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CHAPTER 836
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE REGULATION

FILING CAPTION: Behavioral Health Parity rules, 2021 Or. Laws ch. 629

EFFECTIVE DATE: 01/01/2023

AGENCY APPROVED DATE: 12/21/2022

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RULES:
836-053-0012, 836-053-0320, 836-053-1403, 836-053-1404, 836-053-1405, 836-053-1407, 836-053-1408

AMEND: 836-053-0012

NOTICE FILED DATE: 10/27/2022

RULE SUMMARY: Removes the definition of “mental or nervous condition." Adds a definition for “behavioral health condition”, changes wording from "mental health condition" to "behavioral health condition" and updates the version of the diagnostic materials used for the purpose for defining terms.

CHANGES TO RULE:

836-053-0012
Essential Health Benefits for Plan Years Beginning on and after January 1, 2017 ¶

(1) This rule applies to plan years beginning on and after January 1, 2017.¶
(2) As used in the Insurance Code and OAR chapter 836:¶
(a) "Applied behavior analysis" has that meaning given in ~~Section 2, chapter 771, Oregon Laws 2013 as amended by Section 9, chapter 674, Oregon Laws 2015.~~ORS 676.802. ¶
(b) "Base benchmark health benefit plan" means the PacificSource Health Plans Preferred CoDeduct Value 3000 35 70 small group health benefit plan, including prescription drug benefits, as provided in Exhibit 1 to this rule;¶
(c) "Behavioral health condition" has the meaning given in OAR 836-053-1404.¶
(d) "Essential health benefits" or "EHB" means the following coverage provided in compliance with 45 CFR 156:¶
(A) The base-benchmark health benefit plan with the exclusions and modifications of provisions of that plan as set forth in section (3) to (7) of this rule.;¶
(B) Pediatric dental benefits;¶
(C) Pediatric vision benefits; and¶
(D) Habilitative services and devices.¶
(~~d~~e) "Habilitative services and devices" means services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services and devices must include physical and occupational therapy, speech-language pathology and other services and devices for people with disabilities in a variety of inpatient or outpatient settings.¶

~~(e) "Mental or nervous condition" has that meaning given in OAR 836-053-1404.~~ ¶
(f) "Pediatric dental benefits" means the benefits described in the Dental Plan of the Oregon Health Plan Children's' Health Insurance Plan as provided in Exhibit 2 of this rule. Pediatric dental benefits are payable to persons under 19 years of age.¶
(g) "Pediatric vision benefits" means the benefits described in the vision provisions of the Federal Employee Dental and Vision Insurance Plan Blue Vision High Option as provided in Exhibit 3 of this rule. Pediatric vision benefits are payable to persons under 19 years of age.¶
(h) "Treatment of a ~~ment~~behavioral health condition" includes medical treatments and prescription drugs used to treat a ~~mental or nervous~~behavioral health condition.¶
(3) The following exclusions and modifications are required supplementation to the base-benchmark health benefit plan:¶
(a) The following treatment limitations and exclusions of coverage currently included in the base-benchmark health benefit plan are excluded:¶
(A) The 24-month waiting period for transplant benefits;¶
(B) Visit limits for inpatient and outpatient ~~ment~~behavioral health services, including but not limited to habilitative and rehabilitative benefits;¶
(C) Age limits on treatments that would otherwise be appropriate for individuals outside of the limited age, including but not limited to hearing aids, speech, physical and occupational therapy used in the treatment of ~~mental or nervous~~behavioral health conditions as defined in OAR 836-053-1404;¶
(D) Exclusions for the treatment of erectile dysfunction or sexual dysfunction as defined in the ~~"~~Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition~~" (DSM-5) or the "Diagnostic and Statistical Manual of Mental Disorders, Fourth Edit~~, Text Revision~~"~~ (DSM-~~IV);~~5-TR). ¶
(E) Exclusions for medically necessary surgeries and procedures related to sex transformations and gender identity disorder or gender dysphoria;¶
(F) Any blanket exclusion for a diagnosis made using the diagnostic criteria of ~~the DSM-5 or the DSM-IV;~~Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR).¶
(G) Exclusions for court-order screening interviews or drug or alcohol treatment programs;¶
(H) Any limitations or waiting periods for pre-existing conditions;¶
(I) Time limits for treatment of jaw or teeth or orthognathic surgery; and¶
(b) Dollar limits for coverage of durable medical equipment must comply with the following:¶
(A) Annual dollar limits must be converted to a non-dollar actuarial equivalent.¶
(B) Lifetime dollar limits must be converted to a non-dollar actuarial equivalent.¶
(c) The following provisions of the base-benchmark plan must be modified:¶
(A) Any waiting periods must be consistent with limitations imposed by state or federal law;¶
(B) Wigs following chemotherapy or radiation therapy must be covered up to the actuarial equivalent of $150 per calendar year;¶
(C) The limitation on cosmetic or reconstructive surgery to one attempt within 18 months of injury or defect must be modified to remove these limitations in cases of medical necessity in accordance with 45 CFR 156.125(a) and to avoid discrimination based on health factors under 45 CFR 146.121;¶
(D) Contraceptive coverage must comply with Centers for Medicare and Medicaid Services guidance and requirements related to contraception issued jointly by the United States Departments of Labor, Health and Human Services, and Treasury on May 11, 2015;¶
(E) Provisions related to telemedical health services must reflect changes made to ORS 743A.058 by ~~chapter 340,~~ Oregon Laws 20~~15~~21, chapter 117 (Enrolled ~~Senat~~House Bill ~~144~~2508); and¶
(F) Housing and travel expenses for transplant services are not considered essential health benefits;¶
(4) An insurer that issues a health benefit plan offering essential health benefits may not include as an essential health benefit:¶
(a) Routine non-pediatric dental services;¶
(b) Routine non-pediatric eye exam services;¶
(c) Long-term care or custodial nursing home care benefits; or¶
(d) Non-medically necessary orthodontia services.¶
(5) If both a state law and federal law require coverage of the same or similar service, the insurer must assure that all elements of both laws are met and provide the coverage in the manner most beneficial to the consumer.¶
(6) In the administration of essential health benefits and the EHB base benchmark health benefit plan, an insurer may not discriminate against a provider acting within the scope of the provider's license.¶
(7) In the administration of essential health benefits and the EHB base benchmark health benefit plan an insurer may not exclude services provided by a naturopathic physician if the services are otherwise covered under the plan and the naturopathic physician is acting within the scope of the provider's license.¶
(8) In the administration of essential health benefits and the EHB base benchmark health benefit plan an insurer

may not exclude services provided by a doctor of chiropractic medicine if the services are otherwise covered under the plan and the doctor of chiropractic medicine is acting within the scope of the provider's license.¶
~~[ED. NOTE: Exhibit referenced is available from the agency.]~~
Statutory/Other Authority: ORS 731.097
Statutes/Other Implemented: ORS 731.097, Or Laws 2021, ch 117

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Member

Benefit Handbook

Exhibit 1 to OAR 836-053-0012

Benchmark Sample

Group No.: G0000000

PREFERRED CODEDUCT VALUE 3000+35/70% 0812

Effective: 4/1/2013

PSGCC.OR.0113

PacificSource HEALTH PLANS

We're in it for the people.

Welcome to your PacificSource group health plan. Your employer offers this coverage to help you and your family members stay well, and to protect you in case of illness or injury. Your plan includes a wide range of benefits and services, and we hope you will take the time to become familiar with them.

Using this Handbook

This handbook will help you understand how your plan works and how to use it. Please read it carefully and thoroughly. Although it is only a summary, it is intended to answer most of your questions. If there is a conflict between this benefit handbook and the group health contract, this plan will pay benefits according to the contract language.

Within this handbook you'll find Member Benefit Summaries for your medical plan and any other health benefits provided under your employer's group health contract. The summaries work with this handbook to explain your plan benefits. The handbook explains the services covered by your plan; the benefit summaries tell you how much your plan pays toward expenses and how much you're responsible for.

If anything is unclear to you, the PacificSource Customer Service staff is available to answer your questions. Please give us a call, visit us on the Internet, or stop by our office. We look forward to serving you and your family.

Governing Law

This plan must comply with both state and federal law, including required changes occurring after the plan's effective date. Therefore, coverage is subject to change as required by law.

PacificSource Customer Service Department
Phone (541) 684-5582 or (888) 977-9299
Email cs@pacificsource.com

PacificSource Headquarters
PO Box 7068, Springfield, OR 97475-0068
Phone (541) 686-1242 or (800) 624-6052

Website
PacificSource.com

Para asistirle en español, por favor llame el numero (800) 624-6052, extensión 1009, de Lunes a Viernes, 7:00 a.m. hasta 5:00 p.m.

This benefit book is printed on environmentally friendly paper that uses minimal chemicals and 50% fewer trees than regular paper. PacificSource is proud to align business innovation with environmental responsibility.

CONTENTS

PacificSource HEALTH PLANS

PREFERRED CODEDUCT VALUE 3000+35/70% 0812

MEDICAL BENEFIT SUMMARY

POLICY INFORMATION

Group Name:	Benchmark Sample
Group Number:	G0000000
Plan Name:	PREFERRED CODEDUCT VALUE 3000+35/70% 0812
Provider Network:	Preferred PSN

EMPLOYEE ELIGIBILITY REQUIREMENTS

Minimum Hour Requirement:	Twenty (20) Hours
Waiting Period for New Employees:	1st of month following ninety (90) days

SCHEDULE OF BENEFITS

Annual Deductible $3,000 per person / $9,000 per family

The deductible is an amount of covered medical expenses the member pays each calendar year before the plan's benefits begin. The deductible applies to all services and supplies except those marked with an asterisk (*). Once a member has paid a total amount toward covered expenses during the calendar year equal to the per person amount listed above, the deductible will be satisfied for that person for the rest of that calendar year. Once any covered family members have paid a combined total toward covered expenses during the calendar year equal to the per family amount listed above, the deductible will be satisfied for all covered family members for the rest of that calendar year. Deductible expense is not applied to the out-of-pocket limit.

Annual Out-Of-Pocket Limit

Participating Providers	$5,000 per person / $10,000 per family
Non-participating Providers	$8,000 per person

Only participating provider expense applies to the participating provider out-of-pocket limit and only non-participating provider expense applies to the non-participating out-of-pocket limit. Once the participating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges (after the co-payment is deducted) for participating and network not available providers for the rest of that calendar year. Once the non-participating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges (after the co-payment is deducted) for non-participating providers for the rest of that calendar year. Deductibles, co-payments, benefits paid in full and non-participating provider charges in excess of the allowable fee do not accumulate toward the out-of-pocket limit. Co-payments and non-participating provider charges in excess of the allowable fee will continue to be the member's responsibility even after the out-of-pocket limit is met.

The member is responsible for the above deductible and the following co-pays and co-insurance.

SERVICE:	PARTICIPATING PROVIDERS / NETWORK NOT AVAILABLE:	NON-PARTICIPATING PROVIDERS:
PREVENTIVE CARE		
Well Baby/Well Child Care	No charge*	30% co-insurance*
Routine Physicals	No charge*	30% co-insurance*
Well Woman Visits	No charge*	30% co-insurance*
Immunizations	No charge*	30% co-insurance*
Routine Colonoscopy, age 50-75	No charge*	50% co-insurance
PROFESSIONAL SERVICES		
Office and Home Visits	$35 co-pay/visit*	$35 co-pay/visit plus 30% co-insurance*
Office Procedures and Supplies	30% co-insurance	50% co-insurance
Surgery	30% co-insurance	50% co-insurance
Outpatient Rehabilitation Services	30% co-insurance	40% co-insurance
HOSPITAL SERVICES		
Inpatient Room and Board	30% co-insurance	50% co-insurance
Inpatient Rehabilitation Services	30% co-insurance	50% co-insurance
Skilled Nursing Facility Care	30% co-insurance	50% co-insurance
OUTPATIENT SERVICES		
Outpatient Surgery/Services	30% co-insurance	50% co-insurance
Advanced Diagnostic Imaging	$100 co-pay/test plus 30% co-insurance	$100 co-pay/test plus 50% co-insurance
Diagnostic and Therapeutic Radiology and Lab	No charge for the first $400 of covered expense*, then 30% co-insurance	50% co-insurance
URGENT AND EMERGENCY SERVICES		
Urgent Care Center Visits	$35 co-pay/visit*	$35 co-pay/visit plus 30% co-insurance*
Emergency Room Visits	$250 co-pay/visit plus 30% co-insurance*^	$250 co-pay/visit plus 50% co-insurance*^
Ambulance, Ground	30% co-insurance	30% co-insurance

SERVICE:	PARTICIPATING PROVIDERS / NETWORK NOT AVAILABLE:	NON-PARTICIPATING PROVIDERS:
Ambulance, Air	50% co-insurance	50% co-insurance
MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES		
Office Visits	$35 co-pay/visit*	$35 co-pay/visit plus 30% co-insurance*
Inpatient Care	30% co-insurance	50% co-insurance
Residential Programs	30% co-insurance	50% co-insurance
OTHER COVERED SERVICES		
Allergy Injections	$5 co-pay/visit*	$5 co-pay/visit plus 30% co-insurance*
Durable Medical Equipment	30% co-insurance	50% co-insurance
Home Health Care	30% co-insurance	50% co-insurance

✶ Not subject to annual deductible.

^ Co-pay waived if admitted into hospital. For emergency medical conditions, non-participating providers are paid at the participating provider level.

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. Although participating providers accept the fee allowance as payment in full, non-participating providers may not. Services of non-participating providers could result in out-of-pocket expense in addition to the percentage indicated. Network Not Available payment is allowed when PacificSource has not contracted with providers in the geographical area of the member's residence or work for a specific service or supply. Payment to providers for Network Not Available is based on the usual, customary, and reasonable charge (see 'allowable fee' in the Definitions section) for the geographical area in which the charge is incurred.

Your PacificSource health plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. Your prescription drug plan qualifies as creditable coverage for Medicare Part D.

MEMBER COST SHARE (other than for Specialty Drugs)
Each time a covered pharmaceutical is dispensed, you are responsible for the co-payment and/or co-insurance below:

From a participating retail pharmacy using the PacificSource Pharmacy Program (see below):	**Tier 1: Generic**	**Tier 2: Preferred VDL**	**Tier 3: Non-preferred**
Up to a 30-day supply:	$10	$50	$75
From a participating mail order service (see below):			
Up to a 30-day supply:	$10	$50	$75
31 to 60-day supply:	$20	$100	$150
61 to 90-day supply:	$30	$150	$225

From a participating retail pharmacy without using the PacificSource Pharmacy Program, or from a non-participating pharmacy (see below):	Not covered, except 5 day emergency supply

MEMBER COST SHARE FOR SPECIALTY DRUG
Each time a covered specialty drug is dispensed, you are responsible for the co-payment and/or co-insurance below:

From the participating specialty pharmacy:	
Up to a 30-day supply:	$100 or 20%, whichever is less
From a participating retail pharmacy, from a participating mail order service, or from a nonparticipating pharmacy or pharmaceutical service provider:	Not covered, except 5 day emergency supply

WHAT HAPPENS WHEN A BRAND NAME DRUG IS SELECTED
Regardless of the reason or medical necessity, if you request a brand name drug or if your physician prescribes a brand name drug when a generic is available, you will be responsible for the non-preferred co-payment and/or co-insurance.

USING THE PACIFICSOURCE PHARMACY PROGRAM
Retail Pharmacy Network
To use the PacificSource pharmacy program, you must show the pharmacy plan number on the PacificSource ID card at the participating pharmacy to receive your plan's highest benefit level.
When obtaining prescription drugs at a participating retail pharmacy, the PacificSource pharmacy program can only be accessed through the pharmacy plan number printed on the PacificSource ID card. That plan number allows the pharmacy to collect the appropriate co-payment and/or co-insurance from you and bill PacificSource electronically for the balance.

Mail Order Service

This plan includes a participating mail order service for prescription drugs. Most, but not all, covered prescription drugs are available through this service. Questions about availability of specific drugs may be directed to the PacificSource Customer Service Department or to the plan's participating mail order service vendor. Forms and instructions for using the mail order service are available from PacificSource and on our website, PacificSource.com.

Specialty Drug Program

PacificSource contracts with a specialty pharmacy services provider for high-cost injectable medications and biotech drugs. A pharmacist-led CareTeam provides individual follow-up care and support to covered members with prescriptions for specialty medications by providing them strong clinical support, as well as the best drug pricing for these specific medications and biotech drugs. The CareTeam also provides comprehensive disease education and counseling, assesses patient health status, and offers a supportive environment for patient inquiries.

Participating provider benefits for specialty drugs are available when you use our specialty pharmacy services provider. Specialty drugs are not available through the participating retail pharmacy network or mail order service. More information

regarding our exclusive specialty pharmacy services provider and health conditions and a list of drugs requiring preauthorization and/or are subject to pharmaceutical service restrictions is on our website, PacificSource.com.

OTHER COVERED PHARMACEUTICALS

Supplies covered under the pharmacy plan are in place of, not in addition to, those same covered supplies under the medical plan. Member cost share for items in this section are applied on the same basis as for other prescription drugs, unless otherwise noted.

Diabetic Supplies

- Insulin, diabetic syringes, lancets, and test strips are available.
- Glucagon recovery kits are available for the plan's preferred brand name co-payment.
- Glucostix and glucose monitoring devices are not covered under this pharmacy benefit, but are covered under your medical plan's durable medical equipment benefit.

Contraceptives

Any deductible co-payment, and/or co-insurance amounts listed above are waived for Food and Drug Administration (FDA) approved contraceptive methods for all women with reproductive capacity, as supported by the Health Resources and Services Administration (HRSA), when provided by a participating pharmacy. If a generic exists, preferred brand contraceptives will remain subject to regular pharmacy plan benefits. When no generic exists, preferred brand is covered at no cost. If a generic becomes available, the preferred brand will no longer be covered under preventive care.

Tobacco Cessation

Program specific tobacco cessation medications are covered with active participation in a plan approved tobacco cessation program (see Preventive Care in the policy's Covered Expenses section).

Orally Administered Anticancer Medications

Orally administered anticancer medications used to kill or slow the growth of cancerous cells are available. Co-payments for orally administered anticancer medication are applied on the same basis as for other drugs. Orally administered anticancer medications covered under the pharmacy plan are in place of, not in addition to, those same covered drugs under the medical plan.

LIMITATIONS AND EXCLUSIONS

- This plan only covers drugs prescribed by a licensed physician (or other licensed practitioner eligible for reimbursement under your plan) prescribing within the scope of his or her professional license, except for:
  - Over-the-counter drugs or other drugs that federal law does not prohibit dispensing without a prescription (even if a prescription is required under state law).
  - Drugs for any condition excluded under the health plan. That includes drugs intended to promote fertility, treatments for obesity or weight loss, tobacco cessation drugs (except as specifically provided for under Other Covered Pharmaceuticals), experimental drugs, and drugs available without a prescription (even if a prescription is provided).
  - Some specialty drugs that are not self-administered are not covered by this pharmacy benefit, but are covered under the medical plan's office supply benefit.
  - Immunizations (although not covered by this pharmacy benefit, immunizations may be covered under the medical plan's preventive care benefit.)
  - Drugs and devices to treat erectile dysfunction.
  - Drugs used as a preventive measure against hazards of travel.
  - Vitamins, minerals, and dietary supplements, except for prescription prenatal vitamins and fluoride products, and for services that have a rating of 'A' or 'B' from te U.S Preventive Services Task Force (USPSTF).
- Certain drugs require preauthorization by PacificSource in order to be covered. An up-to-date list of drugs requiring preauthorization is available on our website, PacificSource.com.
- Certain drugs are subject to step therapy protocols. An up-to-date list of drugs subject to step therapy protocols is available on our website, PacificSource.com.
- PacificSource may limit the dispensing quantity through the consideration of medical necessity, generally accepted standards of medical practice, and review of medical literature and governmental approval status.
- Quantities for any drug filled or refilled are limited to no more than a 30-day supply when purchased at retail pharmacy or a 90-day supply when purchased through mail order pharmacy service or a 30-day supply when purchased through

a specialty pharmacy.

- For drugs purchased at non-participating pharmacies or at participating pharmacies without using the PacificSource pharmacy program, reimbursement is limited to an allowable fee.
- Non-participating pharmacy charges are not eligible for reimbursement unless you have a true medical emergency that prevents you from using a participating pharmacy. Drugs obtained at a non-participating pharmacy due to a true medical emergency are limited to a 5-day supply.
- The member cost share for prescription drugs (co-payments, co-insurance, and service charges) does not apply to the medical deductible or out-of-pocket limit of the policy. You continue to be responsible for the prescription drug co-payments and service charges regardless of whether the policy's out-of-pocket limit is satisfied.
- Prescription drug benefits are subject to the plan's coordination of benefits provision. (See Coordination of Benefits in the policy's General Limitations section.)

GENERAL INFORMATION ABOUT PRESCRIPTION DRUGS

A ***drug formulary*** is a list of preferred medications used to treat various medical conditions. The drug formulary for this plan is known as the Value Drug List (VDL). The drug formulary is used to help control rising healthcare costs while ensuring that you receive medications of the highest quality. It is a guide for your physician and pharmacist in selecting drug products that are safe, effective, and cost efficient. The drug formulary is made up of name brand products. A complete list of medications covered under the drug formulary is available on the For Members area on our website, PacificSource.com. The drug formulary is developed by Caremark® in cooperation with PacificSource. Non-preferred drugs are covered brand name medications not on the drug formulary.

Generic Drugs are equivalent to name brand medications. By law, they must have the same standards of their brand name counterpart. Name brand medications lose their patent protection after a number of years. At that time any drug company can produce the drug, and the manufacturer must pass the same strict FDA standards of quality and product safety as the original manufacturer. Generic drugs are less expensive than brand name drugs because there is more competition and there is no need to repeat costly research and development. Your pharmacist and physician are encouraged to use generic drugs whenever they are available.

Step therapy means a program that requires the member to try lower-cost alternative medications (Step 1 drugs) before using more expensive medications (Step 2 drugs). The program will not cover a brand name, or second-line medication, until less expensive, first-line/generic medications in the same therapeutic class have been tried first.

F

USING THE PROVIDER NETWORK

This section explains how your plan's benefits differ when you use participating and non-participating providers. This information is not meant to prevent you from seeking treatment from any provider if you are willing to take increased financial responsibility for the charges incurred.

All healthcare providers are independent contractors. PacificSource cannot be held liable for any claim or damages for injuries you experience while receiving medical care.

PARTICIPATING PROVIDERS

Participating providers contract with PacificSource to furnish medical services and supplies to members enrolled in this plan for a set fee. That fee is called the contracted reimbursement rate. Participating providers agree not to charge more than the contracted reimbursement rate. Participating providers bill PacificSource directly, and we pay them directly. When you receive covered services or supplies from a participating provider, you are only responsible for the amounts stated in your Medical Benefit Summary. Depending on your plan, those amounts can include a deductible, co-payment, or co-insurance payment.

PacificSource contracts directly and/or indirectly with participating providers throughout our Oregon, Idaho, and Montana service areas and in bordering communities in southwest Washington. We also have an agreement with a nationwide provider network, The First Health® Network, which includes more than 550,000 participating physicians and 5,000 participating hospitals. The First Health providers outside our service area are also considered PacificSource participating providers under your plan.

