE AVAILABLE

This Plan only pays claims for covered services obtained when a person's coverage is in effect. Coverage is in effect when the enrollee:

- Is eligible to be covered according to the eligibility provisions of this Plan;
- Has applied for coverage and has been accepted; and
- Has had his or her premiums for the current month paid by OEBC on a timely basis.

When an enrollee is an inpatient in the hospital (as defined below) on the day coverage ends, we will continue to pay claims for covered services for that hospitalization until the enrollee is discharged from the hospital or until benefits have been exhausted, whichever comes first.

HOSPITAL CARE

A "hospital" is a facility that is licensed as an acute care General Hospital and that provides inpatient surgical and medical care of persons who are acutely ill. Its services must be under the supervision of a staff of licensed physicians and must include 24-hour-a-day nursing service by registered nurses. Facilities that are primarily rest, old age or convalescent homes are not considered to be hospitals.

Facilities operated by agencies of the federal government are not considered hospitals. However, the Plan will cover expenses incurred in facilities operated by the federal government where benefit payment is mandated by law. The Plan will also benefit any covered service rendered at any hospital owned or operated by the State of Oregon.

Hospitalization must be directed by a physician and must be medically necessary.

A. Hospital Benefits

Covered expenses consist of the following:

- The actual daily charge for a **hospital room**, but not to exceed the hospital's most common rate for a 2-bed room;
- The charge for **isolation care**, when we agree it is necessary to protect other patients from contagion or to protect you from contracting the illness of another person;
- The charge for an **intensive care unit**. Using the criteria of the Joint Commission on Accreditation of Hospitals as a guide, we reserve the right to decide whether a unit in a particular hospital qualifies as an intensive care unit;
- The **facility charges** for surgery performed in a hospital outpatient department;
- Charges for **other hospital services and supplies** that are necessary for treatment and are ordinarily furnished by a hospital; and
- Charges for **routine nursery care** of a well-newborn infant, including one in-nursery physician's visit, while the mother is confined in the hospital and receiving maternity benefits under this Plan. The Plan deductible is waived for routine nursery care.

Coverage for take-home prescription drugs following a period of hospitalization will be limited to a three-day supply at the same benefit level as for hospitalization.

All inpatient stays require service authorization. See the Cost Containment section, page 8, for additional information regarding service authorization.

B. Inpatient Days Covered

We will allow benefits for an unlimited number of days for acute hospital care, subject to the maximum lifetime benefit amount.

C. Inpatient Rehabilitative Hospital Care

Covered expenses are limited to 30 days of rehabilitative care each plan year for inpatient services delivered in a hospital that has a department specializing in such care. Subject to medical necessity and prior authorization, treatment required following head or spinal cord injury may be covered up to a limit of 60 days per plan year. These benefits are payable only when your condition requires inpatient rehabilitative hospital care.

In order to be a covered expense, rehabilitative services must begin within one year of the onset of the condition from which the need for services arises and must be part of a physician's formal written program to improve and restore lost function following illness or injury. The services must be appropriate to the condition that is being treated.

D. Emergency Room Care

The plan will pay 80% of covered expenses after a \$100 co-payment for each hospital emergency room visit. However, the \$100 emergency room facility co-payment will be waived if you are admitted to the hospital immediately following emergency room service. The \$100 emergency room facility co-payment does not accrue toward the plan year deductible or out-of-pocket maximum.

The emergency room facility co-payment applies to services billed by the facility. Professional fees (e.g., emergency room physician, or x-ray/lab) billed separately are subject to the standard in-network benefit level.

E. Pre-admission Testing

Medically necessary preadmission testing is covered when ordered by the physician.

SKILLED NURSING FACILITY CARE

A skilled nursing facility is a facility licensed under applicable laws to provide inpatient care under the supervision of a medical staff or a medical director. It must provide 24-hour-a-day nursing services by registered nurses.

Skilled Nursing Facility Benefits

The Plan covers a maximum of 60 skilled nursing facility days per plan year subject to medical necessity.

Covered expenses are limited to the daily service rate, but no more than the amount that would be charged if the patient were in a semi-private hospital room.

We will not pay charges related to an admission to a skilled nursing facility that began before the person was enrolled in the Plan or for a stay where care is provided principally for:

- Senile deterioration;
- Alzheimer's disease;
- Mental deficiency or retardation in enrollees age 18 or older; or
- Mental illness.

Expenses for routine nursing care, non-medical self-help or training, personal hygiene or custodial care are not covered under this Plan.

RESIDENTIAL PROGRAMS

All residential and detoxification programs require service authorization. See the Cost Containment section, page 8, for additional information regarding service authorization.
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A. Residential Mental Health Treatment Program (includes Day Treatment and Partial Hospitalization Programs)

All-inclusive per diem charge for room and treatment services by a treatment program that meet the definitions in this Plan. The Plan covers a maximum of forty-five (45) residential mental health days per plan year, subject to medical necessity.

B. Residential Chemical Dependency Treatment Program (includes Day Treatment and Partial Hospitalization Programs)

All-inclusive per diem charge for room and treatment services by a treatment program that meets the definitions in this Plan, subject to medical necessity.

C. Chemical Dependency Detoxification Program

All-inclusive per diem charge for room and treatment services by a treatment program that meets the definitions in this Plan, subject to medical necessity.

AMBULATORY SERVICES

Many ambulatory services require service authorization. For a complete list, visit our website at www.odskompanies.com, and see the Member page. **Failure to obtain required service authorization can result in denial of benefits or payment at the out-of-network benefit level.**

A. Outpatient Surgery

The Plan covers operating rooms and recovery rooms, surgical supplies and other services ordinarily provided by a hospital or surgical center. Outpatient surgery requires service authorization.

Certain surgical procedures are covered only when performed as outpatient surgery. Please ask your in-network physician or professional provider if this applies to your surgery, or contact our Medical Customer Service Department at 503-265-2909 or toll-free at 1-866-923-0409.

B. Diagnostic X-rays and Laboratory Tests

The Plan covers medically necessary diagnostic x-rays and laboratory tests related to treatment of an illness or injury.

C. Radium, Radioisotopic, X-ray Therapy, and Kidney Dialysis

Covered expenses include:

- Treatment planning and simulation;
- Professional services for administration and supervision; and
- Treatments, including therapist, facility and equipment charges.

D. Imaging Procedures

The Plan covers only the following imaging services when medically necessary and related to treatment of an illness or injury:

- Magnetic resonance imaging (MRI);
- Computerized axial tomography (CT or CAT);
- Positron emission tomography (PET); and
- Single photon emission computed tomography (SPECT).

PET and SPECT scans require service authorization.

PHYSICIAN AND PROFESSIONAL PROVIDER SERVICES

Services of physicians and professional providers are covered under this Plan, as described below.

A. Preventive Healthcare

The Plan will waive the deductible and cover the following preventive healthcare benefits when performed by an in-network physician or provider, unless noted otherwise:

1. Periodic Health Exams.

The Plan covers periodic health exams limited to the following schedule:

- Newborn: One hospital visit.
- Infants: Six well-baby visits to a physician's office during the first year of life.
- Age 1: Two exams during the year.
- Age 2 and above: One exam every year.

Exams for licensing or employment purposes do not constitute periodic health exams and are not covered. An exam to rule out a diagnosis of illness based on family history is eligible for benefits as a periodic health exam based on the above schedule.

Routine diagnostic x-ray and lab work related to a periodic health exam are also covered.

Cardiovascular screenings. The Plan covers one Electrocardiogram (EKG) and treadmill test when performed in conjunction with a covered Periodic Health Exam.

Hearing evaluation. Hearing evaluations are covered when performed in conjunction with a covered well-child examination. Hearing evaluations are covered for adults when performed in conjunction with an adult periodic exam.

2. Immunizations.

The Plan covers routine immunizations for both adults and children when administered by your physician. Covered immunizations will be limited to those that are considered the “standard of care” by the local medical community. However, immunizations for the sole purpose of travel or to prevent illness which may be caused by your work environment are not covered.

Meningococcal immunizations and Hepatitis A and/or B immunizations for enrollees age 18 and over must be authorized and are covered only for high-risk individuals who meet our medical necessity criteria.

3. Preventive Women’s Healthcare

The Plan will cover the following preventive women’s healthcare. These services are covered when performed by an in-network or out-of-network physician or provider.

a. A complete and thorough physical examination of the breast, including but not limited to a clinical breast examination, performed by a healthcare provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer as follows:

- i. Annually for women 18 years of age and older; and
- ii. At any time at the recommendation of the women’s healthcare provider.

b. Mammograms are covered as follows:

- Age 35 through 39 1 mammogram
- Age 40 and older 1 mammogram per year

Mammograms for the purpose of diagnosis in symptomatic or designated high risk women are covered when deemed necessary by your physician.

c. Pelvic exam/Pap tests are covered annually for women of all ages, and at any time upon referral of the women’s healthcare provider.

4. Routine Prostate Rectal Exam & Prostate Specific Antigen (PSA) Test. For men age 50 and over, the Plan covers one rectal examination and one PSA test every plan year or as determined by the treating physician. For men younger than 50 years of age who are at high risk for prostate cancer, including African-American men and men with a family medical history of prostate cancer, prostate rectal exam and PSA test are covered as determined by the treating physician. These services are covered when performed by an in-network or out-of-network physician or provider.

5. Colorectal Cancer Screening. The Plan will cover the following colorectal cancer screening exams and laboratory tests if rendered by a physician or provider:

a. The Plan covers one flexible sigmoidoscopy every 5 years for men and women age 50 and over.

- b. The Plan covers one colonoscopy every 10 years for men and women age 50 and over. Related facility and anesthesia fees are included in the colonoscopy benefit.
- c. The Plan covers one double contrast barium enema every 5 years for men and women age 50 and over.
- d. The Plan covers one fecal occult blood test every plan year for men and women age 50 and over.

For enrollees who are at high risk for colorectal cancer with a family medical history of colorectal cancer, a prior occurrence of cancer or precursor neoplastic polyps, a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease or ulcerative colitis, or other predisposing factors, colorectal cancer screening exams and laboratory tests are covered as recommended by the treating physician.

B. Family Planning

Voluntary family planning services are covered when approved and arranged by your physician. These services include vasectomy, tubal ligation, insertion and removal of IUD (device included) and office visits related to these services. This Plan will also provide benefits for oral birth control pills and other contraceptive drugs and devices that cannot legally be dispensed without a prescription, and that by law must bear the legend "Caution-Federal law prohibits dispensing without prescription." Oral birth control pills and contraceptive drugs and devices purchased at the pharmacy will be covered under the pharmacy benefit of this Plan. Prescribed contraceptive drugs and devices received in a doctor's office will be paid at the same benefit level as a supply.

C. Home, Office or Hospital Visits

A "visit" means the patient is actually examined by a physician or professional provider. Covered expenses include physician consultations with written reports, as well as second opinion surgery consultations.

D. Diabetes Self-Management Programs

The Plan will cover diabetes self-management programs associated with the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes, when prescribed by a healthcare professional legally authorized to prescribe such programs. The Plan will cover one diabetes self-management program of assessment and training after diagnosis. Upon a material change of condition, medication or treatment, the Plan will also cover up to three hours per year of assessment and training if:

- Provided through an education program credentialed or accredited by a state or national entity accrediting such programs; or
- Provided by a physician, a registered nurse, a nurse practitioner, a certified diabetes educator or a licensed dietitian with demonstrated expertise in diabetes.

E. Therapeutic Injections

Administrative services for therapeutic injections, such as allergy shots, are covered when given in a physician or professional provider's office. When comparable results can be obtained safely with home self-care, or through oral use of a prescription drug, administrative services for therapeutic injections are not covered.

See Medication Administered by Providers, Infusion Center or Home Infusion on page 33 for additional information.

Vitamin and mineral injections are not covered unless medically necessary for treatment of a specific medical condition.

F. Surgery

Surgery (operative and cutting procedures), including treatment of fractures, dislocations and burns, is covered. We will pay for:

- The primary surgeon;
- The assistant surgeon;
- The anesthesiologist or certified anesthetist; and
- Surgical supplies such as sutures and sterile set-ups when surgery is performed in the physician's office.

The services listed above are paid at the surgery co-payment level.

Eligible surgery performed in a physician's office is covered, subject to the appropriate service authorizations.

G. Circumcision

Circumcision for a newborn is covered when performed within three (3) months of birth and may be performed without service authorization. A circumcision beyond age three months must be medically necessary and requires service authorization.

H. Reconstructive Surgery Following A Mastectomy

The Plan covers reconstructive surgery following a mastectomy for:

- All stages of reconstruction of the breast on which the mastectomy has been performed, including but not limited to nipple reconstruction, skin grafts and stippling of the nipple and areola;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Protheses;
- Treatment of physical complications of the mastectomy, including lymphedemas; and
- Inpatient care related to the mastectomy and post-mastectomy services.

Your physician must contact ODS to receive authorization in advance.

This coverage will be provided in consultation with the patient's attending physician and will be subject to the same terms and conditions, including the plan year deductible and co-payment provisions otherwise applicable under this Plan.

I. Cochlear Implants

Cochlear implants are covered when determined medically necessary and authorized.

J. Cosmetic and Reconstructive Surgery

Cosmetic surgery is surgery that improves or changes appearance without restoring impaired body function. Reconstructive surgery is surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is usually performed to improve function, but may also be performed to approximate a normal appearance.

Cosmetic surgery is not covered. Reconstructive procedures that are partially cosmetic in nature may be covered if the ODS medical director finds the procedure to be medically necessary. All reconstructive procedures must be medically necessary and authorized or benefits will not be paid.

Treatment for complications related to a surgery performed to correct a functional disorder will be covered when determined medically necessary. Treatment for complications related to a surgery that does not correct a functional disorder will be excluded.

When deemed cosmetic surgery by our medical director, nasal rhinoplasty is not covered.

Surgery for breast augmentation, achieving breast symmetry, and replacing breast implants (prosthetics) to accomplish an alteration in breast contour or size are not covered. (Exceptions, see Coverage for Reconstructive Surgery Following a Mastectomy.)

Surgery performed to reduce breast size is covered only when medically necessary and authorized.

Coverage is also available for the following services if authorized and medically necessary:

- Surgical repair of congenital deformities;
- Hormone related conditions; and
- Acne surgery, including cryotherapy, dermabrasion, and excision of acne scarring.

K. Inborn Errors of Metabolism

We will provide coverage, subject to plan benefits and limitations, for treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which standard methods of diagnosis, treatment and monitoring exist. Coverage includes diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.

L. Special Dental Care

Dental services are not covered by this Plan, except for treatment of accidental injury to natural teeth. Natural teeth are teeth which grew/developed in the mouth. All of the following are required to qualify for coverage:

- The accidental injury must have been caused by a foreign object or was caused by acute trauma (e.g., a broken tooth resulting from biting and/or chewing is not an accidental injury);
- Diagnosis is made within 6 months of the date of injury; and
- Treatment is medically necessary and is provided by a physician or dentist while you are enrolled in this Plan.

If you choose to have tooth implant placement as the restoration choice following a covered dental accident, the allowed amount will be limited to that which would have been allowed for a crown, bridge, or partial. Removal of tooth implants or attachments to tooth implants are not covered.

This Plan only covers treatment within 12 months of the date of injury. Covered treatment is limited to that which will restore teeth to a functional state.

M. Maxillofacial Prosthetic Services

The Plan will cover maxillofacial prosthetic services considered necessary for adjunctive treatment, which means restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma or birth and developmental deformities when such restoration and management are performed for the purpose of:

- Controlling or eliminating infection;
- Controlling or eliminating pain; or
- Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.

N. Temporomandibular Joint Syndrome

The Plan covers expense for treatment of temporomandibular joint syndrome (TMJ) for medical reasons only. All TMJ related services, including but not limited to diagnostic and surgical procedures, require service authorization, and will be covered only when medically necessary as established by a history of advanced pathologic process (arthritic degeneration) documented in a physician's medical record, or in cases involving severe acute trauma. Treatment of dental diseases or injuries is excluded.

O. Chiropractors, Naturopaths and Acupuncturists

The Plan pays for the services of licensed chiropractors, naturopaths, and acupuncturists. For the purpose of this section, these providers are known as alternative care providers.

To be covered, a service must be within the scope of the alternative care provider's license. It also must not be specifically excluded under this Plan.

There is an aggregate plan year maximum of \$2,500 for chiropractic, naturopathic and acupuncturist services. Office visits for alternative care providers are reimbursed at the same benefit level as office visits of physicians and professional providers.

Lab and diagnostic x-rays ordered by a chiropractor or naturopath are subject to the Plan's standard reimbursement rate for lab and diagnostic x-rays.

Office supplies and substances provided by a naturopath are covered. Physical therapy ordered by a naturopath is also covered. Reimbursement is at the Plan's standard reimbursement rate for the type of service rendered. For physical therapy services, see Outpatient Rehabilitation on page 30. Physical therapy services are not subject to the \$2,500 maximum for alternative care.

To be covered, a substance must be approved by the Board of Naturopathic Examiners and prescribed and dispensed by a naturopath.

Vitamins and minerals are covered when medically necessary for treatment of an illness or injury and prescribed and dispensed by a naturopath. This applies whether the vitamin or mineral is oral, injectable or transdermal. Benefits for covered vitamins and minerals prescribed and dispensed by a naturopath are subject to the aggregate plan year maximum of \$2,500 for chiropractic, naturopathic and acupuncturist services, when aggregated with such services. For the definition of medically necessary, please see Definitions.

P. Mental Health

The Plan covers medically necessary outpatient services by a mental health provider.

ODS Behavioral Health is available at 503-624-9382 or toll-free at 1-800-799-9391 to assist you in locating in-network physicians, providers and facilities and understanding your mental health benefits.

MATERNITY CARE

Pregnancy care, childbirth and related conditions are covered under this Plan when rendered by a covered professional provider in a covered facility. Covered professional providers do not include midwives unless they are also licensed nurse practitioners. A covered facility means a birthing center that is part of a hospital facility.

This maternity care benefit includes voluntary abortions.

Special Right Upon Childbirth. Group health plans and health insurance issuers offering group insurance coverage may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law does not prohibit the mother's or newborn's attending physician or provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours following a vaginal delivery, or 96 hours following a cesarean section. We do not require a physician or provider to obtain authorization for a length of stay up to 48 hours (or 96 hours for a c-section) following childbirth.

EMERGENCY CARE

You are covered for treatment of emergency medical conditions worldwide. All emergency services will be reimbursed at the in-network benefit level. However, benefits are subject to our contracted rates for in-network physicians and providers and the maximum plan allowance for out-of-network physicians and providers. You are responsible for emergency room facility co-payments in effect at that time along with any other co-payments that may apply to the type of services received. If a covered hospitalization immediately follows emergency services, we will waive emergency room facility co-payments. All other applicable co-payments remain in effect.

