GROUP MEDICAL PLAN

OEBB

Preferred Provider Organization (PPO) Plan

Plan 4B

Effective Date October 1, 2010

www.odscompanies.com

Insurance products provided by ODS Health Plan, Inc.

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SECTION 1. WELCOME

ODS is pleased to have been chosen by the participating organization as its Preferred Provider Organization (PPO) plan. This handbook is designed to provide members with important information about the Plan's benefits, limitations and procedures.

Members also have access to certain value added services through ODS in addition to the benefits outlined in this handbook, including a weight management program and the ODS associated smoking cessation program. Visit myODS or contact the Medical Customer Service Department for more information about these additional value added services.

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.

Members may direct their questions to one of the numbers listed below or visit the ODS member self-help website, myODS, at www.odscompanies.com. myODS is available 24 hours a day, 7 days a week allowing members to access plan information whenever it's convenient.

ODS
P.O. Box 40384
Portland, Oregon 97240

Medical Customer Service Department

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

Pharmacy Customer Service Department

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

ODS Behavioral Health

Portland	503-382-5323
Toll-Free	877-796-3223

Prior Authorization

Portland	503-243-4496
Toll-Free	800-258-2037
TDD/TTY	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.

Note: This handbook may be changed or replaced at any time, by OEBB or ODS, without the consent of any member. The most current handbook is available on myODS, accessed through the ODS website. All plan provisions are governed by OEBB's policy with ODS. This handbook may not contain every plan provision.

SECTION 2. GENERAL PLAN INFORMATION

2.1 **Plan Name:**
OEBB Benefit Plan

2.2 **Plan Sponsor:**
Oregon Educators Benefit Board

2.3 **Type of Plan:** Employee Medical Benefit Plan.

2.4 **Plan Year:** October 1st through September 30th.

2.5 **Plan Administrator:** The Plan Sponsor is the administrator of the Plan.

2.6 **Funding Medium and Type of Plan Administration:** The Plan is fully insured. Benefits are provided under a group insurance policy entered into between Oregon Educators Benefit Board and ODS Health Plan, Inc. Claims for benefits are sent to ODS. ODS, not Oregon Educators Benefit Board, is responsible for paying claims.

The Plan is funded by the participating organization and/or subscriber contributions. The amount of total contributions is determined from time to time by the use of sound actuarial and underwriting methods. The portion a subscriber pays toward the total contribution is determined by the participating organization.

2.7 **Provider of Benefits:** Benefits are provided in accordance with a policy of insurance between ODS Health Plan, Inc. and Oregon Educators Benefit Board.

2.8 **Named Fiduciary:** Oregon Educators Benefit Board.

SECTION 3. SUMMARY OF BENEFITS – A QUICK REFERENCE

This section is a quick reference summarizing the Plan's 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 of an in-network physician or provider, members will receive quality healthcare and will have a higher level of benefits.

Different networks provide in-network services in specific service areas. All members will have access to the ODS Plus Network, which provides services in Oregon, southwest Washington, and Idaho. In addition, a different network may be used for subscribers and their enrolled spouse, domestic partner or child if the subscribers reside outside the ODS Plus Network; any applicable network(s) are identified on the member ID cards. Subscribers who move outside of a network service area must contact ODS' Medical Customer Service Department to find out if another network is available to ensure continued access to in-network physicians and providers.

Coverage for children who reside outside of the family's service area is in section 3.9.

Specific network and provider information is also available on myODS, which includes a network directory located under "Provider Search," or by contacting ODS' Medical Customer Service Department for assistance.

Section 4.1 provides information regarding prior authorization requirements. Members can access a complete list of procedures which require prior authorization by visiting myODS or contacting ODS' Medical Customer Service Department. Failure to obtain required prior authorizations will result in denial of benefits or a penalty.

3.1 MEMBER RESOURCES

ODS Website (access myODS by clicking "a Member" and logging in)
www.odscompanies.com

Medical Customer Service Department
Portland 503-265-2909; Toll-free 866-923-0409; TDD/TTY 800-433-6313; En Español 503-265-2961; Llamado gratis 888-786-7461

Pharmacy Customer Service Department
Portland 503-265-2911; Toll-free 866-923-0411; TDD/TTY 800-433-6313

Prior Authorization
Portland 503-243-4496; Toll-Free 800-258-2037; TDD/TTY 800-433-6313

ODS Behavioral Health
Portland 503-382-5323; Toll-free 1-877-796-3223

Networks
For all members:
ODS Plus Network

For subscribers and their spouse, domestic partner or child(ren) if subscribers reside outside the ODS Plus Network service area:
First Choice Health (FCH)
Health InfoNet (HIN)
Private HealthCare Systems (PHCS)

Note: Only subscribers and their spouse, domestic partner or child(ren) may access the networks listed above and receive the in-network level of benefits if the subscribers reside outside the ODS Plus Network service area. Subscribers and their spouse, domestic partner or child(ren) who reside in the ODS Plus Network service area will receive out-of-network benefits when using any of the other networks listed above.

3.2 SCHEDULE OF BENEFITS

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

This section is subject to changes to comply with subsequent federal guidance.

	In-Network Benefits	**Out-Of-Network Benefits**
Plan year Deductible per Member		**$200**
Maximum plan year Family Aggregate Deductible		**$600**
Per Member plan year Out-of-Pocket Maximum (does not include deductible)	**$1,500**	**$3,000**

BENEFITS	**COPAYMENT/COINSURANCE** (Amount Member Pays)		**DETAILS**
	In-Network	Out-Of-Network	
Emergency Care			
Urgent Care Office Visit	$25 copayment per visit, deductible waived	$25 copayment per visit, deductible waived	Page 31 In-network out-of-pocket maximum applies to mental health and chemical dependency services
Emergency Room Facility	$100 copayment per visit, then 20%	$100 copayment per visit, then 20%	Page 25 Copayment waived if covered hospitalization immediately follows emergency room use. In-network out-of-pocket maximum applies to mental health and chemical dependency services.

BENEFITS	COPAYMENT/COINSURANCE (Amount Member Pays)		DETAILS
	In-Network	Out-Of-Network	
Ambulance Transportation	20%	20%	Page 24 In-network out-of-pocket maximum applies to mental health and chemical dependency services.
Hospital Care			
Inpatient Acute Care	20%	40%	Page 25
Inpatient Rehabilitation	20%	40%	Page 25 Up to 30 days per plan year. May be eligible for up to 60 days for head or spinal cord injury.
Partial Hospitalization Treatment & Day Treatment Programs for Mental Health & Chemical Dependency	20%	40%	Page 26
Chemical Dependency Detoxification	20%	40%	Page 26
Residential Facility Care			
Skilled Nursing Facility Care	20%	40%	Page 26 Up to 60 days per plan year.
Residential Mental Health Treatment Program	20%	40%	Page 26
Residential Chemical Dependency Treatment Program	20%	40%	Page 26
Ambulatory Services			
Outpatient Surgery and Invasive Diagnostic Procedures (Facility Charges)	20%	40%	Page 26 Requires authorization
Outpatient Rehabilitation	$25 copayment per visit, deductible waived	40%	Page 27 Up to 30 sessions per plan year. May be eligible for up to 60 sessions for head or spinal cord injury.
Infusion Therapy			Page 27
Home Infusion	20%	40%	Requires authorization
Outpatient Infusion	20%	40%	Requires authorization
Diagnostic X-ray and Lab	20%	40%	Page 28
Therapeutic X-ray	20%	40%	Page 28
Kidney Dialysis	20%	40%	Page 28
Imaging Procedures	$100 copayment per procedure, then 20%	$100 copayment per procedure, then 40%	Page 28 May require authorization. Copayment waived if billed with a primary diagnosis of cancer.

BENEFITS	COPAYMENT/COINSURANCE (Amount Member Pays)		DETAILS
	In-Network	Out-Of-Network	
Sleep Studies	$100 copayment per study, then 20%	$100 copayment per study, then 40%	Requires authorization
Outpatient Chemical Dependency Services	$25 copayment per visit, deductible waived	40%	Page 29
Professional Services			
Preventive Healthcare			
Evidence-based services rated A or B by the USPST, immunizations recommended by the Advisory Committee on Immunization Practice of the CDCP, and preventive care & screenings recommended by HRSA for infants, children, adolescents & women, including the following:	No copay/ coinsurance, deductible waived	40%	Page 29
Periodic Health Exams	No copayment, deductible waived	40%	Page 29 7 exams from age 1 to 4 One per plan year, age 5+
Immunizations	No copayment, deductible waived	40%	Page 30
Hearing Evaluation	No copayment, deductible waived	40%	Page 30
Routine Vision Screening	No copayment, deductible waived	40%	Page 30 Up to age 5
Women's Yearly Exam & Pap Test	No copayment, deductible waived	40%	Page 30 One per plan year
Routine Mammogram	No copayment, deductible waived	40%	Page 30 One per plan year, age 40+
Routine Colonoscopy	No copayment, deductible waived when performed on an outpatient basis	40%	Page 31 One per 10 plan years, age 50+. Related charges included.
Routine Diagnostic X-ray & Lab	No copayment, deductible waived	40%	Page 29
Cardiovascular Screening	No copayment, deductible waived	40%	Page 30
Prostate Rectal Exam	No copayment, deductible waived	40%	Page 30 One per plan year, age 50+
Prostate Specific Antigen (PSA) Test	No copayment, deductible waived	40%	Page 30 One per plan year, age 50+
Incentive Home and Office Visits (for asthma, heart conditions, cholesterol, high blood pressure, and diabetes)	$10 copayment per visit, deductible waived	40%	Page 31

BENEFITS	COPAYMENT/COINSURANCE (Amount Member Pays)		DETAILS
	In-Network	Out-Of-Network	
Home and Office Visits (all other conditions)	$25 copayment per visit, deductible waived	40%	Page 31
Additional Cost Tier (for certain outpatient and hospital services)	$500 Copayment per procedure, then 20%	$500 copayment per procedure, then 40%	Page 23
Physician Hospital Visits	$25 copayment per visit, deductible waived	40%	Page 31
Outpatient Diabetic Instruction	20%	40%	Page 31 Once, following diagnosis
Therapeutic Injections	20%	40%	Page 32
Surgery	20%	40%	Page 32
Special Dental Care	20%	40%	Page 33
Temporomandibular Joint Syndrome	20%	40%	Page 34
Outpatient Mental Health Services	$25 copayment per visit, deductible waived	40%	Page 34
Tobacco Cessation Treatment			Page 34 age 10+
Consultation (exclusive tobacco cessation program)	No copay/ coinsurance, deductible waived	N/A	
Consultation (all other providers)	No copay/ coinsurance, deductible waived	40%	
Supplies (exclusive tobacco cessation program)	No copay/ coinsurance, deductible waived	N/A	
Supplies (all other providers)	20%	20%	
Hearing Aids and Related Services	20%	20%	Page 34 $4,000 maximum every 48 months for members under age 26. Maximum is subject to annual adjustment
Chiropractic, Naturopathic & Acupuncture Care	$25 copayment per visit, deductible waived	40%	Page 35 $2,000 aggregate plan year maximum Page 35

BENEFITS	COPAYMENT/COINSURANCE (Amount Member Pays)		DETAILS
	In-Network	Out-Of-Network	
Hospice Care			Page 35
Home Care	20%	40%	
Inpatient Care	20%	40%	Up to 12 days
Respite Care	20%	40%	Up to 170 hours
Other Services			
Maternity	Treated same as any other condition.	Treated same as any other condition.	
Transplants	No copayment/ coinsurance†	40%	Page 37 Requires authorization.
Donor Costs	No copayment/ coinsurance†	40%	$25,000 maximum
Biofeedback	20%	40%	Page 38 Up to 10 visits
Home Healthcare	20%	40%	Page 38 Requires authorization. Up to 140 visits per plan year
Outpatient Durable Medical Equipment	20%	40%	Page 39 Requires authorization. One wheelchair per plan year under age 19 and every 3 plan years age 19+.
Supplies and Appliances	20%	40%	Page 39
Disposable Supplies (provided in a physician's office)	20%	40%	Page 39
Medications			
Prescription Drugs			Page 41 Some prescribed drugs require prior authorization $1,000 Plan year out-of-pocket maximum
Retail Pharmacy			Page 41 31 day drug supply per prescription
Value	$4 per prescription	$4 per prescription	
Generic	$8 per prescription	$8 per prescription	
Preferred	$25 per prescription	$25 per prescription	
Non-Preferred	50%	50%	

† Service must be performed at an in-network transplant facility to receive the higher benefit level.

BENEFITS	COPAYMENT/COINSURANCE (Amount Member Pays)		DETAILS
	In-Network	Out-Of-Network	
Mail Order Pharmacy			Page 41 90 day drug supply per prescription
Value	$8 per prescription	$8 per prescription	
Generic	$16 per prescription	$16 per prescription	
Preferred	$50 per prescription	$50 per prescription	
Non-Preferred	50%	50%	Up to a maximum copayment of $100 per prescription
Specialty Pharmacy Provider			Page 41 31 day drug supply per prescription Prior authorization required
Generic	$16 per prescription	$16 per prescription	
Preferred	$50 per prescription	$50 per prescription	
Non-Preferred	50%	50%	Up to a maximum copayment of $100 per prescription

3.3 DEDUCTIBLES

The Plan has a plan year deductible. The deductible is the amount of covered expenses that are paid by each member before benefits are payable by the Plan. The amount of the deductible is shown in section 3.2. Covered services, whether performed in-network or out-of-network, accumulate toward the plan year deductible. The deductible applies separately to each member, but no family will be required to satisfy more than the total family deductible as shown in section 3.2, no matter how many members are in the family. After the deductible has been satisfied, benefits will be paid according to section 3.2. Expenses applied toward the plan year deductible do not apply toward the out-of-pocket maximum.

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

If covered expenses are incurred in the last 3 months of a plan year and applied toward the deductible for that plan year, they will be carried forward and applied toward the deductible for the following plan year when no benefits (subject to deductible) were paid out during the current plan year.

Deductibles are accumulated on a plan year basis.

3.4 PLAN YEAR MAXIMUM OUT-OF-POCKET

After a $1,500 per member plan year out-of-pocket maximum ($3,000 per member per plan year maximum for services rendered out-of-network) is met, 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 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.

Out-of-pocket costs are accumulated on a plan year basis.

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

a. Copayments (including but not limited to copayments for the additional cost tier, imaging procedures, and sleep studies);
b. The out-of-pocket expenses for prescription drugs;
c. The out-of-pocket expenses for transplants performed at out-of-network transplant facilities;
d. Cost containment penalties; and
e. Disallowed charges.

3.5 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. Section 3.2 has more details.

Except for copayments/coinsurance, 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 members. Nothing in this paragraph shall prohibit a physician or provider and a member from entering into an agreement for payment by the member for medical services that are not covered by the Plan.

3.6 HOW BENEFITS WITH MEDICARE ARE COORDINATED

The Plan coordinates benefits with Medicare Part A or B as allowed under federal government rules and regulations (see section 12.5).

3.7 CARE AFTER NORMAL OFFICE HOURS

In-network professional providers have an on-call system to provide 24-hour service. Members who need to contact their in-network professional provider after normal office hours should call the provider's regular office number.

3.8 EMERGENCY CARE

Members are covered for emergency services worldwide (see section 7.4). A member who believes he or she has a medical emergency 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.

3.9 COVERAGE OUTSIDE THE SERVICE AREA FOR CHILDREN

When an enrolled child resides outside the service area, plan benefits will be extended 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:

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

Members must notify ODS customer service when an enrolled child moves outside the service area. The enrolled child will be eligible for out-of-area coverage the first day of the month following the date ODS receives notification.

SECTION 4. COST CONTAINMENT

The Plan contains the following special cost containment provisions that may affect how benefits are paid.

4.1 PRIOR AUTHORIZATION REQUIREMENTS

If a member fails to obtain prior authorization for prescription drugs, inpatient, partial hospitalization, or residential stays, or for outpatient or ambulatory services when authorization is required (other than specified imaging procedures), a 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. The member will be responsible for any charges not covered because of noncompliance with authorization requirements.