It is not safe to assume that when you are treated at a participating medical facility, all services are performed by participating providers. Whenever possible, you should arrange for professional services such as surgery, anesthesiology, and emergency room care to be provided by a participating provider. Doing so will help you maximize your benefits and limit your out-of-pocket expenses.

Risk-sharing Arrangements

A participating provider contracts with PacificSource to furnish medical services and supplies to members enrolled in PacificSource health benefit plans for a set fee. That fee is called the contracted reimbursement rate. By agreement, a participating provider may not bill a member for any amount in excess of the contracted reimbursement rate. However, the agreement does not prohibit the provider from collecting co-payments, deductibles, co-insurance, and non-covered services from the member. And, if PacificSource was to become insolvent, a participating provider agrees to continue to provide covered services to a member for the duration of the period for which premium was paid to PacificSource on behalf of the member. Again, the participating provider may only collect applicable co-payments, deductibles, co-insurance, and amounts for non-covered services from the member.

NON-PARTICIPATING PROVIDERS

When you receive services or supplies from a non-participating provider, your out-of-pocket expense is likely to be higher than if you had used a participating provider. If the same services or supplies are available from a participating provider to whom you have reasonable access (explained in the next section), you may be responsible for more than the deductible, co-payment, and co-insurance amounts stated in your Medical Benefit Summary.

Allowable Fee

To maximize your plan's benefits, always make sure your healthcare provider is a PacificSource participating provider. Do not assume all services at a participating facility are performed by participating providers.

PacificSource bases payment to non-participating providers on our 'allowable fee' for the same services or supplies. We use several sources to determine the allowable fee, depending on the service or supply and the geographical area where it is provided. The allowable fee may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), Viant Health Payment Solutions, other nationally recognized databases, or PacificSource.

In areas where our members have reasonable geographic access to a participating provider, the allowable fee for professional services is based on PacificSource's standard participating provider reimbursement rate or a contracted reimbursement rate. Outside the PacificSource service area and in areas where our members do not have reasonable access to a participating provider (see the Network Not Available Benefits section, below), the allowable fee is based on the usual, customary, and reasonable charge (UCR) at the 85th percentile. UCR is based on data collected for a geographic area. Provider charges for each type of service are collected and ranked from lowest to highest. Charges at the 85th position in the ranking are considered to be the 85th percentile.

To calculate our payment to non-participating providers, we determine the allowable fee, then subtract the non-participating provider co-insurance shown in the 'Non-participating Provider' column of your Medical Benefit Summary. Our allowable fee is often less than the non-participating provider's charge. In that case, the difference between our allowable fee and the provider's billed charge is also your responsibility. That amount does not count toward this plan's out-of-pocket maximum. It also does not apply toward any deductibles or co-payments required by the plan. In any case, after any co-payments or deductibles, the amount PacificSource pays to a non-participating provider will not be less than 50 percent of the allowable fee for a like service or supply.

To maximize your plan's benefits, please check with us before receiving care from a non-participating provider. Our Customer Service Department can help you locate a participating provider in your area. If there is no participating provider for the service or supply you need, our staff will verify that your plan's Network Not Available benefits apply.

Example of Provider Payment

The following illustrates how payment could be made for a covered service billed at $120. In this example, the Medical Benefit Summary shows a participating providers co-insurance of 20 percent and a non-participating providers co-insurance of 30 percent. This is only an example; your plan's benefits may be different.

	Participating Provider	Non-participating Provider
Provider's usual charge	$120	$120
PacificSource's negotiated provider discount	$20	$0
PacificSource's allowable fee	$100	$100
Patient's co-insurance from Medical Benefit Summary	20%	30%
PacificSource's payment	$80	$70
Patient's amount of allowable fee	$20	$30
Charges above the allowable fee	$0	$20
Patient's total payment to provider	$20	$50
Percent of charge paid by PacificSource	80%	58%
Percent of charge paid by patient	20%	42%

When you receive covered services from a participating provider, you are only responsible for the amounts stated in your Medical Benefit Summary.

NETWORK NOT AVAILABLE BENEFITS

The term 'network not available' is used when a PacificSource member does not have reasonable geographic access to a participating provider for a covered medical service or supply.

If you live in an area without access to a participating provider for a specific service or supply, your plan's Network Not Available benefits apply. Here's how that works:

- You seek treatment from a nearby non-participating provider of that service or supply.
- PacificSource determines the allowable fee for that service or supply (the term 'allowable fee' is explained above under Non-participating Providers).
- We apply the Network Not Available benefit level as stated in your Medical Benefit Summary to the allowable fee to calculate covered expenses.
- You are responsible for any co-payments, co-insurance, deductibles, and amounts over the allowable fee.

COVERAGE WHILE TRAVELING

Your PacificSource plan is powered by the PacificSource Network (PSN). The PSN Network covers Oregon, Idaho, Montana, southwest Washington, and eastern Washington. When you need medical services outside of the PSN Network, you can save out-of-pocket expense by using the participating providers available through The First Health® Network.

Nonemergency Care While Traveling

To find a participating provider outside the regions covered by the PacificSource Network, call The First Health® Network at (800) 226-5116. (The phone number is also printed on your PacificSource ID card for convenience.) Representatives are available at any time to help you find a participating physician, hospital, or other outpatient provider. Nonemergency care outside of the United States is not covered.

- If a participating provider is available in your area, your plan's participating provider benefits will apply if you use a participating provider.
- If a participating provider is not available in your area, your plan's Network Not Available benefits will apply.
- If a participating provider is available but you choose to use a non-participating provider, your plan's non-participating provider benefits will apply.

Emergency Services While Traveling

In medical emergencies (see the Covered Expenses - Emergency Services section of this handbook), your plan pays benefits at the participating provider level regardless of your location. Your covered expenses are based on our allowable fee. If you are admitted to a hospital as an inpatient following the stabilization of your emergency condition, your physician or hospital should contact the PacificSource Health Services Department at (888) 691-8209 as soon as possible to make a benefit determination on your admission. If you are admitted to a non-participating hospital, PacificSource may require you to transfer to a participating facility once your condition is stabilized in order to continue receiving benefits at the participating provider level.

FINDING PARTICIPATING PROVIDER INFORMATION

You can find up-to-date participating provider information:

- By asking your healthcare provider if he or she is a participating provider for PacificSource Preferred plans.

- On the PacificSource website, PacificSource.com. Simply click on 'Find a Provider' and you can easily look up participating providers or print your own customized directory.
- By contacting the PacificSource Customer Service Department. Our staff can answer your questions about specific providers. If you'd like a complete provider directory for your plan, just ask--we'll be glad to mail you a directory free of charge.
- By calling The First Health® Network at (800) 226-5116 if you live outside the area covered by the PacificSource Network.

TERMINATION OF PROVIDER CONTRACTS

PacificSource will notify you within ten days of learning of the termination of a provider contractual relationship if you have received services in the previous three months from such a provider when:

- A provider terminates a contractual relationship with PacificSource in accordance with the terms and conditions of the agreement;
- A provider terminates a contractual relationship with an organization under contract with PacificSource; or
- PacificSource terminates a contractual relationship with an individual provider or the organization with which the provider is contracted in accordance with the terms and conditions of the agreement.

For the purposes of continuity of care, PacificSource may require the provider to adhere to the medical services contract and accept the contractual reimbursement rate applicable at the time of contract termination.

BECOMING COVERED

ELIGIBILITY

Employees

Your employer decides the minimum number of hours employees must work each week to be eligible for health insurance benefits. Your employer may also require new employees to satisfy a probationary waiting period before they are eligible for benefits. Your employer's eligibility requirements are stated in your Medical Benefit Summary. All employees who meet those requirements are eligible for coverage.

Family Members

While you are insured under this plan, the following family members are also eligible for coverage:

- Your legal spouse or registered domestic partner.
- Your, your spouse's, or your domestic partner's dependent children under age 26 regardless of the child's place of residence, marital status, or financial dependence on you.
- Your, your spouse's, or your domestic partner's unmarried dependent children age 26 or over who are mentally or physically disabled. To qualify as dependents, they must have been continuously unable to support themselves since turning age 26 because of a mental or physical disability. PacificSource requires documentation of the disability from the child's physician, and will review the case before determining eligibility for coverage.
- Your siblings, nieces, nephews, or grandchildren under age 19 who are unmarried, not in a domestic partnership, registered or otherwise, and for whom you are the court appointed legal custodian or guardian with the expectation that the family member will live in your household for at least a year.
- 'Dependent children' means any natural, step, and adopted children you or your domestic partner are legally obligated to support or contribute support for. It may also include any siblings, nieces,

nephews, or grandchildren under age 19 who are unmarried and expected to live in your household for at least a year, if you are the court appointed legal custodian or guardian.

No family or household members other than those listed above are eligible to enroll under your coverage.

ENROLLING DURING THE INITIAL ENROLLMENT PERIOD

The 'initial enrollment period' is the 31-day period beginning on the date a person is first eligible for enrollment in this plan. Everyone who becomes eligible for coverage has an initial enrollment period.

When you satisfy your employer's probationary waiting period at the hours required for eligibility and become eligible to enroll in this plan, you and your eligible family members must enroll within the initial enrollment period. If you miss your initial enrollment period, you may be subject to a waiting period. (For more information, see 'Special Enrollment Periods' and 'Late Enrollment' under the Enrolling After the Initial Enrollment Period section.) To enroll, you must complete and sign an enrollment application, which is available from your employer. The application must include complete information on yourself and your enrolling family members. Return the application to your employer, and your employer will send it to PacificSource.

Coverage for you and your enrolling family members begins on the first day of the month after you satisfy your employer's probationary waiting period. The probationary waiting period is stated in your Medical Benefit Summary. Coverage will only begin if PacificSource receives your enrollment application and premium with your employer's premium payment for that month.

Newborns

Your, your spouse's, or your domestic partner's natural born baby is eligible for enrollment under this plan during the 31-day initial enrollment period after birth. PacificSource cannot enroll the child and pay benefits until we receive an enrollment application listing the child as your dependent. A claim for maternity care is not considered notification for the purpose of enrolling a newborn child. Anytime there is a delay in providing enrollment information, PacificSource may ask for legal documentation to confirm validity.

Adopted Children

When a child is placed in your home for adoption, the child is eligible for enrollment under this plan during the 31-day initial enrollment period after placement for adoption. 'Placement for adoption' means the assumption and retention by you, your spouse, or your domestic partner of a legal obligation for full or partial support and care of the child in anticipation of adoption of the child. To add the child to your coverage, you must complete and submit an enrollment application listing the child as your dependent. You may be required to submit a copy of the certificate of adoption or other legal documentation from a court or a child placement agency to complete enrollment.

If additional premium is required, then the natural born or adopted child's eligibility for enrollment will end 31-days after placement if PacificSource has not received an enrollment application and premium. Premium is charged from the date of placement and prorated for the first month.

If no additional premium is required, then the natural born or adopted child's eligibility continues as long as you are covered. However, PacificSource cannot enroll the child and pay benefits until we receive an enrollment application listing the child as your dependent.

Family Members Acquired by Marriage

If you marry, you may add your new spouse and any newly eligible dependent children to your coverage during the 31-day initial enrollment period after the marriage. PacificSource must receive your enrollment application and additional premium during the initial enrollment period. Coverage for

your new family members will then begin on the first day of the month after the marriage. You may be required to submit a copy of your marriage certificate to complete enrollment.

Family Members Acquired by Domestic Partnership

If you and your same-gender domestic partner have been issued a Certificate of Registered Domestic Partnership, your domestic partner and your partner's dependent children are eligible for coverage during the 31-day initial enrollment period after the registration of the domestic partnership. PacificSource must receive your enrollment application and additional premium during the initial enrollment period. Coverage for your new family members will then begin on the first day of the month after the registration of the domestic partnership.You may be required to submit a copy of your Certificate of Registered Domestic Partnership to complete enrollment.

Family Members Placed in Your Guardianship

If a court appoints you custodian or guardian of an eligible sibling, niece, nephew, or grandchild, you may add that family member to your coverage. To be eligible for coverage, the family member must be:

- Unmarried
- Not in a domestic partnership, registered or otherwise;
- Under age 19; and
- Expected to live in your household for at least a year

PacificSource must receive your enrollment application and additional premium during the 31-day initial enrollment period beginning on the date of the court appointment.Coverage will then begin on the first day of the month following the date of the court order. You may be required to submit a copy of the court order to complete enrollment.

Qualified Medical Child Support Orders

This health plan complies with qualified medical child support orders (QMCSO) issued by a state court or state child support agency. A QMCSO is a judgment, decree, or order, including approval of a settlement agreement, that provides for health benefit coverage for the child of a plan member.

If a court or state agency orders coverage for your spouse or child, they may enroll in this plan within a 31-day initial enrollment period beginning on the date of the order. Coverage will become effective on the first day of the month after PacificSource receives the enrollment application. You may be required to submit a copy of the QMCSO to complete enrollment.

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD

Returning to Work after a Layoff

If you are laid off and then rehired by your employer within nine months, you will not have to satisfy another probationary waiting period or new exclusion period.

Your health coverage will resume the day you return to work and again meet your employer's minimum hour requirement. If your family members were covered before your layoff, they can resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment application within the 31-day initial enrollment period following your return to work.

Employees returning to work after a layoff are not subject to new exclusion periods for pre-existing and other conditions. If the employee's exclusion periods were satisfied (or partially satisfied) before the layoff, they will be credited at the same level when the employee returns to work. However, your dependents will be subject to new exclusion periods unless they have creditable coverage during the layoff. For information about exclusion periods and creditable coverage, please see 'Exclusion Periods' and 'Credit for Prior Coverage' in the Benefit Limitations and Exclusions section of this handbook.

Returning to Work after a Leave of Absence

If you return to work after an employer-approved leave of absence of six months or less, you will not have to satisfy another probationary waiting period. Your health coverage will resume the day you return to work and again meet your employer's minimum hour requirement. If your family members were covered before your leave of absence, they can resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment application within the 31-day initial enrollment period following your return to work.

Both you and your dependents will be subject to new exclusion periods unless you have creditable coverage during the leave of absence. For information about exclusion periods and creditable coverage, please see 'Exclusion Periods' and 'Credit for Prior Coverage' in the Benefit Limitations and Exclusions section of this handbook.

Special Enrollment Periods

Some employers have agreements with PacificSource allowing employees with other health coverage to waive this plan's coverage. In that case, both you and your family members may decline coverage during your initial enrollment period. If you are eligible to decline coverage and you wish to do so, you must submit a written waiver of coverage to PacificSource through your employer. You and your family members may enroll in this plan later if you qualify under Rule #1, Rule #2, or Rule #3 below.

If the agreement between PacificSource and your employer requires all eligible employees to participate in this plan, you must enroll during your initial enrollment period. However, your family members may decline coverage, and they may enroll in the plan later if they qualify under Rule #1, Rule #2, or Rule #3 below.

To find out if your employer's plan allows employees to decline coverage, ask your health plan administrator.

- Special Enrollment Rule #1

  If you declined enrollment for yourself or your family members because of other health insurance coverage, you or your family members may enroll in the plan later if the other coverage ends involuntarily. 'Involuntarily' means coverage ended because continuation coverage was exhausted, employment terminated, work hours were reduced below the employer's minimum requirement, the other insurance plan was discontinued or the maximum lifetime benefit of the other plan was exhausted, the employer's premium contributions toward the other insurance plan ended, or because of death of a spouse, divorce, or legal separation. To do so, you must request enrollment within 31 days after the other health insurance coverage ends (or within 60 days after the other health insurance coverage ends if the other coverage is through Medicaid or a State Children's Health Insurance Program). Coverage will begin on the first day of the month after the other coverage ends.

- Special Enrollment Rule #2

  If you acquire new dependents because of marriage, registration of domestic partnership, birth, or placement for adoption, you may be able to enroll yourself and/or your newly acquired dependents at that time. To do so, you must request enrollment within 31 days after the marriage, registration of domestic partnership, birth, or placement for adoption. In the case of marriage or domestic partnership, coverage begins on the first day of the month after the marriage or registration of the domestic partnership. In the case of birth or placement for adoption, coverage begins on the date of birth or placement.

- Special Enrollment Rule #3

  If you or your dependents become eligible for a premium assistance subsidy under Medicare or a State Children's Health Insurance Program (CHIP), you may be able to enroll yourself and/or your dependents at that time. To do so, you must request enrollment within 60 days of the date you

and/or your dependents become eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Late Enrollment

If you did not enroll during your initial enrollment period and you do not qualify for a special enrollment period, your enrollment will be delayed until the plan's anniversary date.

A 'late enrollee' is an otherwise eligible employee or dependent who does not qualify for a special enrollment period explained above, and who:

- Did not enroll during the 31-day initial enrollment period; or
- Enrolled during the initial enrollment period but discontinued coverage later.

A late enrollee may enroll by submitting an enrollment application to your employer during an open enrollment period designated by your employer, just prior to the plan's anniversary date. When you or your dependents enroll during the open enrollment period, plan coverage begins on the plan's anniversary date.

The plan's exclusion periods for pre-existing conditions, other conditions, and transplants then apply from the date of coverage unless you have prior creditable coverage (see 'Exclusion Periods' and 'Credit for Prior Coverage' in the Benefit Limitations and Exclusions section of this handbook).

PLAN SELECTION PERIOD

If your employer offers more than one benefit plan option, you may choose another plan option only upon your plan's anniversary date. You may select a different plan option by completing a selection form or application form. Coverage under the new plan option becomes effective on your plan's anniversary date.

TERMINATING COVERAGE

If you leave your job for any reason or your work hours are reduced below your employer's minimum requirement, coverage for you and your enrolled family members will end. Coverage ends on the last day of the last month in which you worked full time and for which a premium was paid. You may, however, be eligible to continue coverage for a limited time; please see the Continuation section of this handbook for more information.

You can voluntarily discontinue coverage for your enrolled family members at any time by completing a Termination of Dependent Coverage form and submitting it to your employer. Keep in mind that once coverage is discontinued, your family members may be subject to the late enrollment waiting period if they wish to re-enroll later.

Divorced Spouses

If you divorce, coverage for your spouse will end on the last day of the month in which the divorce decree or legal separation is final. You must notify your employer of the divorce or separation, and continuation coverage may be available for your spouse. If there are special child custody circumstances, please contact the PacificSource Membership Services Department. Please see the Continuation section for more information.

Dependent Children

When your enrolled child no longer qualifies as a dependent, coverage will end on the last day of that month. Please see the Eligibility section of this handbook for information on when your dependent child is eligible beyond age 25. The Continuation and Individual Portability Policy

sections include information on other coverage options for those who no longer qualify for coverage.

Dissolution of Domestic Partnership

If you dissolve your domestic partnership, coverage for your domestic partner and their children not related to you by birth or adoption will end on the last day of the month in which the dissolution of the domestic partnership is final. You must notify your employer of the dissolution of the domestic partnership. Under Oregon state continuation laws, a registered domestic partner and their covered children may continue this policy's coverage under the same circumstances and to the same extent afforded an enrolled spouse and their enrolled children (see Oregon Continuation in the Continuation of Insurance section). Domestic partners and their covered children are not recognized as qualified beneficiaries under federal COBRA continuation laws. Domestic partners and their covered children may not continue this policy's coverage under COBRA independent of the employee (see COBRA Continuation in the Continuation of Insurance section).

Certificates of Creditable Coverage

A certificate of creditable coverage is used to verify the dates of your prior health plan coverage when you apply for coverage under a new policy. These certificates are issued by health insurers whenever a plan participant's coverage ends. After your or your dependent's coverage under this plan ends, you will receive a certificate of creditable coverage by mail. We have an automated process that generates and mails these certificates whenever coverage ends. We will send a separate certificate for any dependents with an effective or termination date that differs from yours. For questions or requests regarding certificates of creditable coverage, you are welcome to contact our Membership Services Department at (541) 684-5583 or (866) 999-5583.

CONTINUATION OF INSURANCE

Under federal and state laws, you and your family members may have the right to continue this plan's coverage for a specified time. You and your dependents may be eligible if:

- Your employment ends or you have a reduction in hours
- You take a leave of absence for military service
- You divorce
- You die
- You become eligible for Medicare benefits if it causes a loss of coverage for your dependents
- Your children no longer qualify as dependents

The following sections describe your rights to continuation under state and federal laws, and the requirements you must meet to enroll in continuation coverage.

USERRA CONTINUATION

If you take a leave of absence from your job due to military service, you have continuation rights under the Uniformed Services Employment and Re-employment Rights Act (USERRA).

You and your enrolled family members may continue this plan's coverage if you, the employee, no longer qualify for coverage under the plan because of military service. Continuation coverage under USERRA is available for up to 24 months while you are on military leave. If your military service ends and you do not return to work, your eligibility for USERRA continuation coverage will end. Premium for continuation coverage is your responsibility.

The following requirements apply to USERRA continuation:

- Family members who were not enrolled in the group plan cannot take continuation. The only exceptions are newborn babies and newly acquired dependents not covered by another group health plan.
- To apply for continuation, you must submit a completed Continuation Election Form to your employer within 31 days after the last day of coverage under the group plan.
- You must pay continuation premium to your employer by the first of each month. Your employer will include your continuation premium in the group's regular monthly payment. PacificSource cannot accept the premium directly from you.
- Your employer must still be insured by PacificSource. If your employer discontinues this plan, you will no longer qualify for continuation.

OREGON CONTINUATION

Under this plan, you may have continuation rights under Oregon state law.

State Continuation Eligibility

If your employer has fewer than 20 employees, or if your group is not subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended, you may be able to continue your coverage for up to nine months.

You and your enrolled family members may continue coverage if you, the employee, no longer qualify for coverage under the plan (for example, if your work hours are reduced or you quit your job). Your spouse or registered domestic partner and dependent children may also continue coverage under this plan if you divorce, dissolve your domestic partnership, become eligible for Medicare benefits, or die. Your children may also continue coverage under this plan if they no longer qualify as a dependent under the terms of this plan. Continuation coverage can last a maximum of nine months. Premium for continuation coverage is the responsibility of you or your family member.

The following restrictions also apply to anyone taking Oregon continuation coverage:

- To qualify for continuation, you must have been covered under the PacificSource group policy for at least three months. If your employer recently switched to this policy from another group health plan without a break in coverage, you will receive credit for time under the previous plan.
- Family members who were not enrolled in the group plan cannot take continuation. The only exceptions are newborn babies and newly acquired dependents not covered by another group health plan.
- To apply for continuation, you must submit a completed Continuation Election Form and your initial continuation premium payment to your employer within 31 days after the last day of coverage under the group plan, or within ten days after you receive notification of your continuation right, whichever is later.
- You must pay continuation premium to your employer by the first of each month. Your employer will include your continuation premium in the group's regular monthly payment. PacificSource cannot accept the premium directly from you.
- Your employer must still be insured by PacificSource. If your employer discontinues this plan, you will no longer qualify for continuation.

When Continuation Coverage Ends

Although Oregon continuation coverage may last up to nine months, coverage will end before then if any of the following occurs:

- If you do not pay the premium to your employer on time, coverage will end on the last day of the last month for which you paid premium.
- If you become eligible for Medicare, your coverage will end on the last day of the month prior to the Medicare eligibility date.
- If your employer discontinues this group policy, your coverage will end on the last day the policy was in effect.
- If you and your dependents become eligible for another group health plan (such as a spouse's employer's plan or a plan at your new job), your coverage will end on the date you become eligible for that plan.