Service authorization is not required for emergency medical screening exams or treatment to stabilize an emergency medical condition. Service authorization is also not required for emergency services provided by an out-of-network physician or provider when a prudent layperson possessing an average knowledge of health and medicine would reasonably believe that the time required to go to an in-network physician or provider would place the health of the person, or a fetus in the case of a pregnant woman, in serious jeopardy.

If your condition requires hospitalization in an out-of-network facility, the attending physician and our medical director will monitor your condition and determine when the transfer to an in-network facility can be made. The Plan does not provide the in-network benefit level for care beyond the date the attending physician and our medical director determine you can be safely transferred.

The in-network benefit level will not be available if you go to an out-of-network provider for care other than emergency medical care. The following are not emergency medical conditions and are not eligible for the in-network benefit level (this list is not inclusive of all such services):

- Routine adult physical examinations, women's examinations, well-baby and child care, immunizations or routine eye examinations;
- Diagnostic work-ups for chronic conditions; and
- Elective surgery and/or hospitalization unless authorized as services not readily accessible from in-network providers.

AMBULANCE TRANSPORTATION

Ambulance transportation, including local ground transportation by state certified ambulance and certified air ambulance transportation, is covered for medically necessary transport to the nearest facility that has the capability to provide the necessary treatment. Benefits will be paid to you and the provider or directly to the provider. Certified air ambulance transportation is covered when medically necessary.

Services provided by a stretcher car, wheelchair car or other similar methods are considered custodial and are not covered benefits under this Plan.

HOSPICE CARE

Definitions:

Approved hospice means a private or public hospice agency or organization approved by Medicare or accredited by the Oregon Hospice Association (or a similar agency if services are provided outside of Oregon).

Home health aide means an employee of an approved hospice who provides intermittent custodial care under the supervision of a registered nurse, physical therapist, occupational therapist or speech therapist.

Hospice treatment plan means a written plan of care established and periodically reviewed by the enrollee's attending physician. The physician must certify in the plan that the enrollee is terminally ill and the plan must describe the services and supplies for medically necessary or palliative care to be provided by the approved hospice.

We will provide benefits for the services and supplies listed below when included in a hospice treatment plan. Services must be provided by an approved hospice agency to an enrollee who is terminally ill and not seeking further curative treatment.

Note: There is an aggregate maximum benefit of \$20,000 for hospice home care services.

A. Hospice Home Care

We will pay covered charges up to a maximum of \$20,000 for hospice home care services by any of the following:

- A registered or licensed practical nurse;
- A physical, occupational or speech therapist;
- A home health aide; or
- A licensed social worker.

A visit must be for intermittent medically necessary or palliative care.

B. Hospice Inpatient Care

We will pay covered charges for short-term hospice inpatient services and supplies for up to 12 days. This is not subject to the \$20,000 hospice home care benefit maximum.

C. Respite Care

Respite care means care of a hospice patient for a period of time to relieve persons residing with and caring for the patient from their duties. Providing care to allow a caregiver to return to work does not qualify as respite care.

We will pay covered charges for respite care provided to an enrollee who requires continuous assistance when arranged by the attending physician and authorized by ODS. Benefits are limited to 170 hours of care per three-month period of covered hospice care for services provided in what we determine is the most appropriate setting. Benefits are not subject to the \$20,000 hospice home care benefit maximum.

The services and charges of a non-professional provider may be covered for respite care if approval is given by us in advance.

D. Exclusions

In addition to exclusions listed in the Exclusion section, the following are not covered:

- Hospice services provided to other than the terminally ill enrollee, including bereavement counseling for family members;
- Services and supplies not included in the hospice treatment plan or not specifically set forth as a hospice benefit; and
- Services and supplies in excess of the stated limitations.

OTHER SERVICES

A. Home Healthcare

Home healthcare services and supplies are covered when provided by a home healthcare agency for an enrollee who is homebound. "Homebound" means that the enrollee's condition creates a general inability to leave home. If the enrollee does leave home, the absences must be infrequent, of short duration, and mainly for receiving medical treatment. A home healthcare agency is a licensed public or private agency that specializes in providing skilled nursing and other therapeutic services, such as physical therapy, in the enrollee's home.

The home healthcare benefit consists of medically necessary home healthcare visits. A visit must be for intermittent care of not more than two hours in duration. Home healthcare services must be ordered by a physician and be provided by and require the training and skills of one of the following professional providers:

- a registered or licensed practical nurse;
- a physical, occupational, speech, or respiratory therapist; or
- a licensed social worker.

Home health aides do not qualify as a home health service provider under the Plan.

This benefit does not include home healthcare, home care services, or supplies provided as part of a hospice treatment plan. These are covered under other parts of the Plan.

Maximum Visits

There is a two-visit maximum allowed in any one day for the services of a registered or licensed practical nurse. All other home healthcare providers are limited to one visit per day. This Plan provides a maximum of 140 home health visits per plan year.

Service authorization

Home healthcare requires service authorization. Contact ODS at 503-243-4496 or toll-free at 1-800-258-2037 before receiving such care.

B. Outpatient Rehabilitation

Up to 30 sessions are covered each plan year for rehabilitative services provided by a professional provider to an enrollee who is not confined in a hospital. If rehabilitative services are required following head or spinal cord injury, the benefit may be increased to 60 sessions. However, to receive this additional benefit, service authorization must be obtained before the initial 30 sessions have been exhausted.

Rehabilitative services are physical, occupational, or speech therapies necessary to restore or improve lost function caused by illness or injury. Outpatient rehabilitative services are short term in nature with the expectation that the enrollee's condition will improve significantly in a reasonable and generally predictable period of time.

A session is one visit. No more than one session of each type of physical, occupational, or speech therapy is covered in one day.

Therapy performed to maintain a current level of functioning without documentation of significant improvement is considered maintenance therapy and is not covered. Maintenance programs that prevent regression of a condition or function are not covered. This benefit also does not cover recreational or educational therapy, educational testing or training, non-medical self-help or training, services related to treatment, testing or training for learning disabilities, testing or treatment for mental retardation for enrollees age 18 or older, or hippotherapy.

C. Outpatient Chemical Dependency Services

Services for assessment and treatment of chemical dependency in an outpatient treatment program that meets the definitions in this Plan are covered, subject to medical necessity.

ODS Behavioral Health is available at 503-382-5323 or toll-free at 1-877-796-3223 to assist you in locating in-network physicians, providers and facilities and understanding your chemical dependency benefits.

D. Supplies, Appliances and Durable Medical Equipment

Outpatient supplies, appliances and durable medical equipment are covered. If you receive these services from out-of-network physicians or providers, the service will be reimbursed at the out-of-network benefit level.

Covered supplies include the following:

- medical supplies used in physician or provider's office;
- application of a cast;
- supplies related to a colostomy or mastectomy; and
- pumps and meters for diabetes.

The Plan covers prosthetic and orthotic devices, including repair or replacement of such devices, if they are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities. Prosthetic and orthotic devices which are solely for comfort or convenience are not covered.

The first extremity prosthesis after loss of a body part is covered, including artificial eyes and post-mastectomy bra and prosthetic. An additional prosthesis may be authorized if the attending physician provides documentation to us that a new prosthetic device is medically necessary because of changing fit or poor function. Testicular prostheses are not covered.

The Plan will cover one intraocular lens or one contact lens or eyeglasses for each eye operated on following cataract surgery.

An appliance is an item used for performing or facilitating the performance of a particular bodily function. Appliances, including orthopedic braces, are covered expenses. However, the following are not covered: dental appliances and braces, supporting devices such as corsets, compression or therapeutic stockings except when such stockings are medically necessary, hearing aids, eye glasses and contact lenses (see above for the cataract surgery exception).

Orthopedic shoes are covered if they are an integral part of a leg brace or if a physician or professional provider has ordered that orthopedic shoes be individually designed for correction or support of a deformity. If such correction or support is accomplished by modification of a mass-produced shoe, then the covered expense will be limited to the cost of the modification. The covered expense will not include the original cost of the shoe.

Durable medical equipment is equipment and related supplies which we determine are used primarily to serve a medical purpose, are not generally useful to an enrollee in the absence of illness, injury or disease, are appropriate for use in the enrollee's home and are designed to withstand repeated use. Examples of durable medical equipment include a wheelchair, a hospital-type bed, and oxygen. Purchase, rental, lease or maintenance expense of a wheelchair (including scooters, batteries and other accessories) is covered up to a maximum benefit of \$5,000 per plan year. Covered expenses may be paid up to \$10,000 per plan year subject to medical necessity and prior authorization by ODS.

The Plan will cover the rental charge (not to exceed the purchase price) for durable medical equipment. Upon request, you must authorize any supplier furnishing durable medical equipment to provide us with information related to the equipment order and any other records we need to approve a claim payment.

In order to obtain reimbursement for replacement or repair of appliances, including prosthetic devices, equipment or durable medical equipment, you must establish, to the satisfaction of ODS, that the foregoing were not abused, were not used beyond their specifications and not used in a manner to void applicable warranties.

In addition to the exclusions listed in the General Exclusions section, the Plan will not cover the following appliances and equipment, even if they relate to a condition which is otherwise covered by the Plan:

- Those used primarily for comfort, convenience, or cosmetic purposes;
- Wigs and toupees;
- Those used for education or environmental control, such as ramps, hand rails, bath benches, telephones, humidifiers, air filters, air conditioners, heat lamps, tanning lights, whirlpool or hot tubs;
- Therapeutic devices, except for transcutaneous nerve stimulators; and
- Incontinence supplies.

ODS is not liable for any claim or damages connected with illness or injuries arising out of the use of any durable medical equipment.

E. Infusion Therapy

The Plan covers infusion therapy services and supplies as described here, when medically necessary, authorized, and ordered by a physician as a part of an infusion therapy regimen.

Home infusion therapy must be provided by an accredited home infusion therapy agency. In addition, the enrollee receiving the services must qualify as "homebound" (as defined in the Home Health section on page 30.)

Infusion therapy benefits are limited to the following:

- aerosolized pentamidine;
- intravenous drug therapy;
- total parenteral nutrition;
- hydration therapy;
- intravenous/subcutaneous pain management;
- terbutaline infusion therapy;
- SynchroMed pump management;
- IV bolus/push drugs; and
- Blood product administration.

In addition, covered expenses include only the following medically necessary services and supplies:

- solutions, medications, and pharmaceutical additives;
- pharmacy compounding and dispensing services;
- durable medical equipment for the infusion therapy;
- ancillary medical supplies;
- nursing services associated with:
 - patient and/or alternative care giver training;
 - visits necessary to monitor intravenous therapy regimen;
 - emergency services;
 - administration of therapy; and
- collection, analysis, and reporting of the results of laboratory testing services required to monitor response to therapy.

Service authorization

Infusion therapy requires service authorization. Contact ODS at 503-243-4496 or toll-free at 1-800-258-2037 before receiving such care.

F. Nonprescription Enteral Formula For Home Use

The Plan will cover nonprescription elemental enteral formula for home use. The formula must be medically necessary and ordered by the doctor for the treatment of severe intestinal malabsorption and must comprise the sole source, or an essential source, of nutrition.

G. Medication Administered by Providers, Infusion Center or Home Infusion

A medication that is given by injection or infusion (intravenous administration) in the provider's office, infusion center or home infusion (e.g., allergens, Remicade, Xolair) is covered at the same benefit level as a supply. If the pharmaceutical is available in an oral dosage form, the Plan will not cover it in the form of an injectable medication unless ODS agrees that it is medically necessary that the enrollee use the injectable form. In addition, infusion and in-office injectables may require prior authorization by ODS or be subject to specific benefit limitations (visit our website at www.odscompanies.com for more information). See page 45 for coverage under the Prescription Drug Plan Benefit section.

H. Oral Anti-cancer Medication

A prescribed, orally administered anticancer medication that is given in the provider's office is covered at the same benefit level as a supply. In addition, oral anti-cancer medication may require prior authorization by ODS or be subject to specific benefit limitations (visit our website at www.odscompanies.com for more information). See page 45 for coverage under the Prescription Drug Plan Benefit section.

General Limitations

Notwithstanding any other provisions of this Plan, there are limitations on the benefits available under this Plan for the treatment of certain conditions and the use of certain procedures. These limitations are described below.

TRANSPLANTS

We will pay benefits for medically necessary and appropriate transplant procedures which in our judgment conform to accepted medical practice and are not experimental or investigational. (See "Experimental or Investigational Procedures" in General Exclusions section which begins on page 38).

The Plan will pay for covered donor costs up to a maximum of \$25,000 per transplant.

A. Definitions

In-Network Transplant Facility means a healthcare facility with which ODS has contracted or arranged to provide facility transplant services for the Participating District's enrollees.

Contracting Amount means the amount the In-Network Transplant Facility has agreed to accept as payment in full for facility transplant services for a specific type of transplant.

Transplant means:

- A procedure or a series of procedures by which tissue (e.g., solid organ, marrow, stem cells) is removed from the body of one person (donor) and implanted in the body of another person (recipient); and/or
- A procedure or series of procedures by which tissue is removed from one's body and later re-introduced back into the body of the same person.

Transplant does not include

- The collection of and/or transfusion of blood or blood products.
- Corneal transplants.

Transplant period means the time from the day of admission for transplant conditioning through the day of discharge for a transplant.

Complications resulting from a transplant means all medical and surgical treatments except the transplantation of hematopoietic cells or solid organ(s).

B. Covered Benefits

Benefits for transplants are limited as follows:

- We will waive any otherwise applicable deductible or co-payments of the Plan and pay 100% of the contracted amount for facility fees when a transplant is performed at an in-network transplant facility;

- If a transplant procedure is performed at a facility other than an in-network transplant facility, the deductible will apply and we will pay 60% of the amount we would have paid had the services been rendered at an in-network transplant facility. The patient will be responsible for the balance. The deductible and co-payment will not accumulate toward the out-of-pocket maximum amount under the Plan. If the provider's billed charge is less than the amount that would have been paid if the service had been rendered at an in-network transplant facility, reimbursement will not exceed the billed charge. **Note:** Services not performed at an in-network transplant facility will be paid at 60% even if the patient has met the in-network out-of-pocket maximum.
- If the recipient or self-donor is enrolled in this Plan, we will pay for donor costs related to a covered transplant up to a maximum of \$25,000 per transplant. "Donor costs" means the covered expense of removing the tissue from the donor's body and preserving or transporting it to the site where the transplant is performed as well as any other necessary charges directly related to locating and procuring the organ. If the donor is enrolled in this Plan and the recipient is not, we will not pay any benefits toward donor costs. Expenses incurred by an enrolled donor which result from complications and unforeseen effects of the donation will be covered as any other sickness. Expenses incurred by a donor not enrolled in the Plan which result from complications and unforeseen effects of the donation will not be covered.
- Covered transplants are medically necessary and appropriate when they meet the ODS Medical Necessity Criteria for the following organs or tissues:
 - Heart;
 - Heart/lung or lung;
 - Liver;
 - Kidney;
 - Kidney and pancreas when transplanted together in the same operative session;
 - Pancreas (this includes pancreas alone and pancreas after kidney transplantation);
 - Small bowel;
 - Autologous bone marrow or stem cell transplant for the treatment of:
 - acute leukemia;
 - chronic leukemias;
 - lymphoproliferative disorders;
 - germ cell tumors of the testes, ovaries, mediastinum and retroperitoneum;
 - plasma cell disorders;
 - solid tumors of childhood;
 - neuroductal tumors;
 - other malignancies.
 - Homogenic/allogenic bone marrow or stem cell transplant for the treatment of:
 - acute leukemia;
 - chronic leukemias;
 - myelodysplastic syndromes;
 - stem cell disorders;
 - myeloproliferative disorders;
 - lymphoproliferative disorders;
 - inherited metabolic disorders;
 - inherited erythrocyte abnormalities;
 - inherited immune system disorders;
 - other inherited disorders;
 - plasma cell disorders;
 - other malignancies.

- We will pay for physician or professional provider transplant services according to the benefits for physicians and professional providers under the Plan;
- Immunosuppressive drugs provided during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant-related services are paid under the Prescription Drug Plan Benefit.

Please Note:

All transplant related procedures and services, including the pre-transplant evaluation, must be authorized and be medically necessary and appropriate according to criteria established by ODS. To receive maximum plan benefits, the transplant related procedure must be performed at an in-network transplant facility.

C. Service Authorization Requirement

The service authorization requirement relates only to the administration of benefits under the Plan. The outcome of a service authorization request does not constitute a treatment recommendation or requirement. It relates solely to whether the procedure will be covered under the Plan. The actual course of medical treatment the enrollee chooses remains strictly a matter between the enrollee and his or her physician.

Service Authorization Procedures. To request service authorization, the enrollee's physician must contact the Medical Intake Unit of ODS prior to the transplant admission. Service authorization should be obtained as soon as possible after an enrollee has been identified as a possible transplant candidate.

Mail: Medical Intake Unit
The ODS Companies
P.O. Box 40384
Portland, Oregon 97240

Telephone: 503-243-4496 - Portland Area
Toll-free: 1-800-258-2037 - Nationwide

To be valid, service authorization approval must be in writing from ODS.

D. 24-Month Exclusion Period

Transplants will not be covered during the first 24 months an individual is enrolled in this Plan except as follows:

- The 24-month exclusion period will not apply if the enrollee has been continuously enrolled in this Plan since birth;
- The 24-month exclusion period will not apply if the enrollee was continuously enrolled in this Plan together with the Participating District's prior plan (but only if the prior plan included transplant coverage and would have covered the same services) at least 24 months prior to incurring transplant related expenses. If the enrollee had applicable transplant coverage under a prior health benefit plan, each day of creditable coverage the enrollee had under that prior health benefit plan will reduce the 24-month exclusion period by one day.

An enrollee has the right to demonstrate the existence of prior creditable coverage by providing us with a certificate of creditable coverage from a prior plan. You may request a certificate of creditable coverage from a prior plan or insurer within 24 months of coverage termination. If you have been enrolled in more than one prior plan, submit all certificates of creditable coverage, as aggregate periods of creditable coverage can be used to reduce the exclusion period.

E. Exclusions

In addition to the exclusions listed in the GENERAL EXCLUSIONS Section, we will not pay for the following:

- Donation related services or supplies provided to a donor who is an enrollee under this Plan if the recipient is not enrolled in this Plan and eligible for transplant benefits;
- Services or supplies for any transplant not specifically named as covered including the transplant of animal organs or artificial organs; and
- Chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not specifically named as covered above.

BIOFEEDBACK THERAPY

Covered expenses for biofeedback therapy services are limited to treatment of tension or migraine headaches. The Plan will pay for no more than 10 visits during the enrollee's lifetime.

PODIATRY SERVICES

Services of podiatrists are covered for the diagnosis and treatment of a specific current problem. We will not cover the following services:

- Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus);
- Trimming of dystrophic and non-dystrophic nails; and
- Debridement of nail(s) by any method(s).