The prior authorization penalty does not apply toward the Plan's deductible or out-of-pocket maximum. The penalty will not apply in the case of an emergency admission.

Prior authorization does not guarantee coverage. When a service is not medically necessary, or is otherwise excluded from benefits, charges will be denied.

4.1.1 Inpatient Services, Partial Hospitalization, and Residential Programs

All non-emergency hospital confinements that are scheduled in advance, and admission to any residential treatment program, must be prior authorized in order for maximum plan benefits to be payable. If the hospitalization, partial hospitalization or residential stay is not medically necessary, claims will be denied. 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).

Prior authorization involves the following steps:

a. When a professional provider suggests admission to the hospital or a residential program, or a non-emergency surgery, the member should ask that he or she contact ODS for prior authorization.
b. The professional provider or his or her office staff either calls ODS or submits a prior authorization form.
c. ODS will either approve the admission, ask for additional information and/or request that the member get a second opinion. ODS may also specify that the member receive care on an outpatient basis only.
d. 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.)
e. The hospital, professional provider and member are notified of the outcome of the authorization process by letter.

A member may obtain authorization information by contacting ODS' Medical Customer Service Department.

A member may obtain authorization information for mental health or chemical dependency services by contacting ODS Behavioral Health.

4.1.2 Ambulatory Surgery

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

Prior authorization involves the following steps:

a. When a physician suggests a non-emergency surgery, the member should ask that he or she contact ODS for prior authorization.
b. The physician or his or her office staff either calls ODS or submits a prior authorization form.
c. ODS will either approve the surgery, ask for additional information and/or request that the member get a second opinion.
d. The hospital, physician and member are notified of the outcome of the authorization process by letter.

4.1.3 Outpatient Services

The Plan requires prior authorization for many outpatient services.

4.1.4 Prescription Drugs

A complete list of drugs that require prior authorization is available on myODS or by contacting ODS' Medical Customer Service Department. Prior authorization refers to the process by which a member obtains approval from ODS prior to ODS processing payment for a specific drug.

4.2 MANDATORY SECOND SURGICAL OPINION

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

> **Note:**
> If a member 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 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. The member will be responsible for payment of any charges not covered because of non-compliance. The penalty does not apply toward the Plan's deductible or out-of-pocket maximum.

4.3 COST EFFECTIVENESS SERVICES

At its sole discretion and under unique and unusual circumstances, as determined by ODS in its sole discretion, ODS may approve benefits for cost effectiveness services, not otherwise covered by the Plan, when doing so is cost-effective, as determined by ODS' medical director in conjunction with a treatment plan authorized by the member's attending physician.

Payment of benefits for cost effectiveness services shall be at the sole discretion of ODS based on its evaluation of the individual case. The fact that the Plan has paid benefits for cost effectiveness

services for a member shall not obligate it to pay such benefits for any other member, nor shall it obligate the Plan to pay benefits for continued or additional cost effectiveness services for the same member. All amounts paid for cost effectiveness services under this provision shall be included in computing any benefits, limitations, or copayments/coinsurance under the Plan.

SECTION 5. CARE COORDINATION

5.1 CARE COORDINATION

The Plan provides individualized managed care of complex or catastrophic cases. Care Coordinators and Case Managers who are nurses work directly with members, their families, and their physician(s) to coordinate their healthcare needs.

The Plan will coordinate access to a wide range of services spanning all levels of care depending on the member's needs. Having a Nurse Care Coordinator or Case Manager available to coordinate these services ensures improved delivery of healthcare services to members and their physicians(s).

5.2 DISEASE MANAGEMENT

The Plan provides education and support to help members manage a chronic disease or medical condition. Health Coaches help members to identify their healthcare goals, self-manage their disease and prevent the development or progression of complications.

Working with a Health Coach can help members follow the medical care plan prescribed by a physician and improve their health status, quality of life and productivity.

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

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

SECTION 6. DEFINITIONS

The following are definitions of some important terms used in this handbook. **Terms used but not otherwise defined in this handbook shall have the same meaning as those terms in the OEBB Member Benefits Guide and the OEBB Administrative Rules.**

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

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

Annual means a calendar year from January 1st through December 31st.

Authorization see Prior Authorization.

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

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.

Coinsurance means the percentages of covered expenses to be paid by a member.

Condition means a medical condition.

Copay or Copayment means the fixed dollar amounts to be paid by a member to a physician or provider when receiving a covered service.

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

Covered Service is a service or supply that is specifically described as a benefit of the 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 a member obtains new coverage. The term creditable coverage means, with respect to a member, coverage of the member under any of the following:

a. A group health plan;
b. Individual insurance coverage including student health plans;
c. Medicare Part A and B;
d. Medicaid, other than benefits consisting solely of benefits under Section 1928 (pediatric vaccines);
e. Tricare (formerly known as CHAMPUS);
f. A medical care program of the Indian Health Service or of a tribal organization;

g. A State high risk pool;
h. Federal Employees Health Benefit Plan (FEHBP);
i. A public health plan (as defined in regulations);
j. Children's Health Insurance Program (CHIP); or
k. 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:

a. Coverage only for accident, or disability income insurance, or any combination thereof.
b. Coverage issued as a supplement to liability insurance.
c. Liability insurance, including general liability insurance and automobile liability insurance.
d. Workers' Compensation or similar insurance.
e. Automobile medical payment insurance.
f. Credit-only insurance.
g. Coverage for on-site medical clinics.
h. 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 member 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 member from others, or for preventing a member from harming himself or herself.

Day Treatment or **Partial Hospitalization** means an appropriately licensed mental health or chemical dependency facility providing no less than 4 hours of direct, structured treatment services per day.

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 that 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).

Durable Medical Equipment is defined in section 7.11.5.

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention could place the health of a member, 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 of a hospital and all ancillary services routinely available to the emergency department to the extent they are required for the stabilization of a member, and within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize a member

Enroll means to become covered for benefits under the Plan (that is, when coverage becomes effective) without regard to when the person may have completed or filed any forms that are

required in order to become covered. For this purpose, a person who has health coverage is enrolled in the Plan regardless of whether the person elects coverage, the person is a spouse, domestic partner, or child who becomes covered as a result of an election by a subscriber, or the person becomes covered without an election.

Enrolled Dependent means a subscriber's eligible spouse, domestic partner, or child whose application has been accepted by OEBB and who is enrolled in the Plan.

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

Genetic Information pertains to a member or his or her relative, and means information about genetic tests, a request for or receipt of genetic services, or participation in clinical research that includes genetic services. It also includes the manifestation of a disease or disorder in a member's relative.

Group Health Plan means a health benefit plan that is made available to the employees of the participating organization.

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 section 7.10.

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

Implant means a material inserted or grafted into tissue.

Injury means a personal bodily injury to a member caused solely by external, violent and accidental means.

In-Network refers to providers, professional providers, chemical dependency treatment programs and facilities that have contracted with ODS to provide benefits to members covered under the 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.

ODS will process charges for services by an out-of-network physician/provider other than a facility as follows: the maximum amount is the lesser of the amount payable under any supplemental provider fee arrangements ODS may have in place and the 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 member's responsibility.

In certain instances, when a dollar value is not available in the database, the claim is reviewed by 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.

ODS will process charges for services by out-of-network facilities, including, but not limited to, hospitals, ambulatory surgical centers, home health providers, skilled nursing facilities, residential mental health treatment programs, residential chemical dependency treatment programs, hospice, end-stage renal disease (ERSD) facilities or long-term care facilities as follows: the maximum

amount is the lesser of supplemental facility or provider fee arrangements ODS may have in place, 125% of the Medicare Allowable Amount based on data collected from the Centers for Medicare and Medicaid Services (CMS), or the billed charge.

ODS will process charges for emergency services by an out-of-network facility as follows: the maximum amount allowed will be the greatest of the median in-network rate, the maximum amount as calculated according to this definition for out-of-network facility and the Medicare rate.

In each of the above situations relating to an out-of-network physician/provider, any amount above the MPA is the member's responsibility. Depending upon the plan provisions, deductibles and copayments/coinsurance may apply.

Maximum plan allowance for prescription benefits 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 the Average Wholesale Price (AWP) accessed by ODS 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 all other providers will be subject to benefit provisions of the Plan and paid based on the lesser of either contracted rates, AWP or billed charges. In the event AWP is no longer recognized as a pricing standard for prescription drugs, then the MPA amount will be based upon a new pricing source consistent with prescription drug industry standards.

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 are:

a. Appropriate and consistent with the symptoms or diagnosis of the member's condition;
b. Established as the standard treatment by the medical community in the service area in which they are received;
c. Not primarily for the convenience of the member or a physician or provider of services or supplies; and
d. The least costly of the alternative supplies or levels of service that can be safely provided to the member. 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 member's home, without harm to the member.

Medically necessary care does not include custodial care.

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. Further information regarding medical necessity can be found in General Exclusions (see Section 9).

Medicare Allowable Amount is the fixed amount Medicare sets for a covered service.

Member means a subscriber, spouse, domestic partner, child or a individual otherwise eligible for a group health benefit plan who has enrolled for coverage under the terms of the Plan.

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

a. Mental Retardation,
b. Learning Disorders,
c. Paraphilias,
d. Gender Identity Disorders in members age 19 or older, and
e. V-Codes, (this exception does not extend to members 5 years of age or younger for diagnostic codes V61.20, V61.21, and V62.82).

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

Network means a group of professional providers, hospitals and medical suppliers who contract to provide healthcare to members. These groups are called Preferred Provider Organizations (PPOs), and different PPOs provide in-network services in their specific service areas. Covered medical expenses will be paid at a higher rate when an in-network physician or provider is used (see section3.2).

ODS refers to ODS Health Plan, Inc.

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

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 providers, professional providers, chemical dependency treatment programs and facilities that have not contracted with ODS to provide benefits to members. 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 professional provider, with no interval of 60 or more days without a visit.

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

Partial Hospitalization or **Day Treatment** means an appropriately licensed mental health or chemical dependency facility providing no less than 4 hours of direct, structured treatment services per day.

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

The **Plan** is the health benefit plan sponsored by OEBB and insured under the terms of the policy between OEBB and ODS.

Plan Year refers to the twelve month period beginning October 1st and ending September 30th. All deductibles, maximums and limitations shall be accrued on a plan year basis.

The **Policy** is the agreement between OEBB and ODS for insuring the health benefit plan sponsored by OEBB. This handbook is a part of the policy.

Prior Authorization or **Prior Authorized** refers to obtaining approval by ODS prior to the date of service. For a complete list of services that require prior authorization, members may contact ODS' Medical Customer Service Department or visit myODS. Failure to obtain required authorization will result in denial of benefits or a penalty (see section 4.1).

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 the Plan to be eligible for benefits.

a. An acupuncturist;
b. A certified nurse midwife;
c. A chiropractor;
d. 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;
d. 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;
e. A naturopath;
f. An optometrist;
g. A physician (doctor of medicine or osteopathy);
h. A podiatrist;
i. 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;
j. A registered nurse first assistant;
j. A registered physical, occupational, or speech therapist, but only for rehabilitative services provided upon the written referral of a doctor of medicine or osteopathy;
k. A state-licensed audiologist;
l. A state-licensed clinical social worker;
m. A state-licensed marriage and family therapist;
n. A state-licensed mental health counselor;
o. A state-licensed nurse practitioner (including a certified nurse practitioner midwife);
p. A state-licensed physician assistant;
q. A state-licensed professional counselor;
r. A state-licensed psychologist;
s. A state-licensed psychologist associate; and
t. A tobacco cessation program following the United States Public Health guidelines for tobacco use cessation.

The term "professional provider" does not include any class of provider not named above, unless otherwise stated, 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.

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. Residential programs provide overnight 24-hour per day care. Residential program does not include any program that provides less than 4 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.

Skilled Nursing Facility means a facility licensed under applicable laws to provide residential care under the supervision of a medical staff or a medical director. It must provide rehabilitative services and 24-hour-a-day nursing services by registered nurses.

Subscriber means any eligible employee who is enrolled in the Plan.

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.

SECTION 7. BENEFIT DESCRIPTION

This section describes the benefits under the Plan. The Plan covers services and supplies listed when medically necessary for diagnosis and/or treatment of an illness or injury. Payment of covered expenses is always limited to the maximum plan allowance for the physician or professional provider. Some benefits have day or dollar limits. These limits are found in the "Details" column in the Schedule of Benefits (see section 3.2).

Many services require prior authorization. For a complete list, members may contact ODS' Medical Customer Service Department or visit myODS. Failure to obtain required prior authorization will result in denial of benefits or a penalty (see section 4.1).

Members should present their identification cards and make the appropriate copayments before they receive care.

7.1 MEMBERSHIP CARD

After enrollment, members will receive identification cards which will include the group and identification numbers. Members will need to present the cards each time they receive services.

Members may contact ODS' Medical Customer Service Department for replacement of a lost identification card.

7.2 WHEN BENEFITS ARE AVAILABLE

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

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

When a member is a hospital inpatient on the day coverage ends, the Plan will continue to pay claims for covered services for that hospitalization until the member is discharged from the hospital or until benefits have been exhausted, whichever comes first.

7.3 ADDITIONAL COST TIER

When certain procedures are chosen instead of minimally invasive alternatives, they are subject to a copayment in addition to the standard benefit level. Additional cost tier procedures include the following:

a. Arthroscopy (knee and shoulder);
b. Hip replacement;
c. Knee replacement;
d. Outpatient upper endoscopy; and
e. Spine surgery for pain.

Visit myODS or contact ODS' Medical Customer Service Department for more information regarding the Additional Cost Tier.

7.4 EMERGENCY CARE

Members 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 the contracted rates for in-network physicians and providers and the maximum plan allowance for out-of-network physicians and providers. Members are responsible for emergency room facility copayments along with any other copayments/coinsurance that may apply to the type of services received. If a covered hospitalization immediately follows emergency services, emergency room facility copayments will be waived. All other applicable copayments/coinsurance remain in effect.

Prior authorization is not required for emergency medical screening exams or treatment to stabilize an emergency medical condition. Prior 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 member, or a fetus in the case of a pregnant woman, in serious jeopardy.

If a member's condition requires hospitalization in an out-of-network facility, the attending physician and ODS' medical director will monitor the 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 ODS' medical director determine the member can be safely transferred.

The in-network benefit level will not be available for out-of-network 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):

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

7.5 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 the member and the provider or directly to the provider.

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

7.6 HOSPITAL CARE

A hospital is a facility that is licensed as an acute care general hospital and that provides inpatient surgical and medical care to members 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.

7.6.1 Hospital Benefits

Covered expenses consist of the following:

a. The actual daily charge for a **hospital room**, but not to exceed the hospital's most common rate for a 2-bed room;
b. The charge for **isolation care,** when the Plan agrees it is necessary to protect other patients from contagion or to protect a member from contracting the illness of another person;
c. The charge for an **intensive care unit**. Using the criteria of the Joint Commission on Accreditation of Hospitals as a guide, the Plan reserves the right to decide whether a unit in a particular hospital qualifies as an intensive care unit;
d. The **facility charges** for surgery performed in a hospital outpatient department;
e. Charges for **other hospital services and supplies** that are necessary for treatment and are ordinarily furnished by a hospital; and
f. 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 the 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 3-day supply at the same benefit level as for hospitalization.

All inpatient stays require prior authorization. Failure to obtain required prior authorization will result in denial of benefits or a penalty.

7.6.2 Inpatient Days Covered

The Plan will allow benefits for an unlimited number of days for acute hospital care.

7.6.3 Inpatient Rehabilitative Hospital Care

Covered rehabilitative care expenses are subject to a plan year limit for inpatient services delivered in a hospital that has a department specializing in such care. Additional days may be available for treatment required following head or spinal cord injury, subject to medical necessity and prior authorization. These benefits are payable only when a member's 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.