When continuation coverage ends, you may be eligible to purchase an individual portability policy. Please see the Individual Portability Policy section for more information.

Type of Coverage

Under Oregon continuation, you may continue the medical coverage you had before the qualifying event. If your employer provides both medical and dental coverage and you were enrolled in both, you may continue only the medical coverage.

Oregon continuation benefits are always the same as your employer's current benefits. Your employer has the right to change the benefits of its health plan or eliminate the plan entirely. If that happens, any changes to the group health plan will also apply to everyone enrolled in continuation coverage.

WORK STOPPAGE

Labor Unions

If you are a union member, you have certain continuation rights in the event of a labor strike. Your union is responsible for collecting your premium and can answer questions about coverage during the strike.

INDIVIDUAL PORTABILITY POLICY

When coverage under this policy ends, you may be able to purchase a PacificSource individual portability policy. If you are eligible, you may purchase the policy when you lose coverage under this policy, or during your continuation coverage, or as soon as continuation coverage ends. In order to be eligible for the portability policy:

- You must live in Oregon.
- You must have been covered by this plan for at least six months (or by a combination of this plan and another Oregon group health benefit plan with no break in coverage).
- You must apply for the portability policy within 63 days after coverage under this plan or your continuation coverage ends.
- You must pay the premium to PacificSource on time each month.

You are not eligible to purchase a portability policy if you are eligible for this or any other plan provided by your employer, or are covered under another health plan, or are eligible for Medicare. For information on PacificSource individual portability policies, contact our Individual Sales Department at (541) 684-5585 or (866) 695-8684.

COVERED EXPENSES

This plan provides comprehensive medical coverage when care is medically necessary to treat an illness or injury. Be careful--just because a treatment is prescribed by a healthcare professional does not mean it is medically necessary under the terms of this plan. Also remember that just because a service or supply is a covered benefit under this plan does not necessarily mean all billed charges will be paid.

Some medically necessary services and supplies may be excluded from coverage under this plan. Be sure you read and understand the Benefit Limitations and Exclusions section of this book, including the section on Preauthorization. If you ever have a question about your plan benefits, contact the PacificSource Customer Service Department.

Medical Necessity

Except for specified Preventive Care services, the benefits of this group policy are paid only toward the covered expense of medically necessary diagnosis of treatment of illness or injury. This is true even though the service or supply is not specifically excluded. All treatment is subject to review for medical necessity. Review of treatment may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. For additional information, see 'medically necessary' in the Definitions section of this handbook.

Be careful. Your healthcare provider could prescribe services or supplies that are not covered under this plan. Also, just because a service or supply is a covered benefit does not mean all related charges will be paid.

Healthcare Providers

This plan provides benefits only for covered expenses and supplies rendered by a physician (M.D. or O.D.), practitioner, nurse, hospital or specialized treatment facility, durable medical equipment supplier, or other licensed medical provider as specifically stated in this handbook. The services or supplies provided by individuals or companies that are not specified as eligible practitioners are not eligible for reimbursement under the benefits of this plan. For additional information, see 'practitioner', 'specialized treatment facility', and 'durable medical equipment supplier' in the Definitions section of this handbook.

Your Annual Out-of-Pocket Limit

This plan has an out-of-pocket limit provision to protect you from excessive medical expenses. The Medical Benefit Summary shows your plan's annual out-of-pocket limits for participating and/or non-participating providers. If you incur covered expenses over those amounts, this plan will pay 100 percent of eligible charges, subject to the allowable fee.

Your expenses for the following do not count toward the annual out-of-pocket limit:

- Charges applied to deductible, if applicable to your plan
- Co-payments, if applicable to your plan
- Prescription drugs
- Charges over the allowable fee for services of non-participating providers
- Incurred charges that exceed amounts allowed under this plan

Charges over the allowable fee for services of non-participating providers, and incurred charges that exceed amounts allowed under this plan, and co-payments will continue to be your responsibility even after the out-of-pocket or stop-loss limit is reached.

Prescription drug benefits are not affected by the out-of-pocket or stop-loss limit. You will still be responsible for that co-payment or co-insurance payment even after the out-of-pocket or stop-loss limit is reached.

PLAN BENEFITS

This plan provides benefits for the following services and supplies as outlined on your Medical Benefit Summary. These services and supplies may require you to satisfy a deductible, make a co-payment, or both, and they may be subject to additional limitations or maximum dollar amounts. For a medical expense to be eligible for payment, you must be covered under this plan on the date the expense is incurred. Please refer to your Medical Benefit Summary and the Benefit Limitations and Exclusions section of this handbook for more information.

PREVENTIVE CARE SERVICES

This plan covers the following preventive care services when provided by a physician, physician assistant, or nurse practitioner:

- **Routine physicals** for members age 22 and older according to the following schedule:
  - Ages 22-34 One exam every four years
  - Ages 35-59 One exam every two years
  - Ages 60 and over One exam every year

  Only laboratory work tests and other diagnostic testing procedures related to the routine physical exam are covered by this benefit. Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a routine physical examination are not covered by this preventative care benefit. Please see Outpatient Services in this section.
- **Well woman visits**, including the following:
  - One **routine gynecological exam** each calendar year for women 18 and over. Exams may include Pap smear, pelvic exam, breast exam, blood pressure check, and weight check. Covered lab services are limited to occult blood, urinalysis, and complete blood count.
  - **Routine preventive mammograms** for women as recommended.
    - The deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for 'Preventive Care - Well Woman Visits' applies to mammograms that are considered 'routine' according to the guidelines of the U.S. Preventive Services Task Force.
    - The deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for 'Outpatient Services - Diagnostic and Therapeutic Radiology and Lab' applies to diagnostic mammograms related to the ongoing evaluation or treatment of a medical condition.
  - **Pelvic exams and Pap smear exams** at any time upon referral of a women's healthcare provider; and pelvic exams and Pap smear exams annually for women 18 to 64 years of age with or without a referral from a women's healthcare provider.
  - **Breast exams** annually for women 18 years of age or older or at any time when recommended by a women's healthcare provider for the purpose of checking for lumps and other changes for early detection and prevention of breast cancer.
- **Colorectal cancer screening** exams and lab work including the following:
  - A fecal occult blood test
  - A flexible sigmoidoscopy
  - A colonoscopy
    - The deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for 'Preventive Care - Routine Colonoscopy' applies to colonoscopies that

are considered ‘routine’ according to the guidelines of the U.S. Preventive Services Task Force.

    - The deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for ‘Professional Services - Surgery’ and for ‘Outpatient Services - Outpatient Surgery/Services’ apply to colonoscopies related to ongoing evaluation or treatment of a medical condition.)

  - A double contrast barium enema

- **Prostate cancer screening,** including digital rectal examination and a prostate-specific antigen test.
- **Well baby/child care exams**, for members age 21 and younger according to the following schedule:

  - At birth: One standard in-hospital exam
  - Ages 0 - 2: 12 additional exams during the first 36 months of life
  - Ages 3 - 21: One exam per year

  Only laboratory tests and other diagnostic testing procedures related to a well baby/child care exam are covered by this benefit. Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a well baby/child care exam are not covered by this preventative care benefit. Please see Outpatient Services in this section.

- Standard age-appropriate childhood and adult **immunizations** for primary prevention of infectious diseases as recommended by and adopted by the Centers for Disease Control and Prevention, American Academy of Pediatrics, American Academy of Family Physicians, or similar standard-setting body. Benefits do not include immunizations for more elective, investigative, unproven, or discretionary reasons (e.g. travel). Covered immunizations include, but may not be limited to the following:

  - Diphtheria, pertussis, and tetanus (DPT) vaccines, given separately or together
  - Hemophilus influenza B vaccine
  - Hepatitis A vaccine
  - Hepatitis B vaccine
  - Human papillomavirus (HPV) vaccine
  - Influenza vaccine
  - Measles, mumps, and rubella (MMR) vaccines, given separately or together
  - Meningococcal (meningitis) vaccine
  - Pneumococcal vaccine
  - Polio vaccine
  - Varicella (chicken pox) vaccine

- **Tobacco use cessation program services** are covered only when provided by a PacificSource approved program. Approved programs are covered at 100% of the cost up to a maximum lifetime benefit of two quit attempts. Approved programs are limited to members age 15 or older. Specific nicotine replacement therapy will only be covered according to the program’s description. If this policy includes benefits for prescription drugs, tobacco use cessation program will be covered to the same extent this policy covers other prescription medications.

Any plan deductible, co-payment, and/or co-insurance amounts stated in your Medical Benefit Summary are waived for the following recommended preventive care services when provided by a participating provider:

- Services that have a rating of "A" or "B" from the U.S. Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- Preventive care and screening for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA);
- Preventive care and screening for women supported by the HRSA that are not included in the USPSTF recommendations.

Links to the lists of recommended preventive care and screenings from the USPSTF, CDC, and HRSA can be found on the PacificSource website, PacificSource.com. Current USPSTF recommendations include the September 2002 recommendations regarding breast cancer screening, mammography, and prevention, not the November 2009 recommendations.

A and B list for preventive services can be found at:
http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm

The list of Women's preventive services can be found at: http://www.hrsa.gov/womensguidelines/

For enrollees who do not have Internet access, please contact PacificSource Customer Service at (541) 684-5582 or toll-free at 800-624-6052 for a complete description of the preventive services lists.

Current USPSTF recommendations include the September 2002 recommendations regarding breast cancer screening, mammography, and prevention, not the November 2009 recommendations.

PROFESSIONAL SERVICES

This plan covers the following professional services when medically necessary:

- Services of a **physician** (M.D. or D.O.) for diagnosis or treatment of illness or injury
- Services of a licensed **physician assistant** under the supervision of a physician
- Services of a certified **surgical assistant, surgical technician, or registered nurse** (R.N.) when providing medically necessary services as a surgical first assistant during a covered surgery
- Services of a **nurse practitioner**, including certified registered nurse anesthetist (C.R.N.A.) and certified nurse midwife (C.N.M.), for medically necessary diagnosis or treatment of illness or injury
- **Urgent care services** provided by a physician. 'Urgent care' means services for an unforeseen illness or injury that requires treatment within 24 hours to prevent serious deterioration of a patient's health. Urgent conditions are normally less severe than medical emergencies. Examples of conditions that could need urgent care are sprains and strains, vomiting, cuts, and severe headaches.
- **Outpatient rehabilitative services** provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide physical, occupational, or speech therapy. Services must be prescribed in writing by a licensed physician, dentist, podiatrist, nurse practitioner, or physician assistant. The prescription must include site, modality, duration, and frequency of treatment. Total covered expenses for outpatient rehabilitative services is limited to a combined maximum of 30 visits per calendar year subject to preauthorization and concurrent review by PacificSource for medical necessity. Only treatment of neurologic conditions (e.g. stroke, spinal cord injury, head injury, pediatric neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which rehabilitative services would be appropriate for children under 18 years of age) may be considered for additional benefits, not to exceed 30 visits per condition, when criteria for supplemental services are met.

Services for speech therapy will only be allowed when needed to correct stuttering, hearing loss, peripheral speech mechanism problems, and deficits due to neurological disease or injury. Speech and/or cognitive therapy for acute illnesses and injuries are covered up to one year post injury when the services do not duplicate those provided by other eligible providers, including occupational therapists or neuropsychologists.

Outpatient pulmonary rehabilitation programs are covered when prescribed by a physician for patients with severe chronic lung disease that interferes with normal daily activities despite optimal medication management.

For related provisions, see 'motion analysis', 'vocational rehabilitation', 'speech therapy', and 'temporomandibular joint' under 'Excluded Services - Types of Treatments' in the Benefit Limitations and Exclusions section of this handbook.

- Services of a physician or a licensed certified nurse midwife for **pregnancy**. Services are subject to the same payment amounts, conditions, and limitations that apply to similar expenses for illness, except that pregnancy is not considered a pre-existing condition.

Please contact the PacificSource Customer Service Department as soon as you learn of your pregnancy. Our staff will explain your plan's maternity benefits and help you enroll in our free prenatal care program.

- **Routine nursery care** of a newborn while the mother is hospitalized and eligible for pregnancy-related benefits under this plan if the newborn is also eligible and enrolled in this plan.
- Services of a licensed audiologist for medically necessary **audiological (hearing) tests**.
- Services of a dentist or physician to treat **injury of the jaw or natural teeth**. Services must be provided within 18 months of the injury. Except for the initial examination, services for treatment of an injury to the jaw or natural teeth require preauthorization to be covered.
- Services of a dentist or physician for **orthognathic (jaw) surgery** as follows:
  - When medically necessary to repair an accidental injury. Services must be provided within one year after the accident
  - For removal of a malignancy, including reconstruction of the jaw within one year after that surgery
- Services of a board-certified or board-eligible **genetic counselor** when referred by a physician or nurse practitioner for evaluation of genetic disease.
- Medically necessary **telemedical health services** for health services covered by this plan when provided in person by a healthcare professional when the telemedical health service does not duplicate or supplant a health service that is available to the patient in person. The location of the patient receiving telemedical health services may include, but is not limited to: hospital; rural health clinic; federally qualified health center; physician's office; community mental health center; skilled nursing facility; renal dialysis center; or site where public health services are provided. Coverage of telemedical health services are subject to the same deductible, co-payment, or co-insurance requirements that apply to comparable health services provided in person.

HOSPITAL AND SKILLED NURSING FACILITY SERVICES

This plan covers medically necessary **hospital inpatient services**. Charges for a hospital room are covered up to the hospital's semi-private room rate (or private room rate, if the hospital does not offer semi-private rooms). Charges for a private room are covered if the attending physician orders hospitalization in an intensive care unit, coronary care unit, or private room for medically necessary isolation.

In addition to the hospital room, covered inpatient hospital services may include (but are not limited to):

- Cardiac care unit
- Operating room
- Anesthesia and post-anesthesia recovery
- Respiratory care
- Inpatient medications
- Lab and radiology services
- Dressings, equipment, and other necessary supplies

The plan does not cover charges for rental of telephones, radios, or televisions, or for guest meals or other personal items.

Special Information about Childbirth - PacificSource covers hospital inpatient services for childbirth according to the Newborns' and Mothers' Health Protection Act of 1996. This plan does not restrict the length of stay for the mother or newborn child to less than 48 hours after vaginal delivery, or to less than 96 hours after Cesarean section delivery. Your provider is allowed to discharge you or your newborn sooner than that, but only if you both agree. For childbirth, your provider does not need to preauthorize your hospital stay with PacificSource.

Services of a **skilled nursing facility and convalescent homes** are covered for up to 60 days per calendar year when preauthorized by PacificSource. Services must be medically necessary. Confinement for custodial care is not covered.

Inpatient rehabilitative services medically necessary to restore and improve lost body functions after illness or injury. The service must be consistent with the condition being treated, and must be part of a formal written treatment program prescribed by a physician. This benefit is limited to a maximum of 30 days per calendar year, except that treatment for head or spinal cord injuries is covered for up to 60 days per calendar year. Recreation therapy is only covered as part of an inpatient rehabilitation admission.

OUTPATIENT SERVICES

This plan covers the following outpatient care services:

- **Advanced diagnostic imaging procedures** that are medically necessary for the diagnosis of illness or injury. For purposes of this benefit, advanced diagnostic imaging procedures include CT scans, MRIs, PET scans, CATH labs and nuclear cardiology studies. In all situations and settings, benefits are subject to the deductibles, co-payments, and/or co-insurance stated in your Medical Benefit Summary for Outpatient Services - Advanced Diagnostic Imaging applies. Please note that the co-payment for these services is 'per test'. For example, if separate MRIs are performed on different regions of the back, there will be a co-payment charged for each region imaged.
- Diagnostic **radiology and laboratory procedures** provided or ordered by a physician, nurse practitioner, or physician assistant. These services may be performed or provided by laboratories, radiology facilities, hospitals, and physicians, including services in conjunction with office visits.
- **Emergency room services**. The emergency room co-payment stated in your Medical Benefit Summary covers only physician and hospital facility charges in the emergency room. The co-payment does not cover further treatment provided on referral from the emergency room.

  Emergency medical screening and emergency services, including any diagnostic tests necessary for emergency care (including radiology, laboratory work, CT scans and MRIs) are subject to the deductibles, co-payments, and/or co-insurance stated in your Medical Benefit Summary for either 'Outpatient Services - Diagnostic and Therapeutic Radiology and Lab' or 'Outpatient Services - Advanced Diagnostic Imaging', depending on the specific service provided.

  In true medical emergencies, non-participating providers are paid at the participating provider level.

Emergency room charges for services, supplies, or conditions excluded from coverage under this plan are not eligible for payment. That includes conditions subject to the plan's exclusion periods for pre-existing and other conditions. Please see the Benefit Limitations and Exclusions section of this handbook.

- **Surgery** and other outpatient services. Benefits are based on the setting where services are performed.
  - For surgeries or outpatient services performed in a physician's office, the benefit stated in your Medical Benefit Summary for Professional Services - Office Procedures and Supplies applies.
  - For surgeries or outpatient services performed in an ambulatory surgical center or outpatient hospital setting, both the benefits stated in your Medical Benefit Summary for Professional Services - Surgery and the Outpatient Services - Outpatient Surgery/Services apply.
- Therapeutic **radiology services, chemotherapy, and renal dialysis** provided or ordered by a physician. Covered services include a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Benefits for members who are receiving services for **end-stage renal disease (ESRD),** who are eligible for Medicare, are limited to 125% of the current Medicare allowable amount for participating and non-participating ESRD service providers.

  Benefits will continue to be paid at the cost share level applied to other benefits in the same category for members who are not eligible for Medicare.
- Other medically necessary **diagnostic services** provided in a hospital or outpatient setting, including testing or observation to diagnose the extent of a medical condition.

EMERGENCY SERVICES

In a true medical emergency, this plan covers services and supplies necessary to determine the nature and extent of the emergency condition and to stabilize the patient.

An emergency medical condition is an injury or sudden illness, including severe pain, so severe that a prudent layperson with an average knowledge of health and medicine would expect that failure to receive immediate medical attention would risk seriously damaging the health of a person or fetus in the case of a pregnant woman. Examples of emergency medical conditions include (but are not limited to):

- Unusual or heavy bleeding
- Sudden abdominal or chest pains
- Suspected heart attacks
- Major traumatic injuries
- Serious burns
- Poisoning
- Unconsciousness
- Convulsions or seizures
- Difficulty breathing
- Sudden fevers

If you need immediate assistance for a medical emergency, call 911. *If you have an emergency medical condition, you should go directly to the nearest emergency room or appropriate facility. Care for a medical emergency is covered at the participating provider percentage stated in your Medical Benefit Summary even if you are treated at a non-participating hospital.*

If you are admitted to a non-participating hospital after your emergency condition is stabilized, PacificSource may require you to transfer to a participating facility in order to continue receiving benefits at the participating provider level.

MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

This plan covers medically necessary crisis intervention, diagnosis, and treatment of mental health conditions and chemical dependency. Refer to the Benefit Limitations and Exclusions section of this handbook for more information on services not covered by your plan.

Providers Eligible for Reimbursement

A mental and/or chemical healthcare provider (see Definitions section of this handbook) is eligible for reimbursement if:

- The mental and/or chemical healthcare provider is approved by the Oregon Department of Human Services; and
- The mental and/or chemical healthcare provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities; and
- The patient is staying overnight at the mental and/or chemical healthcare facility (see Definitions section of this handbook) and is involved in a structured program at least eight hours per day, five days per week; or
- The mental and/or chemical healthcare provider is providing a covered benefit under this policy; and

Eligible mental and/or chemical healthcare providers are:

- A program licensed, approved, established, maintained, contracted with, or operated by the Addictions and Mental Health Division of the Oregon Health Authority;
- A medical or osteopathic physician licensed by the State Board of Medical Examiners;
- A psychologist (Ph.D.) licensed by the State Board of Psychologists' Examiners;
- A nurse practitioner registered by the State Board of Nursing;
- A clinical social worker (L.C.S.W.) licensed by the State Board of Clinical Social Workers;
- A Licensed Professional Counselor (L.P.C) licensed by the State Board of Licensed Professional Counselors and Therapists;
- A Licensed Marriage and Family Therapist (L.M.F.T) licensed by the State Board of Licensed Professional Counselors and Therapists; and
- A hospital or other healthcare facility licensed by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities for inpatient or residential care and treatment of mental health conditions and/or chemical dependency.

Medical Necessity and Appropriateness of Treatment

- As with all medical treatment, mental health and chemical dependency treatment is subject to review for medical necessity and/or appropriateness. Review of treatment may involve pre-service review, concurrent review of the continuation of treatment, post-treatment review, or a combination

of these. PacificSource will notify the patient and patient's provider when a treatment review is necessary to make a determination of medical necessity. Benefits for long-term residential mental health programs exceeding 45 days of treatment per calendar year will not be authorized.

- A second opinion may be required for a medical necessity determination. PacificSource will notify the patient when this requirement is applicable.
- PacificSource must be notified of an emergency admission within two business days.
- Medication management by an M.D. (such as a psychiatrist) does not require review.
- Treatment of substance abuse and related disorders is subject to placement criteria established by the American Society of Addiction Medicine.

HOME HEALTH AND HOSPICE SERVICES

- This plan covers **home health services** when preauthorized by PacificSource. Covered services include skilled nursing by a R.N. or L.P.N.; physical, occupational, and speech therapy; and medical social work services provided by a licensed home health agency. Private duty nursing is not covered.
- **Home infusion services** are covered when preauthorized by PacificSource. This benefit covers parenteral nutrition, medications, and biologicals (other than immunizations) that cannot be self-administered. Benefits are paid at the percentage stated in your Medical Benefit Summary for home health care.
- This plan covers **hospice services** when preauthorized by PacificSource. Hospice services are intended to meet the physical, emotional, and spiritual needs of the patient and family during the final stages of illness and dying, while maintaining the patient in the home setting. Services are intended to supplement the efforts of an unpaid caregiver. Hospice benefits do not cover services of a primary caregiver such as a relative or friend, or private duty nursing. PacificSource uses the following criteria to determine eligibility for hospice benefits:
  - The member's physician must certify that the member is terminally ill with a life expectancy of less than six months;
  - The member must be living at home;
  - A non-salaried primary caregiver must be available and willing to provide custodial care to the member on a daily basis; and
  - The member must not be undergoing treatment of the terminal illness other than for direct control of adverse symptoms.

Only the following hospice services are covered:

- Home nursing visits.
- Home health aides when necessary to assist in personal care.
- Home visits by a medical social worker.
- Home visits by the hospice physician.
- Prescription medications for the relief of symptoms manifested by the terminal illness.
- Medically necessary physical, occupational, and speech therapy provided in the home.
- Home infusion therapy.
- Durable medical equipment, oxygen, and medical supplies.
- Respite care provided in a nursing facility to provide relief for the primary caregiver, subject to a maximum of five consecutive days and to a lifetime maximum benefit of 30 days. A member must be enrolled in a hospice program to be eligible for respite care benefits.

- Inpatient hospice care when provided by a Medicare-certified or state-certified program when admission to an acute care hospital would otherwise be medically necessary.
- Pastoral care and bereavement services.

The member retains the right to all other services provided under this contract, including active treatment of non-terminal illnesses, except for services of another provider that duplicate the services of the hospice team.