However, we will cover services when otherwise required by the enrollee's medical condition (e.g., diabetes).

General Exclusions

In addition to the limitations and exclusions described elsewhere in this Plan, the following services, procedures and conditions are not covered by your plan, even if otherwise medically necessary, if they relate to a condition that is otherwise covered by the Plan, or if recommended, referred, or provided by a physician or provider.

Behavior Modification

Psychological enrichment or self-help programs for mentally healthy individuals are excluded. This includes assertiveness training, image therapy, sensory movement groups, marathon group therapy, and sensitivity training.

Benefits Not Stated

Services and supplies not specifically described in this Member Handbook as covered expenses under this Plan are excluded.

Birthing Center

Facility charges for services at non-hospital based birthing centers (i.e. birthing centers that are not part of an inpatient hospital facility) are not covered.

Charges Over the Maximum Plan Allowance

Any charge over the maximum plan allowance for services or supplies will be excluded except when required under this Plan's coordination of benefits rules (see page 72).

Comfort and First-Aid Supplies

Comfort and first-aid supplies are excluded. This includes, but is not limited to, footbaths, vaporizers, electric back massagers, footpads, heel cups, shoe inserts, band-aids, cotton balls, cotton swabs, and off-the-shelf wrist, ankle or knee braces.

Cosmetic/Reconstructive Surgery

Cosmetic procedures (any procedure that is requested for the purpose of improving or changing appearance without restoring impaired body function) are excluded under this Plan. Complications of reconstructive surgeries will be covered if medically necessary and not specifically excluded under this Plan. Breast augmentation, lipectomy, liposuction, and hair removal (including electrolysis and laser) are excluded.

Counseling or Treatment in the Absence of Illness

This includes individual or family counseling or treatment for marital, behavioral, financial, family, occupational or religious problems, or treatment of "normal" transitional response to stress.

Court-Ordered Services

This includes a court-ordered sex offender treatment program. This also includes a screening interview or treatment program under ORS 813.021. In addition, court-ordered treatment for chemical dependency is not covered.

Custodial Care

Routine care and hospitalization for assistance with activities of daily living, including, but not limited to, bathing, dressing, feeding, and administration of medications. Custodial care also includes care that is primarily for the purpose of separating a patient from others, or for preventing a patient from harming himself or herself.

Dental Examinations and Treatment; Orthodontia

Except as specifically provided under the "Special Dental Care" provision located in the "Benefit Description" section beginning on page 26, dental examination and treatment and orthodontia are not covered.

Dental Implants

Experimental or Investigational Procedures

Services and supplies are excluded that, in our judgment:

- Are not rendered by an accredited institution, physician or provider within the United States or by one that has not demonstrated medical proficiency in the rendering of the service or supplies;
- Are not recognized by the medical community in the service area in which they are received;
- Involve a treatment for which the approval of one or more government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered;
- Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established; and
- Are available in the United States only as part of clinical trial or research program for the illness or condition being treated.

Additionally, this Plan does not provide coverage for any expenses incidental to or incurred as a direct consequence of experimental or investigational procedures.

Eye Examinations

Routine eye examinations, except as provided under the Plan, including the fitting, provision, or replacement of eyeglasses or contact lenses, and any charges for orthoptics, vitamin therapy, low vision therapy, eye exercises, or fundus photography, are not covered.

Faith Healing

Family Planning

Surgery to reverse voluntary sterilization procedures (vasectomy or tubal ligation) and any contraceptive drug, device or supply that can be legally dispensed without a prescription are not covered under this Plan.

Financial Counseling Services

Food Services

"Meals on Wheels," and similar programs are not covered.

Gender Identity Disorders

Services and supplies related to gender identity disorders in enrollees age nineteen and older are not covered.

Guest Meals in a Hospital or Skilled Nursing Facility

Hearing Aids

The provision or replacement of hearing aids (internal and external) as well as the fitting of hearing aids are excluded. Implantable hearing aids and the surgical procedure to implant them are also excluded.

Home Birth or Delivery

This Plan does not cover charges for home birth other than the professional services billed by a covered professional provider. Charges, including but not limited to, those for travel, portable hot tubs, and transportation of equipment are excluded.

Homemaker or Housekeeping Services**Hospice Services**

The following hospice services are excluded:

- Hospice services provided to other than the terminally ill enrollee, including bereavement counseling for family members;
- Services and supplies not included in the hospice treatment plan or not specifically set forth as a hospice benefit; and
- Services and supplies in excess of the stated limitations.

Immunizations

Immunizations for the sole purpose of travel or to prevent illness which may be caused by a work environment are not covered.

Infertility

All services and supplies for office visits, diagnosis and treatment of infertility, as well as the cause of infertility are excluded under the Plan. This includes, but is not limited to, artificial insemination procedures, in-vitro fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transplant (ZIFT), and Tubal Embryo Transplant (TET).

Inmates

Services and supplies an enrollee receives while in the custody of any state or federal law enforcement authorities or while in jail or prison are not covered.

Legal Counseling**Massage or Massage Therapy**

Even if related to a condition which is otherwise covered by the Plan, massage and massage therapy are not covered.

Mental Examination and Psychological Testing and Evaluations

This Plan does not cover mental examinations for the purpose of adjudication of legal rights, administrative awards or benefits, corrections or social service placement, employment, or any use except as a diagnostic tool for the treatment of mental health illness.

Mental Retardation/Learning Disabilities

Treatment related to mental retardation for enrollees age 18 or older and treatment for learning disabilities are not covered. Custodial services or supplies provided by an institution for the mentally retarded are not covered.

Midwives

The Plan does not cover services provided by a midwife who is not a licensed nurse practitioner.

Missed Appointments

Motor Vehicle Coverage or Other Insurance Liability

Benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, are not payable under this Plan when such contract or insurance is issued to, or makes benefits available to, you or your enrolled dependent, whether or not application is duly made therefore. (See page 67 for complete details).

Necessities of Living

These include, but are not limited to, food, clothing, and household supplies. See also “Supportive Environmental Materials.”

Orthopedic Shoes

These are not covered, except as provided under “Supplies, Appliances and Durable Medical Equipment” on page 31.

Orthognathic Surgery

This includes services and supplies associated with orthognathic surgery.

Paraphilia**Pastoral and Spiritual Counseling****Physical Examinations**

Routine physical examinations and related services for employment, licensing, or insurance coverage are excluded under the Plan.

Physical Exercise Programs

Even if prescribed for a specific condition that is otherwise covered by the Plan, physical exercise programs are not covered.

Private Nursing Services

Even if they relate to a condition that is otherwise covered by the Plan, private nursing services are not covered.

Psychoanalysis or psychotherapy

Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present, is not covered.

Rehabilitation Services

Rehabilitation services are not covered, except as provided in the Rehabilitation section on pages 20 and 30.

Reports and Records

This Plan does not cover charges for the completion of reports or claim forms and the cost of records.

Routine Foot Care

We will not cover the following services:

- Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus);
- Trimming of dystrophic and non-dystrophic nails; and
- Debridement of nail(s) by any method(s).

School Services

Educational or correctional services or sheltered living provided by a school or half-way house are not covered.

Services Otherwise Available

This exclusion includes:

- services and supplies for which payment could be obtained in whole or in part if you or your dependent had applied for payment under any city, county, state, or federal law, except for Medicaid coverage;
- charges for services and supplies for which you or your dependents cannot be held liable because of an agreement between the physician or provider rendering the service and another third party payer which has paid or is obligated to pay for such service or supply;
- services and supplies for which no charge is made, or for which no charge is normally made in the absence of insurance; and
- services or supplies you could have received in a hospital or program operated by a government agency or authority. This exclusion does not apply to:
 - covered services rendered at any hospital owned or operated by the State of Oregon or any state approved community mental health and developmental disabilities program; or
 - if you are a veteran of the armed forces, in which case covered services and supplies furnished by the Veterans' Administration of the United States and which are not service-related are eligible for payment according to the terms of this Plan.

Services Provided By a Member of Your Immediate Family

ODS will not reimburse services provided by you or any member of your family. Family members would include a Spouse, Registered Domestic Partner, or Unregistered Domestic Partner, child, brother, sister, or parent of you or your Spouse, Registered Domestic Partner or Unregistered Domestic Partner.

Services Provided By Volunteer Workers

Service Related Conditions

This Plan does not cover treatment of any condition caused by or arising out of your service in the armed forces of any country or from an insurrection or war.

Services and Supplies Provided for Obesity or Weight Reduction

Services and supplies provided for the treatment of obesity or weight reduction, even if morbid obesity is present, are specifically excluded from this Plan. This includes, but is not limited to:

- Gastric restrictive procedures with or without gastric bypass, or the revision of the same.
- Weight management services such as weight loss programs, exercise programs, counseling, hypnosis, biofeedback, neurolinguistic programming, guided imagery, relaxation training and subliminal suggestion used to modify eating behaviors.
- Any drug or formula related to or resulting from the treatment of weight loss or obesity even if prescribed by your physician.

We will cover services and supplies that are necessary for the treatment of established medical conditions that may be caused by or made worse by obesity, but we will not cover services and supplies that do so by treating the obesity directly.

Sexual Disorders

This Plan covers services delivered by mental health providers for the treatment of sexual dysfunction diagnoses listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV-TR), but does not cover services or supplies delivered by other medical providers for the following treatment:

- Sexual dysfunction; or
- Sex change procedures and complications resulting from sex change procedures.

Support Education

This includes the following:

- Level 0.5 education only programs related to a DUII;
- Education-only, court-mandated Anger Management classes;
- Voluntary mutual support groups, such as Alcoholics Anonymous; and
- Family education or support groups.

Supportive Environmental Materials

These include, but are not limited to, hand rails, ramps, bath benches, humidifiers, air filters, air conditioners, heat lamps, tanning lights, whirlpools, hot tubs, and telephones, and other items that are not for the treatment of a medical condition even if they relate to a condition otherwise covered by the Plan. See also, "Necessities of Living."

Surgery to Alter Refractive Character of the Eye

This Plan does not cover refractive surgery, laser vision correction, and any other procedure that alters the refractive character of the eye, the purpose of which is to cure or reduce myopia, hyperopia, or astigmatism. This exclusion includes, but is not limited to, radial keratotomy, corneal rings, LASIK, PRK, any procedure using the Excimer Laser or the Holmium: YAG laser, and other procedures of the refractive keratoplasty type. Reversals or revisions of any procedures which alter the refractive character of the eye and any complications of these procedures are excluded.

Taxes

TeleHealth and TeleMedicine

Telephone Visits or Consultations, and Telephone Psychotherapy

Telephones and Televisions in a Hospital or Skilled Nursing Facility

Therapies

Services or supplies related to mental retardation for enrollees age 18 or older, services or supplies related to learning disabilities, hippotherapy, and maintenance therapy and programs are not covered.

Third-Party Liability

Services and supplies for treatment of illness or injury for which a third party is or may be responsible are not covered. (See page 67 for complete details)

Tobacco Addiction

Services and supplies related to the treatment of addiction to tobacco, tobacco products or nicotine substitutes are not covered. This includes smoking cessation programs.

Transportation

Separate charges for transportation, except medically necessary ambulance transport, are excluded.

Treatment After Coverage Terminates

This Plan does not cover services or supplies that you or your enrolled dependent receives after coverage ends. The only exception is if you are hospitalized at the time of termination. See “When Benefits Are Available” on page 19.

Treatment for Admissions Prior to Coverage

This Plan does not cover services and supplies for an admission to a hospital, skilled nursing facility or special facility that began before the enrollee’s coverage under this Plan began. Reimbursement for such admission will be the responsibility of the plan under which the enrollee was covered immediately preceding and extending up to the effective date of this Plan. If no such plan was in effect, ODS will provide coverage only for those covered expenses incurred on or after the enrollee’s effective date under this Plan.

Treatment Not Medically Necessary

This Plan does not cover:

- Services or supplies that are not medically necessary for the treatment or diagnosis of a condition otherwise covered under this Plan;
- Services or supplies that are either inappropriate or inconsistent with the symptoms or diagnosis of your condition;
- Services or supplies that are not established as the standard treatment by the medical community in the service area in which they are received;
- Services or supplies that are primarily rendered for the convenience of you or your dependents or a physician or provider of services or supplies; and/or
- Services that are not the least costly of the alternative supplies or levels of service which can be safely provided to you. For example, coverage would not be allowed for an inpatient hospital stay when an appropriate level of treatment could be delivered in an outpatient setting such as an ambulatory surgery facility. For another example, coverage would not be allowed for a residential chemical dependency treatment program, when the appropriate treatment could be delivered in an outpatient chemical dependency treatment program.

Please Note:

The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make the charge a covered expense.

Treatment Prior to Enrollment

This Plan does not cover services or supplies that you or your enrolled dependent received before you were enrolled in this Plan.

Vitamins and Minerals

This Plan does not cover vitamins and minerals unless they are medically necessary for treatment of a specific illness or injury and are prescribed and dispensed by a naturopath or other licensed medical practitioner. This applies whether the vitamin or mineral is oral, injectable, or transdermal.

Wigs, Toupees, Hair Transplants

These services and supplies are not covered even if they relate to a condition that is otherwise covered by the Plan.

Work-Related Conditions

This Plan does not cover services or supplies for treatment of illness or injury arising out of or in the course of employment or self-employment for wages or profit so long as the enrollee is not exempt from state and federal workers’ compensation law. This exclusion applies whether or not the expense for the service or supply is paid under workers' compensation.

Prescription Drug Plan Benefit

ODS THREE TIER CO-PAYMENT PROGRAM

Prescription Drug Plan benefits provide payment for eligible prescription drug charges. The Plan will pay benefits for covered prescription drug charges as follows:

Benefits for Prescriptions filled at Retail:

- 100% of covered expense after a \$5.00 co-payment per prescription for generic drugs;
- 80% for preferred brand name drugs; and
- 50% for non-preferred brand name drugs.

Benefits for Prescriptions filled at Mail-order/ Specialty:

- 100% of covered expense after a \$10.00 co-payment per prescription for generic drugs;
- 80% for preferred brand name drugs; and
- 50% for non-preferred brand name drugs.

ODS three-tier program has a \$1,000 plan year out-of-pocket maximum per member for all prescriptions. The out-of-pocket includes: 1) the amount you pay toward the covered expense for generic, preferred brand name and non-preferred brand name drugs, and 2) the difference between a generic and brand name drug under the Dispense as Written Policy. The \$1,000 plan year out-of-pocket maximum is calculated separately from any other out-of-pocket limit that may apply to the plan. Once the out-of-pocket limit is met, covered prescriptions will be reimbursed at 100%.

Generic Drugs. Generic medications have been determined by physicians and pharmacists to be therapeutically equivalent to the brand name alternative. Generic drugs must contain the same active ingredients as their brand name counterpart and be identical in strength, dosage form and route of administration. Therapeutic equivalency of generic medications is determined by the FDA approval process, the physician at the point of prescribing, and the pharmacist at the point of dispensing according to State Pharmacy Laws. These drugs carry the generic co-payment.

Preferred Brand Name Drugs. Preferred brand medications have been reviewed by ODS and found to be clinically efficacious and cost-effective when compared to other medications in the same therapeutic class. These drugs carry the preferred brand co-payment.

Compounded prescription drugs (containing at least one covered drug as an ingredient) will be paid under preferred brand status.

Specific supplies used for the treatment of diabetes are covered under preferred brand status of the Prescription Drug Plan. Select supplies commonly used for the treatment of other medical conditions may also be covered.

Non-Preferred Brand Name Drugs. Non-preferred brand medications have been reviewed by ODS and in comparison do not have any significant therapeutic advantage over their preferred brand alternative(s). Non-preferred drugs are usually not recommended as first line therapy and have alternative treatment modalities. These drugs carry the non-preferred brand co-payment.

Dispense as Written (DAW) policy. Under the Three Tier Co-pay program, both generic and brand name medications are covered. Regardless of the reason or medical necessity, if you request a brand name drug or your physician prescribes a brand name drug when a generic equivalent is available, you will be responsible for the brand co-pay plus the difference in cost between the generic and brand name drug.

Three Tier Formulary. A formulary list including generic, preferred brand, and non-preferred brand drugs can be accessed online at www.odskompanies.com, through your myODS account or by calling ODS Pharmacy Customer Service at 503-265-2911 in the Portland area or toll-free at 1-866-923-0411.

Please note: this list is subject to change and will periodically be updated. If you should have any questions regarding the list, please do not hesitate to contact pharmacy customer service.

ODS bears no responsibility for any prescribing or dispensing decisions. These decisions are to be made by the physician and pharmacist using their medical and professional judgment. Consult your physician about whether a drug from the preferred list would be appropriate for you. This list is not meant to replace a physician's judgment pertaining to prescribing decisions. The list of preferred drugs and the tiering of medications is subject to change.

DEFINITIONS

In-Network Pharmacy refers to a pharmacy that has contracted with the Oregon Prescription Drug Program to provide prescription drug benefits to persons covered under the Plan.

Legend Medications are those that include the notice "Caution - Federal law prohibits dispensing without prescription".

OPDP refers to the Oregon Prescription Drug Program.

The Plan- for the purposes of this prescription drug rider, refers to the agreement between OEGB, OPDP and ODS Health Plan, Inc.

Maximum Plan Allowance (MPA) is the maximum amount ODS will reimburse for medications. For an in-network pharmacy, the maximum amount is the contracted fee. For out-of-network pharmacies, the maximum amount is no more than the prevailing pharmacy network fee based on Average Wholesale Price (AWP) determined by First Data Bank minus a percentage discount. AWP is a figure that is reported by commercial publishers of drug pricing data, based on wholesale pricing information provided to them by drug manufacturers. Reimbursement for medications dispensed by physicians and providers other than retail pharmacies, mail order pharmacies, and specialty pharmacies will be subject to benefit provisions of the Plan and paid based on the lesser of either contracted rates, Average Wholesale Price (AWP) or billed charges.

Medically Necessary means those drugs that are required for treatment of illness or injury and which, in the judgment of ODS, are:

- Appropriate and consistent with the symptoms or diagnosis of the Enrollee's medical condition;
- Representative of the standard treatment by the medical community in the service area in which they are received;
- Not primarily for the convenience of the enrollee or a physician or provider of services or supplies; and
- Provide a cost-effective option when considering common alternatives that can be safely provided to the enrollee.

Please Note:

The fact that a physician or provider prescribes, orders, recommends, or approves a drug does not, of itself, make the drug medically necessary or a covered drug. Refer to the "Exclusions" section starting on page 49 for further information regarding medical necessity.

COVERED EXPENSES

A **covered expense** is a charge that meets all of the following criteria:

- It is for a covered drug supply that is prescribed for an enrollee;
- The expense is incurred while the enrollee is eligible for the Prescription Drug Plan; and
- The prescribed drug is not excluded under the Plan.