7.6.4 Emergency Room Care

Members are responsible for paying the emergency room facility copayment for each hospital emergency room visit. Emergency room facility fees are paid at the in-network benefit level after the copayment. However, the emergency room facility copayment will be waived if a member is admitted to the hospital immediately following emergency room service. Emergency room facility copayments do not accrue toward the plan year deductible or out-of-pocket maximum.

The emergency room facility copayment 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.

7.6.5 Pre-admission Testing
Medically necessary preadmission testing is covered when ordered by the physician.

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

7.6.7 Partial Hospitalization Treatment and Day Treatment Programs
The Plan covers all-inclusive per diem charge for mental health and/or chemical dependency treatment program providing no less than 4 hours per day of direct treatment services.

7.7 RESIDENTIAL FACILITY CARE

7.7.1 Skilled Nursing Facility Benefits
Covered skilled nursing facility days are subject to a plan year limit and medical necessity.

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

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

a. Senile deterioration;
b. Alzheimer's disease;
c. Mental deficiency or retardation in members age 18 or older; or
d. Mental illness.

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

7.7.2 Residential Mental Health Treatment Program
Covered residential mental health days are subject to medical necessity.

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

7.7.3 Residential Chemical Dependency Treatment Program
Covered residential chemical dependency days are subject to medical necessity.

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

7.8 AMBULATORY SERVICES

Many ambulatory services require prior authorization. For a complete list, members may contact ODS' Medical Customer Service Department or visit myODS. Failure to obtain required prior authorization will result in denial of benefits or a penalty.

7.8.1 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 prior authorization.

Certain surgical procedures are covered only when performed as outpatient surgery. Members should ask their in-network professional provider if this applies to a proposed surgery, or contact ODS' Medical Customer Service Department.

7.8.2 Outpatient Rehabilitation

Rehabilitative services provided by a professional provider to a member who is not confined in a hospital are subject to a plan year limit. If rehabilitative services are required following head or spinal cord injury, the benefit may be increased. However, to receive this additional benefit, prior authorization must be obtained before the initial 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 member'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 members age 18 or older, or hippotherapy.

7.8.3 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. Infusion therapy requires prior authorization. Members should contact ODS' Medical Customer Service Department before receiving such care.

Home infusion therapy must be provided by an accredited home infusion therapy agency. In addition, members receiving the services must qualify as "homebound" (as defined in section 7.11.4).

Infusion therapy benefits are limited to the following:

a. aerosolized pentamidine;
b. intravenous drug therapy;
c. total parenteral nutrition;
d. hydration therapy;
e. intravenous/subcutaneous pain management;
f. terbutaline infusion therapy;
g. SynchroMed pump management;
h. IV bolus/push drugs; and
i. blood product administration.

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

a. solutions, medications, and pharmaceutical additives;
b. pharmacy compounding and dispensing services;
c. durable medical equipment for the infusion therapy;
d. ancillary medical supplies;
e. nursing services associated with:
    i. patient and/or alternative care giver training;
    ii. visits necessary to monitor intravenous therapy regimen;

iii. emergency services;
iv. administration of therapy; and

f. collection, analysis, and reporting of the results of laboratory testing services required to monitor response to therapy.

7.8.4 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.

7.8.5 Radium, Radioisotopic, X-ray Therapy, and Kidney Dialysis

Covered expenses include:

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

7.8.6 Imaging Procedures

The Plan covers all standard imaging procedures when medically necessary and related to treatment of an illness or injury.

The following advanced imaging services require prior authorization:

a. Magnetic resonance imaging (MRI) or magnetic resonance angiography (MRA);
b. Computerized axial tomography (CT or CAT) or computed tomography angiogram (CTA);
c. Positron emission tomography (PET);
d. Single photon emission computed tomography (SPECT); and
e. Nuclear cardiology studies.

Prior authorization for advanced imaging services is required for members utilizing the ODS Plus Network in Oregon and Washington. If authorization is not obtained ***in advance*** of receiving such services, the charges will be denied.

In-network physicians and providers who perform the imaging services are responsible for obtaining prior authorization on the member's behalf. Members using an out-of-network physician or provider are responsible for ensuring that their physician or provider contacts ODS for prior authorization. Services not authorized in advance will be denied. The in-network physician or provider is expected to write off the full charge of the service. If the physician or provider is out-of-network, ***the full charge will be the member's responsibility***.

7.8.7 Routine Costs in Clinical Trial

Routine costs for the care of a member who is enrolled in or participating in qualifying clinical trials are covered. Routine costs mean medically necessary conventional care, items or services covered by the Plan if typically provided absent a clinical trial. Routine costs will be subject to the applicable deductible and standard copayments/coinsurance if provided in the absence of a clinical trial. ODS is not liable for any adverse effects of the clinical trials.

Qualified clinical trials are limited to those:

a. Funded or supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs;
b. Conducted as an investigational new drug application, an investigational device exemption or a biologics license application to the United States Food and Drug Administration; or
c. Exempt by federal law from the requirement to submit an investigational new drug application to the United States Food and Drug Administration.

The Plan does not cover:

a. The drug, device or service being tested in the clinical trial unless it would be covered by the Plan if provided outside of a clinical trial;
b. Items or services required solely for the provision of the drug device or service being tested in the clinical trial;
c. Items or services required solely for the clinically appropriate monitoring of the drug, device or service being tested in the clinical trial;
d. Items or services required solely for the prevention, diagnosis or treatment of complications arising from the provision of the drug, device or service being tested in the clinical trial;
e. Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the member;
f. Items or services customarily provided by a clinical trial sponsor free of charge to any person participating in the clinical trial; or
g. Items or services that are not covered by the Plan if provided outside of the clinical trial.

7.8.8 Outpatient Chemical Dependency Services

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

ODS Behavioral Health can help members locate in-network physicians, providers and facilities and understand their chemical dependency benefits.

7.9 PROFESSIONAL PROVIDER SERVICES

Services of physicians and providers are covered, as described below.

7.9.1 Preventive Healthcare

When performed by an in-network professional provider or provider, evidenced-based services rated A or B by the United States Preventive Services Taskforce, immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention, and preventive care and screenings recommended by the Health Resources and Services Administration for infants, children, adolescents, and women will be covered at no cost to the member. See section 3.2 for benefit level when services are provided out-of-network. Members can call ODS' Medical Customer Service Department to verify if a preventive service is covered at no cost share.

There are additional preventive healthcare services for which the Plan will waive the deductible and any copayments and cover when performed by an in-network physician or provider and billed with a routine diagnosis. Services billed with a medical diagnosis are paid at the standard benefit level.

a. Periodic Health Exams. The Plan covers periodic health exams limited to the following schedule:

    i. Newborn: One hospital visit.
    ii. Infants: 6 well-baby visits to a physician's office during the first year of life.
    iii. Age 1 to 4: 7 exams .
    v. Age 5 and above: One exam every plan 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.

b. Immunizations. The Plan covers routine immunizations for members of all ages when administered by a professional provider. Covered immunizations will be limited to those that are recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention for children and adults. However, immunizations for the sole purpose of travel or to prevent illness that may be caused by a work environment are not covered.

c. Cardiovascular screenings. The Plan covers one Electrocardiogram (EKG) and treadmill test when performed in conjunction with a covered periodic health exam.

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

d. Routine Vision Screening. The Plan will cover screening to detect amblyopia, strabismus and defects in visual acuity in children up to age 5 when performed by an in-network professional provider.

e. 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. Deductible applies to out-of-network benefits.

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

      A. One per plan year for women 18 years of age and older; and
      B. At any time at the recommendation of a professional provider.

   ii. Mammograms are covered as follows:

      A. Age 35 through 39: one mammogram
      B. Age 40 and older: one mammogram per plan year

      Mammograms for the purpose of diagnosis in symptomatic or designated high risk women are covered when deemed necessary by a professional provider. Mammogram is subject to the deductible and is covered under the x-ray benefit level if it is not performed for preventive purposes.

   iii. Pelvic exam/Pap tests are covered once per plan year for women of all ages, and at any time upon referral of a professional provider. Pap tests are subject to the deductible and are covered under the lab test benefit level if not performed for preventive purposes.

f. 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. Deductible applies to out-of-network benefits.

g. Colorectal cancer screening. The Plan will cover the following colorectal cancer screening exams and laboratory tests, including related charges:

   i. The Plan covers one routine flexible sigmoidoscopy and pre-surgical exam or consultation every 5 plan years for members age 50 and over.

   ii. The Plan covers one routine colonoscopy and pre-surgical exam or consultation every 10 plan years for members age 50 and over. Related facility and anesthesia fees are covered and are included in the colonoscopy benefit.

   Colonoscopy is covered under the surgery benefit level if it is not performed for preventive purposes.

   iii. The Plan covers one double contrast barium enema every 5 plan years for members age 50 and over.

   iv. The Plan covers one fecal occult blood test every plan year for members age 50 and over.

   For members 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. Colorectal cancer screening is covered at the medical benefit level if it is not performed for preventive purposes.

7.9.2 Family Planning

Voluntary family planning services are covered when approved and arranged by a professional provider. These services include vasectomy, tubal ligation, insertion and removal of IUD (device included) and office visits related to these services. The 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. Prescribed contraceptive drugs and devices received in a doctor's office will be paid at the same benefit level as a supply.

7.9.3 Home, Office or Hospital Visits

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

7.9.4 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 professional provider 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 3 hours per plan year of assessment and training if:

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

7.9.5 Therapeutic Injections

Administrative services for therapeutic injections, such as allergy shots, are covered when given in a 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 section 7.12.1 for additional information).

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

7.9.6 Surgery

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

a. The primary surgeon;
b. The assistant surgeon;
c. The anesthesiologist or certified anesthetist; and
d. 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 copayment/coinsurance level.

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

7.9.7 Circumcision

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

7.9.8 Reconstructive Surgery Following A Mastectomy

The Plan covers reconstructive surgery following a mastectomy for:

a. 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;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
c. Prostheses;
d. Treatment of physical complications of the mastectomy, including lymphedemas; and
e. Inpatient care related to the mastectomy and post-mastectomy services.

The member's physician must contact ODS to receive prior authorization.

This coverage will be provided in consultation with the member's attending physician and will be subject to the same terms and conditions, including the plan year deductible and copayment/coinsurance provisions otherwise applicable under the Plan.

7.9.9 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 ODS' medical director finds the procedure to be medically necessary. All reconstructive procedures must be medically necessary and prior 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 ODS' 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 (see section 7.9.8 for exception).

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

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

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

7.9.10 Cochlear Implants

Cochlear implants are covered when determined medically necessary and prior authorized.

7.9.11 Inborn Errors of Metabolism

The Plan 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.

7.9.12 Special Dental Care

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

a. 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);
b. Diagnosis is made within 6 months of the date of injury; and
c. Treatment is medically necessary and is provided by a physician or dentist while the member is enrolled in the 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.

The 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.

7.9.13 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:

a. Controlling or eliminating infection;
b. Controlling or eliminating pain; or
c. 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.

7.9.14 Temporomandibular Joint Syndrome

The Plan covers expenses for treatment of temporomandibular joint syndrome (TMJ) for medical reasons only. TMJ related surgical procedures and splints require prior 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 related dental diseases or injuries is excluded.

7.9.15 Mental Health

The Plan covers medically necessary outpatient services by a mental health provider as defined in Section 6.

ODS Behavioral Health can help members locate in-network physicians, providers and facilities and understand their mental health benefits.

7.9.16 Podiatry Services

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

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

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

7.9.17 Treatment for Tobacco Cessation

The Plan covers expenses incurred when a member age 10 or older participates in a tobacco cessation program. Covered expenses include counseling, office visits, medical supplies, and drugs provided or recommended by a tobacco cessation program.

A tobacco cessation program means a professional provider offering an overall treatment program that follows the United States Public Health Service guidelines for tobacco use cessation.

Members may contact ODS' Medical Customer Service Department to locate an exclusive tobacco cessation program.

7.9.18 Hearing Aids

The Plan covers one hearing aid per hearing impaired ear for members under age 26. This benefit is subject to a 48-month maximum that will be adjusted annually as required by Oregon statute. Members must be examined by a physician before obtaining a hearing aid that is prescribed, fitted and dispensed by a licensed audiologist.

Covered benefits include the following up to the dollar maximum every 48 months:

a. A hearing aid (monaural or binaural) prescribed as a result of the examination;
b. Ear molds;
c. Hearing aid instruments;
d. Initial batteries, cords and other necessary supplementary equipment;
e. A warranty; and
f. Repairs, servicing, or alteration of the hearing aid equipment.

7.9.19 Telemedical Health Services

Covered medical services, delivered through a 2-way video communication that allows a professional provider to interact with a member who is at an originating site, are covered. Benefit will be subject to the applicable deductible and standard copayments/coinsurance for the covered medical services.

An originating site includes the following:

a. Hospital;
b. Rural health clinic;
c. Federally qualified health center;
d. Physician's office;
e. Community mental health center;
f. Skilled nursing facility;
g. Renal dialysis center; or
h. Site where public health services are provided.

7.9.20 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 the Plan.

There is an aggregate plan year maximum for chiropractic, naturopathic and acupuncture services. Office visits for alternative care providers are reimbursed at the same benefit level as office visits of 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. Physical therapy services (see section 7.8.2) are not subject to the maximum for alternative care.

To be covered, a substance must be prescribed by a naturopath and approved by the Board of Naturopathic Examiners. Benefits for covered substances prescribed by a naturopath are subject to the aggregate plan year maximum for chiropractic, naturopathic and acupuncture services when aggregated with such services.

7.10 HOSPICE CARE

7.10.1 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 member's attending physician. The physician must certify in the plan that the member 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.

The Plan 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 a member who is terminally ill and not seeking further curative treatment.

7.10.2 Hospice Home Care

Covered charges for hospice home care include services by any of the following:

a. A registered or licensed practical nurse;
b. A physical, occupational or speech therapist;
c. A home health aide; or
d. A licensed social worker.

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

7.10.3 Hospice Inpatient Care

The Plan will pay covered charges for short-term hospice inpatient services and supplies for a limited number of days. This is not subject to the hospice home care benefit maximum.

7.10.4 Respite Care

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

The Plan will pay covered charges for respite care provided to a member who requires continuous assistance when arranged by the attending physician and prior authorized by ODS. Benefits are subject to a limited number of hours in a 3-month period of covered hospice care for services provided in the most appropriate setting.

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

7.10.5 Exclusions

In addition to exclusions listed in Section 9 the following are not covered:

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

7.11 OTHER SERVICES

7.11.1 Maternity Care

Pregnancy care, childbirth and related conditions are covered when rendered by a professional provider. Professional providers do not include midwives unless they are also licensed and certified nurse midwives or certified nurse practitioner midwives. The Plan will cover facility charges for maternity care when rendered at a covered facility, including a birthing center.

This maternity care benefit includes voluntary abortions.

For home births, the Plan does not cover expenses beyond the fees billed by a professional provider. Services that are not rendered at a covered facility as defined above are not covered. Additional information regarding home birth exclusions is in Section 9.

Special Right Upon Childbirth. The Plan 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. Physicians or providers are not required to obtain prior authorization for a length of stay up to 48 hours (or 96 hours for a cesarean section) following childbirth.

7.11.2 Transplants

The Plan will pay benefits for medically necessary and appropriate transplant procedures that conform to accepted medical practice and are not experimental or investigational. (More information regarding experimental or investigational procedures in Section 9).

Covered donor costs are subject to a per transplant maximum.

a. Definitions

In-Network Transplant Facility means a healthcare facility with which ODS has contracted or arranged to provide facility transplant services for participating organization's members.

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:

i. 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
ii. 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.

Corneal transplants and the collection of and/or transfusion of blood or blood products are not considered transplants for the purposes of this section and are not subject to this section's limitations and requirements.