DURABLE MEDICAL EQUIPMENT

- This plan covers **prosthetic and orthotic devices** that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. Benefits include coverage of all services and supplies medically necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device. Benefits also include coverage for any repair or replacement of a prosthetic or orthotic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.
- This plan covers **durable medical equipment** prescribed exclusively to treat medical conditions. Covered equipment includes crutches, wheelchairs, orthopedic braces, home glucose meters, equipment for administering oxygen, and non-power assisted prosthetic limbs and eyes. Durable medical equipment must be prescribed by a licensed M.D., D.O., N.P., P.A., D.D.S., D.M.D., or D.P.M. to be covered. This plan does not cover equipment commonly used for nonmedical purposes, for physical or occupational therapy, or prescribed primarily for comfort. Please see 'Excluded Services - Equipment and Devices' in the Benefit Limitations and Exclusions section for information on items not covered. The following limitations apply to durable medical equipment:
  - The cost of durable medical equipment is covered up to $5,000 per calendar year. Exceptions to this limitation are essential health benefits, such as prosthetics and orthotic devices, oxygen and oxygen supplies, diabetic supplies, wheelchairs, and breast pumps. Medical foods for the treatment of inborn errors of metabolism are also exempt from this limitation.
  - This benefit covers the cost of either purchase or rental of the equipment for the period needed, whichever is less. Repair or replacement of equipment is also covered when necessary, subject to all conditions and limitations of the plan. If the cost of the purchase, rental, repair, or replacement is over $800, preauthorization by PacificSource is required.
  - Only expenses for durable medical equipment, or prosthetic and orthotic devices that are provided by a PacificSource contracted provider or a provider that satisfies the criteria in the Medicare Quality Standards for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Other Items and Services handbook are eligible for reimbursement. Mail order or Internet/Web based providers are not eligible providers.
  - Purchase, rental, repair, lease, or replacement of a power-assisted wheelchair (including batteries and other accessories) requires preauthorization by PacificSource and is payable only in lieu of benefits for a manual wheelchair. For members age 19 or older, this benefit is limited to one power-assisted wheelchair in a lifetime.
  - The durable medical equipment benefit also covers lenses to correct a specific vision defect resulting from a severe medical or surgical problem, such as stroke, neurological disease, trauma, or eye surgery other than refraction procedures. Coverage is subject to the following limitations:
    - The medical or surgical problem must cause visual impairment or disability due to loss of binocular vision or visual field defects (not merely a refractive error or astigmatism) that requires lenses to restore some normalcy to vision.

- The maximum allowance for glasses (lenses and frames), or contact lenses in lieu of glasses, is limited to $200 per initial case. 'Initial case' is defined as the first time surgery or treatment is performed on either eye. Other policy limitations, such as exclusions for extra lenses, other hardware, tinting of lenses, eye exercises, or vision therapy, also apply.
- Benefits for subsequent medically necessary vision corrections to either eye (including an eye not previously treated) are limited to the cost of lenses only.
- Reimbursement is subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment and is in lieu of, and not in addition to benefits payable under any vision endorsement that may be added to this plan.

– The durable medical equipment benefit also covers hearing aids for members under 18 years of age and younger, or 25 years of age and younger if the member is enrolled in a secondary school or an accredited educational institution. Coverage is limited to a maximum benefit of $4,000 every 48 months. The benefit amount shall be adjusted on January 1 of each year to reflect the U.S City Average Consumer Price Index.

– Medically necessary treatment for sleep apnea and other sleeping disorders is covered when preauthorized by PacificSource. Coverage of oral devices includes charges for consultation, fitting, adjustment, follow-up care, and the appliance. The appliance must be prescribed by a physician specializing in evaluation and treatment of obstructive sleep apnea, and the condition must meet criteria for obstructive sleep apnea.

– Wigs following chemotherapy or radiation therapy are covered up to a maximum benefit of $150 per calendar year.

– Breastfeeding pumps, manual and electric, are covered at no cost per pregnancy when purchased or rented from a licensed provider, or purchased from a retail outlet. Hospital-grade breast pumps are excluded under preventive care and regular benefits.

TRANSPLANT SERVICES

This plan covers certain medically necessary organ and tissue transplants. It also covers the cost of acquiring organs or tissues needed for covered transplants and limited travel expenses for the patient, subject to certain limitations.

All pretransplant evaluations, services, treatments, and supplies for transplant procedures require preauthorization by PacificSource.

You must have been covered under this plan for at least 24 consecutive months or since birth to be eligible for transplant benefits, including benefits for transplantation evaluation. See Exclusion Periods - Transplants in the Benefit Limitations and Exclusions section of this handbook for details.

This plan covers the following medically necessary organ and tissue transplants:

- Kidney
- Kidney - Pancreas
- Pancreas whole organ transplantation (under certain criteria)
- Heart
- Heart - Lung
- Lung
- Liver (under certain criteria)
- Bone marrow and peripheral blood stem cell
- Pediatric bowel

This plan only covers transplants of human body organs and tissues. Transplants of artificial, animal, or other non-human organs and tissues are not covered.

Expenses for the acquisition of organs or tissues for transplantation are covered only when the transplantation itself is covered under this contract, and is subject to the following limitations:

- Testing of related or unrelated donors for a potential living related organ donation is payable at the same percentage that would apply to the same testing of an insured recipient.
- Expense for acquisition of cadaver organs is covered, payable at the same percentage and subject to the same maximum dollar limitation, if any, as the transplant itself.
- Medical services required for the removal and transportation of organs or tissues from living donors are covered. Coverage of the organ or tissue donation is at the same percentage payable for the transplant itself and applies to the maximum dollar limitation for the transplant, if any.
  - If the donor is not a PacificSource member, only those complications of the donation that occur during the initial hospitalization are covered, and such complications are covered only to the extent that they are not covered by another health plan or government program. Coverage is at the same percentage payable for the transplant itself, and also applies to the maximum dollar limitation, if any, for the transplant.
  - If the donor is a PacificSource member, complications of the donation are covered as any other illness would be covered.
- Transplant related services, including HLA typing, sibling tissue typing, and evaluation costs, are considered transplant expenses and accumulate toward any transplant benefit limitations and are subject to PacificSource's provider contractual agreements (see Payment of Transplant Benefits, below).

Travel and housing expenses for the recipient are limited to $5,000 per transplant. Travel and living expenses are not covered for the donor.

Payment of Transplant Benefits

If a transplant is performed at a participating Center of Excellence transplantation facility, covered charges of the facility are subject to plan deductibles (co-insurance and co-payment amounts after deductible are waived). If our contract with the facility includes the services of the medical professionals performing the transplant (such as physicians, nurses, and anesthesiologists), those charges are also subject to plan deductibles (co-insurance and co-payment amounts after deductible are waived). If the professional fees are not included in our contract with the facility, then those benefits are provided according to your Medical Benefit Summary.

If transplant services are available through a contracted transplantation facility but are not performed at a contracted facility, you are responsible for satisfying any deductibles or co-payments stated in your Medical Benefit Summary. This plan then pays either 60 percent of the billed amount or $100,000, whichever is less. Services of non-participating medical professionals are paid at the non-participating provider percentages stated in your Medical Benefit Summary.

OTHER COVERED SERVICES, SUPPLIES, AND TREATMENTS

- This plan covers services of a state certified ground or air **ambulance** when private transportation is medically inappropriate because the acute medical condition requires paramedic support. Benefits are provided for emergency ambulance service and/or transport to the nearest facility capable of treating the condition. Air ambulance service is covered only when ground transportation is medically or physically inappropriate. Reimbursement to non-participating air ambulance services are based on 125% of the Medicare allowance. In some cases Medicare allowance may be significantly lower than the provider's billed amount. The provider may hold you responsible for the amount they bill in excess of the Medicare allowance, as well as applicable deductibles and co-insurance.

- This plan covers **biofeedback** to treat migraine headaches or urinary incontinence when provided by an otherwise eligible practitioner. Benefits are limited to a lifetime maximum of ten sessions.
- This plan covers **blood transfusions**, including the cost of blood or blood plasma.
- This plan covers removal, repair, or replacement of an internal **breast prosthesis** due to a contracture or rupture, but only when the original prosthesis was for a medically necessary mastectomy. Preauthorization by PacificSource is required, and eligibility for benefits is subject to the following criteria:
  - The contracture or rupture must be clinically evident by a physician's physical examination, imaging studies, or findings at surgery.
  - This plan covers removal, repair, and/or replacement of the prosthesis; a new reconstruction is not covered.
  - Removal, repair, and/or replacement of the prosthesis is not covered when recommended due to an autoimmune disease, connective tissue disease, arthritis, allergenic syndrome, psychiatric syndrome, fatigue, or other systemic signs or symptoms.
  - PacificSource may require a signed loan receipt/subrogation agreement before providing coverage for this benefit.
- This plan covers **breast reconstruction** in connection with a medically necessary mastectomy. Coverage is provided in a manner determined in consultation with the attending physician and patient for:
  - All stages of reconstruction of the breast on which the mastectomy was performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - Prostheses; and
  - Treatment of physical complications of the mastectomy, including lymphedema

  Benefits for breast reconstruction are subject to all terms and provisions of the plan, including deductibles, co-payments and/or co-insurance stated in your Medical Benefit Summary.
- This plan covers **cardiac rehabilitation** as follows:
  - Phase I (inpatient) services are covered under inpatient hospital benefits.
  - Phase II (short-term outpatient) services are covered subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for outpatient hospital benefits. Benefits are limited to services provided in connection with a cardiac rehabilitation exercise program that does not exceed 36 sessions and that are considered reasonable and necessary.
  - Phase III (long-term outpatient) services are not covered.
- This plan covers IUD, diaphragm, and cervical cap **contraceptive devices** along with their insertion or removal. Contraceptive devices that can be obtained over the counter or without a prescription, such as condoms are not covered.
- This plan covers **corneal transplants**. Preauthorization is not required.
- In the following situations, this plan covers one attempt at **cosmetic or reconstructive surgery:**
  - When necessary to correct a functional disorder; or
  - When necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury; or
  - When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery

Cosmetic or reconstructive surgery must take place within 18 months after the injury, surgery, scar, or defect first occurred. Preauthorization by PacificSource is required for all cosmetic and reconstructive surgeries covered by this plan. For information on breast reconstruction, see 'breast prosthesis' and 'breast reconstruction' in this section.

- This plan covers dental and orthodontic services for the treatment of **craniofacial anomalies** when medically necessary to restore function. Coverage includes but is not limited to physical disorders identifiable at birth that affect the bony structures of the face or head, such as cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome. Coverage is limited to the least costly clinically appropriate treatment. Cosmetic procedures and procedures to improve on the normal range of functions are not covered. See the exclusions for cosmetic/reconstructive services, dental examinations and treatment, jaw surgery, and orthognathic surgery under the 'Excluded Services' section.

- This plan provides coverage for certain **diabetic supplies and training** as follows:
  - Diabetic supplies other than insulin and syringes (such as lancets, test strips, and glucostix) are covered subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment. You may purchase those supplies from any retail outlet and send your receipts to PacificSource, along with your name, group number, and member ID number. We will process the claim and mail you a reimbursement check.
  - Diabetic insulin and syringes are covered under your prescription drug benefit, if your plan includes prescription coverage. Lancets and test strips are also available under that prescription benefit in lieu of those covered supplies under the medical plan.
  - This plan covers one diabetes self-management education program at the time of diagnosis, and up to three hours of education per year if there is a significant change in your condition or its treatment. To be covered, the training must be provided by an accredited diabetes education program, or by a physician, registered nurse, nurse practitioner, certified diabetes educator, or licensed dietitian with expertise in diabetes.
  - This plan covers medically necessary telemedical health services provided in connection with the treatment of diabetes (see Professional Services in this section).
- This plan covers **dietary or nutritional counseling** provided by a registered dietitian under certain circumstances. It is covered under the diabetic education benefit, or for management of inborn errors of metabolism (excluding obesity), or for management of anorexia nervosa or bulimia nervosa (to a lifetime maximum of five visits).
- This plan covers nonprescription **elemental enteral formula** ordered by a physician for home use. Formula is covered when medically necessary to treat severe intestinal malabsorption and the formula comprises a predominant or essential source of nutrition. Coverage is subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment.
- This plan covers routine **foot care** for patients with diabetes mellitus.
- **Hospitalization for dental procedures** is covered when the patient has another serious medical condition that may complicate the dental procedure, such as serious blood disease, unstable diabetes, or severe cardiovascular disease, or the patient is physically or developmentally disabled with a dental condition that cannot be safely and effectively treated in a dental office. Coverage requires preauthorization by PacificSource, and only charges for the facility, anesthesiologist, and assistant physician are covered. Hospitalization because of the patient's apprehension or convenience is not covered.
- This plan covers treatment for **inborn errors of metabolism** involving amino acid, carbohydrate, and fat metabolism for which widely accepted standards of care exist for diagnosis, treatment, and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or

DNA confirmation in tissues. Coverage includes expenses for 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. Nutritional supplies are covered subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment.

- **Injectable drugs and biologicals** administered by a physician are covered when medically necessary for diagnosis or treatment of illness or injury. This benefit does not include immunizations (see Preventive Care Services in this section) or drugs or biologicals that can be self-administered or are dispensed to a patient.
- This plan covers **maxillofacial prosthetic services** when prescribed by a physician as necessary to restore and manage head and facial structures. Coverage is provided only when head and facial structures cannot be replaced with living tissue, and are defective because of disease, trauma, or birth and developmental deformities. To be covered, treatment must be necessary to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing. Coverage is limited to the least costly clinically appropriate treatment, as determined by the physician. Cosmetic procedures and procedures to improve on the normal range of functions are not covered. Dentures, prosthetic devices for treatment of TMJ conditions, and artificial larynx are also not covered.
- For **pediatric dental care** requiring general anesthesia, this plan covers the facility charges of a hospital or ambulatory surgery center. Benefits are limited to a lifetime maximum of $2,000, and preauthorization by PacificSource is required.
- The **routine costs of care associated with qualifying clinical trials** are covered. Benefits are only provided for routine costs of care associated with qualifying clinical trials. Expenses for services or supplies that are not considered routine costs of care are not covered. PacificSource is not, based on the coverage provided, liable for any adverse effects of a clinical trial. For more information, see ‘routine costs of care’ in the Definitions section of this handbook.
- **Sleep studies** are covered when ordered by a pulmonologist, neurologist, otolaryngologist, or certified sleep medicine specialist, and when performed at a certified sleep laboratory.
- This plan covers medically necessary therapy and services for the treatment of **traumatic brain injury.**
- This plan covers **tubal ligation and vasectomy** procedures once the exclusion period has been satisfied (see Exclusion Periods in the following section).

BENEFIT LIMITATIONS AND EXCLUSIONS

Least Costly Setting for Services

Covered services must be performed in the least costly setting where they can be provided safely. If a procedure can be done safely in an outpatient setting but is performed in a hospital inpatient setting, this plan will only pay what it would have paid for the procedure on an outpatient basis. If services are performed in an inappropriate setting, your benefits can be reduced by up to 30 percent or $2,500, whichever is less.

EXCLUDED SERVICES

A Note About Optional Benefits

If your employer provides coverage for optional benefits such as prescription drugs, vision services, chiropractic care, or alternative care, you'll find those Member Benefit Summaries in this handbook. If your employer provides optional benefits for an exclusion listed below, then the exclusion does not apply to the extent that coverage exists under the optional benefit. For example, if your employer provides optional chiropractic coverage, then the exclusion for chiropractic care listed below under 'Types of Treatment' does not apply to you.

This is only a summary of excluded services, supplies, and expenses. For details, please refer to the General Exclusions section of your group health policy.

Types of Treatment - This plan does not cover the following:

- Acupuncture
- Chelation therapy, unless preauthorized by PacificSource for certain medical conditions or heavy metal toxicities
- Chiropractic care
- Day care or custodial care, including help with daily activities such as walking, getting in or out of bed, bathing, dressing, eating, and preparing meals
- Dental examinations and treatment, which means any services or supplies to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures
- Eye examinations (routine)
- Fitness or exercise programs and health or fitness club memberships
- Foot care (routine), unless you are being treated for diabetes mellitus. Routine foot care includes services and supplies for corns and calluses, toenail conditions other than infection, and hypertrophy or hyperplasia of the skin of the feet
- Genetic (DNA) testing, except for tests identified as medically necessary for the diagnosis and standard treatment of specific diseases
- Homeopathic treatment
- Infertility - Services or supplies to diagnose, prevent, or treat sterility, infertility, erectile dysfunction, frigidity, or sexual dysfunction
- Instructional or educational programs, except diabetes self-management programs
- Jaw - Services or supplies for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants, or improving placement of dentures
- Massage, massage therapy, or neuromuscular re-education, even as part of a physical therapy program
- Motion analysis, including physician review
- Myeloablative high dose chemotherapy, except when the related transplant is covered
- Naturopathic treatment
- Obesity (including all categories) or weight control treatment or surgery, even if there are other medical reasons for you to control your weight. Food supplementation programs, behavior modification and self-help programs, and other services and supplies for weight loss are also excluded from coverage.
- Osteopathic manipulation, except for treatment of disorders of the musculoskeletal system
- Physical or eye exams required for administrative purposes, such as participation in athletics, admission to school, or employment

- Private nursing service
- Programs that teach a person to use medical equipment, care for family members, or self-administer drugs or nutrition (except for the diabetic education benefit)
- Screening tests, imaging, and exams solely for screening, and not associated with a specific diagnosis, sign of disease, or abnormality on prior testing (including but not limited to total body CT imaging, CT colonography, and bone density testing), except as allowed under the preventive care benefit
- Self-help or training programs
- Snoring - Services or supplies for the diagnosis or treatment of snoring or upper airway resistance disorders, including somnoplasty
- Speech therapy - Oral/facial motor therapy for strengthening and coordination of speech-producing muscles and structures, except as medically necessary in the restoration or improvement of speech following a traumatic brain injury or for a child 17 years of age or younger diagnosed with a pervasive developmental disorder
- Temporomandibular joint (TMJ)-related services, or treatment for associated myofascial pain, including physical or oromyofacial therapy
- Vocational rehabilitation, functional capacity evaluations, work hardening programs, community reintegration services, and driving evaluations and training programs, except as medically necessary in the restoration or improvement of speech following a traumatic brain injury or for a child 17 years of age or younger diagnosed with a pervasive developmental disorder

Surgeries and Procedures - This plan does not cover the following:

- Abdominoplasty
- Artificial insemination, in vitro fertilization, or GIFT procedures
- Cosmetic or reconstructive services, except as specified in the Covered Expenses - Other Covered Services, Supplies, and Treatments section
- Electronic Beam Tomography (EBT)
- Eye refraction procedures, orthoptics, vision therapy, or other services to correct refractive error
- Jaw surgery - Treatment for abnormalities of the jaw, malocclusion, or improving the placement of dentures and dental implants
- Orthognathic surgery - Treatment to augment or reduce the upper or lower jaw, except for reconstruction due to an injury (see the Covered Expenses - Professional Services section)
- Panniculectomy
- Sex transformations - Excluded procedures include, but are not limited to: staged gender reassignment surgery, including breast augmentation, penile implantation, facial bone reconstruction, blepharoplasty, liposuction, thyroid chondroplasty, laryngoplasty or shortening of the vocal cords, and/or hair removal to assist the appearance or other characteristics of gender reassignment, and complications resulting from gender reassignment procedures.
- Surgery to reverse voluntary sterilization
- Transplants, except as specified in the Covered Expenses - Transplants section

Mental Health Services - This plan does not provide any benefits for any inpatient residential care unless prior authorization is obtained. This plan does not cover the following services, whether provided by a mental health or chemical dependency specialist or by any other provider:

Treatment for the following diagnosis:

- Mental retardation
- Paraphilias

- Learning disorders
- Gender Identity Disorders in Adults (GID)
- Urinary incontinence
- Diagnostic codes V 15.81 through V71.09 (DSM-IV-TR, Fourth Edition) except V61.20, V61.21, and V62.82 when used with children five years of age or younger
- Food dependencies
- Nicotine-related disorders

Treatment programs, training, or therapy as follows:

- Residential mental health programs exceeding 45 days of treatment per calendar year
- Educational or correctional services or sheltered living provided by a school or halfway house
- Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present
- Court-ordered sex offender treatment programs
- Court-ordered screening interviews or drug or alcohol treatment programs
- Marital/partner counseling
- Support groups
- Sensory integration training
- Biofeedback (other than as specifically noted under the Covered Expenses - Other Covered Services, Supplies, and Treatments section)
- Hypnotherapy
- Academic skills training
- Equine/animal therapy
- Narcosynthesis
- Aversion therapy
- Social skill training
- Recreational therapy outside an inpatient or residential treatment setting

Drugs and Medications - This plan does not cover the following:

- Drugs and biologicals that can be self-administered (including injectables), other than those provided in a hospital, emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered
- Growth hormone injections or treatments, except to treat documented growth hormone deficiencies
- Immunizations or other medications or supplies for protection while traveling or at work
- Over-the-counter medications or nonprescription drugs

Equipment and Devices - This plan does not cover the following:

- Computer or electronic equipment for monitoring asthmatic, diabetic, or similar medical conditions or related data
- Equipment commonly used for nonmedical purposes, or marketed to the general public, or intended to alter the physical environment. This includes appliances like adjustable power beds sold as furniture, air conditioners, air purifiers, room humidifiers, heating and cooling pads, home blood pressure monitoring equipment, light boxes, conveyances other than conventional wheelchairs, whirlpool baths, spas, saunas, heat lamps, tanning lights, and pillows. It also includes orthopedic

shoes and shoe modifications. Mattresses and mattress pads are only covered when medically necessary to heal pressure sores.

- Equipment used primarily in athletic or recreational activities. This includes exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal problems.
- Eyeglasses or contact lenses
- Modifications to vehicles or structures to prevent, treat, or accommodate a medical condition
- Replacement costs for worn or damaged durable medical equipment that would otherwise be replaceable without charge under warranty or other agreement
- Personal items such as telephones, televisions, and guest meals during a stay at a hospital or other inpatient facility

Experimental or Investigational Treatment

Your PacificSource plan does not cover experimental or investigational treatment. By that, we mean services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines or the use thereof that are experimental or investigational for the diagnosis and treatment of the patient. It includes treatment that, when and for the purpose rendered:

- Has not yet received full U.S. government agency approval (e.g. FDA) for other than experimental, investigational, or clinical testing;
- Is not of generally accepted medical practice in Oregon or as determined by PacificSource in consultation with medical advisors, medical associations, and/or technology resources;
- Is not approved for reimbursement by the Centers for Medicare and Medicaid Services;
- Is furnished in connection with medical or other research; or
- Is considered by any governmental agency or subdivision to be experimental or investigational, not reasonable and necessary, or any similar finding.

An experimental or investigational service is not made eligible for benefits by the fact that other treatment is considered by your healthcare provider to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.

When making benefit determinations about whether treatments are investigational or experimental, we rely on the above resources as well as:

- Expert opinions of specialists and other medical authorities;
- Published articles in peer-reviewed medical literature;
- External agencies whose role is the evaluation of new technologies and drugs; and
- External review by an independent review organization.

The following will be considered in making the determination whether the service is in an experimental and/or investigational status :

- Whether there is sufficient evidence to permit conclusions concerning the effect of the services on health outcomes;
- Whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;
- Whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects; and
- Whether any improved health outcomes from the services are attainable outside an investigational setting.