COVERED DRUG SUPPLY

A **covered drug supply** includes the following:

- A 31 day supply of medication is available through retail pharmacies.
- A 31 day supply is available through the contracted specialty medication pharmacy.
- A 90 day supply of medication is available through the contracted mail-order pharmacy.
- Refers to a supply of a drug or medicine that is medically necessary for the treatment of an illness or injury that cannot legally be dispensed without a prescription, and that by law must bear the legend "Caution - Federal law prohibits dispensing without prescription."
- Includes insulin (up to a maximum of 100 insulin syringes per 30 days and a maximum of 200 disposable needles per 30 days), insulin pens for premeasured insulin cartridges (up to 4 per year), insulin cartridges for pens, blood glucose test strips, and glucose tablets (separate co-pays are applied to a supply of insulin and to diabetic supplies).
- Selected over-the-counter (OTC) medications, when available in prescription strength and with a valid prescription, will be covered under the Prescription Drug Plan. The same benefit parameters such as co-pay and days supply restrictions will apply to covered over-the-counter medications. Examples of covered OTC medications include Claritin OTC, Zyrtec OTC and Prilosec OTC. For a list of OTC covered medications please visit our website at www.odscompanies.com or call our Pharmacy Customer Service at 503-265-2911 or toll free at 1-866-923-0411.
- Includes federal legend- prescription prenatal vitamins for pregnant women and nursing mothers.
- Specialty medications. This **Plan** provides members prescribed specialty medications, access to enhanced clinical services and an exclusive pharmacy. Please refer to the Specialty Services and Pharmacy section below for more information.
- Contraceptive drugs and devices used for medical reasons and birth control, but only if they cannot legally be dispensed without a prescription, and by law must bear the legend "Caution – Federal law prohibits dispensing without prescription." Coverage includes a 31-day supply of birth control medication. Pre-packaged birth control products packaged in 91-day supply containers, including but not limited to Seasonale and Seasonique, will be assessed three co-payments as defined by your plan benefits.

MAIL ORDER PHARMACY

You also have the option of obtaining prescriptions for covered drugs and medicines through an exclusive Mail Order Pharmacy.

Each mail order prescription is limited to a 90-day supply per prescription.

Prescriptions purchased through the mail order drug program are subject to the ODS Dispense as Written (DAW) policy.

To use the Mail Order Pharmacy, obtain a mail order pharmacy form from your employer or ODS by logging into your myODS account at www.odscompanies.com, or by contacting our Pharmacy Customer Service at 503-265-2911 or toll free at 1-866-923-0411.

SPECIALTY SERVICES AND PHARMACY

This **Plan** provides enrollees prescribed specialty medications, access to enhanced clinical services and an exclusive specialty pharmacy. Certain prescription drugs or medicines, including most self-injectables and other injectable drugs (e.g., Enbrel, Copaxone, Avonex), must be purchased through an exclusive Specialty Pharmacy Provider to be a covered benefit. **If you do not purchase these drugs at the in-network Specialty Pharmacy Provider, your drug expense will not be covered.**

Each specialty prescription is limited to a 31-day supply per prescription.

Prescriptions purchased through the specialty drug program are subject to the ODS Dispense as Written (DAW) policy.

Your pharmacist, physician and other medical providers will advise you if your prescription requires a prior authorization or requires delivery by an in-network Specialty Pharmacy Provider. Specialty medications are often indicated to treat complex chronic health conditions. Respecting that specialty treatments often require special handling techniques, careful administration and a unique ordering process, enhanced member services are provided by the Plan. Information about our clinical services and a list of eligible specialty medications can be accessed online at www.odscompanies.com, through your myODS account or by contacting our Pharmacy Customer Service at 503-265-2911 or toll free at 1-866-923-0411.

In addition, these drugs may require prior authorization by ODS (visit our website at www.odscompanies.com for more information).

Medications given intravenously are typically not considered to be specialty medications. Any new drug approved by the FDA after the date this policy goes into effect is not covered until approved by ODS.

PRIOR AUTHORIZATIONS

Prior-Authorization (PA) refers to the process by which an enrollee obtains approval from ODS prior to purchasing a specific drug. For a complete list of drugs that require authorization log into your myODS account at www.odscompanies.com or contact our Pharmacy Customer Service at 503-265-2911, or toll-free at 1-866-923-0411. Failure to obtain required service authorization will result in denial of benefits.

Certain prescription drugs and/or quantities of prescription drugs may require a prior authorization by ODS. Prior authorization programs are not intended to create barriers or limit access to medications. The practice of administering prior authorization provisions is intended to support cost effectiveness, promote proper use of medications and to ensure the safety of our members. Prior authorizations may be placed on medications for a variety of reasons- examples are listed below.

- **Utilization Control Edits.** Medications may have limited use, be prone to overuse or prescribed in quantities outside the recommended FDA indications.
- **Cost Effectiveness.** There may be therapeutically equivalent medications that are less expensive.
- **Prescribing Guidelines.** Medications may require diagnostic testing to ensure safety and efficacy of the treatment.
- **Benefit Coverage.** Medication may be prescribed for conditions that are excluded under the plan.

LIMITATIONS

This program may impose administrative plan edits and provisions that ensure appropriate access to medications based on patient demographics, high dollar thresholds, quantity limits and in accordance with the parameters of the prescription as written by your provider.

- Retail prescriptions with net cost over \$1,000 will require authorization from ODS.
- Mail-order and specialty prescriptions with net cost over \$3,000 will require authorization from ODS.
- New FDA approved drugs are subject to review and may require additional coverage parameters, requirements, or limits established by the plan.
- Compounded Medications with a net cost over \$150 will require a prior authorization from ODS.
- Immunization agents (other than allergy sera).
- Select immunizations and related administration fees are covered at retail pharmacies (example- influenza, pneumonia and shingles vaccines).
- Select erectile dysfunction medications are limited to a quantity of six for a 31 day supply.
- Selected over-the-counter (OTC) medications, when available in prescription strength and with a valid prescription, will be covered under the Prescription Drug Plan. The same benefit parameters such as co-pay and days supply restrictions will apply to covered over-the-counter medications. Examples of covered OTC medications include Claritin OTC, Zyrtec OTC and Prilosec OTC. For a list of OTC covered medications please visit our website at www.odskompanies.com or call our Pharmacy Customer Service at 503-265-2911 or toll free at 1-866-923-0411.

EXCLUSIONS

The following services, procedures and conditions are not covered by this Plan, even if otherwise medically necessary or if recommended, referred, or provided by a physician or pharmacy.

- **Blood and Blood Products.**
- **Charges Over the Maximum Plan Allowance.** Any charge in excess of the maximum plan allowance for a drug is not covered.
- **Cosmetic.** Drugs prescribed or used for cosmetic purposes are not covered.

- **Devices.** Devices, including, but not limited to therapeutic devices and appliances, hypodermic needles and syringes are not covered. (However, hypodermic needles and syringes for use with covered specialty medications and insulin will be a covered benefit). For contraceptive devices, please see Covered Drug Supply.
- **Drug Administration.** A charge for administration or injection of a drug or medicine is not covered, except when administered for select medications at retail pharmacies.
- **Drugs Covered Under Another Benefit.** A drug that is covered under another ODS benefit (i.e., hospice, home health, medical, etc.).
- **Drugs For Other Purposes.** A drug prescribed for purposes other than treating disease.
- **Excess Quantities.** Prescription refills or quantities of medications that are in excess of the number prescribed by the physician or the number established by the Plan are not covered.
- **Experimental or Investigational Drugs.** The following are not covered:
 - Any drug that is determined by ODS to be experimental or investigational or that is labeled: "Caution - Limited by federal law to investigational use"; or
 - Any drug or medicine that is used for an experimental or investigational purpose, even if it is otherwise approved by the federal government or recognized as neither experimental nor investigative for other uses or health conditions (e.g., progesterone suppositories).
- **Hair Growth Legend Drugs.**
- **Infertility Drugs.**
- **Institutional Drugs or Medicine.** Drugs or medicine that are to be taken by or administered to an enrollee in whole or in part while the enrollee is a patient in a hospital, a sanitarium, a rest home, a skilled nursing facility, an extended care facility, a nursing home, or a similar institution are not covered.
- **Non-Covered Condition.** A drug prescribed to treat a medical condition that is not covered under the Medical Plan.
- **Off-label Usage.** Drugs prescribed for or used for non-FDA approved indications, unless approved by the Health Resources Commission, are not covered.
- **Over the Counter (OTC) Drugs.** If a dosage form of equal or greater strength of a medication (*that by law must bear the legend "Caution – Federal law prohibits dispensing without prescription"*) is available without a prescription under federal law, that drug or medication is not covered unless it appears on ODS' list of covered OTC medications.
- **Sexual Disorders.** Drugs or devices prescribed or used to treat sexual dysfunction (with the exception of drugs used to treat erectile dysfunction, see Limitations) are not covered.
- **Tobacco Disorders.** Drugs or medicine to treat addiction to or dependence on tobacco or tobacco products (e.g., Nicorette) are not covered.
- **Treatment Not Medically Necessary.**

This Plan does not cover:

 - Drugs prescribed for purposes other than treating disease;
 - Drugs that are either inappropriate or inconsistent with the symptoms or diagnosis of your condition;
 - Drugs that are not representative of the standard treatment by the medical community in the service area in which they are received;
 - Drugs that are primarily rendered for the convenience of you or your dependents or a physician or provider; and/or
 - Drugs that are not a cost-effective option when considering common alternatives that can be safely provided to the enrollee
- **Untimely Dispensing.** Drugs or medicines that are dispensed more than one year after the order of a physician are not covered.
- **Vitamins and Minerals.** This plan does not cover vitamins and minerals (with the exception of prescribed federal legend pre-natal vitamins). This applies whether the vitamin or mineral is oral, injectable, or transdermal.

Please Note:

The fact that a physician may prescribe, order, recommend, or approve a drug does not, of itself, make the charge a covered expense.

CLAIMS PROCEDURES

A charge is considered to be incurred at the time the drug or medicine is furnished to the enrollee.

If you go to an In-network Pharmacy:

- Present your ODS ID card;
- Sign the claim form required by the Pharmacy; and
- Pay the prescription co-payment as required by the Plan.

At times, you may be required to submit a claim form and your receipts for reimbursement. For example, if you fill your prescription at a non-participating pharmacy that does not access ODS' claims payment system through MedImpact, you will need to submit a request for reimbursement. When your employer plan provides you with secondary coverage, you will also need to submit a claim form requesting coordination of benefits (COB) reimbursement.

The Claim Procedure Process is as easy as 1, 2, 3 ...

1. Complete the prescription drug claim form. Forms can be found online at www.odscompanies.com, through your myODS online account or by linking directly to the forms page at <http://www.odscompanies.com/members/forms.shtml>.
2. Submit claim forms to:

The ODS Companies
Attn: Pharmacy
P.O. Box 40168
Portland, OR 97240-0168
3. ODS will process the claim request and send reimbursement to you in the form of a check.

A claim must be submitted to ODS within 90 days after the date the expense was incurred. Failure to furnish a claim within the time required shall not invalidate or reduce any claim if it was not reasonably possible to submit the claim within 90 days, provided it is submitted as soon as reasonably possible. In no event, except absence of legal capacity, is a claim valid if submitted later than one year from the date submission is otherwise required.

A claim for which additional information is received will not be reprocessed after the Plan's claim submission period, as described in the previous paragraph

Eligible prescription drugs purchased and paid in full by an enrollee will be reimbursed at the ODS Pharmacy contracted rate minus your co-payment, or the maximum plan allowance minus your co-payment, whichever is less.

Please Note:

Claims should be addressed to:

**ODS Pharmacy Network
P.O. Box 40168
Portland, Oregon 97240-0168
503-265-2911 or 1-866-923-0411**

Eligibility

This section describes who is eligible to enroll in the Plan. Please be aware that the date you become eligible may be different than the date coverage begins. See "When Coverage Begins" for more specific information. This is located in the "Enrollment" section beginning on page 56.

ACTIVE EMPLOYEES

Employee Eligibility

You are eligible to enroll in the Plan if you:

- Are paid on a regular basis through the payroll system, have federal taxes deducted from such pay, and are reported to Social Security;
- Work for the Participating District on a regularly scheduled basis at least:
 - 17.5 hours per week;
 - Such number mutually agreed upon by the school district and OEGB; or
 - You are entitled to coverage under an employment contract
- Satisfy any eligibility waiting period; and
- Apply to and are accepted by OEGB to be included in this Plan.

You are eligible to remain enrolled if you are on an approved leave of absence under the Family and Medical Leave Act of 1993, as amended.

Dependents

Your legal Spouse or Registered Domestic Partner is eligible for coverage. Your Unregistered Domestic Partner is eligible for coverage if he or she complies with the Domestic Partner Affidavit provided by the Participating District. Your dependent children are eligible until their 19th birthday. Your dependent children may be eligible until their 26th birthday if they are not married, are not in a Registered Domestic Partnership, are not in an Unregistered Domestic Partnership and:

- Are a full-time student at an accredited college, university, or vocational school;
- Are living in the home of the Eligible Employee over six months of the calendar year and the Eligible Employee provides over half of the yearly support; or
- Are incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability.

Children eligible due to a court or administrative order are also subject to the Plan's child age limits.

For purposes of determining eligibility, the following are considered "children":

- A biological child of, an adopted child of, or a child placed for adoption with the Eligible Employee, Spouse, Registered Domestic Partner or Unregistered Domestic Partner;
- A legal ward by court decree, a dependent by Affidavit of Dependency, or is under legal guardianship of the Eligible Employee, Spouse, Registered Domestic Partner or Unregistered Domestic Partner, and is living in the home of the Eligible Employee;
- The child must not qualify as any other person's Dependent Child, except that a child of divorced or separated parents meeting conditions under IRC 152(e) can be treated as a dependent of both parents; or
- A newborn child of a covered dependent for the first 31 days of the newborn's life.

If you have a child who has sustained a disability rendering him/her physically or mentally incapable of self-support, that child may be eligible for coverage even though he or she is over 26 years old. To be eligible, the child must be unmarried, not in a Registered or Unregistered Domestic Partnership, principally dependent on you for support and must have had continuous medical insurance coverage (group or individual) prior to attaining age 26 and until the time of the OEBC insurance effective date. The incapacity must have arisen before the child's 26th birthday. You must provide us with a written physician's statement that confirms that these conditions existed continuously prior to the child's 26th birthday. Documentation of the child's medical condition must be reviewed and approved by the ODS medical consultant. Periodic review by the medical consultant will also be required on an ongoing basis.

Dependents on full-time duty in the active military service of the United States are not eligible. This includes members of the Reserve Components serving on active duty or full-time training duty.

Note:

- **Some Participating Districts may not offer opposite sex domestic partner coverage. Check with your Participating District to determine what domestic partner coverage is available.**
- **Your Participating District may offer other dependent coverage limitations due to a collective bargaining or district policy. Check with your Participating District for dependent coverage limitations.**

Qualified Medical Child Support Order (QMCSO)

This Plan will cover individuals deemed to be alternative recipients under a qualified medical child support order (QMCSO). A QMCSO is a court judgment, decree, or order, or a state administrative order that has the force and effect of law, that is typically issued as part of a divorce or as part of a state child support order proceeding, and that requires health plan coverage for an alternative recipient. An alternative recipient is a child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

The child's coverage under the Plan will be effective as of the first day of the month following the date that the Plan Administrator determines that applicable order qualifies as a QMCSO, and that the child is eligible for enrollment in the Plan.

The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You may obtain a copy of such procedures from the Plan Administrator without charge.

RETIREES

Employee Eligibility

You are eligible to enroll in the plan if:

- Receiving a service or disability retirement allowance or pension under the Public Employees Retirement System (PERS) or under any other retirement or disability Benefit Plan or system offered by an OEBC participating organization for its Employees;
- Eligible to receive a service retirement allowance under PERS and has reached earliest retirement age under ORS Chapter 238;
- Eligible to receive a pension under ORS 238A.100 to 238A.245 and has reached earliest retirement age as described in ORS 238A.165; or
- Eligible to receive a service retirement allowance or pension under another retirement benefit plan or system offered by an OEBC participating organization and has reached earliest retirement age under the plan or system.

Dependent Eligibility

If a retiree becomes eligible for Medicare coverage, but his or her currently-enrolled eligible dependents are not, these eligible individuals may continue OEGB medical and dental insurance coverage until such time as they no longer meet OEGB eligibility requirements or become eligible for Medicare coverage, whichever occurs first. The eligible individuals must submit the application for enrollment to the retiree plan administrator within 60 days of the retiree's eligibility for Medicare.

When Retiree Eligibility Ends

A retiree and eligible dependents enrolled in OEGB retiree insurance plans who become eligible for Medicare coverage may not continue an OEGB retiree medical insurance plan. The exception is for Medicare eligibility as a result of end-state renal disease. Insurance coverage ends the last day of the month that eligibility is lost.

NEW DEPENDENTS

If you marry while you are enrolled in this Plan, your Spouse and his or her children are eligible for coverage. A complete and signed application along with a valid marriage certificate must be submitted within 31 days of the date of the marriage. (See "When Coverage Begins.") All dependents must meet eligibility requirements.

If you register a Declaration of Domestic Partnership under the Oregon Family Fairness Act while you are enrolled in this Plan, your Registered Domestic Partner and his or her children are eligible for coverage. A complete and signed application along with a valid Certificate of Registered Domestic Partnership must be submitted within 31 days of the date the Declaration of Domestic Partnership is registered. (See "When Coverage Begins.") All dependents must meet eligibility requirements.

If you file an Affidavit of Domestic Partnership with the Participating District while you are enrolled in the Plan, your Unregistered Domestic Partner and his or her children are eligible for coverage. A complete and signed application along with a copy of the Affidavit of Domestic Partnership must be submitted within 31 days of the date the Affidavit of Domestic Partnership is filed.

Your newborn child or your enrolled dependent's newborn child will be covered for 31 days after birth. The enrolled employee must submit a complete and signed application to the Participating District's payroll or personnel office within 60 days listing the new child as a dependent. If the Participating District does not receive the application, coverage for the child will end 31 days following birth. Proof of legal guardianship will be required for coverage of a grandchild beyond the first 31 days from birth.

Adopted children are covered for the first 31 days from the date of the adoption decree. If a child is placed with you pending the completion of adoption proceedings, that child will be covered for the first 31 days from the date of placement. The enrolled employee must submit a complete and signed application, to the Participating District's payroll or personnel office, along with the placement or adoption paperwork within 60 days listing the child as a dependent.

Placement for adoption means you have assumed and retained a legal obligation for full or partial support of the child in anticipation of adoption.