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:

i. The Plan will waive any otherwise applicable deductible, or copayments/coinsurance and pay 100% of the contracted amount for facility fees when a transplant is performed at an in-network transplant facility;
ii. If a transplant procedure is performed at a facility other than an in-network transplant facility, the deductible will apply and the Plan will pay 60% of the amount

it would have paid had the services been rendered at an in-network transplant facility. The member will be responsible for the balance. The deductible and copayment/coinsurance will not accumulate toward the out-of-pocket maximum amount under the Plan. **Note:** Services not performed at an in-network transplant facility will be paid at 60% even if the member has met the out-of-pocket maximum.

iii. If the recipient or self-donor is enrolled in the Plan, donor costs related to a covered transplant, including expenses resulting from complications and unforeseen effects of the donation, will be paid subject to the per transplant donor cost maximum. "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 the Plan and the recipient is not enrolled or is in the exclusion period, the Plan will not pay any benefits toward donor costs. Expenses incurred by a donor not enrolled in the Plan that result from complications and unforeseen effects of the donation will not be covered.

iv. All transplant services must be prior authorized. Prior authorization requests for transplants will be reviewed to ensure the medical appropriateness and medical necessity of the proposed treatment for the member's medical condition or disease.

v. Professional provider transplant services are paid according to the benefits for professional providers;

vi. 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 Expense Benefit section (see section 7.13) and do not accumulate toward the lifetime transplant maximum benefit.

vii. The Plan will not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage.

Note:
To receive maximum plan benefits, the transplant related procedure must be performed at an in-network transplant facility.

c. Prior Authorization Requirement. A member may obtain prior authorization information by contacting ODS' Medical Customer Service Department.

   The member's physician must contact ODS' Medical Intake Unit prior to the transplant admission to request authorization. Prior authorization should be obtained as soon as possible after a member has been identified as a possible transplant candidate.

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

d. 24-Month Exclusion Period. Transplants will not be covered during the first 24 months a person is enrolled in the Plan (see Section 8).

7.11.3 Biofeedback Therapy

Covered expenses for biofeedback therapy services are limited to treatment of tension or migraine headaches. Covered visits are subject to a lifetime maximum.

7.11.4 Home Healthcare

Home healthcare services and supplies are covered when provided by a home healthcare agency for a member who is homebound. "Homebound" means that the member's condition creates a general inability to leave home. If the member 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 a member's home.

The home healthcare benefit consists of medically necessary home healthcare visits. A visit must be for intermittent care of not more than 2 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. a registered or licensed practical nurse;
b. a physical, occupational, speech, or respiratory therapist; or
c. 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.

There is a 2-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. Home health visits are also subject to a per plan year maximum.

Home healthcare requires prior authorization. Members should contact ODS' Medical Customer Service Department before receiving such care.

7.11.5 Supplies, Appliances and Durable Medical Equipment

Outpatient supplies, appliances and durable medical equipment are covered. If members 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:

a. medical supplies used in a professional provider's office;
b. application of a cast;
c. supplies related to a colostomy or mastectomy; and
d. 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 that 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 ODS 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 except as stated in section 7.9.18, 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 they are ordered by a professional provider and are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities. 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. Orthopedic shoes or modifications will not be covered if they are solely for comfort or convenience.

Durable medical equipment is equipment and related supplies that are used primarily to serve a medical purpose, are not generally useful to a member in the absence of illness, injury or disease, are appropriate for use in the member'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 coverage limit (see section 3.2).

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

In order to obtain reimbursement for replacement or repair of appliances, including prosthetic devices, equipment or durable medical equipment, members 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 Section 9, the Plan will not cover the following appliances and equipment, even if they relate to a condition that is otherwise covered by the Plan:

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

7.11.6 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 a physician for the treatment of severe intestinal malabsorption and must comprise the sole source, or an essential source, of nutrition.

7.12 MEDICATIONS

7.12.1 Medication Administered by Providers, Infusion Center or Home Infusion

A medication that is given by injection or infusion (intravenous administration) in the professional 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 it is medically necessary that the member uses the injectable form. In addition, infusion and in-office injectables may require prior authorization by ODS or be subject to specific benefit limitations (more information is available on the ODS website). Prescription drug expense benefit is in section 7.13.

7.12.2 Oral Anti-cancer Medication

A prescribed, orally administered anticancer medication that is given in the professional 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 (more information is available on the ODS website). Prescription drug expense benefit is in section 7.13.

7.13 PRESCRIPTION DRUG BENEFIT

7.13.1 ODS Preferred Pharmacy Program

The Plan will pay benefits for covered prescription drug charges as follows:

7.13.2 Benefits for prescriptions filled at a retail pharmacy (31 day supply):

a. 100% of covered expenses after a $4 copayment per prescription for value drugs;
b. 100% of covered expenses after a $8 copayment per prescription for generic drugs;
c. 100% of covered expenses after a $25 copayment per prescription preferred drugs; and
d. 50% of covered expenses for non-preferred drugs.

7.13.3 Benefits for prescriptions filled at a mail-order pharmacy (90 day supply):

a. 100% of covered expenses after a $8 copayment per prescription for value drugs;
b. 100% of covered expenses after a $16 copayment per prescription for generic drugs;
c. 100% of covered expenses after a $50 copayment per prescription for preferred drugs; and
d. 50% of covered expenses for non-preferred drugs, up to a maximum copayment of $100 per prescription.

7.13.4 Benefits for prescriptions filled at a Specialty Pharmacy (31 day supply):

a. 100% of covered expenses after a $16 copayment for generic drugs;
b. 100% of covered expenses after a $50 copayment for preferred drugs; and
c. 50% of covered expenses for non-preferred drugs, up to a maximum copayment of $100 per prescription.

The Plan has a $1,000 plan year out-of-pocket maximum for prescription drug expenses (retail, mail order and specialty pharmacy providers). The out-of-pocket maximum includes copayments/coinsurance for generic and preferred drugs. The amount members pay towards non-covered expenses (e.g. the difference in cost between a generic and the brand equivelant) does not accrue towards the out-of-pocket maximum. 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 maximum is met, covered prescriptions will be reimbursed at 100%.

7.13.5 Definitions

Brand Name Drugs. A brand name drug is sold under a trademark and protected name. These products are considered exclusive and can only be produced and sold by the manufacturer holding the patent.

Compounded Prescription Drugs. Compounded medications (containing at least one covered drug as an ingredient) are covered.

Formulary. An ODS formulary (preferred drug list) including generic, brand, and specialty drugs is available on myODS or by contacting ODS' Pharmacy Customer Service Department.

ODS Preferred Drug Lists are not all-inclusive lists. They are intended to provide information pertaining to the coverage of commonly prescribed medications. Generic and brand name medications that are not listed are covered by the Plan, unless they fall in a category outlined in section 7.13.13 or Section 9. Coverage for brand medications can be verified using the formulary look-up and price quote tool in myODS or by contacting ODS' Pharmacy Customer Service Department. New FDA approved drugs are subject to review and may be subject to additional coverage parameters, requirements, or limits established by ODS. Medications that are new to the market are not included in the drug benefit until reviewed by the ODS Pharmacy and Therapeutics Committee.

Note: The ODS preferred drug lists are subject to change and will be periodically updated. Members with any questions regarding coverage for medications should contact ODS' Pharmacy Customer Service Department.

ODS and the Plan bear 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. Members should consult their physicians about whether a drug from the preferred list would be appropriate for them. This list is not meant to replace a physician's judgment pertaining to prescribing decisions.

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. This benefit level may also includes select brand medications that have been identified as favorable from a clinical and cost effective perspective.

Generic Substitution. Both generic and brand name medications are covered. If a member requests a brand name drug or the treating physician prescribes a brand name drug when a generic equivalent is available, the member will be responsible for the brand copay/coinsurance plus the difference in cost between the generic and brand name drug. As the difference in cost between the generic and the brand name drug is not a covered expense, the member will at all times be responsible for payment of this difference. The difference in cost between the generic and brand name drug does not apply towards the member's plan year out of pocket maximum.

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

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

Maximum Plan Allowance for prescription benefits is the maximum amount ODS will reimburse for medications. For in-network pharmacies, 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 the Average Wholesale Price (AWP) accessed by ODS 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 all other providers will be subject to benefit provisions of the Plan and paid based on the lesser of either contracted rates, AWP or billed charges. In the event AWP is no longer recognized as a pricing standard for prescription drugs, then the MPA amount will be based upon a new pricing source consistent with prescription drug industry standards.

Medically Necessary means those drugs that are required for treatment of illness or injury and are:

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

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. Further information regarding medical necessity can be found in Section 9 (Exclusions).

Non Preferred means brand drugs that have been reviewed by ODS and in comparison do not have any significant therapeutic advantage over their preferred alternative(s). Drugs that are usually not recommended as first line therapy and have alternative treatment modalities are also considered non-preferred drugs.

OPDP refers to the Oregon Prescription Drug Program.

Orphan Drugs. An orphan drug is considered a specialty medication that has been developed to treat a rare medical condition. The Food and Drug Administration (FDA) closely regulates medications with orphan drug status and supports the research and development of these products. Orphan drugs must be prior authorized and medically necessary.

Preferred designates those medications which have limited alternatives available, but have been found to be clinically effective at a favorable cost over the non-preferred alternative(s) within the same therapeutic class and/or category. In addition, select generic medications that have been identified as having no more favorable outcomes from a clinical perspective than other more cost effective generics are included.

Specialty Drugs. Certain prescription drugs or medicines, including many self-injectables as well as other medications are defined as specialty products (e.g., Enbrel, Copaxone, Avonex). Specialty medications are often indicated to treat complex chronic health conditions. Specialty treatments often require special handling techniques, careful administration and a unique ordering process. Specialty drugs must be prior authorized and medically necessary.

Step Therapy. This is a common practice of beginning a drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other medications within the same drug class or therapeutic category if medically necessary. Reimbursement will be subject to the step therapy provision (see section 7.13.11), which will provide financial incentives through the benefit design to encourage members to try lower cost medications that are therapeutically equivalent in regards to their efficacy and safety profiles.

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

Value Drugs. Value medications include select commonly prescribed products used to treat chronic medical conditions and preserve health. A list of value medications is available on myODS.

7.13.6 Covered Expenses

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

a. It is for a covered drug supply that is prescribed for a member;
b. The expense is incurred while the member is eligible under the Plan; and

c. The prescribed drug is not excluded under the Plan.

7.13.7 Covered Drug Supply

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

a. A 31 day supply of medication is available through retail pharmacies.
b. A 31 day supply is available through the contracted specialty pharmacy provider.
c. A 90 day supply of medication is available through the contracted mail-order pharmacy.
d. 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."
e. Must be prescribed by an approved provider type and dispensed from a licensed pharmacy employing licensed registered pharmacists.
f. Selected over-the-counter (OTC) products (such as covered diabetic supplies and insulins), when accompanied with a valid prescription, will be covered under the Plan. The same benefit parameters such as copay and days supply restrictions will apply to covered over-the-counter products. Members may call ODS' Pharmacy Customer Service Department or visit their myODS account for additional information related to covered OTC products.
g. Includes federal legend-prescription prenatal vitamins.
h. Specialty medications. The Plan provides members prescribed specialty medications, access to enhanced clinical services and an exclusive pharmacy. More information is available in the section 7.13.9.
i. Contraceptive drugs and devices used for medical reasons and for 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 copayments as defined by the Plan benefits.
j. Covered expenses for select immunizations and related administration fees are covered at 100% at in-network retail pharmacies (e.g. influenza, pneumonia and shingles vaccines). Covered immunizations will be limited to those that are recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention. Immunizations for the sole purpose of travel or to prevent illness which may be caused by work environment are not covered.

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.

7.13.8 Mail Order Pharmacy

Members also have the option of obtaining prescriptions for covered drugs and medicines through an exclusive mail order pharmacy, Wellpartner.

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 generic substitution policy.

A mail order pharmacy form can be obtained from ODS online through myODS, through ODS' Pharmacy Customer Service Department or by calling Wellparter at 866-680-4672.

7.13.9 Specialty Services And Pharmacy

Members prescribed specialty medications (including orphan drugs) have access to enhanced clinical services and an exclusive specialty pharmacy through BioScrip Pharmacy Services. Certain prescription drugs or medicines, including most self-injectables as well as other medications defined

as specialty products (e.g., Enbrel, Copaxone, Avonex), must be purchased through BioScrip to be a covered benefit. **If a member does not purchase these drugs through BioScrip, the drug expense will not be covered.**

Each specialty prescription is up to a 31 day supply per prescription.

Prescriptions purchased through the specialty drug program are subject to the ODS generic substitution policy.

Member's pharmacist, physician and other medical providers will advise them if a 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 the clinical services and a list of eligible specialty medications can be accessed on myODS or through ODS' Pharmacy Customer Service Department at 503-265-2911 or toll free at 866-923-0411 or from BioScrip at 877-316-8921.

In addition, these drugs will require prior authorization by ODS. More information is available on myODS.

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.

7.13.10 Prior Authorizations

Prior authorization refers to the process by which a member obtains approval from ODS prior to ODS processing payment for a specific drug. A complete list of drugs that require prior authorization is available on myODS or by contacting ODS' Pharmacy Customer Service Department. Failure to obtain required prior authorization may result in denial of benefits or a penalty (see section 4.1).

Certain prescription drugs and/or quantities of prescription drugs may require prior authorization. Prior authorization programs are not intended to create barriers or limit access to medications. Requiring prior authorization is intended to support cost effectiveness, promote proper use of medications and to ensure the safety of all members. Prior authorizations may be required on medications for a variety of reasons, including the examples listed below:

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

7.13.11 Step Therapy

A step therapy provision may apply for certain therapeutic classes. A step therapy provision will require members to try and fail selected medications before proceeding to higher cost alternatives. Preferred and non-preferred medications are available in accordance with plan benefits once members have tried and failed first line therapies. Requests for medications that are subject to the step therapy provision but are not considered first line therapies will be reimbursed at the non-preferred tier.

7.13.12 Limitations

The Plan may imposes 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 a member's professional provider.

a. Retail prescriptions with a net cost over $1,000 for a 31 day supply require authorization.
b. Mail-order and specialty prescriptions with a net cost over $3,000 require authorization.
c. New FDA approved drugs are subject to review and may be subject to additional coverage parameters, requirements, or limits established by the Plan.
d. Compounded medications with a net cost over $150 for a 31 day supply require a prior authorization.
e. Immunization agents (other than allergy sera).
f. Select specialty medications may be limited to a 15 day supply for products that have been determined to have a high discontinuation rate following the first couple of weeks of therapy.

7.13.13 Exclusions

The following services, procedures and conditions are not covered by the Plan, even if otherwise medically necessary or if recommended, referred, or provided by a professional provider, pharmacist or pharmacy. In addition, any direct complication or consequence that arises from these exclusions will not be covered. See Section 9 for additional exclusions that may apply.

a. **Blood and Blood Products.**
b. **Charges Over the Maximum Plan Allowance.** Any charge in excess of the maximum plan allowance for a drug is not covered.
c. **Cosmetic.** Drugs prescribed or used for cosmetic purposes are not covered.
d. **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). Information for contraceptive devices is in section 7.9.2.
e. **Drug Administration.** A charge for administration or injection of a drug or medicine is not covered, except when administered for selected medications at retail pharmacies.
f. **Drugs Covered Under Another Benefit.** A drug that is covered under another plan benefit (i.e., home health, medical, etc.).
g. **Drugs for Other Purposes.** A drug prescribed for purposes other than treating a health condition or disease that is covered by the Plan.
h. **Drugs Prescribed by a Relative.** Prescriptions written or ordered by members or their relatives, including a spouse, domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner, are not covered.
i. **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.
j. **Experimental or Investigational Drugs.** The following are not covered:
    i. Any drug that is experimental or investigational or that is labeled: "Caution -- Limited by federal law to investigational use"; or
    ii. 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).
k. **Gender Reassignment.** Drugs prescribed (such as hormone supplements) for purposes to support gender reassignment are not covered.
l. **Hair Growth Legend Drugs.**
m. **Infertility Drugs.**
n. **Institutional Drugs or Medicine.** Drugs or medicine that are to be taken by or administered to a member in whole or in part while the member 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.

o. **Non-Covered Condition.** A drug prescribed to treat a medical condition that is not covered under the Plan.
p. **Nutritional Supplements and Medical Foods** are not covered, unless determined to be medically necessary**.**
q. **Off-label Usage.** Drugs prescribed for or used for non-FDA approved indications, unless approved by the Health Resources Commission, are not covered.
r. **Over the Counter (OTC) Drugs.**
s. **Repackaged Medications.**
t. **Replacement Medications and/or Supplies.** A replacement supply for reasons including but not limited to; lost, stolen, destroyed or damaged medications are not covered.
u. **Sexual Disorders.** Drugs or devices prescribed or used to treat sexual dysfunction are not covered.
v. **Tobacco Disorders.** Drugs or medicine to treat addiction to or dependence on tobacco or tobacco products (e.g., Nicorette) are covered under section 7.9.17.
w. **Treatment Not Medically Necessary.** The Plan does not cover:
    i. Drugs prescribed for purposes other than treating disease;
    ii. Drugs that are either inappropriate or inconsistent with the symptoms or diagnosis of a member's condition;
    iii. Drugs that are not representative of the standard treatment by the medical community in the service area in which they are received;
    iv. Drugs that are primarily rendered for the convenience of a member or a physician or provider; and/or
    v. Drugs that are not a cost-effective option when considering common alternatives that can be safely provided to a member.
x. **Untimely Dispensing.** Drugs or medicines that are dispensed more than one year after the order of a physician are not covered.
y. **Vitamins and Minerals.** The Plan does not cover over-the-counter (OTC) vitamins and minerals. Prescribed federal legend vitamins and minerals are covered.
z. **Weight Loss Drugs.**

7.13.14 Right Of Recovery

If the amount of payment made by the Plan is more than allowed based on eligibility and covered benefits at the time the prescription was dispensed, the 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 member. Overpayment may result in a reduction in future benefits until the full amount of the excess payment is recovered.