If you or your provider have any concerns about whether a course of treatment will be covered, we encourage you to contact our Customer Service Department. We will arrange for medical review of your case against our criteria, and notify you of whether the proposed treatment will be covered.

Other Items - This plan does not cover the following:

- Services or supplies that are not medically necessary
- Charges for inpatient stays that began before you were covered by this plan
- Services or supplies received before this plan's coverage began
- Services or supplies received after enrollment in this plan ends. (The only exception is that if this policy is replaced by another group health policy while you are hospitalized, PacificSource will continue paying covered hospital expenses until you are released or your benefits are exhausted, whichever occurs first.)
- Care and related services designed essentially to assist a person in maintaining activities of daily living, e.g. services to assist with walking, getting in/out of bed, bathing, dressing, feeding, preparation of meals, homemaker services, special diets, rest cures, day care, and diapers. Custodial care is only covered in conjunction with respite care allowed under this policy's hospice benefit (see Covered Expenses - Hospital, Skilled Nursing Facility, Home Health, and Hospice Services).
- Treatment of any illness or injury resulting from an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement authority
- Services or supplies available to you from another source, including those available through a government agency
- Services or supplies with no charge, or which your employer would have paid for if you had applied, or which you are not legally required to pay for. This includes services provided by yourself or an immediate family member.
- Charges that are the responsibility of a third party who may have caused the illness or injury or other insurers covering the incident (such as workers' compensation insurers, automobile insurers, and general liability insurers)
- Services or supplies for which you are not willing to release the medical or eligibility information PacificSource needs to determine the benefits payable under this plan
- Treatment of any condition caused by a war, armed invasion, or act of aggression, or while serving in the armed forces
- Treatment of any work-related illness or injury, unless you are the owner, partner, or principal of the employer group insured by PacificSource, injured in the course of employment of the employer group insured by PacificSource, and are otherwise exempt from, and not covered by, state or federal workers' compensation insurance. This includes illness or injury caused by any for-profit activity, whether through employment or self-employment.
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims
- Any amounts in excess of the allowable fee for a given service or supply
- Services of providers who are not eligible for reimbursement under this plan. An individual, organization, facility, or program is not eligible for reimbursement for services or supplies, regardless of whether this plan includes benefits for such services or supplies, unless the individual, organization, facility, or program is licensed by the state in which services are provided as an independent practitioner, hospital, ambulatory surgical center, skilled nursing facility, durable medical equipment supplier, or mental and/or chemical healthcare facility. And, to the extent PacificSource maintains credentialing requirements the practitioner or facility must satisfy those requirements in order to be considered an eligible provider.
- Scheduled and/or non-emergent medical care outside of the United States.
- Any services or supplies not specifically listed as covered benefits under this plan

EXCLUSION PERIODS

Pre-existing Conditions

A pre-existing condition is any physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended by or received from a licensed provider during a six-month 'look back' period. That look back period is the six-month period ending on your enrollment date or the first day of your employer's probationary waiting period, whichever is earlier. For late enrollees and enrollment under special enrollment periods (see the Becoming Covered - Enrolling After the Initial Enrollment Period section), the look back period ends on the effective date of coverage.

The plan excludes coverage for pre-existing conditions for:

- Six months from your effective date of coverage; or
- Ten months from the start of any probationary waiting period required by your employer, whichever is earlier.

Your share or expenses for pre-existing conditions does not accumulate toward your plan's out-of-pocket maximum.

The pre-existing conditions exclusion period does not apply to:

- Members under the age of 19
- Employees who re-enroll after a layoff if they returned to work within nine months, to the extent the exclusion period was satisfied before the layoff. The exclusion period does apply to their family members age 19 or older, however.
- Employees who re-enroll after leave under the Family Medical Leave Act, and their previously enrolled dependents age 19 or older, to the extent the exclusion period was satisfied before the leave.

For late enrollees, pre-existing conditions are excluded for six months after the effective date of coverage. (For more information, see the Becoming Covered - Enrolling After the Initial Enrollment Period section.)

If you were covered under another health insurance plan before enrolling in this plan, you can receive credit for prior coverage. See the Credit for Prior Coverage section, below.

Other Conditions

In addition to pre-existing conditions, the following services are not covered during your first six months under this plan:

- Surgical procedures for inner or middle ear infections
- Elective surgeries and procedures (those that are unlikely to have an adverse affect on your health if delayed six months)
- Removal of tonsils or adenoids
- Vasectomies
- Tubal ligations (except those performed at the time of a covered newborn delivery)

If you were covered under another health insurance plan before enrolling in this plan, you can receive credit for prior coverage. See the Credit for Prior Coverage section, below.

Transplants

Except for corneal transplants, organ and tissue transplants are not covered until you have been enrolled in this plan for 24 months. If you were covered under another health insurance plan before

enrolling in this plan, you can receive credit for your prior coverage. See the Credit for Prior Coverage section, below.

CREDIT FOR PRIOR COVERAGE

You can receive credit toward this plan's exclusion periods if you had qualifying healthcare coverage before enrolling in this plan. To qualify for this credit, there may not have been more than a 63-day gap between your last day of coverage under the previous health plan and your first day of coverage (or the first day of your employer's probationary waiting period) under this plan.

Your prior coverage must have been a group health plan, COBRA or state continuation coverage, individual health policy (including student plans), Medicare, Medicaid, TRICARE, State Children's Health Insurance Program, and coverage through high risk pools and the Peace Corps. If you were covered as a dependent under a plan that meets these qualifications, you will qualify for credit. Many people elect the COBRA or state continuation coverage available under a prior plan to make sure they won't have more than a 63-day gap in coverage.

It is your responsibility to show you had creditable coverage. If you qualify for credit, PacificSource will count every day of coverage under your prior plan toward this plan's exclusion periods for pre-existing conditions, other specified conditions, and transplants (explained above).

Evidence of Prior Creditable Coverage

You can show evidence of creditable coverage by sending PacificSource a Certificate of Creditable Coverage from your previous health plan. All health plans, insurance companies, and HMOs are required by law to provide these certificates on request. Most insurers issue these certificates automatically whenever someone's coverage ends. The certificate shows how long you were covered under your previous plan and when your coverage ended.

If you do not have a certificate of prior coverage, contact your previous insurance company or plan sponsor (such as your former employer, if you had a group health plan). You have the right to request a certificate from any prior plan, insurer, HMO, or other entity through which you had creditable coverage. If you are unable to obtain a certificate, contact our Membership Services Department and we will assist you.

PREAUTHORIZATION

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called 'preauthorization'.

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

Your medical provider can request preauthorization from the PacificSource Health Services Department by phone, fax, mail, or email. If your provider will not request preauthorization for you, you may contact us yourself. In some cases, we may ask for more information or require a second opinion before authorizing coverage.

If your treatment is not preauthorized, you can still seek treatment, but you will be held responsible for the expense if it is not medically necessary or is not covered by this plan. Remember, any time you are unsure if an expense will be covered, contact the PacificSource Customer Service Department.

Because of the changing nature of medicine, PacificSource continually reviews new technologies and standards of medical practice. The list of procedures and services requiring preauthorization is therefore subject to revision and update. ***The list is not intended to suggest that all the items included are necessarily covered by the benefits of this policy.*** You'll find the most current preauthorization list on our website, PacificSource.com.

Notification of PacificSource's benefit determination will be communicated by letter, fax, or electronic transmission to the hospital, the provider, and you. If time is a factor, notification will be made by telephone and followed up in writing.

PacificSource reserves the right to employ a third party to perform preauthorization procedures on its behalf.

In a medical emergency, services and supplies necessary to determine the nature and extent of the emergency condition and to stabilize the patient are covered without preauthorization requirements. PacificSource must be notified of an emergency admission to a hospital or specialized treatment center as an inpatient within two business days.

If your provider's preauthorization request is denied as not medically necessary or as experimental, your provider may appeal our benefit determination. You retain the right to appeal our benefit determination independent from your provider.

CASE MANAGEMENT

Case management is a service provided by Registered Nurses with specialized skills to respond to the complexity of a member's healthcare needs. Case management services may be initiated by PacificSource when there is a high utilization of health services or multiple providers, or for health problems such as, but not limited to, transplantation, high risk obstetric or neonatal care, open heart surgery, neuromuscular disease, spinal cord injury, or any acute or chronic condition that may necessitate specialized treatment or care coordination. When case management services are implemented, the nurse care manager will work in collaboration with the patient's primary care provider and the PacificSource Chief Medical Officer to enhance the quality of care and maximize available health plan benefits. A case manager may authorize benefits for supplemental services not otherwise covered by this policy (See Individual Benefits Management in this section).

PacificSource reserves the right to employ a third party to assist with, or perform the function of, case management.

INDIVIDUAL BENEFITS MANAGEMENT

Individual benefits management addresses, as an alternative to providing covered services, PacificSource's discretionary consideration of economically justified alternative benefits. The decision to allow alternative benefits will be made by PacificSource in its sole discretion on a case-by-case basis. PacificSource's determination to cover and pay for alternative benefits for an individual shall not be deemed to waive, alter or affect PacificSource's right to reject any other or subsequent request or recommendation. PacificSource may elect to provide alternative benefits if PacificSource and the individual's attending provider concur in the request for and in the advisability of alternative benefits in lieu of specified covered services, and, in addition, PacificSource in its discretion, concludes that substantial future expenditures for covered services for the individual could be significantly diminished by providing such alternative benefits under the individual benefit management program (See Case Management above).

UTILIZATION REVIEW

PacificSource has a utilization review program to determine coverage of hospital admissions. This program is administered by our Health Services Department. All hospital admissions are reviewed by PacificSource Nurse Case Managers, who are all registered nurses and certified case managers. Questions regarding medical necessity, possible experimental or investigational services, appropriate setting, and appropriate treatment are forwarded to the PacificSource Chief Medical Officer, an M.D., for review and benefit determination.

PacificSource reserves the right to delegate a third party to assist with or perform the function of utilization management.

Authorization of Hospital Admissions

When a PacificSource member is admitted to a hospital within the area covered by PacificSource's provider networks (see the Using the Provider Network - Coverage While Traveling section), the hospital's admitting clerk calls PacificSource to verify the patient's eligibility and benefits. The clerk gives us information about the patient's diagnosis, procedure, and attending physician. We use that information to create a daily report of all PacificSource members currently admitted to hospitals within our service area. The authorization status with regards to available benefits for each admission is documented in the report.

As part of the utilization review process, PacificSource evaluates how long each patient is expected to remain hospitalized. This is called the 'target length of stay.' We use the target length of stay to monitor the patient's progress and plan for any necessary follow-up care after the patient is discharged.

The PacificSource Health Services Department assigns the target length of stay based on the patient's diagnosis and/or procedure. For standard hospitalizations, we use written procedures that were developed based on the following guidelines:

- Milliman & Robertson Optimal Recovery Guidelines
- HCIA Length of Stay by Diagnosis & Operation, Western Region, 50th percentile
- Standard of practice in the state of Oregon

If we are unable to assign a length of stay based on those guidelines, our Nurse Case Manager contacts the hospital's utilization review coordinator for more specific information about the case. We then use that information to assign an expected length of stay for the patient.

Extension of Hospital Stays

If a patient's hospital stay extends beyond the assigned length of stay, a Nurse Case Manager contacts the hospital's utilization review coordinator. We obtain current information about the patient's medical progress and assign a new length of stay or begin planning for the patient's discharge. The PacificSource Chief Medical Officer may review the case to determine if extended hospitalization meets coverage criteria.

Occasionally, patients choose to extend their hospital stay beyond the length the attending physician considers medically necessary. Charges for hospital days and services beyond those determined to be medically necessary are the member's responsibility.

Timeliness for Responding to Coverage Request

When PacificSource receives a request for coverage of an admission or extension of a hospital stay, we are generally able to provide an answer that same day. If we do not have enough information to make a benefit determination, we request further information and attempt to provide a determination on the day we receive that information. If a member is discharged before we receive the information we need, the case is reviewed retrospectively by the Nurse Case Manager and the Chief Medical Officer for a determination regarding coverage.

Questions About Specific Utilization Review Decisions

If you would like information on how we reached a particular utilization review benefit determination, please contact our Health Services Department by phone at (541) 684-5584 or (888) 691-8209, or by email at healthservices@pacificsource.com. We will provide you with a written summary of information we may consider in utilization review of the particular condition, if we in fact maintain such criteria.

CLAIMS PAYMENT

How to File a Claim

When a PacificSource participating provider treats you, your claims are automatically sent to PacificSource and processed. All you need to do is show your PacificSource ID card to the provider.

If you receive care from a non-participating provider, the provider may submit the claim to PacificSource for you. If not, you are responsible for sending the claim to us for processing. Your claim must include a copy of your provider's itemized bill. It must also include your name, PacificSource ID number or social security number, group name, group number, and the patient's name. If you were treated for an accidental injury, please include the date, time, place, and circumstances of the accident.

All claims for benefits must be turned in to PacificSource within 90 days of the date of service. If it is not possible to submit a claim within 90 days, turn in the claim with an explanation as soon as possible. In some cases PacificSource may accept the late claim. We will never pay a claim that was submitted more than a year after the date of service, though.

All claims should be sent to:

PacificSource Health Plans
Attn: Claims
PO Box 7068
Springfield OR 97475-0068

Claim Handling Procedures

A claim for benefits under this plan will be examined by PacificSource on a pre-service, concurrent, and/or a post-services basis. Each time your claim is examined, a new claims determination will be made regarding the category (pre-service, concurrent, or post-service) into which the claim falls at that particular time. In each case, PacificSource must render a claim determination within a prescribed period of time.

Pre-service claims--Your plan subjects the receipt of benefits for some services or supplies to a preauthorization review. Although a preauthorization review is generally done on a pre-service basis, it may in some case be conducted on a post-service basis. Unless a response is needed sooner due to the urgency of the situation, a pre-service preauthorization review will be completed and notification made to you and your medical provider as soon as possible, generally within two working days, but no later than 15 days within receipt of the request.

Urgent care claims--If the time period for making a non-urgent care determination could seriously jeopardize your life, health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is proposed, a preauthorization review will be completed as soon as possible, generally within 24 hours, but no later than 72 hours of receipt of the request.

Concurrent care review--Inpatient hospital or rehabilitative facilities, skilled nursing facilities, intensive outpatient, and residential behavioral health care require concurrent review for a benefit determination with regard to an appropriate length of stay or duration of service. Benefit determinations will be made as soon as possible but no later than one working day of receipt of all the information necessary to make such a determination.

Post-service claims--A claim determination that involves only the payment of reimbursement of the cost of medical care that has already been provided will be made as soon as reasonably possible but no later than 30 days from the day after receiving the claim.

Retrospective review--A claim for benefits for which the service or supply requires a preauthorization review but was not submitted for review on a pre-service basis will be reviewed on a retrospective basis within 30 working days after receipt of the information necessary to make a claims determination.

Extension of time--Despite the specified timeframes, nothing prevents the member from voluntarily agreeing to extend the above timeframes. Unless additional information is needed to process your claim, PacificSource will make every effort to meet the timeframes stated above. If a claim cannot be paid within the stated timeframes because additional information is needed, we will acknowledge receipt of the claim and explain why payment is delayed. If we do not receive the necessary information within 15 days of the delay notice, we will either deny the claim or notify you every 45 days while the claim remains under investigation. No extension is permitted for urgent care claims.

Payment of claims--PacificSource has the sole right to pay benefits to the member, the provider, or both jointly. Neither the benefits of this policy nor a claim for payment of benefits under the policy are assignable in whole or in part to any person or entity.

Adverse benefit determinations--A decision made to reduce or deny benefits applied on a pre-service, post-service, or concurrent care basis may be appealed in accordance with the plan's Appeals procedures (see Complaints, Grievances, and Appeals section below).

Questions About Claims

If you have questions about the status of a claim, you are welcome to contact the PacificSource Customer Service Department. You may also contact Customer Service if you believe a claim was denied in error. We will review your claim and your group policy benefits to determine if the claim is eligible for payment. Then we will either reprocess the claim for payment, or contact you with an explanation.

Benefits Paid in Error

If PacificSource makes a payment to you that you are not entitled to, or pays a person who is not eligible for payment, we may recover the payment. We may also deduct the amount paid in error from your future benefits.

In the same manner, if PacificSource applies medical expense to the plan deductible that would not otherwise be reimbursable under the terms of this policy; we may deduct a like amount from the accumulated deductible amount and/or recover payment of medical expense that would have otherwise been applied to the deductible. Examples of amounts recoverable under this provision include, but are not limited to benefits provided for incurred expense for the treatment of an excluded pre-existing medical condition (see Pre-existing condition in Definitions section). The fact that a medical expense was applied to the plan's deductible or a drug was provided under the plan's prescription drug program does not in itself create an eligible expense or infer that benefits will continue to be provided for an otherwise excluded condition.

COORDINATION OF BENEFITS

If you, or your enrolled dependents, are covered by more than one group insurance plan, PacificSource will work with your other insurance carriers to pay up to 100 percent of your covered expenses. This is called 'coordination of benefits.' We do this so you receive the maximum benefits available from all sources for the cost of your care.

When benefits are coordinated, one plan pays benefits first (the 'primary coverage') and the other pays based on the remaining balance (the 'secondary coverage'). If your primary and/or secondary coverage include a deductible, you will be required to satisfy each of those deductibles concurrently before benefits are available. The secondary plan shall credit to its deductible any amounts it would have credited to its deductible in the absence of the primary plan. This plan's rules for coordination of benefits are consistent with the requirements of coordination of benefits provision in Oregon Insurance regulations.

Here is how this plan's benefits are coordinated with your other group coverage:

- If the other plan does not include 'coordination of benefits,' that plan is primary and this plan is secondary.
- If you are covered as an employee on one plan and a dependent on another, your employer's plan is primary.
- When a child is covered under both parents' policies and the parents are either married or are living together (regardless of whether or not they have ever been married):
  - The parent whose birthday falls first in a calendar year has the primary plan; or
  - If both parents have the same birthday, the parent who has been covered the longest has the primary plan.

EXAMPLE *If your birthday is March 1 and your spouse's birthday is October 15, your plan is primary for your children.*

- When a child is covered under both parents' policies and the parents are divorced, separated, or not living together (regardless of whether or not they have ever been married):
  - If a court order specifies that one parent is responsible for the child's healthcare expenses, the mandated parent's coverage is primary regardless of custody.
  - If a court order specifies that both parents are responsible for the child's healthcare expenses, the parent whose birthday falls first in a calendar year has the primary plan. If both parents have the same birthday, the parent who has been covered the longest has the primary plan.
  - If a court order specifies that both parents have joint custody without specifying that one parent has responsibility for the child's healthcare expenses, the parent whose birthday falls first in a calendar year has the primary plan. If both parents have the same birthday, the parent who has been covered the longest has the primary plan.
  - If there is no court order, the order of benefits for the child are as follows:
    - The custodial parent's coverage is primary;
    - The spouse of the custodial parent's coverage pays second;
    - The natural parent without custody's coverage pays third; and
    - The spouse of the natural parent without custody's coverage pays fourth.
- If a plan covers you as an active employee or a dependent of an active employee, that plan is primary. Another plan covering you as inactive, laid off, or retired is secondary.
- If none of these rules apply, the coverage that has been in place longest is primary.

Most insurance companies send you an explanation of benefits, or EOB, when they pay a claim. If your other plan's coverage is primary, send PacificSource the other plan's EOB with your original bill and we will process your claim. If this plan is primary, send your PacificSource EOB and the original bill to your other insurance company. In most cases that is all the insurer needs to process your claim.

If you receive more than you should when your benefits are coordinated, you will be expected to repay any over-payment.

Coordination with Medicare

- *Medicare eligibility due to age:* If you are Medicare eligible due to age, this plan only pays the portion of covered charges that would not be paid by Medicare Parts A and B. This rule applies regardless of whether you are actually enrolled in Medicare Parts A and B. In other words, this plan pays secondary for anyone eligible for Medicare Parts A and B, even if they have not enrolled in Medicare.

If you are Medicare eligible due to age, and your employer has 19 or fewer employees, and you have not applied for both Medicare Parts A and B, please contact the PacificSource Membership Services Department immediately. We may arrange to pay your claims without a reduction in benefits until your next opportunity to enroll in Medicare coverage. You can reach Membership Services by phone at (541) 684-5583 or toll-free (866) 999-5583, or by email at membership@pacificsource.com.

- *Medicare disabled and end-stage renal disease (ESRD) patients*: The rules above may not apply to disabled people under 65 and ESRD patients enrolled in Medicare. For information on coordination of benefits in those situations, please contact PacificSource.

THIRD PARTY LIABILITY

Third party liability means claims that are the responsibility of someone other than PacificSource. The liable party may be a person, firm, or corporation. Auto accidents and 'slip-and-fall' property accidents are examples of common third party liability cases. If you use this plan's benefits for an illness or injury you think may involve another party, contact PacificSource immediately.

A third party includes liability and casualty insurance, and any other form of insurance that may pay money to or on behalf of a member, including but not limited to uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, PIP coverage, homeowner's insurance, and workers' compensation insurance.

If you use this plan's benefits for an illness or injury you think may involve another party, contact PacificSource right away.

When we receive a claim that might involve a third party, we will send you a questionnaire to help us determine responsibility.

In all third party liability situations, this plan's coverage is secondary. By enrolling in this plan, you automatically agree to the following terms regarding third party liability situations:

- If PacificSource pays any claim determined to be the responsibility of another party, you will hold the right of recovery against the other party in trust for PacificSource.
- PacificSource is entitled to reimbursement for any paid claims if there is a settlement or judgment from the other party. This is so regardless of whether the other party or insurer admits liability or fault.
- PacificSource may subtract a proportionate share of the reasonable attorney's fees you incurred from the money you are to pay back to PacificSource.
- PacificSource may ask you to take action to recover medical expenses we have paid from the responsible party. PacificSource may also assign a representative to do so on your behalf. If there is a recovery, PacificSource will be reimbursed for any expenses or attorney's fees out of that recovery.
- If you receive a third party settlement, that money must be used to pay your related medical expenses incurred both before and after the settlement. If you have ongoing medical expenses after the settlement, PacificSource may deny your related claims until the full settlement (less reasonable attorney's fees) has been used to pay those expenses.
- In a third party liability situation, PacificSource will ask you to agree to the third party liability terms of the group health policy by signing an agreement. PacificSource is not required to pay benefits until that agreement is signed and returned.

Motor Vehicle and Other Accidents

If you are involved in a motor vehicle accident or other accident, your related medical expenses are not covered by this plan if they are covered by any other type of insurance policy.

PacificSource may pay your medical claims from the accident if an insurance claim has been filed with the other insurance company and that insurance has not yet paid. But before we do that, you must sign a written agreement to reimburse PacificSource out of any money you recover.

By enrolling in this plan, you agree to the terms in the previous section regarding third party liability.

On-the-Job Illness or Injury and Workers' Compensation

This plan does not cover any work-related illness or injury, including those arising from self-employment. The only exception is if you are an owner, partner, or principal of the employer group insured by PacificSource, injured in the course of employment of the employer group insured by PacificSource, and are otherwise exempt from, and not covered by, state or federal workers' compensation insurance.

If you are not the owner, partner, or principal of this group then PacificSource may pay your medical claims if a workers' compensation claim has been denied on the basis that the illness or injury is not work related, and the denial is under appeal. But before we do that, you must sign a written agreement to reimburse PacificSource out of any money you recover from the workers' compensation coverage.