<p>Note: A new dependent may cause a premium increase. Premiums will be adjusted accordingly. Such adjustments will apply during the first 31 days of coverage for newborn or adopted children.</p>
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Enrollment

This section explains how to enroll in the Plan.

WHEN YOU FIRST BECOME ELIGIBLE

You must file a complete and signed application for yourself and any dependents you want enrolled within 31 days of when you become eligible to apply for coverage. Employees become eligible to apply on the date of hire or the end of any required waiting period. File the application with the Participating District's payroll or personnel office.

You must notify your School District whenever you change your address.

ENROLLING NEW DEPENDENTS

You may obtain coverage for newly acquired or newly eligible dependents by submitting a complete and signed application, to the Participating District's payroll or personnel office, within 31 days of their eligibility. For newborn children, an adopted child, or a child placed for adoption, you must submit a complete and signed dependent application along with the placement or adoption paperwork within 60 days of adoption or placement.

You must notify your School District if family members are added or dropped from coverage, even if it does not affect your premiums.

OPEN ENROLLMENT

If you do not enroll yourself and/or your eligible dependents within 31 days (60 days for newborn children and an adopted child or a child placed for adoption) of first becoming eligible, you will be considered a "late enrollee" and must wait for the next open enrollment period to enroll. Open enrollment occurs once a year at renewal. However, an eligible individual shall not be considered a late enrollee if he or she meets one of the exceptions under "Late Enrollee" on page 14, including eligibility under "Special Enrollment Rights" as described below.

SPECIAL ENROLLMENT RIGHTS

A. Loss Of Other Coverage

If you decline coverage for yourself or your dependent(s) when eligible to enroll because of other health coverage, you may enroll yourself or your dependent(s) in this Plan outside of the open enrollment period, but only if you satisfy the following criteria:

- The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;
- The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason enrollment was declined;
- The employee requests such enrollment not later than 31 days after the previous coverage ended; and

- One of the following events has occurred:
 - 1) The employee's or dependent's prior coverage was under COBRA continuation provision and the coverage under such provision was exhausted; this includes reaching the lifetime maximum while on COBRA coverage.
 - 2) The employee's or dependent's prior coverage was terminated as a result of loss of eligibility for the coverage. Examples of when coverage under a plan may be lost include:
 - legal separation or divorce;
 - loss of dependent status per plan terms;
 - death;
 - termination of employment;
 - reduction in the number of hours of employment;
 - reaching the lifetime maximum on all benefits;
 - the plan ceasing to offer coverage to a group of similarly situated individuals;
 - moving out of an HMO service area that results in termination of coverage and no other option is available under the plan;
 - termination of the benefit packet option, unless a substitute option is offered.
 - 3) The employer contributions toward the employee's or dependent's other coverage were terminated. (If employer contributions cease, the employee or dependent does not have to terminate coverage under the prior plan in order to be eligible for special enrollment.)

This special enrollment right, as described above, applies:

- To a current employee who loses other coverage;
- To an enrolled employee's dependent who loses coverage under the other plan;
- To both the current employee and the dependent if neither is enrolled in the Plan, and either loses coverage under the other plan.

To enroll yourself or your dependent you will need to submit a complete and signed application.

B. New Dependents

New dependents under the terms of this Plan may enroll outside of open enrollment periods if they request special enrollment within 31 days after the event that caused the employee to gain a new dependent (e.g., marriage, the registration of a Declaration of Domestic Partnership or the filing of an Affidavit of Domestic Partnership). Enrollment must be submitted within 60 days for newborn children and an adopted child or a child placed for adoption. The employee and his or her Spouse or Registered Domestic Partner will also have special enrollment rights if they are eligible but not enrolled at the time of the event that caused the employee to gain a new dependent; however, other existing dependents will not.

To enroll your new dependent you will need to submit a complete and signed application and, when applicable, a marriage certificate, a Certificate of Registered Domestic Partnership, a copy of the filed Affidavit of Domestic Partnership, or adoption or placement for adoption paperwork.

WHEN COVERAGE BEGINS

Coverage will begin for you and any enrolled dependents on the first day of the month following the Participating District's waiting period.

Coverage for new dependents through marriage will begin the first day of the month if the marriage date is the first day of the month. Otherwise, coverage begins on the first day of the month following the date of marriage.

Coverage for new dependents through the registration of a Declaration of Domestic Partnership under the Oregon Family Fairness Act will begin on the first day of the month if the Declaration of Domestic Partnership is registered on the first day of the month. Otherwise, coverage begins on the first day of the month following the date the Declaration of Domestic Partnership is registered.

Coverage for new dependents through the filing of an Affidavit of Domestic Partnership with the Participating District will begin on the first day of the month if the Affidavit of Domestic Partnership is filed on the first day of the month. Otherwise, coverage begins on the first day of the month following the date the Affidavit of Domestic Partnership is filed.

When the new dependent is due to the birth of a newborn, coverage is effective on the date of the newborn's birth. When the dependent is due to an adoption or placement for adoption, coverage is effective on the date of adoption or placement. Court ordered coverage is effective on the date specified by the court order.

The necessary premiums must also be paid for coverage to become effective.

If you apply for coverage as a late enrollee, coverage will begin for you and/or your dependents on the date we specify with the acceptance of your application. All other plan provisions will apply.

WHEN INSURANCE ENDS

There are a variety of circumstances in which coverage for you and/or your enrolled dependents will end. These are described in the following paragraphs.

A. Group Plan Termination

If the Plan is terminated for any reason, coverage ends for the Participating District, you and your enrolled dependents on the date the Plan ends. There is one exception to this rule. If OEGB terminates this Plan and an enrollee is hospitalized on the day the Plan ends, coverage under this Plan (including all terms, limitations, and conditions) shall continue until the hospital confinement ends or hospital benefits under the Plan are exhausted, whichever is earlier.

If OEGB has not paid the premiums by the premium due date, ODS will issue a notice to OEGB advising that if the premiums are not received by the end of the grace period, the policy will be terminated. The notice will be issued at least 10 days prior to the end of the grace period, and will explain your rights to continuation or Portability coverage under federal and/or state law. If the policy is subsequently terminated due to nonpayment of premiums, it is the duty of OEGB to send you notice of termination.

ODS may terminate the group policy for fraud, material misrepresentation, or concealment by OEGB, or for OEGB's noncompliance with material policy provisions.

In the event the group policy is terminated for a reason other than nonpayment of premiums and OEGB does not replace the insurance coverage, we will mail a notice of termination to OEGB. Our notice will be mailed within 10 working days of the date of termination. The notice will explain your rights under federal and state law regarding Portability, conversion and continuation of coverage. It is the responsibility of OEGB to send you the information contained in the notice.

If we do not give notice as required by this provision, the group policy shall remain in full force from the date notice should have been provided until the date the notice is received by OEGB, and we will waive the premiums owing for this period. In this case, the period during which you or your enrolled dependents have to apply for continuation or Portability coverage will begin on the date OEGB receives the notice.

B. Termination By Enrolled Employee

You may terminate your coverage, or coverage for any enrolled dependent, by giving us written notice through OEGB. Coverage will end on the last day of the month through which premiums are paid. If you terminate your own coverage, coverage for your dependents also ends at the same time.

C. Death

If you die, coverage for your enrolled dependents ends on the last day of the month in which your death occurs. Note that your enrolled dependents may extend their coverage for up to 3 years if the requirements for continuation of coverage are met (see page 81 for details). OEGB must notify us of any continuation of coverage and appropriate premiums must be paid along with OEGB's regular monthly payment.

D. Loss of Eligibility

If your employment terminates, your coverage will end for you and your enrolled dependents on the last day of the month in which termination occurred, unless you choose to continue coverage as provided under this Plan (see page 81 for details).

E. Rescission By Insurer

We may rescind your coverage, and/or the coverage of your enrolled dependents, back to your effective date, or deny claims at any time for fraud, material misrepresentation, or concealment by you or your enrolled dependents. As used herein, fraud, material misrepresentation, or concealment may include, but is not limited to, enrolling ineligible individuals on the Plan, falsifying or withholding documentation or information that is the basis for eligibility or employment, falsification or alteration of claims. We reserve the right to retain premiums paid by you as liquidated damages, and you shall be responsible for the full balance of any benefits paid. Should we terminate coverage under this section, we may, to the extent permitted by law, deny future enrollment of you and your dependents under any ODS Health Plan, Inc. policy or contract, or the contract of any of our affiliates.

F. Family and Medical Leave

If the Participating District grants you a leave of absence under the Family and Medical Leave Act of 1993, as amended (FMLA), the following rules will apply:

- You and your enrolled dependents will remain eligible for coverage during your FMLA leave.
- If you and/or your enrolled dependents elect not to remain enrolled during FMLA leave, you (and/or your enrolled dependents) will be eligible to re-enroll in the Plan on the date you return from leave. To re-enroll, you must submit a complete and signed application within 60 days of your return to work. All of the terms and conditions of the policy will resume at the time of re-enrollment as if there had been no lapse in coverage. You will receive credit for

any exclusion period served prior to the FMLA leave and you will not have to re-serve any eligibility-waiting period under the Plan. However, you will receive no exclusion period credits for the period of the leave.

- Your rights under FMLA will be governed by that statute and its regulations.

G. Leave of Absence

If you are granted a non-FMLA leave of absence by the Participating District, you may continue coverage for up to three months. Premiums must be paid through OEGB in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by the Participating District at your request during which you are still considered to be employed and are carried on the employment records of the Participating District. A leave can be granted for any reason acceptable to the Participating District, including disability and maternity.

H. Strike or Lockout

If you are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, you may continue your coverage for up to six months. You must pay the full premiums, including any part usually paid by the Participating District, directly to the union or trust that represents you, and the union or trust must continue to pay us the premiums when due.

Continuation of coverage during a strike or lockout will not occur if:

- Fewer than 75% of those normally enrolled choose to continue their coverage;
- You accept full-time employment with another employer; or
- You otherwise lose eligibility under the Plan.

I. Termination of Employment

If your employment terminates, your coverage will end for you and all enrolled dependents on the last day of the month in which termination occurs, unless you choose to continue coverage (see page 81).

If you are laid-off by the Participating District and return to active work within six months of being laid off, you and any previously enrolled dependents may re-enroll in the group plan on the date you are rehired. Your coverage will begin on the date of rehire.

If you experience a reduction in hours that causes you to lose coverage, and within six months your hours increase and you again qualify for benefits, you and any previously enrolled dependents may re-enroll in the group plan on the date you qualify. Your coverage will begin on the date you qualify.

All plan provisions will resume at the time you re-enroll whether or not there was a lapse in your coverage. Any exclusion period for pre-existing conditions that you did not complete at the time you were laid off or had a reduction in hours must be satisfied. However, the period of your layoff will be counted toward the exclusion period. At the time you re-enroll in the Plan, you do not have to re-serve any waiting period required by the Plan.

OEGB must notify us that you have been rehired following a lay-off or that your hours have been increased, and the necessary premiums for your coverage must be paid.

J. Loss of Eligibility by Dependent

An enrolled child will lose eligibility when he or she no longer meets the requirements to qualify as a dependent as described on page 53 or when the enrolled employee is no longer legally required to provide coverage for the child. Coverage will end on the last day of the month in which the child's eligibility ends, unless the child continues coverage as provided under this Plan (see page 81).

Coverage ends for an enrolled Spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), unless the divorced Spouse continues coverage as provided under this Plan (see page 81).

Coverage ends for a Registered Domestic Partner on the last day of the month in which a judgment of dissolution or annulment of the domestic partnership has been entered, unless the former Registered Domestic Partner continues coverage as provided under this Plan (see page 81).

Coverage ends for an Unregistered Domestic Partner on the last day of the month in which the domestic partnership no longer meets the requirements of the Affidavit of Domestic Partnership filed with the Participating District, unless the former Unregistered Domestic Partner continues coverage as provided under this Plan (see page 81).

K. Certificates of Creditable Coverage

Certificates of creditable coverage will be issued when coverage ends, when COBRA coverage ends, and when an individual requests a certificate while covered under the Plan or within two years of losing coverage.

L. Other

See "Continuation of Health Coverage" section starting on page 81. See also "Individual Portability Coverage" which begins on page 88.

Claims Administration & Payment

The following section explains how claims are administered.

SUBMISSION AND PAYMENT OF CLAIMS

A claim must be submitted to ODS within 90 days after the date the expense was incurred. Failure to furnish a claim within the time required shall not invalidate or reduce any claim if it was not reasonably possible to submit the claim within 90 days, provided it is submitted as soon as reasonably possible. In no event, except absence of legal capacity or in the case of a Medicaid claim, is a claim valid if submitted later than one year from the date submission is otherwise required. Claims submitted by Medicaid must be sent to ODS within 3 years after the date the expense was incurred.

A claim for which additional information is received will not be reprocessed after the Plan's claim submission period, as described in the above paragraph.

A. Hospital Claims

If you or an enrolled dependent are hospitalized, you must present your ODS identification card to the admitting office. In most cases, the hospital will bill us directly for the cost of the hospital services. We will pay the hospital and send you copies of our payment record. The hospital will then bill you for any charges that were not covered under this Plan.

Sometimes, a hospital will require you, at the time of discharge, to pay charges that might not be covered by this Plan. If this happens, you must pay these amounts yourself. We will reimburse you if any of the charges you pay are later determined to be covered by this Plan.

You may be billed by the hospital directly. In order to claim your benefits for these charges, send a copy of the bill to us, and be sure it includes all of the following information:

- The patient's name;
- The employee's name and group and identification numbers;
- A description of the diagnosis or symptoms treated; and
- A description of the services and the dates on which they were provided.

The same procedure should be followed with bills for hospital, physician or professional provider care you receive outside the United States.

B. Physician and Professional Provider Claims

Your physician or professional provider may bill charges directly to us. If not, please forward the bills directly to us at the address listed below. Be sure the physician or professional provider uses his or her billing form and that the following are shown on the bill:

- The patient's name and the group and identification numbers;
- The date of treatment;
- The diagnosis; and
- An itemized description of services and charges.

The ODS Companies
Attn: Medical
P.O. Box 40384
Portland, Oregon 97240

If the treatment is for an accidental injury, include a statement explaining the date, time, place, and circumstances of the accident when you send us the bill.

C. Ambulance Claims

Bills for ambulance service must show where the patient was picked up and taken. It should also show the date of service, and the patient's name, group number, and identification number.

D. Explanation of Benefits (EOB)

Soon after you make a claim, we will report to you on the action we have taken by sending you a document called an Explanation of Benefits. We may pay claims, deny them, or accumulate them toward satisfying the deductible, if any. If we deny all or part of a claim, the reason for our action will be stated in the Explanation of Benefits.

If you do not receive an Explanation of Benefits within a few weeks of the date of service, this may indicate that ODS has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period noted under Submission and Payment of Claims.

E. Claim Inquiries

If you have any questions about how to file a claim, the status of a pending claim, or any action taken on a claim, please call us at 503-265-2909 or toll-free at 1-866-923-0409 or write to our Medical Customer Service Department. For questions regarding a pharmacy claim, please call our Pharmacy Drug Benefit Customer Service at 503-265-2911 or toll-free at 1-866-923-0411. We will respond to your inquiry within 30 days of receipt.

GRIEVANCE AND APPEALS

A. Grievance

Complaint means an expression of dissatisfaction about a specific problem you have encountered or about a decision by an insurer or an agent acting on behalf of ODS, and which includes a request for action to resolve the problem or change the decision. A complaint does not include an inquiry.

Grievance means a written complaint submitted by you or on your behalf regarding:

- Availability, delivery, or quality of healthcare services, including a complaint regarding an adverse determination made pursuant to a utilization review;
- Claims payment, handling, or reimbursement for healthcare services; or
- Matters pertaining to the contractual relationship between you and ODS.

Inquiry means a written request for information or clarification about any subject related to your health benefit plan. An inquiry does not in itself constitute a complaint.

Note:

The timelines addressed in the paragraphs below do not apply when:

- The time period is too long to accommodate the clinical urgency of the situation;
- You do not reasonably cooperate; or
- Circumstances beyond the control of either party prevents that party from complying with the standards set but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise.

If you have a **grievance**, you must submit it in writing to ODS and ask for a review. If you need assistance on filing a grievance, contact ODS Medical Customer Service at 503-265-2909 or toll-free at 1-866-923-0409, or Pharmacy Drug Benefit Customer Service at 503-265-2911 or toll-free at 1-866-923-0411 for pharmacy claims, to discuss the issue as it may be possible to resolve it with a phone call. We will acknowledge receipt of the written grievance within seven (7) days of receipt and conduct an investigation. We will inform you of the results of the investigation and any action we intend to take within 30 days of receiving the grievance. If more time is needed, we will issue a notice of delay, and complete the investigation within an additional 15 days (i.e., 45 days from the date we receive the grievance).

Claims Grievances:

If you disagree with a decision made regarding coverage of services (denial of benefits received, or a disagreement on amount of benefits), your grievance must be filed within 60 days of the date of our action on your claim (the date on the Explanation of Benefits provided upon action/payment for the claim at issue). Claims grievances filed outside the 60-day limit will not be considered.

B. Appeals

If you disagree with our decision made in response to a grievance, you may appeal the decision. ODS has a two level formal appeal process. Your appeal must be made within 60 days of the date of our action on your initial grievance. You may also call our Medical Customer Service Department at 503-265-2909 or toll-free at 1-866-923-0409, or Pharmacy Drug Benefit Customer Service at 503-265-2911 or toll-free at 1-866-923-0411, to discuss the issue as it may be possible to resolve it without filing a formal appeal.

First Level Appeal If you request a First Level Appeal, you must submit your appeal in writing along with any additional relevant information you wish to submit. ODS will acknowledge receipt of a written appeal, in writing, within seven days. ODS will conduct an investigation by persons who were not involved in the review of your grievance. ODS will keep you informed of the progress, including if additional time or investigation is required for a full and complete review. Within 30 days of receipt of the appeal, we will send you a written notice of the decision on your appeal, including the basis for the decision. If applicable, the notice will include information on your right to a Second Level of Appeal.

Second Level Appeal If you are still dissatisfied after the First Level Appeal, you may request a Second Level Appeal by persons who were not involved in the review of the grievance or First Level Appeal. You must submit your second appeal in writing within 60 days of the date of our action on your First Level Appeal. ODS will acknowledge receipt of a written appeal, in writing, within seven days and conduct an investigation. ODS will keep you informed of the progress, including if additional time or investigation is required for a full and complete review. Within 30 days of receipt of the appeal, ODS will notify you in writing of the decision.

You have the option to appear before the panel in person or by conference call or other appropriate technology. ODS will allow your representative to act on your behalf in the appeal process if you choose. Your appeal will be reviewed within 23 calendar days of its receipt and a written decision will be sent to you within seven calendar days after the decision is made.