7.13.15 Claims Procedures

Members who go to an in-network pharmacy should present their ODS ID card and pay the prescription copayment/coinsurance as required by the Plan.

At times, members may be required to submit a claim form and applicable receipts for reimbursement. For example, a member who fills a prescription at an out-of-network pharmacy that does not access ODS' claims payment system will need to submit a request for reimbursement (see section 12.1.5).

7.13.16 Pharmacy Coordination Of Benefits (COB)

Claims subject to the COB provision of the Plan may be submitted electronically by the pharmacy or through the direct member reimbursement paper claim process. The preferred method is for the pharmacy to electronically transmit the remaining balance on the primary plan to ODS for processing. If approved, the secondary claim will be automatically processed according to plan benefits. The ability for a pharmacy to support electronic COB submission procedures can be dependent upon the capabilities of their claim processing software. Members who are unable to have their secondary claims processed electronically may submit a claim reimbursement request directly

to ODS (see section 12.1.5). For more information on determining primary and secondary coverage, see Section 13.

COB Processing Guidelines
The manner in which a pharmacy claim is paid by the primary payer will affect how ODS pays for the claim as the secondary plan.

Denied by the Primary: If a claim is denied by the primary plan, ODS will process the claim as if it is primary.

Approved by the Primary:

a. **Primary plan approves a claim, but does not pay anything toward the claim.** Reasons for this may include, but are not limited to; the member has not satisfied a deductible (if applicable) or the cost of the medication is less than the primary plan's copayment/coinsurance. In this scenario, ODS will pay as if it is primary.

b. **Primary plan approves a claim and benefits are paid.** In this scenario, ODS will pay up to what the Plan would have allowed had it been the primary payer. The Plan will not pay more than the member's total out of pocket expense under the primary plan.

Additional information on COB is in Section 13.

SECTION 8. EXCLUSION PERIODS

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

8.1 24-MONTH EXCLUSION PERIOD FOR TRANSPLANTS

Transplants will not be covered during the first 24 months a member is enrolled in the Plan except as follows:

a. The 24-month exclusion period will not apply if the member has been continuously enrolled in the Plan since birth;
b. The 24-month exclusion period will not apply if the member was continuously enrolled in the Plan together with the participating organization'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 member had applicable transplant coverage under a prior health benefit plan, each day of creditable coverage the member had under that prior health benefit plan will reduce the 24-month exclusion period by one day.

Members have the right to demonstrate the existence of prior creditable coverage by providing ODS with a certificate of creditable coverage from a prior plan. A certificate of creditable coverage may be requested from a prior plan or insurer within 24 months of coverage termination. Members who have been enrolled in more than one prior plan should submit all certificates of creditable coverage, as aggregate periods of creditable coverage can be used to reduce the exclusion period.

SECTION 9. GENERAL EXCLUSIONS

In addition to the limitations and exclusions described elsewhere in the Plan, the following services, procedures and conditions are not covered, 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 an in-network physician or provider. In addition, any direct complication or consequence that arises from these exclusions will not be covered except for emergency medical conditions.

Behavior Modification
Psychological enrichment or self-help programs for mentally healthy persons 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 handbook as covered expenses under the Plan are excluded.

Charges Over the Maximum Plan Allowance
Any charge over the maximum plan allowance for services or supplies will be excluded except when required under the Plan's coordination of benefits rules (see section 13.1).

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 the Plan. Exceptions are provided for reconstructive surgery following a mastectomy (see section 7.9.8). Complications of reconstructive surgeries will be covered if medically necessary and not specifically excluded. 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
Court-ordered services are not covered. This includes a court-ordered sex offender treatment program and a screening interview or treatment program related to driving under the influence of intoxicants for members age 18 or older. This exclusion does not apply to chemical dependency services for members age 17 or younger or to services provided pursuant to civil commitment proceedings for mental illness.

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 member from others, or for preventing a member from harming himself or herself.

Dental Examinations and Treatment; Orthodontia
Except as specifically provided for in section 7.9.12, dental examination and treatment and orthodontia are not covered.

Dental Implants

Experimental or Investigational Procedures
Services and supplies are excluded that:

a. 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;
b. Are not recognized by the medical community in the service area in which they are received;
c. 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;
d. 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
e. Are available in the United States only as part of clinical trial or research program for the illness or condition being treated except that routine costs of certain clinical trials are covered (see section 7.8.7).

Additionally, the 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 the Plan. In addition, prescribed contraceptive drugs and devices obtained at a pharmacy are not covered.

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 members age 19 and older are not covered.

Guest Meals in a Hospital or Skilled Nursing Facility

Hearing Aids
The Plan does not cover:

a. Implantable hearing aids and surgical procedure to implant them;
b. Hearing aids for members age 26 or above;
c. Replacement of a hearing aid, for any reason, in a 48-month period after the maximum is met;

d. Batteries or other supplementary equipment other than those obtained upon purchase of the hearing aid; and
e. Expenses incurred after coverage ends, unless the hearing aid is ordered before coverage terminated and it is received within 90 days of the end date.

Home Birth or Delivery
The Plan does not cover charges for home birth other than the professional services billed by a 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:

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

Illegal Acts
The Plan does not cover treatment of any condition caused by or arising out of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the member, if the member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony if such member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude services for injuries resulting from an act of domestic violence or a medical condition (i.e. a physical or mental health condition.)

Immunizations
Immunizations for the sole purpose of travel or to prevent illness that 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 a member 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 that is otherwise covered by the Plan, massage and massage therapy are not covered.

Mental Examination and Psychological Testing and Evaluations
The 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 illness.

Mental Retardation/Learning Disabilities

Treatment related to mental retardation for members 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 and certified nurse midwife or a licensed and certified nurse practitioner midwife.

Missed Appointments

Necessities of Living
These include, but are not limited to, food, clothing, and household supplies. Related exclusion is under "Supportive Environmental Materials."

Orthopedic Shoes
These are not covered, except as provided for in section 7.11.5.

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.

Professional Athletic Contests
The Plan does not cover diagnosis, treatment and rehabilitation services for injuries sustained while practicing for or competing in a professional (full time, for payment or under sponsorship) or semi-professional (part time, for payment or under sponsorship) athletic contest.

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 for in sections 7.6.3 and 7.8.2.

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

Routine Foot Care
The Plan will not cover the following services:

a. Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus);
b. Trimming of dystrophic and non-dystrophic nails; and

c. 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:

a. services and supplies for which payment could be obtained in whole or in part if a member had applied for payment under any city, county, state or federal law, except for Medicaid coverage;
b. charges for services and supplies for which a member 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;
c. services and supplies for which no charge is made, or for which no charge is normally made in the absence of insurance; and
d. services or supplies a member could have received in a hospital or program operated by a government agency or authority. This exclusion does not apply to:
    i. 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
    ii. veterans of the armed forces, in which case covered services and supplies furnished by the Veterans' Administration of the United States that are not service-related are eligible for payment according to the terms of the Plan.

Services Provided By a Relative
ODS will not reimburse services provided by members or their relatives. Relatives, for the purpose of this exclusion, include a spouse or domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner.

Services Provided By Volunteer Workers

Service, War or Insurrection, Riot or Rebellion
The Plan does not cover treatment of any condition caused by or arising out of service in the armed forces of any country or the active participation in a war or insurrection, or the voluntary participation in a riot or rebellion.

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 the Plan. This includes, but is not limited to:

a. Gastric restrictive procedures with or without gastric bypass, or the revision of the same.
b. 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.
c. Any drug or formula related to or resulting from the treatment of weight loss or obesity even if prescribed by a physician.

The Plan 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 services and supplies that do so by treating the obesity directly are not covered, except for those rated A or B by the United States Preventive Services Taskforce.

Sexual Disorders
The 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:

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

Support Education
This includes the following:

a. Level 0.5 education-only programs related to a DUII;
b. Education-only, court-mandated anger management classes;
c. Voluntary mutual support groups, such as Alcoholics Anonymous; and
d. Family education or support groups except for support groups rated A or B by the United States Preventive Services Taskforce..

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. Related exclusion is under "Necessities of Living."

Surgery to Alter Refractive Character of the Eye
The 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 that alter the refractive character of the eye and any complications of these procedures are excluded.

Taxes

Telemedical Health Services
Telemedical health services for services excluded under the Plan are not covered.

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 members age 18 or older, services or supplies related to learning disabilities, hippotherapy, and maintenance therapy and programs are not covered.

Third Party Liability Claims
Services and supplies for treatment of illness or injury for which a third party is or may be responsible are excluded to the extent of any recovery received from or on behalf of the third party. This includes 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, when such contract or insurance is issued to, or makes benefits available to, a member, whether or not such benefits are requested (see section 12.4.2).

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

Treatment After Coverage Terminates
The Plan does not cover services or supplies that a member receives after coverage ends. The only exception is if a member is hospitalized at the time of termination (see section 7.2).

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

Treatment Not Medically Necessary
The Plan does not cover:

a. Services or supplies that are not medically necessary for the treatment or diagnosis of a condition otherwise covered under the Plan;
b. Services or supplies that are either inappropriate or inconsistent with the symptoms or diagnosis of a member's condition;
c. Services or supplies that are not established as the standard treatment by the medical community in the service area in which they are received;
d. Services or supplies that are primarily rendered for the convenience of a member or a physician or provider of services or supplies; and/or
e. Services that are not the least costly of the alternative supplies or levels of service that can be safely provided to a member. 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. As 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.

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
The Plan does not cover services or supplies that a member received before enrollment in the Plan.

Vitamins and Minerals
The 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
The 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 member 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.

SECTION 10. ELIGIBILITY

The Plan's eligibility rules are outlined in the Oregon Administrative Rules under OAR 111-015-0001. Members may also refer to the OEBB Member Benefits Guide for additional information on eligibility. The date a person becomes eligible may be different than the date coverage begins. More specific information can be found under "When Coverage Begins," located in the "Enrollment" section (see Section 11).

SECTION 11. ENROLLMENT

This section explains how to enroll in the Plan.

11.1 NEWLY-HIRED AND NEWLY-ELIGIBLE ACTIVE ELIGIBLE EMPLOYEES

The Plan's enrollment rules for newly-hired and newly-eligible active eligible employees are outlined in the Oregon Administrative Rules under OAR 111-040-0010. Members may also refer to the OEBB Member Benefits Guide for additional information on enrollment.

11.2 QUALIFIED STATUS CHANGES

The Plan's enrollment rules for qualified status changes are outlined in the Oregon Administrative Rules under OAR 111-040-0040. Members may also refer to the OEBB Member Benefits Guide for additional information on qualified status changes.

Eligible employees and their spouse, domestic partner, and children may also have additional enrollment rights under the Children's Health Insurance Program Reauthorization Act of 2009 if prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage was terminated due to loss of eligibility. Special enrollment must be requested within 60 days of the termination.

Additionally, if an eligible employee, spouse, domestic partner or child covered under Medicaid or CHIP becomes eligible for a premium assistance subsidy, and special enrollment is requested within 60 days of the determination of eligibility, they may enroll in the Plan outside of the open enrollment period.

The special enrollment rights as described above apply:

a. To an eligible employee who loses other coverage or becomes eligible for a premium assistance subsidy;
b. To a spouse, domestic partner, or child who loses coverage under the other plan or becomes eligible for a premium assistance subsidy; or,
c. To both if neither is enrolled in the Plan, and either loses coverage under the other plan or becomes eligible for a premium assistance subsidy.

To enroll, an eligible employee will need to submit a complete and signed application within the required timeframe, along with a certificate of creditable coverage from the previous plan.

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. If payment is required but not received, the child will not be covered. Proof of legal guardianship or a signed Affidavit of Dependency will be required for coverage of a grandchild beyond the first 31 days from birth.

11.3 EFFECTIVE DATES

The Plan's effective dates for enrollment are outlined in the Oregon Administrative Rules under OAR 111-040-0001. Members may also refer to the OEBB Member Benefits Guide for additional information on the effective date of coverage.

11.4 OPEN ENROLLMENT

The Plan's open enrollment rules are outlined in the Oregon Administrative Rules under OAR 111-040-0020. Members may also refer to the OEBB Member Benefits Guide for additional information on open enrollment.

11.5 LATE ENROLLMENT

The Plan's late enrollment rules are outlined in the Oregon Administrative Rules under OAR 111-040-0030. Members may also refer to the OEBB Member Benefits Guide for additional information on late enrollment.

11.6 RETURNING TO ACTIVE ELIGIBLE EMPLOYEE STATUS

The Plan's enrollment rules for those individuals returning to active eligible employee status are outlined in the Oregon Administrative Rules under OAR 111-040-0035. Members may also refer to the OEBB Member Benefits Guide for additional information on returning to active eligible employee status.

All plan provisions will resume at re-enrollment whether or not there was a lapse in coverage. Any exclusion period that was not completed at the time the subscriber was laid off or had a reduction in hours must be satisfied. However, the period of layoff or reduction in hours will be counted toward the exclusion period. Upon re-enrollment in the Plan, any waiting period required by the Plan will not have to be re-served.

11.7 REMOVING AN INELIGIBLE INDIVIDUAL FROM BENEFIT PLANS

The Plan's rules for removing an ineligible individual from the Plan are outlined in the Oregon Administrative Rules under OAR 111-040-0015. Members may also refer to the OEBB Member Benefits Guide for additional information on removing an ineligible individual from the Plan.

11.8 WHEN COVERAGE ENDS

Termination dates for loss of eligibility, death of the active eligible employee, and retirement of the active eligible employee are outlined in the Oregon Administrative Rules under OAR 111-040-0005. In addition, there are a variety of other circumstances in which a member's coverage will end. These are described in the following paragraphs.

11.8.1 Group Plan Termination

If the Plan is terminated for any reason, coverage ends for the participating organization and members on the date the Plan ends. There is one exception to this rule. If the OEBB terminates the Plan and a member is hospitalized on the day the Plan ends, coverage under the 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.

ODS may terminate the group policy for fraud or intentional misrepresentation of material fact by OEBB, or for OEBB's noncompliance with material policy provisions.

In the event the group policy is terminated for a reason other than nonpayment of premiums and OEBB does not replace the insurance coverage, ODS will mail a notice of termination to OEBB. Group Plan termination includes termination of a multiple employer trust policy. ODS' notice will be mailed within 10 working days of the date of termination. The notice will explain members' rights under federal and state law regarding Portability, conversion and continuation of coverage. It is the responsibility of OEBB to send the information contained in the notice to members.