The contractual rules for third party liability, motor vehicle and other accidents, and on-the-job illness or injury are complicated and specific. Please refer to your group policy for complete details, or contact the PacificSource Third Party Claims Department.

COMPLAINTS, GRIEVANCES, AND APPEALS

Questions, Concerns, or Complaints

PacificSource understands that you may have questions or concerns about your benefits, eligibility, the quality of care you receive, or how we reached a claim determination or handled a claim. We try to answer your questions promptly and give you clear, accurate answers.

If you have a question, concern, or complaint about your PacificSource coverage, please contact our Customer Service Department. Many times our Customer Service staff can answer your question or resolve an issue to your satisfaction right away. If you feel your issues have not been addressed, you have the right to submit a grievance and/or appeal in accordance with this section.

GRIEVANCE PROCEDURES

If you are dissatisfied with the availability, delivery, or the quality of healthcare services; or claims payment, handling or reimbursement for healthcare services; or matters pertaining to the contractual relationship between you and PacificSource, you may file a grievance in writing. PacificSource will attempt to address your grievance, generally within 30 days of receipt (see How to Submit Grievances or Appeals below).

APPEAL PROCEDURES

First Appeal: If you believe PacificSource has, reduced or terminated a health care item or service, or failed or refused to provide or make a payment in whole or in part for a health care item or service, that is based on any of the reasons listed below, you or your authorized representative may request an appeal (review). Except in the case of an expedited review request, the request for appeal must be made in writing and within 180 days of the adverse benefit determination (see How to Submit Grievances or Appeals below). You may appeal if there is an adverse benefit determination based on a:

- Denial of eligibility for or termination of enrollment in a healthcare plan;
- Rescission or cancellation of your policy;

- Imposition of a pre-existing condition exclusion, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered services or items;
- Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate; or
- Determination that a course or plan of treatment you are undergoing is an active course of treatment for the purpose of continuity of care.

PacificSource staff involved in the initial adverse benefit determination will not be involved in the internal appeal.

You or your authorized representative may submit additional comments, documents, records and other materials relating to the adverse benefit determination that is the subject of the appeal.

You will receive continued coverage under the health benefit plan for otherwise covered services pending the conclusion of the internal appeals process. If PacificSource makes payment for any service or item on your behalf that is later determined not to be a covered service or item, you will be expected to reimburse PacificSource for the non-covered service or item.

Second Internal Appeal: If you are not satisfied with the first internal appeal decision, you may request an additional review. Your appeal and any additional information not presented with your first internal appeal should be forwarded to PacificSource within 60 days of the first appeal response.

Request for Expedited Response: If there is a clinical urgency to do so, you or your authorized representative may request in writing or orally, an expedited response to an internal or external review of an adverse benefit determination. To qualify for an expedited response, your attending physician must attest to the fact that the time period for making a non-urgent benefit determination could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request. If your appeal qualifies for an expedited review and would also qualify for external review (see External Independent Review below) you may request that the internal and external reviews be performed at the same time.

External Independent Review: If your dispute with PacificSource relates to an adverse benefit determination that a course or plan of treatment is not medically necessary; is experimental or investigational; is not an active course of treatment for purposes of continuity of care; or is not delivered in an appropriate health care setting and with the appropriate level of care, you or your authorized representative may request an external review by an independent review organization (see How to Submit Grievances or Appeals below).

Your request for an independent review must be made within 180 days of the date of the second internal appeal response. External independent review is available at no cost to you, but is generally only available when coverage has been denied for the reasons stated above and only after all internal grievance levels are exhausted.

PacificSource may, at its discretion and with your consent, waive the requirements of compliance with the internal appeals process and have a dispute referred directly to external review. You shall be deemed to have exhausted internal appeals if PacificSource fails to strictly comply with its appeals process and with state and federal requirements for internal appeals. If PacificSource fails to comply with the decision of the independent review organization assigned under Oregon law, you have a private right of action (sue) against PacificSource for damages arising from an adverse benefit determination subject to the external review.

If you have questions regarding Oregon's external review process, you may contact the Oregon Insurance Division at (503) 947-7984 or the toll-free message line at (888) 877-4894.

Timelines for Responding to Appeals

You will be afforded two levels of internal appeal and, if applicable to your case, an external review. PacificSource will acknowledge receipt of an appeal no later than seven days after receipt. A decision in response to the appeal will be made within 30 days after receiving notice of the appeal.

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

Information Available with Regard to an Adverse Benefit Determination

Upon request, PacificSource will provide you with access to the following information at no charge:

- Any documents, records, and other information relevant to the adverse benefit determination;
- A copy of the specific internal rule or guideline PacificSource used in the adverse benefit determination; and
- An explanation of the scientific or clinical judgment for the adverse benefit determination, if the adverse benefit determination is based on medical necessity, experimental treatment, or a similar exclusion.

HOW TO SUBMIT GRIEVANCES OR APPEALS

Before submitting a grievance or appeal, we suggest you contact our Customer Service Department with your concerns. You can reach us by phone at (541) 684-5582 or toll-free at (888) 977-9299, or by email at cs@pacificsource.com. Issues can often be resolved at this level. Otherwise, you may file a grievance or appeal by:

- **Writing to:**

  PacificSource Health Plans
  Attn: Grievance Review
  PO Box 7068
  Springfield, OR 97475-0068

- **Emailing** a message to lc@pacificsource.com, with ‘Grievance’ as the subject
- **Faxing** your message to (541) 225-3628

If you are unsure of what to say or how to prepare a grievance, please call our Customer Service Department. We will help you through the grievance process and answer any questions you have.

Assistance Outside PacificSource

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

- By calling (503) 947-7984 or the toll-free message line at (888) 877-4894
- By writing to:

  The Oregon Insurance Division
  Consumer Advocacy Unit
  PO Box 14489
  Salem, OR 97309-0405

- Through the Internet at http://insurance.oregon.gov/consumer/consumer.html
- Or by email at cp.ins@state.or.us

SOURCES FOR INFORMATION AND ASSISTANCE

Assistance in Other Languages

PacificSource members who do not speak English may contact our Customer Service Department for assistance. We can usually arrange for a multilingual staff member or interpreter to speak with them in their native language.

Information Available from PacificSource

PacificSource makes the following written information available to you free of charge. You may contact our Customer Service Department by phone, mail, or email to request any of the following:

- A directory of participating healthcare providers under your plan
- Information about our drug formulary, if your plan benefits include coverage for prescription drugs
- A copy of our annual report on complaints and appeals
- A description (consistent with risk-sharing information required by the Centers for Medicare and Medicaid Services, formerly known as Health Care Financing Administration) of any risk-sharing arrangements we have with providers
- A description of our efforts to monitor and improve the quality of health services
- Information about how we check the credentials of our network providers and how you can obtain the names and qualifications of your healthcare providers
- Information about our preauthorization and utilization review procedures

Information Available from the Oregon Insurance Division

The following consumer information is available from the Oregon Insurance Division:

- The results of all publicly available accreditation surveys
- A summary of our health promotion and disease prevention activities
- Samples of the written summaries delivered to PacificSource policyholders
- An annual summary of grievances and appeals against PacificSource
- An annual summary of our utilization review policies
- An annual summary of our quality assessment activities
- An annual summary of the scope of our provider network and accessibility of healthcare services

You can request this information by contacting the Oregon Insurance Division by writing to the Oregon Insurance Division, Consumer Advocacy Unit, PO Box 14489, Salem, OR 97309-0405 or by phone at (503) 947-7984, or the toll-free message line at (888) 877-4894, on the Internet at http://insurance.oregon.gov/consumeer/consumer.html, or by email at cp.ins@state.or.us.

FEEDBACK AND SUGGESTIONS

As a PacificSource member, you are encouraged to help shape our corporate policies and practices. We welcome any suggestions you have for improving your plan or our services.

You may send comments or feedback using the 'Contact Us' form on our website, PacificSource.com. You may also write to us at:

PacificSource Health Plans
Attn: Executive Vice President and Chief Operating Officer
PO Box 7068
Springfield OR 97475-0068

RIGHTS AND RESPONSIBILITIES

PacificSource is committed to providing you with the highest level of service in the industry. By respecting your rights and clearly explaining your responsibilities under this plan, we will promote effective healthcare.

Your Rights as a Member:

- You have a right to receive information about PacificSource, our services, our providers, and your rights and responsibilities.
- You have a right to expect clear explanations of your plan benefits and exclusions.
- You have a right to be treated with respect and dignity.
- You have a right to impartial access to healthcare without regard to race, religion, gender, national origin, or disability.
- You have a right to honest discussion of appropriate or medically necessary treatment options. You are entitled to discuss those options regardless of how much the treatment costs or if it is covered by this plan.
- You have a right to the confidential protection of your medical records and personal information.
- You have a right to voice complaints about PacificSource or the care you receive, and to appeal decisions you believe are wrong.
- You have a right to participate with your healthcare provider in decision-making regarding your care.
- You have a right to know why any tests, procedures, or treatments are performed and any risks involved.
- You have a right to refuse treatment and be informed of any possible medical consequences.
- You have a right to refuse to sign any consent form you do not fully understand, or cross out any part you do not want applied to your care.
- You have a right to change your mind about treatment you previously agreed to.

Your Responsibilities as a Member:

- You are responsible for reading this benefit handbook and all other communications from PacificSource, and for understanding your plan's benefits. You are responsible for contacting PacificSource Customer Service if anything is unclear to you.

- You are responsible for making sure your provider obtains preauthorization for any services that require it before you are treated.
- You are responsible for providing PacificSource with all the information required to provide benefits under your plan.
- You are responsible for giving your healthcare provider complete health information to help accurately diagnose and treat you.
- You are responsible for telling your providers you are covered by PacificSource and showing your ID card when you receive care.
- You are responsible for being on time for appointments, and calling your provider ahead of time if you need to cancel. You are responsible for any fees the provider charges for late cancellations or 'no shows.'
- You are responsible for following the treatment plans or instructions agreed on by you and your healthcare provider.
- You are responsible for contacting PacificSource if you believe you are not receiving adequate care.

PRIVACY AND CONFIDENTIALITY

PacificSource has strict policies in place to protect the confidentiality of your personal information, including your medical records. Your personal information is only available to the PacificSource staff members who need that information to do their jobs.

Disclosure outside PacificSource is allowed only when necessary to provide your coverage, or when otherwise allowed by law. Except when certain statutory exceptions apply, Oregon law requires us to have written authorization from you (or your representative) before disclosing your personal information outside PacificSource. An example of one exception is that we do not need written authorization to disclose information to a designee performing utilization management, quality assurance, or peer review on our behalf.

PLAN ADMINISTRATION

Group Insurance Contract

This plan is fully insured. Benefits are provided under a group insurance contract between your employer and PacificSource Health Plans. Your employer--the policyholder--has a copy of the group insurance contract, which contains specific information regarding eligibility and benefits. Under the insurance contract, PacificSource--not the policyholder--is responsible for paying claims. However, the policyholder and PacificSource share responsibility for administering the plan's eligibility and enrollment requirements. The policyholder has given PacificSource discretionary authority to determine eligibility for benefits under the plan and to interpret the terms of the plan.

If there are any conflicts between this benefit book and the group health contract, the group health contract will govern.

Our address is:

PacificSource Health Plans
PO Box 7068
Springfield OR 97475-0068

Plan Funding

Insurance premiums for employees are paid in whole or in part by the plan sponsor (your employer) out of its general assets. Any portion not paid by the plan sponsor is paid by employee payroll deductions.

Plan Changes

The terms, conditions, and benefits of this plan may be changed from time to time. The following people have the authority to accept or approve changes or terminate this plan:

- The policyholder's board of directors or other governing body
- The owner or partners of the business
- Anyone authorized by the above people to take such action

The plan administrator is authorized to apply for and accept policy changes on behalf of the policyholder.

If changes occur, PacificSource will provide your plan administrator with information to notify you of changes to your plan. Your plan administrator will then communicate any benefit changes to you.

If your group policy terminates and your employer does not replace the coverage with another group policy, your employer is required by law to advise you in writing of the termination. When this policy terminates, PacificSource will notify your employer about any continuation or portability coverage available to you.

Legal Procedures

You may not take legal action against PacificSource to enforce any provision of the group contract until 60 days after your claim is submitted to us. Also, you must exhaust this plan's claims procedures before filing benefits litigation. You may not take legal action against PacificSource more than three years after the deadline for claim submission has expired.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Generally, health benefit plans subject to ERISA include employer-sponsored plans, but do not include governmental and church plans or any other statute-exempt plan. If the plan under which you are covered is an ERISA plan, you have the right to bring civil action under ERISA section 502 to enforce your current or future rights under the terms of the plan or to recover benefits due you. Although PacificSource offers you the opportunity of a second level appeal and an independent review, ERISA permits civil action after you have received our decision at the first level appeal as described under the Complaints, Grievances, and Appeals - Grievance and Appeal Procedures section.

Your rights under ERISA

As a participant in an ERISA plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). The policyholder (your employer) is the 'plan administrator' as defined in ERISA. The plan administrator is an agent of those individually enrolled under the group policy, and is not the agent of PacificSource. ERISA states that all plan participants are entitled to:

Receive information about your plan and benefits.

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report (Form 5500 Series). The plan administrator is required by law to furnish each participant with a copy of this summary annual report only in a year in which the plan has to file an annual report.

Continue group health plan coverage.

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for six months (12 months for late enrollees) after your enrollment date in your coverage.

Prudent actions by plan fiduciaries.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called 'fiduciaries' of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising any rights under ERISA.

Enforce your rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see the Complaints, Grievances, and Appeals - Appeal Procedures section).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. (A claimant will need to exhaust the plan's claims procedure before filing benefits litigation; see the Complaints, Grievances, and Appeals - Appeal Procedures section and the first paragraph of this section.) In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance with your questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of Employee Benefits Security Administration., U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration., U.S. Department of

Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEFINITIONS

Wherever used in this plan, the following definitions apply to the terms listed below, and the masculine includes the feminine and the singular includes the plural. For the purpose of this plan, 'employee' includes the employer when covered by this plan. Other terms are defined where they are first used in the text.

Accident means an unforeseen or unexpected event causing injury that requires medical attention.

Advanced diagnostic imaging means diagnostic examinations using CT scans, MRIs, PET scans, CATH labs, and nuclear cardiology studies.

Adverse benefit determination means PacificSource's denial, reduction, or termination of a healthcare item or service, or PacificSource's failure or refusal to provide or to make a payment in whole or in part for a healthcare item or service, that is based on PacificSource's:

- Denial of eligibility for or termination of enrollment in a health benefit plan;
- Rescission or cancellation of a policy or coverage;
- Imposition of a pre-existing condition exclusion, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;
- Determination that a healthcare item or service is experimental, investigational, or not medically necessary, effective, or appropriate; or
- Determination that a course or plan of treatment that a member is undergoing it an active course of treatment for purposes of continuity of care under ORS 743.854.

Allowable fee is the dollar amount established by PacificSource for reimbursement of charges for specific services or supplies provided by non-participating providers. PacificSource uses several sources to determine the allowable fee. Depending on the service or supply and the geographical area in which it is provided, the allowable fee may be based on data collected from the Centers for Medicare and Medicaid Services (CMS), Viant Health Payment Solutions, PacificSource Health Plans, or other nationally recognized databases.

Where the provider network is deemed adequate, the allowable fee for professional services is based on PacificSource's standard participating provider reimbursement rate or a contracted reimbursement rate. Outside the PacificSource service area and in areas where the participating provider network is not deemed adequate, the allowable fee is based on the usual, customary, and reasonable charge (UCR) at the 85th percentile. UCR is based on data collected for a geographic area. Provider charges for each type of service are collected and ranked from lowest to highest. Charges at the 85th position in the ranking are considered to be the 85th percentile.

Ambulatory surgical center means a facility licensed by the appropriate state or federal agency to perform surgical procedures on an outpatient basis.

Authorized representative is an individual who by law or by the contest of a person may act on behalf of the person.

Benefit determination means the activity taken to determine or fulfill PacificSource's responsibility for provisions under this health benefit plan and provide reimbursement for healthcare in accordance with those provisions. Such activity may include:

- Eligibility and coverage determinations (including coordination of benefits), and adjudication or subrogation of health benefit claims;

- Review of healthcare services with respect to medical necessity (including underlying criteria), coverage under the health plan, appropriateness of care, experimental/investigational treatment, justification of charges; and
- Utilization review activities, including precertification and preauthorization of services and concurrent and retrospective review of services.

Calendar year means the 12-month period beginning on each January 1 and ending on the next December 31.

Cardiac rehabilitation refers to a comprehensive program that generally involves medical evaluation, prescribed exercise, and cardiac risk factor modification. Education, counseling, and behavioral interventions are sometimes used as well. Phase I refers to inpatient services that typically occur during hospitalization for heart attack or heart surgery. Phase II refers to a short-term outpatient program, usually involving ECG-monitored exercise. Phase III refers to a long-term program, usually at home or in a community-based facility, with little or no ECG monitoring.

Chemical dependency means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological, or physical adjustment to common problems on a recurring basis. Chemical dependency does not include addiction to, or dependency on, tobacco products or foods.

Complaint means an expression of dissatisfaction directly to PacificSource that is about a specific problem encountered by a member, or about a benefit determination by PacificSource or an agent acting on behalf of PacificSource, and that includes a request for action to resolve the problem or change the benefit determination. Complaint does not include an inquiry.

Contract year means a 12-month period beginning on the date the insurance contract is issued or the anniversary of the date the insurance contract was issued. If changes are made to the insurance contract on a date other than the anniversary of issuance, a new contract year may start on the date the changes become effective if so agreed by PacificSource and the policyholder. A contract year may or may not coincide with a calendar year.

Contracted reimbursement rate is an amount PacificSource agrees to pay a participating provider for a given service or supply through direct or indirect contract.

Co-payment or co-insurance is the out-of-pocket amount a member is required to pay to a provider.

Creditable coverage means a member's prior health coverage that meets the following criteria:

- There was no more than a 63-day break between the last day of coverage under the previous policy and the first day of coverage under this policy. The 63-day limit excludes the employer's eligibility waiting period.
- The prior coverage was one of the following types of insurance: group coverage (including Federal Employee Health Benefit Plans and Peace Corps), individual coverage (including student health plans), Medicaid, Medicare, TRICARE, Indian Health Service or tribal organization coverage, state high-risk pool coverage, and public health plans.

Deductible means the portion of the healthcare expense that must be paid by the member before the benefits of this plan are applied.

Durable medical equipment means equipment that can withstand repeated use; is primarily and customarily used to serve a medical purpose rather than convenience or comfort; is generally not useful to a person in the absence of an illness or injury; is appropriate for use in the home; and is prescribed by a physician. Examples of durable medical equipment include but are not limited to hospital beds, wheelchairs, crutches, canes, walkers, nebulizers, commodes, suction machines, traction equipment, respirators, TENS units, and hearing aids.

Durable medical equipment supplier means a PacificSource contracted provider or a provider that satisfies the criteria in the Medicare Qualify Standards for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS) and Other Items and Services handbook.

Elective surgery or procedure refers to a surgery or procedure for a condition that does not require immediate attention and for which a delay would not have a substantial likelihood of adversely affecting the health of the patient.

Eligible employee means an employee who works on a regularly scheduled basis, with a normal workweek of 17.5 or more hours. Eligible employee does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed for fewer than 90 days are not eligible employees unless the employer and PacificSource so agree. Eligible employees may be covered under the group health policy only if they meet the eligibility requirements according to the terms of the policy (see Administrative Provisions - Eligibility).

Emergency medical condition means a medical condition:

- That manifests itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:
  - Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;
  - Result in serious impairment to bodily functions; or
  - Result in serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.

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

Emergency services means, with respect to an emergency medical condition:

- An emergency medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to stabilize the patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.

Employee means any individual employed by an employer.

Endorsement is a written attachment that alters and supersedes any of the terms or conditions set forth in this contract.

Enrollee means an employee, dependent of the employee, or individual otherwise eligible and enrolled for coverage under this plan. In this policy, enrollee is referred to as subscriber or member.

Essential health benefits are services defined as such by the Secretary of the U.S. Department of Health and Human Services. Essential health benefits fall into the following categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;

- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

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

Experimental or investigational procedures means services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines, or the use thereof, that are experimental or investigational for the diagnosis and treatment of illness or injury.

- Experimental or investigational services and supplies include, but are not limited to, services, supplies, procedures, devices, chemotherapy, drugs or medicines, or the use thereof, which at the time they are rendered and for the purpose and in the manner they are being used:
  - Have not yet received full U.S. government agency required approval (e.g., FDA) for other than experimental, investigational, or clinical testing;
  - Are not of generally accepted medical practice in the state of Oregon or as determined by PacificSource in consultation with medical advisors, medical associations, and/or technology resources;
  - Are not approved for reimbursement by the Centers for Medicare and Medicaid Services;
  - Are furnished in connection with medical or other research; or
  - Are considered by any governmental agency or subdivision to be experimental or investigational, not considered reasonable and necessary, or any similar finding.
- When making decisions about whether treatments are investigational or experimental, PacificSource relies on the above resources as well as:
  - Expert opinions of specialists and other medical authorities;
  - Published articles in peer-reviewed medical literature;
  - External agencies whose role is the evaluation of new technologies and drugs; and
  - External review by an independent review organization.
- The following will be considered in making the determination whether the service is in an experimental and/or investigational status:
  - Whether there is sufficient evidence to permit conclusions concerning the effect of the services on health outcomes;
  - Whether the scientific evidence demonstrates that the services improve health outcomes as much or more than established alternatives;
  - Whether the scientific evidence demonstrates that the services' beneficial effects outweigh any harmful effects; and
  - Whether any improved health outcomes from the services are attainable outside an investigational setting.

Generic drugs are drugs that, under federal law, require a prescription by a licensed physician (M.D. or D.O.) or other licensed medical provider and are not a brand name medication. By law, generic

drugs must have the same active ingredients as the brand name medication and are subject to the same standards of their brand name counterpart.

Grievance means:

- A request submitted by a member or an authorized representative of a member;
  - In writing, for an internal appeal or an external review; or
  - In writing or orally, for an expedited internal review or an expedited external review; or
- A written complaint submitted by a member or an authorized representative of a member regarding:
  - The availability, delivery, or quality of a healthcare service;
  - Claims payment, handling, or reimbursement for healthcare services and, unless the member has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or
  - Matters pertaining to the contractual relationship between a member and PacificSource.

Health benefit plan means any hospital expense, medical expense, or hospital or medical expense policy or certificate, healthcare contractor or health maintenance organization subscriber contract, or any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that plan is subject to state regulation.

Hearing aids mean any nondisposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords. Hearing aids include any amplifying device that does not produce as its output an electrical signal that directly stimulates the auditory nerve. For the purpose of this definition, such amplifying devices include air conduction and bone conduction devices, as well as those that provide vibratory input to the middle ear.

Homebound means the ability to leave home only with great difficulty with absences infrequently and of short duration. Infants and toddlers will not be considered homebound without medical documentation that clearly establishes the need for home skilled care. Lack of transportation is not considered sufficient medical criterion for establishing that a person is homebound.

Hospital means an institution licensed as a 'general hospital' or 'intermediate general hospital' by the appropriate state agency in the state in which it is located.