If you are not satisfied with the outcome of the Second Level Appeal, and your complaint meets the specifications outlined under External Review, you may request that the complaint be reviewed by an Independent Review Organization. You will need to exhaust the Grievance and the First and Second Levels of Appeal to proceed to the External Review, unless ODS agrees otherwise.

C. External Review

If you are not satisfied with the outcome of the Second Level Appeal, and your claim meets the criteria below, you may request that the claim be reviewed by an Independent Review Organization, appointed by the Insurance Division.

1. The dispute must relate to an adverse decision on one or more of the following:
 - whether a course or plan of treatment is medically necessary;
 - whether a course or plan of treatment is experimental or investigational; or
 - whether a course or plan of treatment that a covered individual is undergoing is an active course of treatment for purposes of continuity of care under this Plan (see page 65 for additional information);
2. You must apply in writing for External Review, and not later than the 180th day after receipt of ODS' final written decision following the grievance and appeal process as described in this section;
3. You must sign a waiver granting the Independent Review Organization access to your medical records;
4. You must have exhausted the grievance and appeal process described in this section. However, ODS may waive the requirement of compliance with exhausting the process and have a dispute referred directly to the External Review with your consent; and
5. If you apply for External Review of an adverse decision, you shall provide complete and accurate information to the Independent Review Organization in a timely manner.

ODS agrees to be bound by the decision of the Independent Review Organization with respect to whether a course or plan of treatment is medically necessary, notwithstanding the definition of medical necessity in the plan; whether a course or plan of treatment is experimental or investigational; or whether a course or plan of treatment that a covered individual is undergoing is an active course of treatment for purposes of continuity of care under this Plan (see page 65 for additional information).

D. Additional Enrollee Rights

You have the right to file a complaint or seek other assistance from the Oregon Insurance Division. Assistance is available:

By calling: (503) 947-7984
By writing: Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, Oregon 97310

By internet <http://www.cbs.state.or.us/external/ins/>

Information included in the "Additional Enrollee Rights" is subject to change upon notice from the Director of the Oregon Insurance Division.

CONTINUITY OF CARE

A. Continuity of Care

Continuity of care means the feature of a health benefit plan under which an enrollee who is receiving care from an individual physician or provider is entitled to continue with care with the individual physician or provider for a limited period of time after the medical services contract terminates.

ODS will provide continuity of care if a medical services contract or other contract for an individual provider's services is terminated, the provider no longer participates in the provider network, and the Plan does not cover services when services are provided to enrollees by the individual provider or covers services at a benefit level below the benefit level specified in the Plan for out-of-network physicians or providers.

Continuity of care is conditional upon the willingness of the individual physician or provider to adhere to the medical services contract that had most recently been in effect between the physician or provider and ODS and the provider accepts the contractual reimbursement rate applicable to the time of contract termination, or if the contractual reimbursement rate was not based on a fee for service, a rate equivalent to the contractual rate.

For an enrollee to receive continuity of care, all of the following conditions must be satisfied:

1. The enrollee must request continuity of care from ODS;
2. The enrollee is undergoing an active course of treatment that is medically necessary and, by agreement of the individual provider and the enrollee, it is desirable to maintain continuity of care; and
3. The contractual relationship between the individual provider and ODS, with respect to the plan covering the enrollee has ended.

However, ODS will not be required to provide continuity of care when the contractual relationship between the individual provider and ODS ends under one of the following circumstances:

1. The contractual relationship between the individual physician or provider and ODS has ended because the individual physician or provider:
 - has retired;
 - has died;
 - no longer holds an active license;
 - has relocated out of the service area;
 - has gone on sabbatical; or
 - is prevented from continuing to care for patients because of other circumstances; or
2. The contractual relationship has terminated in accordance with provisions of the medical services contract relating to quality of care and all contractual appeal rights of the individual physician or provider have been exhausted.

ODS will not provide continuity of care if the enrollee leaves the Plan or if OEGB discontinues the Plan in which the enrollee is enrolled.

B. Length of Continuity of Care

Except in the case of pregnancy, an enrollee who is entitled to continuity of care shall receive the care until the earlier of the following dates:

- The day following the date on which the active course of treatment entitling the enrollee to continuity of care is completed; or
- The 120th day after the date of notification by ODS to the enrollee of the termination of the contractual relationship with the individual physician or provider.

An enrollee who is undergoing care for pregnancy and who becomes entitled to continuity of care after commencement of the second trimester of the pregnancy shall receive the care until the later of the following dates:

- The 45th day after the birth; or
- As long as the enrollee continues under an active course of treatment, but not later than the 120th day after the date of notification by the insurer to the enrollee of the termination of the contractual relationship with the individual physician or provider.

C. Notice Requirement

ODS will give written notice of the termination of the contractual relationship with an individual physician or provider and of the right to obtain continuity of care to those enrollees that ODS knows or reasonably should know are under the care of the individual physician or provider. The notice shall be given to the enrollees no later than the 10th day after the date on which the termination of the contractual relationship takes effect or no later than the 10th day after ODS first learns the identity of an affected enrollee after the date of termination of the contractual relationship.

If the individual physician or provider belongs to a provider group, the provider group may deliver the notice if the notice clearly provides the information that the Plan is required to provide to the affected enrollee.

For purposes of notifying an enrollee of the termination of the contractual relationship between ODS and the individual physician or provider and the right to obtain continuity of care, the date of notification by ODS is the earlier of the date on which the enrollee receives the notice or the date on which ODS receives or approves the request for continuity of care.

BENEFITS AVAILABLE FROM OTHER SOURCES

Situations may arise in which your healthcare expenses may be the responsibility of someone other than ODS. Here are descriptions of the situations that may arise.

A. Coordination of Benefits (COB)

This provision applies to this Plan when you or your enrolled dependent has healthcare coverage under more than one plan. For a complete explanation of COB see the section titled "Coordination of Benefits."

B. Third-Party Liability

An individual covered by us may have a legal right to recover benefit or healthcare costs from another person, organization or entity, or an insurer, as a result of an illness or injury for which benefits or healthcare costs were paid by us. For example, an individual who is injured may be able to recover the benefits or healthcare costs from an individual or entity responsible for the injury or from an insurer, including different forms of liability insurance, or uninsured motorist coverage or under-insured motorist coverage. As another example, an individual may become sick or be injured in the course of employment, in which case the employer or a workers' compensation insurer may be responsible for healthcare expenses connected with the illness or injury. Should we make an advance payment of Benefits, as described below, we are entitled to be reimbursed for any benefits paid by us that are associated with any illness or injury that are or may be recoverable from a Third Party or other source. Amounts received by us through these recoveries help reduce the cost of premiums and providing benefits.

Because recovery from a Third Party may be difficult and take a long time, and payment of benefits where a Third Party may be legally liable is excluded under the terms of this Plan/Insurance, as a service to you, we will pay a Covered Individuals' expenses based on the understanding and agreement that the Covered Individual is required to honor our rights of subrogation as discussed below, and, if requested by us, to reimburse us in full from any recovery the Covered Individual may receive, no matter how the recovery is characterized.

Upon claiming or accepting Benefits, or the provision of Benefits, under the terms of this Plan/Coverage, the member agrees that we shall have the remedies and rights as stated in this Section. We may elect to seek recovery under one or more of the procedures outlined in this Section. The Covered Individual agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, our right of reimbursement or subrogation as discussed in this Section. We have the sole discretion to interpret and construe these reimbursement and subrogation provisions.

Definitions:

For purposes of this Section relating to Third Party Liability, the following definitions apply:

Covered Individual means an individual covered by us, including a dependent of a Member/Insured. Covered Individual also includes the estate, heirs, guardian or conservator of the individual for whom benefits have been paid or may be paid by us, and includes any trust established for the purpose of receiving Recovery Funds and paying for the future income, care or medical expenses of such individual.

Benefits means any amount paid by us, or submitted to us for payment to or on behalf of the Covered Individual. Bills, statements or invoices submitted to us by a provider of services, supplies or facilities to or on behalf of a Covered Individual are considered requests for payment of Benefits by the Covered Individual.

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a Third Party (or any right to assert the foregoing) by or on behalf of a Covered Individual, regardless of the characterization of the claims or damages of the Covered Individual, and regardless of the characterization of the Recovery Funds. (For example, a Covered Individual who has received payment of medical expenses from us may file a Third Party claim against the party responsible for the Covered Individual's injuries, but only seek the recovery of non-economic damages. In that case, we are still entitled to recover Benefits as described herein.)

Third Party means any individual or entity responsible for the injury or illness, or the aggravation of an injury or illness, of the Covered Individual. Third Party includes any insurer of such individual or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the Covered Individual including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, PIP coverage, and workers' compensation insurance.

Recovery Funds means any amount recovered from a Third Party.

Subrogation

Upon payment by the Plan/Coverage, we shall be subrogated to all of the Covered Individual's rights of recoveries therefore, and the Covered Individual shall do whatever is necessary to secure such rights and do nothing to prejudice them.

Under this sub-section, we may pursue the Third Party in our own name, or in the name of the member. We are entitled to all subrogation rights and remedies under the common and statutory law, as well as under this Plan/Coverage.

Right of Recovery

In addition to our subrogation rights, we may, at our sole discretion and option, ask that the Covered Individual, and his or her attorney, if any, protect our reimbursement rights. If we elect to proceed under this sub-section, the following rules apply:

1. The Covered Individual holds any rights of recovery against the Third Party in trust for us, but only for the amount of Benefits we paid for that illness or injury.
2. We are entitled to receive the amount of Benefits we have paid for that illness or injury out of any settlement or judgment which results from exercising the right of recovery against the Third Party. This is so regardless of whether the Third Party admits liability or asserts that the Covered Individual is also at fault. In addition, we are entitled to receive the amount of Benefits we have paid whether the health care expenses are itemized or expressly excluded in the Third Party recovery.
3. If, and only if, we ask the Covered Individual, and his or her attorney, to protect our reimbursement rights under this sub-section, then the Covered Individual may subtract from the money to be paid back to us, as an expense for collecting from the other party, a proportionate share of reasonable attorney fees.
4. We may ask the Covered Individual to sign an agreement to abide by the terms of this Right of Recovery sub-section. If we elect to proceed under this sub-section we will not be required to pay benefits for the illness or injury until the agreement is properly signed and returned.
5. This right of recovery includes the full amount of the Benefits paid, or pending payment by us, out of any recovery made by the Covered Individual from the Third Party, including, without limitation, any and all amounts from the first dollars paid or payable to the Covered Individual (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or medical expenses of the Covered Individual), regardless of the characterization of the recovery, whether or not the Covered Individual is made whole, or whether or not any amounts are paid or payable directly by the Third Party, an insurer or another source. Our recovery rights will not be reduced due to the Covered Individual's own negligence.
6. If it is reasonable to expect that the Covered Individual will incur future expenses for which Benefits might be paid by us, the Covered Individual shall seek recovery of such future expenses in any Third Party Claim.

Motor Vehicle Accidents

Any expense for injury or illness which results from a motor vehicle accident, and which is payable under a motor vehicle insurance policy is not a covered Benefit under this Plan/Coverage and will not be paid by us.

If a claim for health care expenses arising out of a motor vehicle accident is filed with us, and if motor vehicle insurance has not yet paid, then we may advance Benefits, subject to the rights and remedies outlined in the Subrogation and Right of Recovery sub-sections stated above, and subject to the next paragraph.

In addition to the rights and remedies outlined in the Subrogation and Right of Recovery sub-sections stated above, in Third Party claims involving the use or operation of a motor vehicle, we, at our sole discretion and option, are entitled to seek reimbursement under the Personal Injury Protection statutes of the state of Oregon, including ORS 742.534, ORS 742.536, or ORS 742.538.

Additional Third Party Liability Section Provisions

In connection with our rights to obtain reimbursement, or to exercise our right of subrogation, or direct recovery in motor vehicle accidents, as discussed in the above sub-sections, Covered Individuals shall do one or more of the following and agrees that we may do one or more of the following, at our discretion:

1. If the Covered Individual seeks payment by us of any Benefits for which there may be a Third Party Claim, the Covered Individual shall notify us of the potential Third Party Claim. The Covered Individual has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to us by a Provider to the Covered Individual.
2. Upon request from us, the Covered Individual shall provide to us all information available to the Covered Individual, or any representative, or attorney representing the Covered Individual, relating to the potential Third Party Claim. The Covered Individual and his or her representatives shall have the obligation to notify us in advance of any claim (written or oral) and/or any lawsuit made against a Third Party seeking recovery of any damages from the Third Party, whether or not the Covered Individual is seeking recovery of Benefits paid by us from the Third Party.
3. In order to receive an advance payment of Benefits pursuant to this Section, we require that any Covered Individual seeking payment of Benefits by us, and if the Covered Individual is a minor or legally incapable of contracting, then the Covered Individual's parent or guardian, must fill out, sign and return to our office a Third-Party Questionnaire and Agreement that includes a questionnaire about the accident and the potential Third-Party claim. If the Covered Individual has retained an attorney to represent the Covered Individual with respect to a Third-Party Claim, then the attorney must sign the Third-Party Recovery Agreement, acknowledging the obligations described in that Agreement.
4. The Covered Individual shall cooperate with us to protect our recovery rights under this Section, and in addition, but not by way of limitation, shall:
 - Sign and deliver such documents as we reasonably require to protect our rights;
 - Provide any information to us relevant to the application of the provisions of this Section, including medical information (including doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments; and
 - Take such actions as we may reasonably request to assist us in enforcing our rights to be reimbursed from Third Party recoveries.
5. By accepting the payment of benefits by us, the Covered Individual agrees that we have the right to intervene in any lawsuit or arbitration filed by or on behalf of a Covered Individual seeking damages from a Third Party.
6. The Covered Individual agrees that we may notify any Third Party, or Third Party's representatives or insurers of our recovery rights set forth herein.
7. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of this Section.
8. This Section applies to any Covered Individual for whom advance payment of Benefits is made by us whether or not the event giving rise to the Covered Individual's injuries occurred before the individual became covered by us.

9. If the Covered Individual continues to receive medical treatment for an illness or injury after obtaining a settlement or recovery from a Third Party, we will provide Benefits for the continuing treatment of that illness or injury only to the extent that the Covered Individual can establish that any sums that may have been recovered from the Third Party for the continuing medical treatment have been exhausted for that purpose.
10. If the Covered Individual or the Covered Individual's representatives fail to do any of the foregoing acts at our request, then we have the right to not advance payment of Benefits or to suspend payment of any Benefits for or on behalf of the Covered Individual related to any sickness, illness, injury or medical condition arising out of the event giving rise to, or the allegations in, the Third Party Claim. In exercising this right, we may notify medical providers seeking authorization or pre-authorization of payment of Benefits that all payments have been suspended, and may not be paid.
11. Coordination of Benefits (where the Covered Individual has healthcare coverage under more than one Plan or health insurance policy) is not considered a Third Party Claim.
12. If any term, provision, agreement or condition of this Section is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

MEDICARE

To the extent permitted by law, this Plan will not pay benefits for any part of a covered expense to the extent the covered expense is actually paid or would have been paid under Medicare Part A or B had the eligible enrollee properly enrolled in Medicare and applied for benefits. This means that for coordination of benefits purposes, this Plan will estimate what Medicare would have paid and reduce its benefits based on the estimate. This Plan will not pay benefits toward any part of a covered expense to the extent the covered expense is covered by Medicare.

In addition, if this group health benefit plan is secondary to Medicare, we will not pay for any part of expenses incurred from providers who have opted out of Medicare participation.

Coordination of Benefits

Coordination of Benefits (COB) occurs when you have healthcare coverage under more than one plan.

DEFINITIONS

For purposes of this section on Coordination of Benefits, the following definitions apply:

Plan means any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes:

- Group insurance contracts and group-type contracts;
- HMO (Health Maintenance Organization) coverage;
- Coverage under a labor-management trustee plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Medical care components of group long-term care contracts, such as skilled nursing care;
- Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law; or
- Other arrangements of insured or self-insured group or group-type coverage.

Plan does not include:

- Hospital indemnity coverage or other fixed indemnity coverage;
- Accident-only coverage;
- Specified disease or specified accident coverage;
- School accident coverage;
- Benefits for non-medical components of group long-term care policies;
- Medicare supplement policies;
- Medicaid policies; or
- Coverage under other federal governmental plans, unless permitted by law.

Each contract or other arrangement for coverage described above is a separate Plan. If a Plan has two parts and COB rules apply to only one of the two, each of the parts is treated as a separate Plan.

Complying Plan is a plan that complies with these COB rules.

Non-complying Plan is a plan that does not comply with these COB rules.

Claim means a request that benefits of a plan be provided or paid.

Claimant means the enrollee for whom the claim is made.

An **Allowable Expense** means a healthcare expense, including deductibles, coinsurance, and co-payments, which is covered at least in part by any plan covering the claimant. When a plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by

any plan covering the claimant is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a claimant is not an allowable expense.

The following are examples of expenses that are **not** allowable expenses:

- The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the plans provides coverage for private hospital room expenses;
- The amount of the reduction by the primary plan because a claimant has failed to comply with the plan provisions concerning second surgical opinions or prior authorization of admissions or services, or because the claimant has a lower benefit because that claimant did not use an in-network provider;
- Any amount in excess of the highest reimbursement amount for a specific benefit, if a claimant is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology;
- Any amount in excess of the highest of the negotiated fees, if a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees;
- If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
- If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any healthcare expense incurred that may not be subject to the deductible as described in Section 223(c)(2)(C).

This Plan is the part of this group contract that provides benefits for healthcare expenses to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing healthcare benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

A **Closed Panel Plan** is a plan that provides healthcare benefits to covered persons primarily in the form of services through a network of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by an in-network provider.

Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

HOW COB WORKS

If the claimant is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then the other plan(s) pay(s). The order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

The **Primary Plan** (the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The **Secondary Plan** (the plan(s) that pay(s) benefits after the primary plan) will reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall provide benefits as if it were the primary plan when an enrollee uses an out-of-network provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

This Plan will coordinate with a plan that is “excess” or “always secondary” or that uses order of benefit determination rules that are inconsistent with those contained in OAR 836-020-0770 to 836-020-0805 (non-complying plan) on the following basis:

- If this Plan is primary, it will provide its benefits first.
- If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan’s benefits. This Plan will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan.
- If the non-complying plan reduces its benefits so that the enrollee receives less in benefits than s/he would have received had this Plan provided its benefits as the secondary plan and the non-complying plan provided its benefits as the primary plan, then this Plan shall advance additional benefits equal to the difference between the amount that was actually paid and the amount that should have been paid if the non-complying plan had not improperly reduced its benefits. Additional payment will be limited so that ODS will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the enrollee against the non-complying plan.

WHICH PLAN PAYS FIRST?