If ODS does 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 OEBB, and ODS will waive the premiums owing for this period. In this case, the period during which members

have to apply for continuation or Portability coverage will begin on the date OEBB receives the notice.

11.8.2 Termination By A Subscriber

A subscriber may terminate his or her coverage, or coverage for any enrolled dependent, by giving ODS written notice through OEBB in accordance with OEBB's administrative rules. Coverage will end on the last day of the month through which premiums are paid. If a subscriber terminates his or her own coverage, coverage for any enrolled dependents also ends at the same time.

11.8.3 Rescission By Insurer

The Plan's enrollment rules for rescission by insurer are outlined in OEBB's Administrative Rules. Members may also refer to the OEBB Member Benefits Guide for additional information on rescinding.

11.8.4 Certificates of Creditable Coverage

Certificates of creditable coverage will be issued when coverage ends, when COBRA coverage ends, and when a member requests a certificate while covered under the Plan or within 2 years of losing coverage.

11.8.5 Other

Additional information is in Continuation of Health Coverage (see Section 15) and Individual Portability Coverage (see Section 16).

11.9 DECLINATION OF COVERAGE

The Plan's rules for declining coverage are outlined in the Oregon Administrative Rules under OAR 111-040-0050. Members may also refer to the OEBB Member Benefits Guide for additional information on declining coverage.

SECTION 12. CLAIMS ADMINISTRATION & PAYMENT

The following sections explain how claims are administered.

12.1 SUBMISSION AND PAYMENT OF CLAIMS

In no event, except absence of legal capacity or in the case of a Medicaid claim, is a claim valid if submitted later than 12 months from the date the expense was incurred. Claims submitted by Medicaid must be sent to ODS within 3 years after the date the expense was incurred.

12.1.1 Hospital Claims

If a member is hospitalized, his or her identification card must be presented to the admitting office. In most cases, the hospital will bill ODS directly for the cost of the hospital services. ODS will pay the hospital and send copies of its payment record to the member. The hospital will then bill the member for any charges that were not covered under the Plan.

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

When a member is billed by the hospital directly, he or she should send a copy of the bill to ODS, and include all of the following information:

a. The patient's name;
b. The subscriber's name and group and identification numbers;
c. A description of the diagnosis or symptoms treated; and
d. A description of the services and the dates on which they were provided.

The same procedure should be followed with bills for hospital or professional provider care received outside the United States.

12.1.2 Professional Provider Claims

A professional provider may bill charges directly to ODS. If not, the member should forward the bills to ODS at the address listed below.. The professional provider should use his or her billing form and the following must be shown on the bill:

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

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

If the treatment is for an accidental injury, a statement explaining the date, time, place, and circumstances of the accident must be included with the bill.

12.1.3 Ambulance Claims

Bills for ambulance service must show where the member was picked up and taken as well as the date of service and the member's name, group number, and identification number.

12.1.4 Claims for Tobacco Cessation Program

Members participating in the exclusive tobacco cessation program may obtain prescription medications at participating pharmacies and will be responsible for the applicable copay/coinsurance. Members not participating in the exclusive tobacco cessation program should follow the claim submission procedures in section 12.1.5 for prescribed drugs treating tobacco cessation..

ODS will be billed directly by the exclusive tobacco cessation program for the cost of counseling, consultation and supplies. Other providers may require a member to pay the charges and submit the claim to ODS. If this happens, the member must pay these amounts and submit the claim form specific to the tobacco cessation program. This form is available by visiting myODS or contacting ODS' Medical Customer Service Department. ODS will reimburse the member for covered expenses.

12.1.5 Prescription Drug Claims

Members who go to an in-network pharmacy should present the ODS ID card and pay the prescription copayment/coinsurance as required by the Plan.

At times, members may be required to submit a claim form and applicable receipts for reimbursement. For example, a member who fills a prescription at an out-of-network pharmacy that does not access ODS' claims payment system will need to submit a request for reimbursement.

It is important to utilize an ODS prescription drug claim form to ensure timely processing of a reimbursement request. Forms are available by visiting myODS. Members should complete the Med Impact prescription drug claim form to request benefit reimbursement for prescribed drugs.

Submit the claim to: ODS Pharmacy Network
P.O. Box 40168
Portland, OR 97240-0168

Eligible prescription drugs purchased and paid in full by a member will be reimbursed at the ODS pharmacy contracted rate minus applicable copayment/coinsurance, or the maximum plan allowance minus applicable copayment/coinsurance, whichever is less.

Claims are subject to the administrative and benefit plan provisions, including but not limited to prior authorization requirements, step therapy and quantity level and day supply limitations.

12.1.6 Explanation of Benefits (EOB)

Soon after receiving a claim, ODS will report its action on the claim by sending the member a document called an Explanation of Benefits. ODS may pay claims, deny them, or accumulate them toward satisfying the deductible, if any. If all or part of a claim is denied, the reason will be stated in the Explanation of Benefits.

If a member does 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 explained in section 12.1.

12.1.7 Claim Inquiries

ODS' Medical Customer Service Department can answer questions about how to file a claim, the status of a pending claim, or any action taken on a claim. ODS' Pharmacy Customer Service Department can answer questions regarding a pharmacy claim. ODS will respond to an inquiry within 30 days of receipt.

12.2 DISPUTE RESOLUTION

12.2.1 Definitions

For purposes of section 12.2, the following definitions apply:

Adverse Benefit Determination means a written notice from ODS, in the form of a letter or an Explanation of Benefits (EOB), of any of the following: rescission of coverage, or a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including one based on a determination of a member's eligibility to participate in the Plan and one resulting from the application of any pre-existing condition exclusion or utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not necessary and customary by the standards of generally accepted practice for the prevention or treatment of disease or accidental injury. A **Final Internal Adverse Benefit Determination** is an adverse benefit determination that has been upheld by ODS at the completion of the internal appeal process or with respect to which the internal appeal process has been exhausted.

Appeal means a request for action/resolution on a denial of authorization for a covered service, denial of payment for a claim, or a denial of benefits. Appeals include first and second level of appeals.

Claim Involving Urgent Care means any claim for medical care or treatment in which the application of the regular time period to review a denial of a pre-service claim could seriously jeopardize a member's life or health or ability to regain maximum function, or, in the opinion of a physician with knowledge of a member's medical condition, would subject the member to severe pain that cannot be adequately managed without the requested care or treatment.

Grievance means an expression of dissatisfaction, other than an appeal, about a specific problem a member has encountered or about a decision by ODS 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 a request for information or clarification about any subject related to the Plan.

Post-service Claim means any claim for a benefit under the Plan for care or services that have already been received by a member.

Pre-service Claim means any claim for a benefit under the Plan for care or services that require prior authorization.

Utilization Review means a system of reviewing the medical necessity, appropriateness, or quality of medical care services and supplies using specified guidelines, including preadmission certification, the application of practice guidelines, continued stay review, discharge planning, prior authorization of ambulatory procedures, and retrospective review. An adverse benefit determination that the item or service is not medically necessary or appropriate, is investigational or experimental, or in which the decision as to whether a benefit is covered involved a medical judgment is a utilization review decision.

12.2.2 Time Limit for Submitting Appeals

A member has **180 days** from the date of an adverse benefit determination to submit an initial written appeal. If an appeal is not submitted within the timeframes outlined in this section, the rights to the appeals process will be lost.

12.2.3 The Review Process

The Plan has a 2-level internal review process consisting of a first level appeal and a second level appeal. If a member is not satisfied with the outcome of the second level appeal, and the complaint

meets the specifications outlined in section 12.2.6, the member may request external review by an independent review organization. The first and second levels of appeal will need to be exhausted to proceed to external review, unless ODS agrees otherwise.

Note:
The timelines addressed in the sections below do not apply when the member does 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).

12.2.4 First Level Appeals

It may be possible to resolve an appeal with a phone call to ODS' Medical Customer Service Department or for pharmacy claims, ODS' Pharmacy Customer Service Department. Otherwise, an appeal must be submitted in writing to ODS. If necessary, ODS' Customer Service Department can provide assistance filing an appeal. The member may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on his or her behalf. ODS will acknowledge receipt of the written appeal within 7 days and conduct an investigation by persons who were not involved in the initial determination.

An appeal related to an urgent care claim will be entitled to expedited review upon verbal or written request. An expedited review will be completed no later than 72 hours after receipt of the appeal by ODS, unless the member fails to provide sufficient information for ODS to make a decision. In this case, ODS will notify the member within 24 hours of receipt of the appeal of the specific information necessary to make a decision. The member will have 48 hours to provide the specified information. The investigation of an urgent care claim will be completed no later than 48 hours following the earlier of (a) ODS' receipt of the specified information, or (b) the end of the period provided to submit the specified additional information.

Investigation of a pre-service appeal will be completed within 15 days. Investigation of a post-service appeal or a complaint will be completed within 30 days.

When an investigation has been completed, ODS will notify the member in writing of the decision,, the basis for the decision, and if applicable, information on the right to a second level appeal.

12.2.5 Second Level Appeals

A member who disagrees with the decision regarding the first level appeal may request a review of the decision. The second level appeal must be submitted in writing within 60 days of the date of ODS' action on the first level appeal.

Investigations and responses to a second level appeal will be by persons who were not involved in the initial determinations, and will follow the same timelines as those for a first level appeal. The member may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on his or her behalf. If new or additional evidence or rationale is used by ODS in connection with the claim, it will be provided to the member, in advance and free of charge, before any final internal adverse benefit determination. Members may respond to this information before ODS' determination is sent. ODS will notify the member in writing of the decision, the basis for the decision, and if applicable, information on the right to request an external review.

12.2.6 External Review

If the claim meets the criteria below, a member may request that the claim be reviewed by an independent review organization appointed by the Oregon Insurance Division.

a. The dispute must relate to an adverse benefit determination based on a utilization review decision: whether a course or plan of treatment that a member is undergoing is an active course of treatment for purposes of continuity of care (see section 12.3); or cases in which ODS fails to meet the internal timeline for review or to provide all of the information and notices requred under federal law for appeals involving those issues;
b. The request for external review must be in writing no more than 180 days after receipt of the final internal adverse benefit determination;
c. The member must sign a waiver granting the independent review organization access to his or her medical records;
d. The member must have exhausted the appeal process described in sections 12.2.4 and 12.2.5. However, ODS may waive the requirement and have a dispute referred directly to the external review with the member's consent; and
e. The member shall provide complete and accurate information to the independent review organization in a timely manner.

A final internal adverse benefit determination based on specific exclusions or limitations on the amount, duration or scope of coverage that does not involve medical judgement or a decision on whether a person is a member under the Plan does not qualify for external review. A complaint decision does not qualify for external review.

12.2.7 Additional Member Rights

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

By phone: 503-947-7984 or toll-free 888-877-4894
By mail: Consumer Advocacy
Department of Consumer and Business Services
350 Winter Street NE, Room 440-2
Salem, Oregon 97301

By internet www.cbs.state.or.us/external/ins/

This information is subject to change upon notice from the Director of the Oregon Insurance Division.

12.3 CONTINUITY OF CARE

12.3.1 Continuity of Care

Continuity of care is a feature of the Plan under which a member who is receiving care from an individual professional provider is entitled to continue care with that professional 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 a professional provider's services is terminated, the provider no longer participates in the network, and the Plan does not cover services when services are provided to members by the professional provider or covers services at a benefit level below the benefit level specified in the Plan for out-of-network professional providers.

Continuity of care is conditional upon the willingness of the professional provider to adhere to the medical services contract that had most recently been in effect between the professional provider and ODS and the professional 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 a member to receive continuity of care, all of the following conditions must be satisfied:

a. The member must request continuity of care from ODS;
b. The member is undergoing an active course of treatment that is medically necessary and, by agreement of the professional provider and the member, it is desirable to maintain continuity of care; and
c. The contractual relationship between the professional provider and ODS, with respect to the Plan covering the member has ended.

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

a. The contractual relationship between a professional provider and ODS has ended because he or she:

    i. has retired;
    ii. has died;
    iii. no longer holds an active license;
    iv. has relocated out of the service area;
    v. has gone on sabbatical; or
    vi. is prevented from continuing to care for patients because of other circumstances; or

b. 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 professional provider have been exhausted.

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

12.3.2 Length of Continuity of Care

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

a. The day following the date on which the active course of treatment entitling the member to continuity of care is completed; or
b. The 120th day after the date of notification by ODS to the member of the termination of the contractual relationship with the professional provider.

A member 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:

a. The 45th day after the birth; or
b. As long as the member continues under an active course of treatment, but not later than the 120th day after the date of notification by ODS to the member of the termination of the contractual relationship with the professional provider.

12.3.3 Notice Requirement

ODS will give written notice of the termination of the contractual relationship with a professional provider, and of the right to obtain continuity of care, to those members that ODS knows or reasonably should know are under the care of the professional provider. The notice shall be given to the members 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 member after the date of termination of the contractual relationship.

If the professional 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 members.

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

12.4 BENEFITS AVAILABLE FROM OTHER SOURCES

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

12.4.1 Coordination Of Benefits (COB)

This provision applies to the Plan when a member has healthcare coverage under more than one plan. A complete explanation of COB is in Section 13.

12.4.2 Third-Party Liability

A member 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 ODS. For example, a member who is injured may be able to recover the benefits or healthcare costs from a person 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, a member 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 ODS make an advance payment of benefits, as described below, it is entitled to be reimbursed for any benefits it paid that are associated with any illness or injury that are or may be recoverable from a third party or other source. Amounts received by ODS 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 the Plan, as a service to the member, ODS will pay a member's expenses based on the understanding and agreement that the member is required to honor ODS' rights of subrogation as discussed below, and, if requested, to reimburse ODS in full from any recovery the member may receive, no matter how the recovery is characterized.

Upon claiming or accepting benefits, or the provision of benefits, under the terms of the Plan, the member agrees that ODS shall have the remedies and rights as stated in this section. ODS may elect to seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, ODS' right of reimbursement or subrogation as discussed in this section. ODS has the sole discretion to interpret and construe these reimbursement and subrogation provisions.

12.4.2.1 Definitions

For purposes of section 12.4.2, the following definitions apply:

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

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 member, regardless of the characterization of the claims or damages of the member, and regardless of the characterization of the recovery funds. (For example, a member who has received payment of medical expenses from ODS may file a third party claim against the party responsible for the member's injuries, but only seek the recovery of non-economic damages. In that case, ODS is still entitled to recover benefits as described in section 12.4.2.)

Third Party means any person or entity responsible for the injury or illness, or the aggravation of an injury or illness, of a member. Third party includes any insurer of such person or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the member 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.

12.4.2.2 Subrogation

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

Under this section, ODS may pursue the third party in its own name, or in the name of the member. ODS is entitled to all subrogation rights and remedies under the common and statutory law, as well as under the Plan.

12.4.2.3 Right of Recovery

In addition to its subrogation rights, ODS may, at its sole discretion and option, ask that a member, and his or her attorney, if any, protect its reimbursement rights. If ODS elects to proceed under this section, the following rules apply:

a. The member holds any rights of recovery against the third party in trust for ODS, but only for the amount of benefits ODS paid for that illness or injury.

b. ODS is entitled to receive the amount of benefits it has 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 member is also at fault. In addition, ODS is entitled to receive the amount of benefits it has paid whether the health care expenses are itemized or expressly excluded in the third party recovery.

c. If, and only if, ODS asks the member, and his or her attorney, to protect its reimbursement rights under this section, then the member may subtract from the money to be paid back to ODS, as an expense for collecting from the other party, a proportionate share of reasonable attorney fees.

d. ODS may ask the member to sign an agreement to abide by the terms of this section. If ODS elects to proceed under this section it will not be required to pay benefits for the illness or injury until the agreement is properly signed and returned.

e. This right of recovery includes the full amount of the benefits paid, or pending payment by ODS, out of any recovery made by the member from the third party, including, without limitation, any and all amounts from the first dollars paid or payable to the member (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 member), regardless of the characterization of the recovery, whether or not the member is made whole, or whether or not any amounts are paid or payable directly by the third party, an insurer or another source. ODS' recovery rights will not be reduced due to the member's own negligence.

f. If it is reasonable to expect that the member will incur future expenses for which benefits might be paid by ODS, the member shall seek recovery of such future expenses in any third party claim.