Illness includes a physical or mental condition that results in a covered expense. Physical illness is a disease or bodily disorder. Mental illness is a psychological disorder that results in pain or distress and substantial impairment of basic or normal functioning.

Incurred expense means charges of a healthcare provider for services or supplies for which a member becomes obligated to pay. The expense of a service is incurred on the day the service is rendered, and the expense of a supply is incurred on the day the supply is delivered.

Initial enrollment period means a period of 31 days following the date an individual is first eligible to enroll.

Injury means bodily trauma or damage that is independent of disease or infirmity. The damage must be caused solely by external and accidental means and does not include muscular strain sustained while performing a physical activity.

Inquiry means a written request for information or clarification about any subject matter related to the member's health benefit plan.

Internal appeal means a review by PacificSource of an adverse benefit determination made by PacificSource.

Leave of absence is a period of time off work granted to an employee by the employer at the employee's request and during which the employee is still considered to be employed and is carried on the employment records of the employer. A leave can be granted for any reason acceptable to the employer, including disability and pregnancy.

Lifetime maximum or lifetime benefit means the maximum benefit that will be provided toward the expenses incurred by any one person while the person is covered by a PacificSource insurance policy issued to the employer sponsoring this group health benefit plan. If any covered expense that includes a lifetime maximum benefit amount is deemed to be an 'essential health benefit' as determined by the Secretary of the U.S. Department of Health and Human Services, the lifetime maximum amount will not apply to that covered expense in accordance with the standards established by the Secretary.

Mastectomy is the surgical removal of all or part of a breast or a breast tumor suspected to be malignant.

Medically necessary means those services and supplies that are required for diagnosis or treatment of illness or injury and that are:

- Consistent with the symptoms or diagnosis and treatment of the condition;
- Consistent with generally accepted standards of good medical practice in the state of Oregon, or expert consensus physician opinion published in peer-reviewed medical literature, or the results of clinical outcome trials published in peer-reviewed medical literature;
- As likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any other service or supply, both as to the disease or injury involved and the patient's overall health condition;
- Not for the convenience of the member or a provider of services or supplies;
- The least costly of the alternative services or supplies that can be safely provided. When specifically applied to a hospital inpatient, it further means that the services or supplies cannot be safely provided in other than a hospital inpatient setting without adversely affecting the patient's condition or the quality of medical care rendered.

Services and supplies intended to diagnose or screen for a medical condition in the absence of signs or symptoms, or of abnormalities on prior testing, including exposure to infectious or toxic materials or family history of genetic disease, are not considered medically necessary under this definition (see General Exclusions - Screening tests).

Medical supplies means items of a disposable nature that may be essential to effectively carry out the care a physician has ordered for the treatment or diagnosis of an illness or injury. Examples of medical supplies include but are not limited to syringes and needles, splints and slings, ostomy supplies, sterile dressings, elastic stockings, enteral foods, drugs or biologicals that must be put directly into the equipment in order to achieve the therapeutic benefit of the durable medical equipment or to assure the proper functioning of this equipment (e.g. Albuterol for use in a nebulizer).

Member means an individual insured under a PacificSource health policy.

Mental and/or chemical healthcare facility means a corporate or governmental entity or other provider of services for the care and treatment of chemical dependency and/or mental or nervous conditions which is licensed or accredited by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities for the level of care which the facility provides.

Mental and/or chemical healthcare program means a particular type or level of service that is organizationally distinct within a mental and/or chemical healthcare facility.

Mental and/or chemical healthcare provider means a person that has met the credentialing requirements of PacificSource, is otherwise eligible to receive reimbursement under the policy and is:

- A healthcare facility;

- A residential program or facility where appropriately licensed or accredited by the Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities;
- A day or partial hospitalization program;
- An outpatient service; or
- An individual behavioral health or medical professional authorized for reimbursement under Oregon law.

Mental or nervous conditions health means all disorders listed in the 'Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition' except for:

- Mental Retardation (diagnostic codes 317, 318.0, 318.1, 318.2, 319);
- Learning Disorders (diagnostic codes 315.00, 315.1, 315.2, 315.9);
- Paraphilias (diagnostic codes 302.4, 302.81, 302.89, 302.2, 302.83, 302.84, 302.82, 302.9);
- Gender Identity Disorders in Adults (diagnostic codes 302.85, 302.6, 302.9 - this exception does not extend to children and adolescents 18 years of age or younger); and
- 'V' codes (diagnostic codes V15.81 through V71.09 - this exception does not extend to children five years of age or younger for diagnostic codes V61.20, V61.21, and V62.82).

Network not available means a member does not have reasonable geographic access to a PacificSource participating provider for a medical service or supply.

Non-participating provider is a provider of covered medical services or supplies that does not directly or indirectly hold a provider contract or agreement with PacificSource.

Non-preferred drugs are covered brand name medications not on the Value Drug List.

Orthotic devices means rigid or semirigid devices 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. Benefits for orthotic devices include orthopedic appliances or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. An orthotic device differs from a prosthetic in that, rather than replacing a body part, it supports and/or rehabilitates existing body parts. Orthotic devices are usually customized for an individual's use and are not appropriate for anyone else. Examples of orthotic devices include but are not limited to Ankle Foot Orthosis (AFO), Knee Ankle Foot Orthosis (KAFO), Lumbosacral Orthosis (LSO), and foot orthotics.

Participating provider means a physician, healthcare professional, hospital, medical facility, or supplier of medical supplies that directly or indirectly holds a provider contract or agreement with PacificSource.

Physical/occupational therapy is comprised of the services provided by (or under the direction and supervision of) a licensed physical or occupational therapist. Physical/occupational therapy includes emphasis on examination, evaluation, and intervention to alleviate impairment and functional limitation and to prevent further impairment or disability.

Physician means a state-licensed Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.).

Physician assistant is a person who is licensed by an appropriate state agency as a physician assistant.

Practitioner means Doctor or Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Licensed Nurse Practitioner (including Certified Nurse Midwife (C.N.M.) and Certified Registered Nurse Anesthetist (C.R.N.A.)), Registered Physical Therapist (R.P.T.), Speech Therapist, Occupational Therapist, Psychologist (Ph.D.), Licensed Clinical Social Worker (L.C.S.W.), Licensed Professional Counselor (L.P.C.), Licensed Marriage and Family

Therapist (LMFT), Licensed Psychologist Associate (LPA), Physician Assistant (PA), Audiologist, Acupuncturist, Naturopathic Physician, and Licensed Massage Therapist.

Pre-existing condition means a condition (physical or mental) for which medical advice, diagnosis, care, or treatment was recommended by or received from a licensed provider within the six-month period ending on the enrollment date. For the purpose of this definition, the enrollment date of a member is the earlier of the effective date of coverage or the first day of any required group eligibility waiting period, and the enrollment date of a late enrollee is the effective date of coverage. Pregnancy does not constitute a pre-existing condition, nor does genetic information without a diagnosis of a condition related to such information.

Preferred is a list of approved brand name medications used to treat various medical conditions. The Value Drug List is developed by the pharmacy benefits management company and PacificSource.

Prescription drugs are drugs that, under federal law, require a prescription by a licensed physician (M.D. or D.O.) or other licensed medical provider.

Prosthetic devices (excluding dental) means artificial limb devices or appliances designed to replace in whole or in part an arm or a leg. Benefits for prosthetic devices include coverage of devices that replace all or part of an internal or external body organ, or replace all or part of the function of a permanently inoperative or malfunctioning internal or external organ, and are furnished on a physician's order. Examples of prosthetic devices include but are not limited to artificial limbs, cardiac pacemakers, prosthetic lenses, breast prosthesis (including mastectomy bras), and maxillofacial devices.

Registered domestic partner means a same gender individual, age 18 or older, who is joined in a domestic partnership, and whose domestic partnership is registered with the state of Oregon.

Routine costs of care means medically necessary conventional care, items, or services covered by the health benefit plan if typically provided absent a clinical trial. Routine costs of care do not include:

- The drug, device, or service being tested in the clinical trial unless the drug, device, or service would be covered for that indication by the policy if provided outside of a clinical trial;
- Items or services required solely for the provisions of the drug, device, or service being tested in the clinical trial;
- Items or services required solely for the clinically appropriate monitoring of the drug, device, or service being tested in the clinical trial;
- Items of 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;
- 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 patient;
- Items or services customarily provided by a clinical trial sponsor free of charge to any participant in the clinical trial; or
- Items or services that are not covered by the policy if provided outside of the clinical trial.

Seasonal employee is an employee who is hired with the agreement that their employment will end after a predetermined period of time.

Skilled nursing facility convalescent home means an institution that provides skilled nursing care under the supervision of a physician, provides 24-hour nursing service by or under the supervision of a registered nurse (R.N.), and maintains a daily record of each patient. Skilled nursing facilities must be licensed by an appropriate state agency and approved for payment of Medicare benefits to be eligible for reimbursement.

Specialized treatment facility means a facility that provides specialized short-term or long-term care. The term specialized treatment facility includes ambulatory surgical centers, birthing centers, chemical

dependency/substance abuse day treatment facilities, hospice facilities, inpatient rehabilitation facilities, mental and/or chemical healthcare facilities, organ transplant facilities, psychiatric day treatment facilities, residential treatment facilities, skilled nursing facilities, substance abuse treatment facilities, and urgent care treatment facilities.

Small employer means an employer that employed an average of at least two but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within the state of Oregon, and that employs at least two eligible employees on the date on which coverage takes effect under a health benefit plan offered by the employer.

Any person that is treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. The determination of whether an employer that was not in existence throughout the preceding calendar year is a small employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

Specialty drugs are high dollar oral, injectable, infused or inhaled biotech medications prescribed for the treatment of chronic and/or genetic disorders with complex care issues that have to be managed. The major conditions these drugs treat include but are not limited to: cancer, HIV/AIDS, hemophilia, hepatitis C, multiple sclerosis, Crohn's disease, rheumatoid arthritis, and growth hormone deficiency.

Specialty pharmacies specialize in the distribution of specialty drugs and providing pharmacy care management services designed to assist patients in effectively managing their condition.

Stabilize means to provide medical treatment as necessary to ensure that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur during or to result from the transfer of the patient from a facility; and with respect to a pregnant woman who is in active labor, to perform the delivery, including the delivery of the placenta.

Step therapy means a program that requires the member to try lower-cost alternative medications (Step 1 drugs) before using more expensive medications (Step 2 drugs). The program will not cover a brand name, or second-line medication, until less expensive, first-line/generic medications in the same therapeutic class have been tried first

Subscriber means an employee or former employee insured under a PacificSource health policy. When a family unit that does not include an employee or former employee is insured under a policy, the oldest family member is referred to as the subscriber.

Surgical procedure means any of the following operative procedures:

- Procedures accomplished by cutting or incision
- Suturing of wounds
- Treatment of fractures, dislocations, and burns
- Manipulations under general anesthesia
- Visual examination of the hollow organs of the body including biopsy, or removal of tumors or foreign body
- Procedures accomplished by the use of cannulas, needling, or endoscopic instruments
- Destruction of tissue by thermal, chemical, electrical, laser, or ultrasound means

Telemedical means medical services delivered through a two-way video communication that allows a provider to interact with a patient who is at a different physical location than the provider.

Tobacco use cessation program means a program recommended by a physician that follows the United States Public Health Services guidelines for tobacco use cessation. Tobacco use cessation program includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products.

Urgent care treatment facility means a healthcare facility whose primary purpose is the provision of immediate, short-term medical care for minor, but urgent, medical conditions.

Women's healthcare provider means an obstetrician, gynecologist, physician assistant or nurse practitioner specializing in women's health, or certified nurse midwife practicing within the applicable scope of practice.

Our Privacy Policy

PacificSource HEALTH PLANS

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Our Commitment to Ensure Your Privacy

The privacy of your medical information is important to PacificSource. Although we are required by law to maintain the privacy of your protected health information and provide you with this notice, we are sincere in our pledge to ensure the confidentiality of your nonpublic personal information, including your medical records. This information pertains to you and any covered dependents, so please be sure to share it with any family members covered under your plan.

How We May Use and Disclose Medical Information About You

We may share a member's personal information for the purpose of claims processing and payment. By signing an application for enrollment, the member acknowledges that personal information can be shared for that express purpose.

We may use and disclose medical information as follows:

Treatment

We may share your information with doctors or hospitals to help them provide medical care to you. For example, we might create a treatment plan with your doctor to help improve your health.

Payment

We may use and disclose medical information to process your medical claims or coordinate your benefits with other health plans. For example, we may need to disclose medical information to determine your eligibility for benefits, or to examine medical necessity.

Healthcare Operations

We may use and disclose medical information for regular health plan operations. For example, we may disclose medical information to underwrite your policies, ensure proper billing, engage in case coordination or case management, protect you against fraud, and provide you with excellent customer service. Please note that we are prohibited from using or disclosing protected health information that is genetic information about you for underwriting purposes.

Business Associates

Business associates provide necessary services to our organization through contracts. Some examples of business associates are prescription drug benefit administrators, utilization management organizations, and entities that perform quality assurance or peer review on our behalf. We may disclose the minimum necessary medical information to our business associates so they can perform the job we have asked them to do. To protect your medical information, we require our business associates to appropriately safeguard your information. We will not share your information with these outside groups unless there is a business need to do so and they agree to keep it protected. We require our business partners to treat your private information with the same high degree of confidentiality that we do.

Plan Administration

We may share enrollment information with your employer to verify your coverage and your family's coverage for benefits. We may share summary data that cannot be individually identified. We do not share any other information with employers unless we have your written authorization.

Marketing

We will never sell information about you to any third party for marketing or any other purpose not described in this notice. Further, we do not use personal information for investigative consumer research or reporting.

Individuals Involved in Your Care or Payment for Your Care

We may disclose your medical information to a family member, friend, or other person who you indicate is involved in your care or payment for your care. This only pertains to your medical information that is directly relevant to their involvement. We will only make this disclosure if you agree or when required or authorized by law. In the event of your incapacity or in an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

As Required By Law and For Law Enforcement

We may use or disclose your medical information when required or permitted by federal, state, or local law, or by a court order.

Public Health and Safety

We may disclose medical information about you to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others.

State and Federal Agencies

We may be required to report information to state and federal agencies that regulate us, such as the United States Department of Health and Human Services.

Lawsuits and Disputes

If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We will only make such disclosures if efforts have been made to tell you about the request.

Continued on reverse

Military and National Security
Under certain circumstances, we may disclose to military authorities the medical information of armed forces personnel. To authorized federal officials, we may disclose medical information required for lawful intelligence, counterintelligence, and other national security activities.

Workers' Compensation
We may disclose medical information to coordinate benefits with workers' compensation insurance carriers.

Information About Health-Related Benefits
We, or our Business Associate, may communicate to you about other services or health-related benefits that may be of interest to you.

Other Uses and Disclosures
If we use or disclose your information for any reason other than those listed above, we will first obtain your written authorization. State laws may prohibit us from disclosing the following types of sensitive personal information without your authorization: chemical dependency, mental health, psychotherapy, genetic, or HIV/AIDS records. If you give us written authorization, you may revoke it at any time. This will not affect information that has already been shared.

Your Rights Regarding Your Medical Information
You have these rights regarding protected health information we maintain about you:

Right to Inspect and Copy
You have the right to inspect and obtain a copy of most information we maintain about you. To do so, request and complete a form we will provide. You may be charged a fee for the cost of copying your records.

Right to Request a Correction
If you believe that medical information we have about you is incorrect or incomplete, you have the right to ask us to change or amend the information. To do so, request and complete a correction form available from us.

Right to an Accounting of Disclosures
You have the right to request a list of disclosures we have made of your medical information for purposes other than treatment, payment, healthcare operations, and other limited activities. To do so, request and complete a form available from us. Your request may not be for a record of more than six years and may not include dates before April 14, 2003.

Right to Request Restrictions
You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or healthcare operations. You also have the right to ask us to restrict information we may give to those involved in your care, such as a family member or friend. You must make this request using a form we will provide. While we may honor your request for restrictions, we are not required to agree to these restrictions. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment or comply with a legal requirement.

Right to Request Confidential Communications
You have the right to ask that we communicate with you about health matters in a certain way or at a certain location. We will attempt to accommodate all reasonable requests and may require that you make your request in writing.

Right to Receive a Paper Copy of This Notice
You have the right to ask for a paper copy of this notice at any time, and it will always be available on our Web site at PacificSource.com/privacy.aspx.

If you wish to exercise any of these rights, please contact PacificSource. You will find our contact information below

How to Report a Problem or File a Complaint
You may contact any of the people listed below to report a problem or file a complaint. You must do so in writing. Your benefits will not be affected by any complaints you make. We will not take any action against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe is unlawful.

Changes to this Notice of Privacy Practices
This Notice of Privacy Practices takes effect on April 14, 2003, and will remain in effect until we update or replace it. In the future, we may change our Notice of Privacy Practices. Any changes will apply to medical information we already have about you as well as any information we receive in the future. Before we make a significant change to our privacy practices, we will change this notice and supply a copy to you within 60 days.

You may request that this notice be mailed to you at any time, and it will always be available on our Web site at PacificSource.com/privacy.aspx.

Contact Information
If you have any questions about this notice or want more information, you're welcome to contact us.

PacificSource Health Plans

Contact:	Customer Service Department, PacificSource Health Plans
Office Hours:	Monday through Friday, 8:00 A.M. to 5:00 P.M.
Address:	PO Box 7068 Springfield, OR 97475
Telephone:	(541) 684-5582 or toll-free (888) 977-9299
Fax:	(541) 684-5264
E-mail:	cs@pacificsource.com
Web site:	PacificSource.com

Health and Human Services

Contact:	Office for Civil Rights, U.S. DHHS
Address:	2201 Sixth Ave - Mail Stop RX-11 Seattle, WA 98121
Telephone:	(206) 615-2290
TDD:	(206) 615-2296
Fax:	(206) 615-2297
E-mail:	ocrcomplaint@hhs.gov

Value Added

Programs and Services

PacificSource Extras: Valuable Programs and Services That Enhance Your Coverage

We hope you take advantage of the no-cost "extras" that are part of your PacificSource coverage.

Wellness Programs

Tobacco Cessation
Our Quit For Life™ program offers one-on-one treatment sessions with a professional Quit Coach to help tobacco users kick the habit. As a participant, you may also receive gum or patches as nicotine replacement therapy. When prescribed by your doctor, certain prescription medications to help you quit tobacco are available. These medications are subject to your pharmacy copayment. See our website or our Quit For Life Program flier for more information. Or call (866) QUIT-4-LIFE (784-8454).

Health and Wellness Education
You can receive a reimbursement for hospital-based health and wellness education classes in your area. The program will reimburse you for up to $50 per eligible class or class series, up to $150 per member per plan year. See our website or our Hospital-Based Health Education Classes flier for more information.

Prenatal Care
Our Prenatal Care Program helps expectant mothers learn more about their pregnancy and the development of their child. Participants receive educational materials and toll-free telephone access to a nurse consultant. High-risk members receive additional nurse support. See our website or our Prenatal Program flier for more information.

In addition, pregnant members with pharmacy coverage are eligible to receive nine months of prenatal vitamins at no cost. For details, see our website or contact our Pharmacy Services Department.

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If you have questions, you are welcome to contact our Customer Service Department at 888.977.9299 or email cs@pacificsource.com.

PacificSource HEALTH PLANS

Our Caremark® Prescription Discount Program, helps you save money on any prescription drugs not covered by your health plan. See our website PacificSource.com or our Prescription Discount Program flier for more information.

Save on Popular Weight Management Programs

As a part of your PacificSource medical coverage:

- Participate in a **Weight Watchers®** program and receive an annual reimbursement of $100 ($40 if an online Weight Watchers participant) for your Weight Watchers membership. Complete a minimum of ten weeks during a consecutive four-month period to be eligible.
- Receive **Jenny Craig®** program discounts: Free 30-Day Trial Program, 25% off a Premium Program.

For full details and eligibility requirements, visit the For Our Members > Health and Wellness area of PacificSource.com.

Discounted Gym Membership

As a PacificSource member you have access to discounted gym memberships of up to $120 per year through GlobalFit.

For full details, visit the For Our Members > Health and Wellness area of PacificSource.com.

Wellness for Kids

Six- and nine-year-olds currently covered by a PacificSource medical plan are invited by mail to join HealthKicks!, a children's program that promotes healthy behaviors.

Children enrolling in HealthKicks! will receive a total of four age-appropriate, educational activity books in the mail—one about every three months.

Travel Emergency Assistance Program

Assist America® Global Emergency Services

If you experience a medical emergency while traveling 100 or more miles from home or abroad, you can access services provided by Assist America at no cost. Services include medical consultation and evaluation, medical referrals, foreign hospital admission guarantee, critical care monitoring, and when medically necessary, evacuation to a facility that can provide treatment. For more information, see our website or our Global Emergency Services Provided by Assist America flier.

Pharmacy

Prescription Discount Program

Our Caremark prescription discount program helps you save money on any prescription drugs not covered by your health plan. Simply present your PacificSource member ID card at any Caremark network pharmacy to receive a discount on the cash price of any drugs that aren't covered by your plan or costing less than your copay or coinsurance.

Mail Order Service

We partner with both CVS Caremark and Wellpartner Pharmacy for mail order services. If your plan includes prescription drug coverage, mail order is a convenient and cost-saving option.

CVS Caremark
Caremark.com
(866) 329-3051

CVS Caremark
PO Box 659541
San Antonio, TX 78265-9541

Wellpartner
Wellpartner.com
(877) 568-6460

Wellpartner, Inc.
PO Box 5909
Portland, OR 97228-5909

Care Management

AccordantCare

Our AccordantCare® Rare Disease Program provides ongoing one-on-one support and care coordination to people with certain chronic, rare conditions. The program helps ensure optimal care, decrease complications, and improve health outcomes. See our website or our AccordantCare Rare Disease Program flier for more information.

Caremark Specialty Pharmacy

Members with conditions that require injectable medications and biotech drugs have access to our specialty pharmacy program through Caremark® Specialty Pharmacy Services. A pharmacist-led CareTeam provides individual follow-up care and support. See our website or contact PacificSource Customer Service for more information.

Case Management Services

If you have an ongoing medical need, our Nurse Case Managers can help. PacificSource Case Managers, all of whom are registered nurses with extensive experience, work with you and your healthcare providers to ensure continuity of care and prevent breaks in necessary medical services. Should you need help managing specific healthcare needs in the future, our Case Managers will become involved, helping improve your health, financial outcomes, and quality of life. Examples include:

- Special-needs children
- Transplants
- Chronic pain
- Extended hospital care
- Skilled nursing care
- Coordination of home health or equipment.

For more information on case management services, contact PacificSource Customer Service.

Online Tools and Resources

Our website, PacificSource.com, offers you a wealth of tools, information, and resources to help you make the most of your PacificSource benefits.

InTouch: Access Coverage and Benefit Information

By logging into InTouch, you can easily and conveniently manage your insurance coverage and health 24/7. InTouch lets you:

- Look up coverage information and review benefit summaries in your Member Handbook.
- Check the status of a claim and access your claim history.
- View Explanation of Benefits for paid claims.
- Review your family enrollment history.
- Change your address.
- Take a health risk assessment.
- Calculate expenses accumulated towards your plan's deductible.
- Order new ID cards.
- Take advantage of smoking cessation or other wellness programs through Health Manager.

For more information, visit PacificSource.com or see our InTouch for Members brochure.