The first of the following rules that applies will govern:

1. **Non-dependent/Dependent.** If a plan covers the claimant as other than a dependent, for example, an employee, member, subscriber, or retiree, then that plan will determine its benefits before a plan which covers the person as a dependent. However, if the claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber, or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

2. **Dependent Child/Parents Married, Registered under the Oregon Family Fairness Act, or Living Together.** If the claimant is a dependent child whose parents are married, registered under the Oregon Family Fairness Act, or are living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the 'Birthday Rule'.) This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
3. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the claimant is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, then the following rules apply:
 - If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
 - If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses of the child, the 'birthday rule' described above applies.
 - If there is not a court decree allocating responsibility for the dependent child's healthcare expenses, the order of benefits is as follows:
 - The plan covering the custodial parent;
 - The plan covering the Spouse or Partner of the custodial parent;
 - The plan covering the non-custodial parent; and then
 - The plan covering the Spouse or Partner of the non-custodial parent.

This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
4. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of individuals who are not the parents of the child, the first applicable provision (#2 or #3) above shall determine the order of benefits as if those individuals were the parents of the child. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
5. **Active/Retired or Laid Off Employee.** The plan that covers a claimant as an active employee, that is, one who is neither laid off nor retired (or as that employee's dependent) determines its benefits before those of a plan that covers a claimant as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
6. **COBRA or State Continuation Coverage.** If a claimant whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering that claimant as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
7. **Longer/Shorter Length of Coverage.** The plan that covered an employee, member, subscriber, or retiree (non-dependent) longer is the primary plan and the plan that covered the claimant for the shorter period of time is the secondary plan. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
8. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

Where part of a plan coordinates benefits and a part does not, each part will be treated as a separate plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other healthcare coverage.

If a claimant is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by an out-of-network provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

OUR RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. ODS may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the claimant. ODS need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give ODS any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

If another plan makes payments we should have made under this coordination provision, we can reimburse the other plan directly. Any such reimbursement payments will count as benefits paid under this Plan and we will be released from liability to you regarding them. The term 'payments' includes providing benefits in the form of services, in which case 'payments' means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of payments made by this Plan is more than it should have paid under this COB provision, this Plan may recover the excess payment from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Miscellaneous Provisions

The following describes other procedures and policies in effect when processing your claims.

REQUEST FOR INFORMATION

When necessary to process claims, we may require that you submit information concerning benefits to which you or your dependent is entitled. We may also require that you authorize any physician or healthcare provider to provide us with information about a condition for which you claim benefits.

DISCLOSURE OF BENEFIT REDUCTION

ODS will provide notification of material reductions in covered services or benefits to OEBC no later than 60 days after the adoption of the change.

CONFIDENTIALITY OF ENROLLEE INFORMATION

The confidentiality of your protected health information is of extreme importance to ODS. Your protected health information includes, but is not limited to enrollment, claims, and medical and dental information. We use your information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. We do not sell your information. For more complete detail about how ODS uses your information, please refer to the Notice of Privacy Practices. A copy of the notice is available on our website at www.odscorporation.com or by calling ODS at 503-243-4492.

TRANSFER OF BENEFITS

Only you and your enrolled dependents are entitled to benefits under this Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on us.

RECOVERY OF BENEFITS PAID BY MISTAKE

If we mistakenly make a payment for you or an enrolled dependent to which you are not entitled, or if we pay a person who is not eligible for payments at all, we have the right to recover the payment from the person we paid or anyone else who benefited from it, including a physician or provider of services. Our right to recovery includes the right to deduct the amount paid by mistake from future benefits we would provide for you or any enrolled dependent even if the mistaken payment was not made on that person's behalf.

PLAN PROVISIONS

OEBB's policy with ODS Health Plan, Inc. and this Member Handbook plus any endorsements or amendments are the entire agreement between the parties. No promises, terms, conditions or obligations exist other than those contained herein. This policy plus such endorsements or amendments, if any, shall supersede all other communications, representations or agreements, either verbal or written between the parties.

RESPONSIBILITY FOR QUALITY OF MEDICAL CARE

In all cases, you or your enrolled dependents have the exclusive right to choose your facility, physician or professional provider. We are not responsible for the quality of medical care you receive, since all those who provide care do so as independent contractors. We cannot be held liable for any claim or damages connected with injuries you or your enrolled dependent suffer while receiving medical services or supplies.

WARRANTIES

All statements made by OEBB, or an enrollee, unless fraudulent, will be considered as representations and not warranties. No statement made for the purpose of effecting insurance coverage will avoid the insurance or reduce benefits unless contained in a written form and signed by OEBB or the enrollee, a copy of which has been given to OEBB or to the enrollee or the beneficiary of the enrollee.

GUARANTEED RENEWABILITY

ODS is required to renew coverage at the option of OEBB. Coverage may only be discontinued or non-renewed:

- For nonpayment of the required premiums by OEBB.
- For fraud or misrepresentation of OEBB, or with respect to coverage of individual enrollees, the enrollees or their representatives.
- When the number or percentage of enrollees is less than required by participation requirements.
- For non-compliance with our employer contribution requirements under the health benefit plan.
- When ODS discontinues offering or renewing, or offering and renewing, all of its group health benefit plans in this state or in a specified service area within this state. In order to discontinue plans under this provision, ODS:
 - Must give notice of the decision to the Director of the Department of Consumer and Business Services and to all groups, covered by the plans;
 - May not cancel coverage under the plans for 180 days after the date of the notice required immediately above if coverage is discontinued in the entire state or, except as provided in the next subsection of this paragraph, in a specified service area;
 - May not cancel coverage under the plans for 90 days after the date of the notice required above if coverage is discontinued in a specified service area because of an inability to reach an agreement with the healthcare providers or organization of healthcare providers to provide services under the plans within the service area; and
 - Must discontinue offering or renewing, or offering and renewing, all health benefit plans issued by ODS in the group market in this state or in the specified service area.

- When ODS discontinues offering and renewing a group health benefit plan in a specified service area within this state because of an inability to reach an agreement with the healthcare providers or organization of healthcare providers to provide services under the plan within the service area. In order to discontinue a plan under this provision, ODS:
 - Must give notice of the decision to the director and to all groups, covered by the plan;
 - May not cancel coverage under the plan for 90 days after the date of the notice required immediately above; and
 - Must offer in writing to each group, covered by the plan, all other group health benefit plans that ODS offers in the specified service area. ODS shall offer the plans at least 90 days prior to discontinuation.
- When ODS discontinues offering or renewing, or offering and renewing, a health benefit plan for all groups, in this state or in a specified service area within this state, other than a plan discontinued under the paragraph immediately above. With respect to plans that are being discontinued, ODS must:
 - Offer in writing to each group, covered by the plan, one or more health benefit plans that ODS offers in the specified service area.
 - Offer the plans at least 180 days prior to discontinuation.
 - Act uniformly without regard to the claims experience of the affected groups, of the health status of any current or prospective enrollee.
- When the director orders ODS to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:
 - not be in the best interest of the enrollees; or
 - impair our ability to meet contractual obligations.
- When, in the case of a group health benefit plan that delivers covered services through a specified network of healthcare providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.
- When, in the case of a health benefit plan that is offered in the group market only through one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any employee.
- For misuse of a provider network provision. As used in this paragraph, ‘misuse of a provider network provision’ means a disruptive, unruly or abusive action taken by an enrollee that threatens the physical health or well-being of healthcare staff and seriously impairs ODS’ ability or its in-network providers to provide services to an enrollee. An enrollee under this paragraph retains the rights of an enrollee under ORS 743.804.

NO WAIVER

Any waiver of any provision of this Plan, or any performance under this Plan, must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. No delay or omission on the part of ODS in exercising any right, power or remedy provided in this Plan, including, without limitation, our delay or omission in denying a claim under the Plan, shall operate as a waiver thereof.

GROUP IS THE AGENT

OEBB is your and your enrolled dependents’ agent for all purposes under this Plan. OEBB is not the agent of ODS Health Plan, Inc.

GOVERNING LAW

To the extent this Plan is governed by state law, it shall be governed by and construed in accordance with the laws of the State of Oregon.

WHERE ANY LEGAL ACTION MUST BE FILED

Any legal action arising out of this Plan must be filed in either a state or federal court in the State of Oregon.

TIME LIMITS FOR FILING A LAWSUIT

Any legal action arising out of, or related to, this Plan and filed against us by you, any of your dependents, any enrollee or any third party, must be filed in court within three years of the time the claim arose. For example, a claim that benefits were not authorized or provided, and any and all damages relating thereto, would arise when the last level of administrative appeal under the Plan has ended.

EVALUATION OF NEW TECHNOLOGY

ODS develops medical necessity criteria for new technologies and new use of current technologies. ODS physicians and nurses do the reviews. They use medical studies, national, regional or local clinical practice guidelines, and local and national carrier benefits to develop the criteria. The reviews are performed once a year or more often if needed.

Continuation Of Health Coverage

IMPORTANT NOTICE

The following sections on continuation of coverage may apply to you. Please check with the Participating District's benefits manager to find out whether you qualify for this coverage. You and your dependents should read the following notices carefully.

OREGON CONTINUATION COVERAGE FOR SPOUSES & DOMESTIC PARTNERS AGE 55 AND OVER

A. Introduction

ORS 743.600 to 743.602 are state regulations requiring certain group health insurance policies to offer enrolled Spouses and Registered Domestic Partners the opportunity to request a temporary extension of health insurance coverage for themselves and their dependents if coverage is lost due to a specific event identified in the statutes ("55+ Oregon Continuation"). OEGB has also elected to extend this coverage to Unregistered Domestic Partners.

55+ Oregon Continuation only applies to employers with 20 or more employees. ODS will provide 55+ Oregon Continuation coverage to those eligible dependents who elect coverage under ORS 743.600 to 743.602, subject to the following conditions:

- Other than the inclusion of Unregistered Domestic Partners, ODS will offer no greater rights than ORS 743.600 to 743.602 requires;
- ODS will not provide 55+ Oregon Continuation coverage for dependents who do not comply with the notice, election, or other requirements outlined below; and
- As the Plan Administrator, OEGB is responsible for providing the required notices within the statutory time periods, including the notice of death and the election notice. If OEGB fails to notify the eligible Spouse, Registered Domestic Partner or Unregistered Domestic Partner, premiums shall be waived from the date the notice was required until the date notice is received by the Spouse, Registered Domestic Partner or Unregistered Domestic Partner. OEGB shall be responsible for such premiums.

B. Eligibility Requirements For 55+ Oregon Continuation Coverage

If you are the Spouse, Registered Domestic Partner or Unregistered Domestic Partner of the employee, you may elect 55+ Oregon Continuation coverage for yourself and your enrolled dependents if you meet the following requirements:

- You lose coverage because of the death of the employee, dissolution of marriage or domestic partnership with the employee, or legal separation from the employee;
- You are 55 years of age or older at the time of such event; and
- You are not eligible for Medicare.

C. Notice And Election Requirements For 55+ Oregon Continuation Coverage

Notice of Divorce, Dissolution, Termination or Legal Separation. Within 60 days of legal separation, the entry of a judgment of dissolution of marriage or registered domestic partnership, or the termination of an unregistered domestic partnership, a legally separated or divorced Spouse, or a legally separated or former Registered or Unregistered Domestic Partner, eligible for 55+ Oregon Continuation who seeks such coverage shall give the Plan Administrator written notice of the legal separation, dissolution, or termination. The notice shall include the mailing address of the legally separated or divorced Spouse, or the legally separated or former Registered or Unregistered Domestic Partner, seeking coverage.

Notice of Death. Within 30 days of the death of the employee whose surviving Spouse, Registered Domestic Partner or Unregistered Domestic Partner is eligible for 55+ Oregon Continuation, the Participating District shall give the Plan Administrator written notice of the death and the mailing address of the surviving Spouse, Registered Domestic Partner or Unregistered Domestic Partner.

Election Notice. Within 14 days of receipt of the above notice, the Plan Administrator shall provide notice to the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, that coverage can be continued, along with an election form. If the Plan Administrator fails to notify the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, within the required 14 days, premiums shall be waived until the date notice is received.

Election. The surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, must return the election form within 60 days after the Plan Administrator mails it. Failure to exercise this election within 60 days of the notification shall terminate the right to continued benefits under this section.

D. Premiums For 55+ Oregon Continuation Coverage

The monthly premiums for 55+ Oregon Continuation is limited to 102% of the premiums paid by a current employee. The first premium shall be paid by the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, to the Participating District within 45 days of the date of election. All remaining monthly premiums must be paid within 30 days of the premium due date.

E. When 55+ Oregon Continuation Coverage Ends

55+ Oregon Continuation will end on the earliest of any of the following:

- The failure to pay premiums when due, including any grace period allowed by the policy;
- The date that the Plan terminates unless a different group policy is made available;
- The date on which the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, becomes insured under any other group health plan;
- The date on which the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, remarries, registers another domestic partnership under the Oregon Family Fairness Act, or files another Affidavit of Domestic Partnership, and becomes covered under another group health plan; or
- The date on which the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, becomes eligible for Medicare.

COBRA CONTINUATION COVERAGE

A. Introduction

The Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) is a federal law requiring certain employer-sponsored group health plans to offer qualified beneficiaries the opportunity to elect a temporary extension of health insurance coverage if coverage is lost due to a qualifying event. For purposes of this section, a qualified beneficiary is someone who is covered under the Plan the day before a qualifying event, and can include the enrolled employee (or retired employee), the enrolled employee’s Spouse, and the dependent children of the enrolled employee. Specific qualifying events are listed below.

ODS will provide COBRA continuation coverage to those qualified beneficiaries who elect coverage under COBRA, subject to the following conditions:

- Other than the inclusion of Registered and Unregistered Domestic Partners, ODS will offer no greater COBRA rights than the COBRA statute requires;
- ODS will not provide COBRA coverage for those qualified beneficiaries who do not comply with the notice, election or other requirements outlined below; and
- ODS will not provide COBRA coverage if the Participating District or Plan Administrator fails to provide the required COBRA notices within the statutory time periods, including the initial notice, the election notice, and notice of a qualifying event, or if the Participating District or Plan Administrator otherwise fails to comply with any of the requirements outlined below.

B. Qualifying Events

Employee. As an employee covered by this Plan, you may elect continuation coverage if you lose coverage because of termination of employment (other than termination for gross misconduct on your part, which may include, but is not limited to, misrepresenting immigration status to obtain employment), or a reduction in hours.

Spouse. If you are the Spouse of an employee (or of a retiree qualifying under the last bullet below) covered by the Plan, you have the right to choose continuation coverage for yourself if you lose coverage for **any** of the following four qualifying events:

- The death of your Spouse;
- The termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment with the Participating District;
- Divorce or legal separation from your Spouse; or
- Your Spouse becomes entitled to Medicare.

(Also, if an employee eliminates coverage for his or her Spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-Spouse lost coverage earlier. If the ex-Spouse notifies the Plan Administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)

Domestic Partners. A Registered or Unregistered Domestic Partner, who at the time of the qualifying event was covered under the Plan, can elect COBRA continuation coverage. Under this plan, the Registered or Unregistered Domestic Partner would have the same rights to COBRA continuation coverage as a Spouse does, unless otherwise stated. Where this section refers to divorce or legal separation, termination of an Affidavit of Domestic Partnership for Unregistered Domestic Partners or dissolution of a registered domestic partnership under the Oregon Family Fairness Act for Registered Domestic Partners would also apply.

Children. A dependent child of an employee (or of a retiree qualifying under the last bullet below) covered by the Plan, has the right to continuation coverage if coverage is lost for **any** of the following five qualifying events:

- The death of the employee parent;
- The termination of the employee parent's employment (for reasons other than gross misconduct) or reduction in an employee parent's hours of employment with the Participating District;

- Parents' divorce or legal separation;
- Employee parent becomes entitled to Medicare; or
- The dependent ceases to be a "dependent child" under the Plan.

C. Other Coverage

The right to elect continuation coverage shall be available to individuals who are entitled to Medicare at the time of the election or are covered under another group health plan at the time of the election.

D. Notice And Election Requirements

Qualifying Event Notice. The Plan provides that your family member's coverage terminates as of the last day of the month in which a divorce or legal separation occurs (Spouse's coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the employee or a family member has the responsibility to notify the Plan Administrator if one of these events occurs by mailing or hand-delivering a written notice to the Plan Administrator. The notice must include the following: 1) the name of the Group for the plan; 2) the name and social security number of the enrollee(s); 3) the affected beneficiary(ies); 4) the event (e.g. divorce); and 5) the date the event occurred. Notice must be given no later than 60 days after the loss of coverage under the Plan. If notice of the event is not timely given, continuation coverage will not be available.

Election Notice. When the Plan Administrator receives a timely Qualifying Event Notice, you, your Spouse, and/or dependent child will be notified of your right to continuation coverage within 14 days after the Plan Administrator receives the notice.

Otherwise, you, your Spouse and dependent children will be notified by the Plan Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the employee's termination of employment (other than for gross misconduct), reduction in hours, death of the employee, or the employee's becoming entitled to Medicare.

Election. You or your family member must elect continuation coverage within 60 days after plan coverage ends, or, if later, 60 days after the Plan Administrator sends you or your family member notice of the right to elect continuation coverage. If continuation coverage or Portability coverage (discussed below) is not elected, your, your Spouse's and your dependent's group health insurance coverage will end.

An enrolled employee or the Spouse may elect continuation coverage for eligible family members. However, each family member has an independent right to elect COBRA coverage. This means that a Spouse or child may elect continuation coverage even if the employee does not.

E. COBRA Premiums

If you are eligible for continuation coverage, you do not have to show that you are insurable. However, under the law, you are responsible for all premiums for continuation coverage. Your first payment for continuation coverage is due within 45 days after you provide notice of electing coverage (this is the date your election notice is postmarked, if mailed, or the date your election notice is received by the Plan Administrator, if hand-delivered). This payment must include the amount necessary to cover all months that have ended between the date regular coverage ended and the payment date. Subsequent payments are due on the first day of the month; however, you will have a grace period of 30 days to pay the premiums. If you do not pay the applicable premiums, in good funds, when due, your continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

F. Length Of Continuation Coverage

If you choose continuation coverage, the Participating District will provide the same coverage as is available to similarly situated employees or dependents under the Plan.

18-Month Continuation Period. In the case of a loss of coverage due to end of employment (other than for gross misconduct) or a reduction of hours of employment, coverage generally may be continued only for up to a total of 18 months.

36-Month Continuation Period. In the case of losses of coverage due to an employee's death, divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the Plan, coverage under the Plan may be continued for up to a total of 36 months.

When the qualifying event is the end of employment (other than for gross misconduct) or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the enrolled employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

G. Extending The Length Of Cobra Coverage

If you elect COBRA, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Plan Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage.

Disability. If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from an enrolled employee's termination of employment or reduction of hours may be extended to a total of up to 29 months. The disability must have started at some time before the 61st day after the enrolled employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the enrolled employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the enrolled employee's termination or reduction of hours.