12.4.2.4 Motor Vehicle Accidents

Any expense for injury or illness that results from a motor vehicle accident and is payable under a motor vehicle insurance policy is not a covered benefit under the Plan and will not be paid by ODS.

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

In addition to the rights and remedies outlined in the Subrogation and Right of Recovery sections stated above, in third party claims involving the use or operation of a motor vehicle, ODS, at its sole discretion and option, is 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.

12.4.2.5 Additional Third Party Liability Provisions

In connection with ODS' rights to obtain reimbursement, or to exercise its right of subrogation, or direct recovery in motor vehicle accidents, as discussed in the above sections, members shall do one or more of the following, and agree that ODS may do one or more of the following, at its discretion:

a. If the member seeks payment by ODS of any benefits for which there may be a third party claim, the member shall notify ODS of the potential third party claim. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to ODS by the member's provider.

b. Upon request from ODS, the member shall provide all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. The member and his or her representatives shall have the obligation to notify ODS 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 member is seeking recovery of benefits paid by ODS from the third party.

c. In order to receive an advance payment of benefits pursuant to section 12.4.2, ODS requires that any member seeking payment of benefits by ODS, and if the member is a minor or legally incapable of contracting, then the member's parent or guardian, must fill out, sign and return to ODS a Third-Party Questionnaire and Agreement that includes a questionnaire about the accident and the potential third-party claim. If the member has retained an attorney to represent himself or herself with respect to a third-party claim, then the attorney must sign the Third-Party Recovery Agreement, acknowledging the obligations described in that agreement.

d. The member shall cooperate with ODS to protect its recovery rights in section 12.4.2, and in addition, but not by way of limitation, shall:

   i. Sign and deliver such documents as ODS reasonably requires to protect its rights;
   ii. Provide any information to ODS relevant to the application of the provisions of section 12.4.2, 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
   iii. Take such actions as ODS may reasonably request to assist ODS in enforcing its rights to be reimbursed from third party recoveries.

e. By accepting the payment of benefits by ODS, the member agrees that ODS has the right to intervene in any lawsuit or arbitration filed by or on behalf of a member seeking damages from a third party.

f. The member agrees that ODS may notify any third party, or third party's representatives or insurers, of its recovery rights set forth in section 12.4.2.

g. Even without the member's written authorization, ODS may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 12.4.2.

h. This section applies to any member for whom advance payment of benefits is made by ODS whether or not the event giving rise to the member's injuries occurred before the member became covered by ODS.

i. If the member continues to receive medical treatment for an illness or injury after obtaining a settlement or recovery from a third party, ODS will provide benefits for the continuing treatment of that illness or injury only to the extent that the member 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.

j. If the member or the member's representatives fail to do any of the foregoing acts at ODS' request, then ODS has the right to not advance payment of benefits or to suspend payment of any benefits for or on behalf of the member 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, ODS may notify medical providers seeking authorization or prior authorization of payment of benefits that all payments have been suspended, and may not be paid.

k. Coordination of benefits (where the member has healthcare coverage under more than one plan or health insurance policy) is not considered a third party claim.

l. If any term, provision, agreement or condition of section 12.4.2 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.

12.5 MEDICARE

To the extent permitted by law, the 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 member properly enrolled in Medicare and applied for benefits. This means that for coordination of benefits purposes, the Plan will estimate what Medicare would have paid and reduce its benefits based on the estimate. The 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 the Plan is secondary to Medicare, ODS will not pay for any part of expenses incurred from providers who have opted out of Medicare participation.

SECTION 13. COORDINATION OF BENEFITS

Coordination of Benefits (COB) occurs when a member has healthcare coverage under more than one plan.

13.1 DEFINITIONS

For purposes of Section 13, 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 covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes:

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

Plan does not include:

a. Hospital indemnity coverage or other fixed indemnity coverage;
b. Accident-only coverage;
c. Specified disease or specified accident coverage;
d. School accident coverage;
e. Benefits for non-medical components of group long-term care policies;
f. Medicare supplement policies;
g. Medicaid policies; or
h. 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 2 parts and COB rules apply to only one of the 2, 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.

An **Allowable Expense** means a healthcare expense, including deductibles and copayments/coinsurance, that is covered at least in part by any plan covering the member. 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 member 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 member is not an allowable expense.

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

a. 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;
b. The amount of the reduction by the primary plan because a member has failed to comply with the plan provisions concerning second surgical opinions or prior authorization of admissions or services, or because the member has a lower benefit due to not using an in-network provider;
c. Any amount in excess of the highest reimbursement amount for a specific benefit, if a member is covered by 2 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;
d. Any amount in excess of the highest of the negotiated fees, if a member is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees;
e. If a member 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 member that all plans covering the member are high-deductible health plans and the member 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 policy 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 policy providing healthcare benefits is separate from this Plan. A policy 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.

13.2 HOW COB WORKS

If the member 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 a member 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:

a. If this Plan is primary, it will provide its benefits first.
b. 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.
c. If the non-complying plan reduces its benefits so that the member receives less in benefits than he or she 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 member against the non-complying plan.

13.3 ORDER OF BENEFIT DETERMINATION (WHICH PLAN PAYS FIRST?)

The first of the following rules that applies will govern:

a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent, for example, an employee, member of an organization, subscriber, or retiree, then that plan will determine its benefits before a plan which covers the member as a dependent. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a dependent and primary to the plan covering the member 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 member as an employee, member of an organization, subscriber, or retiree is the secondary plan and the other plan covering the member as a dependent is the primary plan.
b. **Dependent Child/Parents Married, Registered under the Oregon Family Fairness Act, or Living Together.** If the member 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.
c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member 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:

i. 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.

ii. 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.

iii. If there is not a court decree allocating responsibility for the dependent child's healthcare expenses, the order of benefits is as follows:

A. The plan covering the custodial parent;
B. The plan covering the spouse or domestic partner of the custodial parent;
C. The plan covering the non-custodial parent; and then
D. The plan covering the spouse or domestic partner of the non-custodial parent.

This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

d. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (b or c) above shall determine the order of benefits as if those persons were the parents of the child. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

e. **Active/Retired or Laid Off Employee.** The plan that covers a member 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 the member 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.

f. **COBRA or State Continuation Coverage.** If a member 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 the member as an employee, member of an organization, subscriber, or retiree or as a dependent of the same, 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.

g. **Longer/Shorter Length of Coverage.** The plan that covered a member as an employee, member of an organization, subscriber, or retiree (non-dependent) longer is the primary plan and the plan that covered the member 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.

h. **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.

13.4 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 member is enrolled in 2 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.

13.5 ODS' 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 member. 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.

13.6 FACILITY OF PAYMENT

If another plan makes payments this Plan should have made under this coordination provision, this Plan can reimburse the other plan directly. Any such reimbursement payments will count as benefits paid under this Plan and this Plan will be released from liability 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.

13.7 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 member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 14. MISCELLANEOUS PROVISIONS

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

14.1 REQUEST FOR INFORMATION

When necessary to process claims, ODS may require a member to submit information concerning benefits to which the member is entitled. ODS may also require a member to authorize any physician or healthcare provider to provide ODS with information about a condition for which a member claims benefits.

14.2 CONFIDENTIALITY OF MEMBER INFORMATION

The confidentiality of a member's protected health information is of extreme importance to ODS. Protected health information includes, but is not limited to enrollment, claims, and medical and dental information. ODS uses such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. ODS does not sell this information. The Notice of Privacy Practices provides more complete detail about how ODS uses members' information. A copy of the notice is available on the ODS website by following the HIPAA link or by calling ODS at 503-243-4492.

14.3 TRANSFER OF BENEFITS

Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on ODS.

14.4 RECOVERY OF BENEFITS PAID BY MISTAKE

If ODS mistakenly makes a payment for a member to which he or she is not entitled, or pays a person who is not eligible for payments at all, ODS has the right to recover the payment from the person paid or anyone else who benefited from it, including a physician or provider of services. ODS' right to recovery includes the right to deduct the amount paid by mistake from future benefits it would provide for a member even if the mistaken payment was not made on that member's behalf.

14.5 CONTRACT PROVISIONS

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

14.6 RESPONSIBILITY FOR QUALITY OF MEDICAL CARE

In all cases, members have the exclusive right to choose their facility or professional provider. ODS is not responsible for the quality of medical care a member receives, since all those who provide care

do so as independent contractors. ODS cannot be held liable for any claim or damages connected with injuries a member suffers while receiving medical services or supplies.

14.7 WARRANTIES

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

14.8 GUARANTEED RENEWABILITY

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

a. For nonpayment of the required premiums by OEBB.
b. For fraud or intentional material misrepresentation of OEBB, or with respect to coverage of individual members, the members or their representatives.
a. When the number or percentage of members is less than required by participation requirements.
b. For non-compliance with the employer contribution requirements in the group policy.
c. When ODS discontinues offering or renewing, or offering and renewing, all of its group health benefit plans in Oregon or in a specified service area within Oregon. In order to discontinue plans under this provision, ODS:
    i. Must give notice of the decision to the Director of the Department of Consumer and Business Services and to all groups, associations, trusts, and discretionary groups covered by the plans;
    ii. 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;
    iii. 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
    iv. Must discontinue offering or renewing, or offering and renewing, all health benefit plans issued by ODS in the group market in Oregon or in the specified service area.
d. When ODS discontinues offering and renewing a group health benefit plan in a specified service area within Oregon 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:
    i. Must give notice of the decision to the director and to all groups, associations, trusts, and discretionary groups, covered by the plan;
    ii. May not cancel coverage under the plan for 90 days after the date of the notice required immediately above; and
    iii. Must offer in writing to each group, association, trust, and discretionary 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.
e. When ODS discontinues offering or renewing, or offering and renewing, a health benefit plan for all groups, associations, trusts, and discretionary groups in Oregon or in a specified service area within Oregon, other than a plan discontinued under the paragraph immediately above. With respect to plans that are being discontinued, ODS must:

i. Offer in writing to each group, association, trust, and discretionary group covered by the plan, one or more health benefit plans that ODS offers in the specified service area.
ii. Offer the plans at least 180 days prior to discontinuation.
iii. Act uniformly without regard to the claims experience of the affected groups, associations, trusts, and discretionary groups of the health status of any current or prospective members.

f. 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:
i. not be in the best interest of the members; or
ii. impair ODS' ability to meet contractual obligations.

g. 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 member who lives, resides or works in the service area of the provider network.

h. 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 member.

i. 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 a member 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 the member. The member under this paragraph retains the rights as described under ORS 743.804.

14.9 NO WAIVER

Any waiver of any provision of the Plan, or any performance under the 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 the Plan, including, without limitation, a delay or omission in denying a claim under the Plan, shall operate as a waiver thereof.

14.10 GROUP IS THE AGENT

OEBB is the member's agent for all purposes under the Plan. OEBB is not the agent of ODS.

14.11 GOVERNING LAW

To the extent the Plan is governed by state law, it shall be governed by and construed in accordance with the laws of the state of Oregon. Should federal law, including but not limited to the Affordable Care Act of 2010, supersede state law and create a discrepancy between state and federal law, federal law shall govern.

14.12 WHERE ANY LEGAL ACTION MUST BE FILED

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

14.13 TIME LIMITS FOR FILING A LAWSUIT

Any legal action arising out of, or related to, the Plan and filed against ODS by a member or any third party, must be filed in court within 3 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.

14.14 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.

SECTION 15. CONTINUATION OF HEALTH COVERAGE

The Plan's continuation of coverage rules are outlined in the Oregon Administrative Rules under OAR 111-050-0001 through OAR 111-050-0080. Additional guidance on how to obtain continuation of coverage is outlined in the following sections.

15.1 FAMILY AND MEDICAL LEAVE

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

a. Affected member(s) will remain eligible for coverage during FMLA leave.
b. If members elect not to remain enrolled during a FMLA leave, they will be eligible to re-enroll in the Plan on the date the subscriber returns from leave. To re-enroll, a complete and signed application must be submitted within 60 days of the 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. Any exclusion period served prior to the FMLA leave will be credited and any eligibility-waiting period under the Plan will not have to be re-served. However, no exclusion period credits will be received for the period of the leave.
c. A subscriber's rights under FMLA will be governed by that statute and its regulations.

15.2 LEAVE OF ABSENCE

If granted a non-FMLA leave of absence by the participating organization, a subscriber may continue coverage for up to 3 months. Premiums must be paid through OEBB in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by the participating organization at a subscriber's request during which he or she is still considered to be employed and is carried on the employment records of the participating organization. A leave can be granted for any reason acceptable to the participating organization, including disability and maternity.

15.3 STRIKE OR LOCKOUT

If employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, a subscriber may continue coverage for up to 6 months. The subscriber must pay the full premiums, including any part usually paid by the participating organization, directly to the union or trust, and the union or trust must continue to pay ODS the premiums when due.

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

a. Fewer than 75% of those normally enrolled choose to continue their coverage;
b. A subscriber accepts full-time employment with another employer; or
c. A subscriber otherwise loses eligibility under the Plan.

The Plan's continuation rules for retirees are outlined in the Oregon Administrative Rules under OAR 111-050-0010 through 111-050-0050. Members may also refer to the OEBB Member Benefits Guide for additional information on retiree continuation.

15.4 RETIREES

The Plan's continuation rules for retirees are outlined in the Oregon Administrative Rules under OAR 111-050-0010 through 111-050-0050. Members may also refer to the OEBB Member Benefits Guide for additional information on retiree continuation.

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

15.5.1 Introduction

ORS 743.600 to 743.602 are state regulations requiring certain group health insurance policies to offer enrolled spouses and 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").

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

a. Other than the inclusion of domestic partners, ODS will offer no greater rights than ORS 743.600 to 743.602 requires;
b. ODS will not provide 55+ Oregon Continuation coverage for members who do not comply with the notice, election, or other requirements outlined in section 15.5.3; and
c. As the Plan Administrator, OEBB or its designated third party administrator is responsible for providing the required notices within the statutory time periods, including the notice of death and the election notice. If OEBB or the third party administrator fails to notify the eligible spouse or domestic partner, premiums shall be waived from the date the notice was required until the date notice is received by the spouse or domestic partner. OEBB shall be responsible for such premiums.

15.5.2 Eligibility Requirements For 55+ Oregon Continuation Coverage

The spouse or domestic partner of the subscriber may elect 55+ Oregon Continuation coverage for himself or herself and any enrolled children if the following requirements are met:

a. Coverage is lost because of the death of the subscriber, dissolution of marriage or domestic partnership with the subscriber, or legal separation from the subscriber;
b. The spouse or domestic partner is 55 years of age or older at the time of such event; and
c. The spouse or domestic partner is not eligible for Medicare.

15.5.3 Notice And Election Requirements For 55+ Oregon Continuation Coverage

Notice of Divorce, Dissolution, or Legal Separation. Within 60 days of legal separation or the entry of a judgment of dissolution of marriage or domestic partnership, a legally separated or divorced spouse, or a legally separated or former domestic partner, eligible for 55+ Oregon Continuation who seeks such coverage shall give OEBB or its designated third party administrator written notice of the legal separation or dissolution. The notice shall include the mailing address of the legally separated or divorced spouse, or the legally separated or former domestic partner, seeking coverage.

Notice of Death. Within 30 days of the death of the subscriber whose surviving spouse or domestic partner is eligible for 55+ Oregon Continuation, the participating organization shall give the designated third party administrator, if any, written notice of the death and the mailing address of the surviving spouse or domestic partner.

Election Notice. Within 14 days of receipt of the above notice (or within 44 days of the death of the subscriber if there is no third party administrator), OEBB or its designated third party administrator shall provide notice to the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, that coverage can be continued, along with an election form. If OEBB or its designated third party administrator fails to notify the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, within the required 14 days (or 44 days if there is no third party administrator), 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 domestic partner, must return the election form within 60 days after the form is mailed. Failure to exercise this election within 60 days of the notification shall terminate the right to continued benefits under this section.