You must provide the Plan Administrator a copy of the Social Security Administration's determination within the 18-month period and not later than 60 days after the Social Security Administration's determination was made. If the notice is not provided to the Plan Administrator during the 60-day notice period and within 18 months after the enrolled employee's termination of employment or reduction of hours, then there will be no disability extension of COBRA coverage. The premiums for COBRA coverage may increase after the 18th month of coverage to 150% of the premiums.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Event: An extension of coverage will be available to Spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the enrolled employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Such second qualifying events may include the death of an enrolled employee, divorce or legal separation from the enrolled employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when an enrolled employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.).

This extension due to a second qualifying event is available only if you notify the Plan Administrator in writing of the second qualifying event within 60 days after the date of the second qualifying event. If this notice is not provided to the Plan Administrator during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event.

Note: Longer continuation coverage may be available under Oregon Law for an employee's Spouse or Registered or Unregistered Domestic Partner age 55 and older who loses coverage due to the employee's death, or due to legal separation, dissolution of marriage or registered domestic partnership, or termination of an unregistered domestic partnership. See page 81 for details.

H. Newborn Or Adopted Child

If, during continuation coverage, a child is born to or placed for adoption with the enrolled employee, the child is considered a qualified beneficiary. The employee may elect continuation coverage for the child provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The employee or a family member must notify the Participating District within 31 days of the birth or placement to obtain continuation coverage. If the employee or family member fails to notify the Participating District in a timely fashion, the child will not be eligible for continuation coverage.

I. Special Enrollment And Open Enrollment

Under continuation coverage, qualified beneficiaries have the same rights afforded similarly-situated plan participants who are not enrolled in COBRA. A qualified beneficiary may add newborns, new Spouses, Registered Domestic Partners, or Unregistered Domestic Partners, and adopted children (or children placed for adoption) as covered dependents in accordance with the Plan's eligibility and enrollment rules, including HIPAA special enrollment. If non-COBRA participants can change plans at open enrollment, COBRA participants may also change plans at open enrollment.

J. When Continuation Coverage Ends

This notice shows the maximum period of COBRA coverage available to the qualified beneficiaries. COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premiums are not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- the Participating District ceases to provide any group health plan for its employees; or

- during a disability extension period (the disability extension is explained above), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate).

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

When COBRA continuation coverage ends, you and/or your enrolled dependents *may* be eligible to enroll in an individual Portability Plan provided by ODS.

If you have any questions about COBRA, please contact the Plan Administrator. Please notify the Plan Administrator if you or your Spouse have changed addresses.

K. Trade Act Of 2002

This COBRA provision applies only to employees who have lost their jobs or had a reduction in hours as a result of import competition or shifts of production to other countries.

Second Election Period for Certain Trade-Displaced Individuals. Certain enrolled employees who did not elect COBRA coverage are entitled to elect COBRA coverage during a special second election period. Enrolled employees who are eligible to make a COBRA election during this special second election period (Trade Adjustment Assistance (TAA) Eligible Employees) must satisfy each of the following requirements:

- They must be receiving a trade readjustment allowance under the Trade Act of 1974 (or be eligible for such an allowance once unemployment compensation is exhausted) or receiving alternative trade adjustment assistance under the Trade Act of 1974;
- They must have lost group health plan coverage due to a termination of employment or reduction of hours that resulted in eligibility for a trade readjustment allowance or alternative trade adjustment assistance; and
- They did not elect COBRA during the regular COBRA election period available to them as a result of their termination of employment or reduction of hours.

The special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which a TAA Eligible Employee began receiving a trade readjustment allowance (or would have become eligible for such an allowance but for the requirement to exhaust unemployment compensation) or began receiving alternative trade adjustment assistance, but only if the election is made within six months after the initial loss of group health plan coverage that occurred in connection with the TAA Eligible Employee's termination of employment.

Duration of COBRA Coverage Elected During the Special Second Election Period. COBRA coverage elected during the special second election period is not retroactive. Coverage commences on the day that the special second election period began, and the maximum COBRA coverage period will terminate on the same day that it would have terminated if COBRA coverage had been elected during the regular 60-day election period.

COBRA Tax Credit. The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance coverage, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.cfm.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Coverage will terminate if an employee is called to active duty by any of the armed forces of the United States of America. However, if an employee requests to continue coverage under USERRA, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, if the employee pays any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

If an employee does not elect continuation coverage under the Uniformed Services Employment and Reemployment Rights Act or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day he or she returns to active employment with the group if released under honorable conditions, but only if he or she returns to active employment:

- On the first full business day following completion of his or her military service for a leave of 30 days or less;
- Within 14 days of completing military service for a leave of 31 to 180 days; or
- Within 90 days of completing military service for a leave of more than 180 days.

Regardless of the length of the leave, a reasonable amount of travel time or recovery time for an illness or injury determined by the VA to be service connected will be allowed.

When coverage under this Plan is reinstated, all plan provisions and limitations will apply to the extent that they would have applied if the employee had not taken military leave and coverage had been continuous under this Plan. There will be no additional eligibility-waiting period and the pre-existing condition limitation will be credited as if the employee had been continuously covered under this Plan from the original effective date. (This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by military service, as determined by the VA. For complete information regarding rights under the Uniformed Services Employment and Reemployment Rights Act, contact the Participating District).

Individual Portability Coverage

The Oregon Portability program is implemented as a "State Alternative Mechanism" for guaranteed availability of coverage to Eligible Individuals. Eligibility for the Oregon Portability Program is extended to all individuals who qualify under Oregon or federal law, whichever is more favorable.

If you or your enrolled dependents lose eligibility for insurance coverage under this Plan, you may be entitled to convert to one of our two Portability plans. The benefits contained in the Portability plan will likely be different from the benefits under this Plan.

ELIGIBILITY FOR PORTABILITY COVERAGE

An individual covered under an ODS plan has the right to convert to either of our two Portability plans if he/she is an "Eligible Individual." An "Eligible Individual" is one who has left coverage that was continuously in effect for a period of 180 days or more under one or more Oregon group health benefit plans, or meets the eligibility requirements of the Health Insurance Portability and Accountability Act of 1998. In either case, the individual must apply for Portability coverage not later than the 63rd day after termination of group coverage issued by an Oregon carrier and be an Oregon resident at the time of such application.

With an exception noted below, the term "Eligible Individual" does not include an individual who remains eligible for his/her prior group coverage or would remain eligible for prior group coverage in a plan under the Federal Employee Retirement Income Security Act of 1974, as amended (ERISA), were it not for action by the plan sponsor relating to the actual or expected health condition of the individual, or who is covered under another health benefit plan or is eligible for the federal Medicare program. However, an individual who is eligible to obtain a Portability plan may obtain such a plan regardless of whether the Eligible Individual has exercised rights under federal law (COBRA) or under ORS 743.610 (continuation under state law) to continue coverage under a group health benefit plan, or whether the Eligible Individual, having exercised such rights, has received any benefits thereunder, unless he/she is an Eligible Individual who is leaving or has left an employee welfare benefit plan or multiple employer welfare arrangement that is exempt from state regulation under ERISA.

If an enrollee in a Portability health benefit plan elects not to enroll an eligible dependent when the enrollee's coverage commences, that dependent is not eligible for enrollment as a dependent in the plan at any later date. For the purposes of this rule, an "eligible dependent" is a dependent of the enrollee that was covered by the enrollee's prior group health benefit plan, provided that such dependent meets the eligibility requirements of the Portability health benefit plan. After an enrollee's coverage commences in a Portability health benefit plan, we shall accept for enrollment any new dependent that is acquired by the enrollee, provided that such dependent meets the eligibility requirement of the Portability health benefit plan.

Unregistered Domestic Partners covered through the filing of an Affidavit of Domestic Partnership with the Participating District are not eligible dependents under a Portability health plan and will not be able to enroll in a Portability plan as the former employee's dependent. Such Unregistered Domestic Partners who otherwise meet the eligibility criteria listed above will need to enroll in a Portability plan as a policyholder.

The Portability plans are not available if OEGB terminates the Plan and replaces it with a similar group plan within 31 days, and the coverage takes effect immediately following the date of termination.

PURPOSE OF PORTABILITY

Oregon law requires group health insurers to offer employees certain benefit plans when they leave employment. The purpose is to make health coverage portable, or in other words, to improve the availability and affordability of health benefit plans for individuals leaving group coverage.

ISSUANCE AND RENEWABILITY

Portability plans must be offered on a "guaranteed" issue basis, be guaranteed renewable and may be retained indefinitely subject to certain exceptions as stated below. Additionally, Portability plans cannot contain pre-existing condition provisions, exclusion periods, waiting periods or other similar limitations on coverage.

Portability health benefit plans shall be renewable with respect to all enrollees at the option of the enrollee, except:

- For nonpayment of the required premiums by the Portability plan policyholder;
- For fraud or misrepresentation by the Portability plan policyholder;
- When the carrier elects to discontinue offering all of its group health benefit plans in accordance with ORS 743.737 and 743.754; or
- When the director orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:
 - Not be in the best interests of the enrollees; or
 - Impair the carrier's ability to meet its contractual obligations.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

An explanation of Portability coverage will be provided directly to an individual losing group coverage, for any reason other than group replacement of coverage, within 10 days following the date of any administrative action taken by a carrier to initiate or document the loss of coverage.

You must submit a written application and pay the first premium no later than the 63rd day after the date your coverage terminated under this Plan. Coverage becomes effective on the day following termination of coverage under this Plan. Eligible Individuals may enroll in Portability coverage before, during, or at the end of their COBRA or state continuation coverage. Portability coverage is guaranteed renewable and may be retained indefinitely.

You may select COBRA or state continuation (whichever applies to your group situation) or select Portability.

Please Note:

If you choose Portability rather than COBRA or state continuation, you will not be eligible to select COBRA or state continuation at a later date.

PORTABILITY OPTIONS

Portability coverage via the Oregon Medical Insurance Pool (OMIP) is available to Eligible Individuals who were covered by a non-Oregon group plan while a resident of Oregon.

Portability coverage via OMIP is also available to Eligible Individuals who were covered by a self-funded multiple employer welfare arrangement or a self-funded group plan operated by a public entity in Oregon. However, these individuals must first complete continuation coverage offered through federal or state law, if they are eligible for such coverage.

ODS offers two options for Portability coverage:

- The Prevailing Plan reflects benefit coverages that are prevalent in the group health insurance market; and
- The Low Cost Plan emphasizes affordability for Eligible Individuals.

Please contact the ODS Portability Coordinator toll-free at 1-877-277-7073 for further information regarding the Prevailing and Low Cost Plans.

Patient Protection Act

The Patient Protection Act, also known as Senate Bill 21, was passed by the 1997 Oregon State Legislature to assure, among other things, that patients, physicians and providers are informed about their health insurance plans. To that end, ODS provides this question and answer section to outline some important terms and conditions of our plans.

1. What are an enrollee's rights and responsibilities?

Enrollees have the right to:

- Be treated with respect and recognition of their dignity and need for privacy.
- Have access to urgent and emergency services, 24 hours a day, 7 days a week.
- Know what their rights and responsibilities are. Enrollees will be given information about their health plan and how to use it. Enrollees will be given information about the physicians and providers who will care for them. This information will be provided in a way that enrollees can understand.
- Participate in decision making regarding their healthcare. Enrollees have a right to a discussion of appropriate or medically necessary treatment options for their conditions, whether or not the cost or benefit is covered by ODS.
- Refuse care. Enrollees have the right to be advised of the medical result of their refusal.
- Receive services as described in their plan benefit handbooks.
- Have their medical and personal information remain private. Personal information will be handled in compliance with state and federal law, and will be given to third parties only as necessary to administer the plan, as required by law, or as permitted by the enrollee.
- Change to a new primary care physician (PCP). (Not all plans require enrollees to choose a PCP.)
- File a complaint or appeal about any aspect of the plan. Enrollees have a right to a timely response to their complaint or appeal. Enrollees are welcome to make suggestions to the plan.
- Enrollees have the right to have a statement of wishes for treatment on file with their physician. A statement of wishes for treatment is known as an Advanced Directive. Enrollees also have the right to have a power of attorney filed. A power of attorney allows the enrollee to give someone else the right to make healthcare choices when the enrollee is unable to make these decisions.
- Make recommendations regarding the ODS enrollees' rights and responsibilities policy.

Enrollees have the responsibility to:

- Read the plan benefit handbook to make sure they understand the Plan. Enrollees are advised to call the Medical Customer Service Department or Pharmacy Drug Benefit Customer Service Department with any questions.
- Select a PCP for those plans that require it.
- Treat all physicians and providers and their staff with courtesy and respect.
- Provide all the information needed for their physician or provider to provide good healthcare.
- Participate in making decisions about their medical care and forming a treatment plan.
- Follow instructions for care they have agreed to with their physician or provider.
- To the extent required by the plan, seek medical services only from their PCP.
- If required by the plan, obtain approval from their PCP before going to a specialist.
- Present their medical identification card when seeking medical care.

- Notify physicians and providers of any other insurance policies that may provide coverage.
- Reimburse ODS from any third party payments they may receive.
- Keep appointments and be on time. If this is not possible, enrollees must call ahead to let the physician or provider know they will be late or cannot keep their appointment.
- Seek regular health checkups and preventive services.
- Provide adequate information to the plan to properly administer benefits and resolve any issues or concerns that may arise.

If you have any questions about these rights and responsibilities, please call the ODS Medical Customer Service Department at 503-265-2909 or toll-free at 1-866-923-0409. The TDD/TTY number (for hearing and speech impaired) is 1-800-433-6313.

2. What do I do if I have a medical emergency?

If you believe you have a medical emergency, you should call 9-1-1 or seek care from the nearest appropriate physician or provider, such as a physician's office or clinic, urgent care facility or emergency room.

3. How will I know if benefits are changed or terminated?

It is the responsibility of OEBC to notify you of benefit changes or termination of coverage. If the group policy terminates and OEBC does not replace the coverage with another group policy, OEBC is required by law to inform you in writing of the termination.

4. If I am not satisfied with my health plan, how do I file a grievance or appeal?

You can file a grievance or appeal by contacting our Medical Customer Service Department at 503-265-2909, or toll-free at 1-866-923-0409 or 1-800-433-6313 (for hearing impaired). For pharmacy claims contact our Pharmacy Drug Benefit Customer Service at 503-265-2911 or toll-free at 1-866-923-0411. You can also write a letter to The ODS Companies, (P.O. Box 40384, Portland, Oregon 97240). See the section titled "Grievance and Appeals" for complete information.

You may also contact the Oregon Insurance Division:

By calling: (503) 947-7984
 By writing: Oregon Insurance Division
 Consumer Protection Unit
 350 Winter Street NE, Room 440-2
 Salem, Oregon 97310

By internet: <http://www.cbs.state.or.us/external/ins/>

5. What are your prior authorization and utilization review criteria?

Prior authorization, also known as service authorization, is the process we use to determine whether a service is covered under the Plan (including whether it is medically necessary) prior to the service being rendered. Contact ODS at 503-243-4496, or toll-free at 1-800-258-2037, or visit our website at www.odscompanies.com and see the Member page, for a list of services that require service authorization. Many types of treatment may be available for certain conditions; the service authorization process helps determine which treatment is covered under the Plan.

Obtaining a service authorization is your assurance that the services and supplies recommended by your physician or provider are medically necessary and covered under your health plan. Except in the case of fraud or misrepresentation, prior authorization for benefit coverage and medical necessity shall be binding if obtained no more than 30 days prior to the date the service is provided, and prior authorization for enrollee eligibility shall be binding if obtained no more than five business days prior to the date the service is provided.

Utilization review is the process of reviewing services after they are rendered to ensure that they were medically necessary and appropriate with regard to widely accepted standards of good medical practice. For further explanation, see the definition of “medically necessary.”

For a written summary of information that may be included in our utilization review of a particular condition or disease, call ODS at 503-243-4496, or toll-free at 1-800-258-2037 or 1-800-433-6313 (for hearing impaired).

6. How are important documents, such as my medical records, kept confidential?

ODS protects your information in several ways:

- We have a written policy to protect the confidentiality of health information.
- Only employees who need to access your information in order to perform their job functions are allowed to do so.
- Disclosure outside the company is permitted only when necessary to perform functions related to providing your coverage and/or when otherwise allowed by law.
- Most documentation is stored securely in electronic files with designated access.

7. How can I participate in the development of your corporate policies and practices?

Your feedback is very important to us. If you have suggestions for improvements about your plan or our services, we would like to hear from you.

We have formed advisory committees – including the Group Advisory Committee for employers, and the Quality Council for healthcare professionals – to allow participation in the development of corporate policies and to provide feedback. The committees generally meet two times per year. Please note that committee membership is limited. For more information, contact us at:

The ODS Companies
601 S.W. Second Avenue
Portland, Oregon 97204
www.odscompanies.com

8. How can non-English speaking enrollees get information about the Plan?

Call our Medical Customer Service Department at 503-265-2909, or toll-free at 1-866-923-0409 or 1-800-433-6313 (for hearing impaired). Our Pharmacy Drug Benefit Customer Service can be contacted at 503-265-2911 or toll-free at 1-866-923-0411. One of our representatives will coordinate the services of an interpreter over the phone.

9. What additional information can I get upon request?

The following documents are available by calling a Medical Customer Service representative at 503-265-2909 or toll-free at 1-866-923-0409:

1. A copy of our annual report on complaints and appeals.
2. A description of our efforts to monitor and improve the quality of health services.
3. Information about procedures for credentialing network providers and how to obtain the names, qualifications, and titles of the physicians and providers responsible for an Enrollee's care.
4. Information about our prior authorization and utilization review procedures.

10. What information can I get about ODS from the Oregon Insurance Division?

The following information regarding the ODS health benefit plans is available from the Oregon Insurance Division:

1. The results of all publicly available accreditation surveys.
2. A summary of our health promotion and disease prevention activities.
3. An annual summary of grievances and appeals.
4. An annual summary of utilization review policies.
5. An annual summary of quality assessment activities.
6. An annual summary of scope of network and accessibility of services.

Contact:

Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, Oregon 97310
(503) 947-7984
<http://www.cbs.state.or.us/external/ins/>
dcbs.in@mail@state.or.us



THE **ODS** COMPANIES

P.O. Box 40384
Portland, OR 97240
www.odscompanies.com

Member Inquiries

Portland 503-265-2909
Toll-Free 1-866-293-0410

Service Authorization

Portland 503-243-4496
Toll-Free 1-800-258-2037

Spanish Medical Customer Service (Servicio al Cliente Area de Salud)

Portland 503-265-2961
Toll-Free 1-888-786-7461
(llamado gratis)

10/2008
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Member handbooks and other services are available at www.odscompanies.com.

Administered by ODS Health Plan, Inc.