15.5.4 Premiums For 55+ Oregon Continuation Coverage

The monthly premiums for 55+ Oregon Continuation is limited to 102% of the premiums paid by a current subscriber. The first premium shall be paid by the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, to the Participating Organization or its designated third party administrator within 45 days of the date of election. All remaining monthly premiums must be paid within 30 days of the premium due date.

15.5.5 When 55+ Oregon Continuation Coverage Ends

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

a. The failure to pay premiums when due, including any grace period allowed by the Plan;
b. The date that the Plan terminates, unless a different group policy is made available;
c. The date on which the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, becomes insured under any other group health plan;
d. The date on which the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, remarries or registers another domestic partnership under the Oregon Family Fairness Act and becomes covered under another group health plan; or
e. The date on which the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, becomes eligible for Medicare.

15.6 COBRA CONTINUATION COVERAGE

15.6.1 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 section 15.6, a qualified beneficiary is someone who is covered under the Plan the day before a qualifying event, and can include the subscriber and the subscriber's spouse and dependent children. The Plan Administrator means either OEBB or a third party administrator delegated by OEBB to handle COBRA administration. 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:

a. Other than the inclusion of domestic partners, ODS will offer no greater COBRA rights than the COBRA statute requires;
b. ODS will not provide COBRA coverage for those qualified beneficiaries who do not comply with the notice, election or other requirements outlined below;

c. ODS will not provide COBRA coverage if the participating organization 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 organization or Plan Administrator otherwise fails to comply with any of the requirements outlined below; and
d. ODS will not provide a disability extension if the participating organization or Plan Administrator fails to notify ODS within 60 days of its receipt of a disability extension notice from a qualified beneficiary.

15.6.2 Qualifying Events

Subscriber. A subscriber may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct, which may include, but is not limited to, misrepresenting immigration status to obtain employment), or a reduction in hours.

Spouse. The spouse of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:

a. The death of the subscriber;
b. The termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the participating organization;
c. Divorce or legal separation from the subscriber;
d. The subscriber becomes entitled to Medicare; or

(Also, if a subscriber 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.)

Children. A dependent child of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:

a. The death of the subscriber;
b. The termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in a subscriber's hours of employment with the participating organization;
c. Parents' divorce or legal separation;
d. The subscriber becomes entitled to Medicare;
e. The dependent ceases to be a "dependent child" under the Plan; or

Domestic Partners. A domestic partner, who at the time of the qualifying event was covered under the Plan, can elect COBRA continuation coverage. Under the Plan, the domestic partner would have the same rights to COBRA continuation coverage as a spouse does, unless otherwise stated. Where this COBRA section refers to divorce or legal separation, termination of domestic partnership would apply for domestic partners.

15.6.3 Other Coverage

The right to elect continuation coverage shall be available to persons 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.

15.6.4 Notice And Election Requirements

Qualifying Event Notice. The Plan provides that a dependent 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 subscriber 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; 2) the name and social security number of the member(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, members will be notified of their right to continuation coverage within 14 days after the Plan Administrator receives the notice.

Otherwise, members 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 subscriber's termination of employment (other than for gross misconduct), reduction in hours, death of the subscriber, the subscriber's becoming entitled to Medicare.

Election. A member must elect continuation coverage within 60 days after plan coverage ends, or, if later, 60 days after the Plan Administrator sends notice of the right to elect continuation coverage to the members. If continuation coverage or Portability coverage (see Section 16) is not elected, group health insurance coverage for all members will end.

A subscriber 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 subscriber does not.

15.6.5 COBRA Premiums

Those eligible for continuation coverage do not have to show that they are insurable. However, under the law, they are responsible for all premiums for continuation coverage except for members who qualify for premium reduction under any applicable federal law. The first payment for continuation coverage is due within 45 days after a qualified beneficiary provides notice of electing coverage (this is the date the election notice is postmarked, if mailed, or the date the election notice is received by the Plan Administrator, if hand-delivered). This payment must include the amount necessary to cover all months that have elapsed between the date regular coverage ended and the payment date. Subsequent payments are due on the first day of the month; however, there will be a grace period of 30 days to pay the premiums. ODS will not send a bill for any payments due. The qualified beneficiary is responsible for paying the applicable premiums, in good funds, when due; otherwise continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

15.6.6 Length Of Continuation Coverage

If COBRA is elected, the participating organization will provide the same coverage as is available to similarly situated members 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 for up to a total of 18 months.

36-Month Continuation Period. In the case of losses of coverage due to a subscriber'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 subscriber's hours of employment, and the subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan for qualified beneficiaries (other than the subscriber) 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 subscriber becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

15.6.7 Extending The Length Of COBRA Coverage

If COBRA is elected, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. The Plan Administrator must be notified of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure of the qualified beneficiary 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 a subscriber'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 subscriber'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 the Plan Administrator is notified in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

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

A qualified beneficiary 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 subscriber'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, he or she 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 subscriber'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 a subscriber, divorce or legal separation from the subscriber, 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 a subscriber 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 the Plan Administrator is notified 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 a subscriber's spouse or domestic partner who has entered into a "Declaration of Domestic Partnership" that is recognized under Oregon law age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership. (see section 15.5).

15.6.8 Newborn Or Adopted Child

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

15.6.9 Special Enrollment And Open Enrollment

Under continuation coverage, qualified beneficiaries have the same rights afforded similarly-situated members who are not enrolled in COBRA. A qualified beneficiary may add newborns, new spouses, or 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 members can change plans at open enrollment, COBRA members may also change plans at open enrollment.

15.6.10 When Continuation Coverage Ends

COBRA coverage will automatically terminate before the end of the maximum period if:

a. any required premiums are not paid in full on time;
b. 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);
c. a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. ;
d. the participating organization ceases to provide any group health plan for its employees; or
e. during a disability extension period (see section 15.6.7), 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 member not receiving COBRA coverage (such as fraud).

When COBRA continuation coverage ends, members *may* be eligible to enroll in an individual Portability Plan provided by ODS.

Questions about COBRA should be directed to the Plan Administrator. The Plan Administrator should be informed of any address changes.

15.6.11 The American Recovery and Reinvestment Act of 2009 as amended

This Act provides for premium reductions and additional election opportunities for continuation coverage under COBRA. Eligible members pay 35% of their COBRA premiums. The premium reduction applies to periods of health coverage beginning on or after February 17, 2009 and continues up to 15 months for those eligible for COBRA due to an involuntary termination of employment that occurred during the period beginning September 1, 2008 and ending May 31, 2010 (or a later date if this Act is amended subsequently). Questions about this Act and related notice requirements should be directed to the Plan Administrator.

15.6.12 Trade Act Of 2002

This COBRA provision applies only to subscribers 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 subscribers who did not elect COBRA coverage are entitled to elect COBRA coverage during a special second election period. Subscribers 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:

a. 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;
b. 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
c. 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 6 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. As a result of The American Recovery and Reinvestment Act of 2009, COBRA coverage for TAA Eligible Employees will be extended if it would have termed on or after February 17, 2009. Such extension will end on the date the member no longer qualifies as a TAA Eligible Employee or December 31, 2010, whichever is earlier.

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

15.7 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Coverage will terminate if a subscriber is called to active duty by any of the armed forces of the United States of America. However, if a subscriber 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, provided the subscriber 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 eligible employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

If a subscriber 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 participating organization if released under honorable conditions, but only if he or she returns to active employment:

a. On the first full business day following completion of his or her military service for a leave of 30 days or less;
b. Within 14 days of completing military service for a leave of 31 to 180 days; or
c. 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 Veteran's Administration (VA) to be service connected will be allowed.

When coverage under the Plan is reinstated, all plan provisions and limitations will apply to the extent that they would have applied if the subscriber had not taken military leave and coverage had been continuous under the Plan. There will be no additional eligibility-waiting period. (This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by military service, as determined by the VA. Complete information regarding rights under the Uniformed Services Employment and Reemployment Rights Act is available from the participating organization).

SECTION 16. 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 persons who qualify under Oregon or federal law, whichever is more favorable.

A member who loses eligibility for coverage under the Plan may be entitled to convert to one of ODS' Portability plans. The benefits contained in the Portability plan will likely be different from the benefits under the Plan.

16.1 ELIGIBILITY FOR PORTABILITY COVERAGE

A member has the right to convert to an ODS Portability plan if he or 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 member must apply for Portability coverage not later than the 63rd day after termination of group coverage issued by ODS and be an Oregon resident at the time of such application.

With an exception noted below, the term "eligible individual" does not include a person who remains eligible for his or her prior group coverage or would remain eligible for prior group coverage in a plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA), were it not for action by OEBB relating to the actual or expected health condition of the person, or who is covered under another health benefit plan or is eligible for the federal Medicare program. However, a person who is eligible to obtain a Portability plan may obtain such a plan regardless of whether he or she 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 person, having exercised such rights, has received any benefits thereunder, unless he or 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 eligible dependent is not enrolled when Portability 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 who was covered by the prior group health benefit plan, provided that such dependent meets the eligibility requirements of the Portability plan. After a Portability coverage commences, ODS shall accept for enrollment any new dependent, provided that such dependent meets the eligibility requirement of the Portability plan.

Domestic partners who have not entered into a "Declaration of Domestic Partnership" that is recognized under Oregon law 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 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 OEBB terminates the policy and replaces it with a similar group policy within 31 days, and the coverage takes effect immediately following the date of termination.

16.2 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 persons leaving group coverage.

16.3 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 plans shall be renewable with respect to all Portability plan members except:

a. For nonpayment of the required premiums by the Portability plan subscriber;
b. For fraud or misrepresentation by the Portability plan subscriber;
c. When ODS elects to discontinue offering all of its group health benefit plans in accordance with ORS 743.737 and 743.754; or
d. 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:

    i. Not be in the best interests of the members; or
    ii. Impair ODS' ability to meet its contractual obligations.

16.4 ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

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

Eligible individuals must submit a written application and pay the first premium no later than the 63rd day after the date coverage terminated under the Plan. Coverage becomes effective on the day following termination of coverage under the 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.

A member may select COBRA or state continuation (whichever applies to the group situation) or select Portability.

Note:
When Portability coverage is chosen rather than COBRA or state continuation, members will not be eligible to select COBRA or state continuation at a later date.

16.5 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.

ODS offers the following Portability plan options:

a. The Prevailing Plan reflects benefit coverages that are prevalent in the group health insurance market; and
b. The Low Cost Plan emphasizes affordability for eligible individuals.

For more information regarding the Prevailing and Low Cost Plans, members may contact ODS' Medical Customer Service Department.

SECTION 17. RESERVED FOR FUTURE USE

SECTION 18. PATIENT PROTECTION ACT

The Patient Protection Act 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 its plans.

18.1 What are a member's rights and responsibilities?

Members have the right to:

a. Be treated with respect and recognition of their dignity and need for privacy.
b. Have access to urgent and emergency services, 24 hours a day, 7 days a week.
c. Know what their rights and responsibilities are. Members will be given information about the Plan and how to use it, and about the physicians and providers who will care for them. This information will be provided in a way that members can understand.
d. Participate in decision making regarding their healthcare. Members 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.
e. Refuse care. Members have the right to be advised of the medical result of their refusal.
f. Receive services as described in this handbook.
g. 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 member.
h. File a complaint or appeal about any aspect of the plan. Members have a right to a timely response to their complaint or appeal. Members are welcome to make suggestions to the Plan.
i. Obtain free language assistance services, including verbal interpretation services, when communicating with the Plan.
j. Have a statement of wishes for treatment on file with their physicians. This statement is known as an Advanced Directive. Members also have the right to have a power of attorney filed. A power of attorney allows the member to give someone else the right to make healthcare choices when the member is unable to make these decisions.
k. Make recommendations regarding ODS' policy on members' rights and responsibilities.

Members have the responsibility to:

a. Read this handbook to make sure they understand the Plan. Members are advised to call ODS' Medical or Pharmacy Customer Service Department with any questions.
b. Treat all physicians and providers and their staff with courtesy and respect.
c. Provide all the information needed for their physician or provider to provide good healthcare.
d. Participate in making decisions about their medical care and forming a treatment plan.
e. Follow instructions for care they have agreed to with their physician or provider.
f. Present their medical identification card when seeking medical care.
g. Notify physicians and providers of any other insurance policies that may provide coverage.

h. Reimburse ODS from any third party payments they may receive.
i. Keep appointments and be on time. If this is not possible, members must call ahead to let the physician or provider know they will be late or cannot keep their appointment.
j. Seek regular health checkups and preventive services.
k. Provide adequate information to the Plan to properly administer benefits and resolve any issues or concerns that may arise.

Members may call ODS' Medical Customer Service Department for questions about these rights and responsibilities.

18.2 What if a member has a medical emergency?

A member who believes he or she has a medical emergency 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.

18.3 How will a member know if benefits are changed or terminated?

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

18.4 If a member is not satisfied with the plan, how can an appeal be filed?

A member can file an appeal by contacting ODS' Medical Customer Service Department or Pharmacy Customer Service Department on pharmacy claims or by writing a letter to ODS (P.O. Box 40384, Portland, Oregon 97240). Complete information in section 12.2.

A member may also contact the Oregon Insurance Division:

By phone: 503-947-7984 or toll-free 888-877-4894
By mail: Consumer Advocacy
Department of Consumer and Business Services
350 Winter Street NE, Room 440-2
Salem, Oregon 97301
By internet: www.cbs.state.or.us/external/ins/

18.5 What are the prior authorization and utilization review criteria?

Prior authorization is the process ODS uses to determine whether a service is covered under the Plan (including whether it is medically necessary) prior to the service being rendered. Members may contact ODS' Medical Customer Service Department or visit myODS for a list of services that require prior authorization. Many types of treatment may be available for certain conditions; the prior authorization process helps determine which treatment is covered under the Plan.

Obtaining a prior authorization is the member's assurance that the services and supplies recommended by the physician or provider are medically necessary and covered under the 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 member eligibility shall be binding if

obtained no more than 5 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.

A written summary of information that may be included in ODS' utilization review of a particular condition or disease can be obtained by calling ODS' Medical Customer Service Department.

18.6 How are important documents, such as medical records, kept confidential?

ODS protects members' information in several ways:

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

18.7 How can a member participate in the development of ODS' corporate policies and practices?

Member feedback is very important to ODS. ODS welcomes any suggestions for improvements about its health benefit plans or its services.

ODS has 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 2 times per year. However, committee membership is limited. Members may obtain more information by contacting ODS at:

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

18.8 How can non-English speaking members get information about the Plan?

A representative will coordinate the services of an interpreter over the phone when a member calls ODS' Medical or Pharmacy Customer Service Department for assistance.

18.9 What additional information is available upon request?

The following documents are available by calling ODS' Medical Customer Service representative:

a. A copy of ODS' annual report on complaints and appeals.
b. A description of ODS' efforts to monitor and improve the quality of health services.
c. Information about procedures for credentialing network providers and how to obtain the names, qualifications, and titles of the physicians and providers responsible for a

member's care.

d. Information about ODS' prior authorization and utilization review procedures.

18.10 What information about ODS is available from the Oregon Insurance Division?

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

a. The results of all publicly available accreditation surveys.
b. A summary of ODS' health promotion and disease prevention activities.
c. An annual summary of appeals.
d. An annual summary of utilization review policies.
e. An annual summary of quality assessment activities.
f. An annual summary of scope of network and accessibility of services.

Contact:

Consumer Advocacy
Department of Consumer and Business Services
350 Winter Street NE, Room 440-2
Salem, Oregon 97301
503-947-7984 or toll-free 888-877-4894
www.cbs.state.or.us/external/ins/
cp.ins@state.or.us

P.O. Box 40384
Portland, OR 97204

Member Inquiries
503-265-2909 or 866-923-0409
En Español: 503-433-6313
Llamado Gratis: 888-786-7461

www.odscompanies.com

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