Health Manager

The Health Manager is your personal online health and wellness center. Powered by WebMD®, our site includes personalized wellness information and a variety of helpful, easy-to-use online tools designed to help you maximize your health. Log into InTouch and click Health Manager to:

- Assess your health

With InTouch for Members, you have secure online access to your coverage information and a variety of health and wellness resources.

continued on next page

If you have questions, you are welcome to contact our Customer Service Department at 888.977.9299 or email cs@pacificsource.com.

- Research healthcare issues
- Subscribe to newsletters
- Participate in programs to improve your health
- Keep records
- Track your progress and more.

Provider Directory

Our online provider directory makes it easy to find participating healthcare providers for your plan. You can search by specialty, name, location, or other details to access a listing of providers that fit your criteria. Or, you can create your own personalized provider directory to download and print.

To access the directory, go to PacificSource.com and click on Find a Provider > PacificSource Provider Directory.

Please note: These value-added programs are not available with all plans. Check with your plan administrator or our Customer Service Department for details.

PacificSource HEALTH PLANS

Direct: 541.684.5582
Toll Free: 888.977.9299

PacificSource.com

Coverage Away From Home

Your Healthcare Benefits When Traveling

The First Health® Network

The First Health® Network is a national healthcare provider network that includes physicians, hospitals, and other outpatient care facilities. We have a contract in place which makes First Health providers available when you need medical care outside of Oregon, Idaho, Montana, and southwest Washington. You will receive your plan's participating provider benefits when you use First Health providers for services outside your plan's service area.

How can I find a First Health provider?

No matter where you're traveling within the United States, you can find First Health providers over the Internet or by phone.

- Online: You can look up providers in your area using First Health's online provider directory. To get there, go to our website, PacificSource.com, click on Find a Provider, and then click the First Health Network link.
- By phone: Call First Health toll-free at (800) 226-5116. Representatives are available 24 hours a day, seven days a week. They'll help you find a physician, hospital, or other outpatient provider in your area, or tell you if a specific provider or facility participates with First Health. Si habla Español—Spanish speaking representatives are available as well.

What if the provider I want to use is not a member of the First Health Network?

If the provider does not participate with First Health and a First Health provider is available in that area, you will receive your plan's nonparticipating provider benefits unless it is a true medical emergency. If you have a true medical emergency, go directly to the nearest emergency room or appropriate facility, and there will be no reduction in benefits.

What if there are no First Health Network providers where I'm traveling?

The First Health Network is growing and adding new providers around the country all the time. If a First Health provider is not available where you are

continued on reverse

First Health® Network is national healthcare network available when traveling outside Oregon, Idaho, Montana, and southwest Washington.

Assist America® is global emergency services company that can help you get the care you need when traveling 100 miles or more from home or abroad.

PacificSource HEALTH PLANS

traveling, your plan pays your covered expenses based on a usual, customary, and reasonable charge for that area. First Health provider availability is based on PacificSource criteria.

What If I need to be hospitalized when I'm out of the area?

For a non-emergency hospitalization, have your physician preauthorize your hospital treatment by calling our Health Services Department at (888) 691-8209. Our staff can also help locate a First Health hospital in the area.

You may also call First Health yourself at (800) 226-5116 to find out if there is a participating hospital in the area. Then check with your physician to see if he or she has hospital privileges with a participating First Health hospital. Finally, have your physician preauthorize your admission by calling our Health Services Department at (888) 691-8209.

For emergency care outside your service area:

For a true medical emergency, call 911 or go directly to the nearest hospital emergency room or appropriate treatment facility. An emergency medical condition is an injury or sudden illness so severe that a prudent layperson with an average knowledge of health and medicine would expect that failure to receive immediate medical attention would risk seriously damaging the health of a person or fetus. Examples of true medical emergencies include severe bleeding, sudden abdominal or chest pains, suspected heart attacks, serious burns, poisoning, unconsciousness, convulsions or seizures, and difficulty breathing. In true medical emergencies, your plan pays benefits at the participating provider level even if you are treated at a nonparticipating hospital.

If you are admitted to a hospital after your emergency condition is stabilized, your physician should contact our Health Services Department as soon as possible.

How are my claims paid when I receive treatment outside the service area?

If you use a First Health provider, simply show your PacificSource member ID card. The provider will send your claim to us automatically and you will not have to file any paperwork.

If you use a nonparticipating provider, the provider may or may not bill us directly. If not, you will need to pay for the services up front, then send a claim to PacificSource for reimbursement. Your claim must include a copy of the provider's itemized bill, along with your name, PacificSource member ID number, group name and number, and the patient's name. If you were treated for an accidental injury, please include the date, time, place, and circumstances of the accident as well.

Assist America®

If you experience a medical emergency when you're traveling 100 miles or more away from your primary residence or abroad, Assist America can help. Assist America provides a variety of services to help you get the care you need, including medical consultation and evaluation, medical referrals, critical care monitoring and if medically necessary, evacuation to the nearest facility that can appropriately treat your situation. When you are ready to be discharged from a hospital and need medical assistance to return home (or to a rehabilitation facility), Assist America will arrange for your transportation and provide an escort, if necessary.

Call them as soon as possible during your medical emergency (once your situation is non-life threatening). Services arranged by Assist America are provided at no cost to you. Once you are under the care of a physician or medical facility, your PacificSource coverage applies.

For more information about Assist America's services, visit the For Our Members section of our website, at PacificSource.com.

If you have questions, you are welcome to contact our Customer Service Department at 888.977.9299 or email cs@pacificsource.com.

PacificSource HEALTH PLANS

Direct: 541.684.5582
Toll Free: 888.977.9299

PacificSource.com

InTouch Online Access to Your Information

Access Your Coverage Information and Wellness Resources Online with InTouch

We know your busy schedule doesn't always coincide with our customer service hours. To help, we offer PacificSource InTouch for Members, a secure website available to any individual who is covered under a PacificSource health plan.

Once you've registered, you can review claim and coverage information, check your family enrollment history, find resources to help you manage your health, and more—at your convenience from any computer with Internet access.

PacificSource InTouch for Members is easy to use

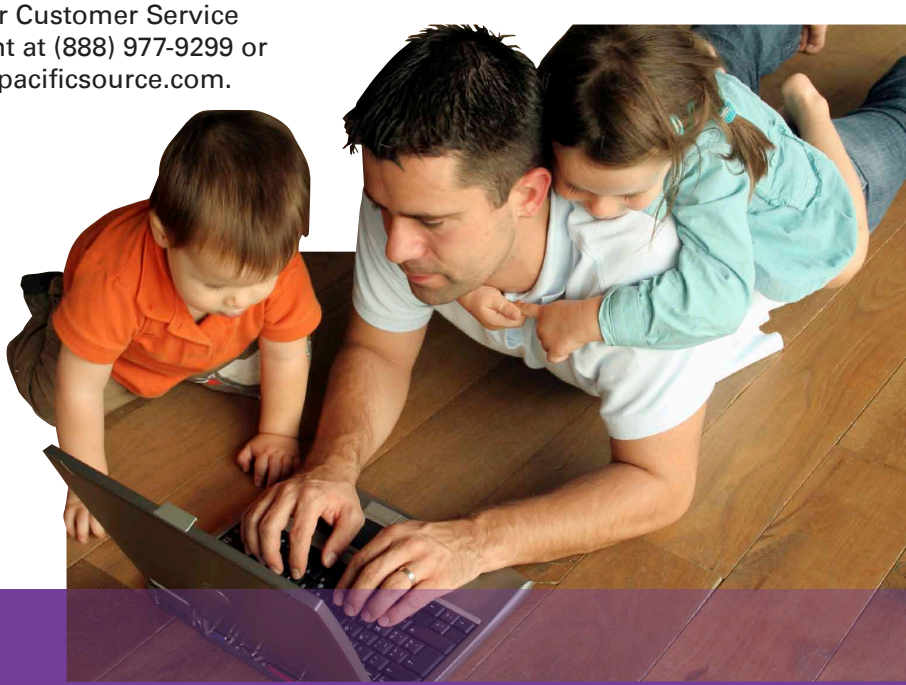
- Look up coverage information and review benefit summaries in your Member Handbook
- Check the status of a claim and access your claim history
- View Explanation of Benefits (EOB) statements for paid claims
- Go paperless by setting your preferences to receive notices such as EOB alerts by email
- Change your address
- Check your out-of-pocket amounts
- Order new and print temporary ID cards
- Use Health Manager to take a health risk assessment and participate in wellness programs

Register for InTouch Today!

1. Have your PacificSource Member ID card or your Social Security number handy.
2. Go to PacificSource.com.
3. Click on the Register Now link in the upper right corner of your screen.
4. Follow the instructions.

If you have questions, please contact our Customer Service Department at (888) 977-9299 or email cs@pacificsource.com.

With InTouch for Members, you have secure online access to your coverage information and a variety of health and wellness resources.



PacificSource HEALTH PLANS

Direct: 541.684.5582
Toll Free: 888.977.9299

PacificSource.com

PacificSource
HEALTH PLANS

We're in it for the people.

Customer Service

Idaho
208.333.1596 Local *(Boise)*
800.688.5008 Toll-free

Montana
406.442.6589 Local *(Helena)*
877.590.1596 Toll-free

Oregon
541.684.5582 Local *(Eugene/Springfield)*
888.977.9299 Toll-free
541.225.3631 Fax
cs@pacificsource.com Email

Headquarters

PO Box 7068
Springfield, OR 97475-0068
541.686.1242 Local *(Eugene/Springfield)*
800.624.6052 Toll-free

Website

PacificSource.com

Simplified Chart of OHP Coverage of Dental Services

Please see OAR 410-123-1000 through 1670 for details

(November 19, 2013)

Service	OHP Plus Child	OHP Plus Pregnant Adults	Non-pregnant OHP Plus Adults
Exams (D0120-D0180)	2 times every 12 months	1 time every 12 months	1 time every 12 months
Imaging (D0210-D0395)	Yearly routine and bitewings; panoramic and complete series every 5 years; more if medically/dentally appropriate		
Prophylaxis (D1110-D1120)	2 times every 12 months (more if "high risk")	1 time every 12 months (more if "high risk")	
Fluoride (D1204-D1208)	2 times every 12 months, plus additional (up to 4 if "high risk")	1 time every 12 months (up to 4 if "high risk")	
Sealant (D1351)	1 treatment per permanent molar every 5 years (unless failure)	Not covered	Not covered
Space maintainers (D1510-D1555)	Covered	Not covered	Not covered
Amalgam and Resin-Based Composite Restorations (D2140-D2394)	Amalgam only for posterior 2+ surfaces; otherwise amalgam and resin covered (i.e. cover D2140 – D2391)		
Crowns (D2390-D2752)	Covered	Covered	Not covered
Endodontic Therapy (D3230-D3330)	Covered (on primary, anterior, bicuspid, and 1st/2nd molars)	Covered (on anterior, bicuspid and only 1st molar)	Covered (on anterior and bicuspid)
Endodontic Retreatment (D3346-D3354)	Covered for symptomatic anterior	Covered for symptomatic anterior	Covered for symptomatic anterior
Scaling and Root Planing (D4341-D4342)	1 time every 2 years	1 time every 3 years, plus more if necessary	1 time every 3 years
Full Mouth Debridement (D4355)	1 time every 2 years	1 time every 3 years	1 time every 3 years
Periodontal Maintenance (D4910)	1 time every 6 months, more if medically/dentally necessary	1 time every 12 months, more if medically/dentally necessary	1 time every 12 months, more if medically/dentally necessary
Full Dentures (D5110-D5140)	Covered	Covered if recently endentulous	Covered if recently edentulous

Service	OHP Plus Child	OHP Plus Pregnant Adults	Non-pregnant OHP Plus Adults
Partial Dentures (D5211-D5212)	Covered if 1+ missing anterior or 4+ missing posterior per arch	Covered if 1+ missing anterior or 6+ missing posterior per arch	
Replacement of Full or Partial Dentures (D5110-D5212)	1 time every 10 years	No replacement of full dentures, partial dentures 1 time every 10 years	No replacement of full dentures, partial dentures 1 time every 10 years
Denture Adjustment and Repairs (D5410-D5671)	Covered w/no limits	Covered, with limits	Covered, with limits
Denture Rebases (D5710-D5721)	1 time every 3 years	1 time every 5 years	1 time every 5 years
Denture Relines (D5730-D5761)	1 time every 3 years	1 time every 5 years	1 time every 5 years
Interim Partial Denture (D5820-D5821)	Covered, must have 1 or more missing anterior, replacement 1 time every 5 years		
Extractions (D7111-D7251)	Covered	Covered	Covered
Alveoplasty not in Conjunction with Extractions (D7320-D7321)	Covered	Covered	Not covered
Frenulectomy, Frenulosplasty (D7960, D7963)	1 time per lifetime per arch	Not covered	Not covered
Excision of Periocoronal Gingival (D7971)	Covered	Covered	Not covered
Orthodontics (D8000-D8999)	Covered if cleft palate	Not covered	Not covered

Simplified Chart of OHP Coverage of Dental Services

Though a service may be covered (✓), there may be limitations on frequency or tooth. This chart lists some but not all of these limits. This chart is only a general guide that is intended to give a snapshot of coverage. Please see OAR 410-123-1000 to 1670 for details**.**

Service	OHP Plus Child	OHP Plus Adult	OHP Plus Supplemental (for pregnant adults)
Comprehensive Dental Exam	✓ twice a year	✓once a year	✓ once a year
X-rays	✓	✓	✓
Routine Cleanings	✓	✓	✓
Professionally-Applied Fluoride	✓twice a year or up to 4 if "high risk"	✓ once a year or up to 4 if "high risk"	✓ once a year or up to 4 if "high risk"
Sealants	✓	X	X
Fillings	✓	✓	✓
Crowns	✓	X	✓
Root Canals	✓ anterior teeth and bicuspids	✓ anterior teeth and bicuspids	✓ anterior teeth and bicuspids
	✓ 1st molars	X 1st molars	✓ 1st molars
	✓ 2nd molars	X 2nd molars	X 2nd molars
Scaling and Root Planing (a periodontal disease treatment)	✓ once every 2 years	✓ once every 3 years	✓ once every 3 years, plus more if necessary
Extractions	✓	✓	✓
Orthodontics	Only covered in cases of cleft palate	X	X

Hospital Dentistry	✓ kids ≤ 3 with extensive dental needs ✓ kids age 4+ who meet at least one criterion (ex. extensive dental trauma, failed attempt to treat in office with nitrous, developmental disability with acute situational anxiety and extreme uncooperative behavior)	✓ for adults who meet at least one criterion. The criteria for adults are somewhat more restrictive, generally requiring extensive dental trauma or a need for hospitalization due to severe disability.	✓ for adults who meet at least one criterion. The criteria for adults are somewhat more restrictive, generally requiring extensive dental trauma or a need for hospitalization due to severe disability.
First Full Upper or Lower Denture	✓(age 16-21)	✓ **only** if last tooth in the jaw was removed within last 6 months	✓ **only** if last tooth in the jaw was removed within last 6 months
First Partial Upper or Lower Denture	✓ if missing 1+ front or 4+ back teeth, wisdom teeth don't count	✓ **only** if missing 1+ front or 6+ back teeth, and wisdom teeth don't count	✓ **only** if missing 1+ front or 6+ back teeth, and wisdom teeth don't count
Replace Partial Denture	✓ once every **10** years if needed	✓ once every **10** years if needed	✓ once every **10** years if needed
Replace Full Denture	✓	X	X
Denture Adjustments, Repairs, Rebases, and Relines	✓ (with substantial frequency limits)	✓ (with substantial frequency limits)	✓ (with substantial frequency limits)
Interim Partial Denture ("Flipper")	✓ if missing 1+ front teeth; replacement every 5 years	✓ if missing 1+ front teeth; replacement every 5 years	✓ if missing 1+ front teeth; replacement every 5 years

CAWEM (Citizen/Alien-Waived Emergency Medicaid) is a Medicaid program for clients who would be eligible for OHP but do not meet the citizenship and immigration requirements. There are two benefit packages:

- **CAWEM Standard:** dental coverage is limited to services provided in an emergency department hospital setting.
- **CAWEM Plus**: must be pregnant; dental coverage is equivalent to OHP Plus Supplemental for pregnant adults.

Oregon Health Plan Client Handbook

Department of Human Services

Oregon HEALTH PLAN

July 2007

This booklet contains important information about your OHP

Benefit packages:

- Premiums
- Copayments

Covered services:

- Medical
- Dental
- Mental health

Medical Care ID

Service Delivery:

- Fee-for-Service
- Managed Care

Rights and responsibilities

Client resources

July 1, 2013

Update your OHP Client Handbook

If you need help to update your handbook or need a different format or language, please ask your worker or call 1-800-699-9075.

Page 2: Prioritized List of Health Services

- The Oregon Health Evidence Review Commission now updates this list.

Page 3: OHP Plus and OHP with Limited Drug vision benefit reduced

- Non-pregnant adults age 21 years or older do not receive routine vision testing and eyeglasses.
- Pregnant adults age 21 years or older receive these services as part of the OHP Plus Supplemental benefit package.

Pages 4 and 5: Copayment amounts have been reduced

- Copayments on many prescription drugs have been reduced or eliminated. Copayments are $0 - $3. Your pharmacy knows the correct copayment and will charge you the reduced amount.

Page 5: OHP Standard benefit added - effective Jan. 1, 2012

- OHP Standard now covers scheduled, medically appropriate, inpatient and outpatient hospital care and surgeries, in addition to emergency hospital services.

Pages 7 and 49: Phone number for OHP Premium Billing Office

- The phone number is 1-888-647-2729.

Page 7: Benefit packages - CAWEM Plus benefit package available in some counties

- Eligibility: The program helps pregnant women receiving CAWEM benefits who live in the following counties:
  - Benton
  - Clackamas
  - Columbia
  - Crook
  - Deschutes
  - Douglas
  - Hood River
  - Jackson
  - Jefferson
  - Lane
  - Morrow
  - Multnomah
  - Union
  - Wasco
- Benefits: CAWEM Plus covers all OHP Plus benefits except for sterilizations, therapeutic abortions, hospice services, and Death with Dignity services.

Page 7: Benefit packages - OHP Plus Supplemental available to pregnant adults

- Eligibility: The program helps pregnant adults age 21 or older who receive OHP benefits. If you become pregnant, let your caseworker know.
- Benefits: Routine vision testing and eyeglasses; some additional dental services.

Page 8: Health care services

See page 2 of your coverage letter (not your Medical Care ID) to find out what type of coverage you have.

Page 10: Quick Reference Benefit Chart - *Attached (updated Jan. 2013)*

Page 11: Benefit packages - OHP Plus Supplemental available to pregnant adults

- Eligibility: The program helps pregnant adults age 21 or older who receive OHP benefits. If you become pregnant, let your caseworker know.
- Benefits: Routine vision testing and eyeglasses; some additional dental services.

Pages 11 and 12 - Chemical dependency Substance Use Disorder Treatment (replace with the following):

Chemical dependency is now called chemical dependency Substance Use Disorder.

Outpatient treatment and methadone services medication treatment

OHP covers outpatient treatment and methadone medication treatment such as: Methadone, Suboxone, Buprenorphine, Vivitrol and other medication services that help reduce the use of or abstain from alcohol or other drugs.

Some of the outpatient treatment services are:

- Screening and assessment
- Acupuncture
- Detoxification
- Individual and group counseling
- Medication
- Family/couple counseling
- Physical examination
- Urine Analysis (UAs)

Residential treatment services

OHP covers residential treatment services including treatments provided in a 24-hour care facility, for both adults and youth. There are residential treatment facilities that allow parents to bring their young children to treatment with them. Some of the residential treatment services are:

- Screening and assessment
- Acupuncture
- Detoxification
- Individual and group counseling
- Medication
- Family/couple counseling
- Physical examination
- Urine Analysis (UAs)

Page 12: Oregon Tobacco Quit Line telephone number

- English: 800-QUIT NOW (800-784-8669)
- Español: 877-2 NO FUME (877-266-3863)
- TTY: 877-777-6534

Page 13: Pregnancy care coverage

- Pregnant OHP clients receive services under OHP Plus, OHP with Limited Drug and OHP Plus Supplemental.
- In some counties, pregnant CAWEM clients receive services under CAWEM Plus.

Pages 15, 16 and 17: Medical Identification Card - *Attached (3 pages)*

- The Medical Care ID is now called the Oregon Health ID. You can still use your DHS Medical Care ID.
- The state only issues the ID when you are new to OHP, your name changes, or your ID number changes.
- The coverage letter (not the ID) shows your branch office name, phone number, your worker's code, and the benefit package, copayment and plan information for everyone in your household.

Page 18 - Medical Transportation Services

Keeping your health care appointments is important. If you do not have your own transportation, you might:

- Take the bus.
- Ask a friend or relative to drive you.
- Find a volunteer from a community service agency.
- Call the transportation brokerage call center that serves OHP clients free of charge in your county.

In some cases, you may be reimbursed for medical transportation expenses. You need to get approval for reimbursement before you go to your health care appointment.

To get approval for reimbursement for medical transportation expenses:

- Contact your DHS branch office if you live in the following counties:

Baker	Clackamas	Crook	Deschutes
Grant	Harney	Jefferson	Malheur
Marion	Multnomah	Polk	Union
Wallowa	Washington	Yamhill	

- For all other counties, contact the transportation brokerage listed on the attached chart.

Page 18: Lane County medical transportation telephone number

Note: Transportation brokerage services are available at no cost to clients who don't have other transportation resources or options and have OHP Plus, OHP Plus Supplemental, CAWEM Plus, or OHP with Limited Drug benefits.

- RideSource (Lane County), call 541-682-5566 or 1-877-800-9899 (TTY 800-735-2900)

Page 18: Oregon Tobacco Quit Line telephone number

- English: 800-QUIT NOW (800-784-8669)
- Español: 877-2 NO FUME (877-266-3863)
- TTY 877-777-6534

Page 19: Service delivery

To find out if you are in a managed care plan or coordinated care organization, look at your coverage letter (not your Medical ID).

Check the "Date of issue" on page 1, and the Managed Care/TPR enrollments field on pages 2 and 3 of your coverage letter, to make sure nothing has changed.

Your worker's phone number is on page 1 of your coverage letter.

Page 19: Pregnancy care coverage

- Pregnant OHP clients receive services under OHP Plus, OHP with Limited Drug and OHP Plus Supplemental.
- In some counties, pregnant CAWEM clients receive services under CAWEM Plus.

Pages 20, 21 and 23: Phone contact updates

If you have a complaint about the way you were treated at a health care appointment, call DMAP Client Services at 1-800-273-0557 (TTY 711).

24/7 Nurse Advice telephone number

- Page 20: 24/7 Health Care Advice, call 1-800-562-4620
- Page 21: Urgent Care Advice, call 1-800-562-4620
- Page 23: Disease or Case Management Program, call 1-800-562-4620

Page 24: Pharmacy Benefit Management Program

Your assigned pharmacy will show in the Managed Care/TPR enrollments field on pages 2 and 3 of your coverage letter (not on your Medical ID).

Page 25: Longer hours for the OHP home-delivery pharmacy

- Customer service is available Monday through Friday, 7:30 a.m. to 5:30 p.m.

Page 28: Managed care

- If you are in managed care, you may be enrolled in one or more of the following:
  - Coordinated care organization (CCOA), for coordinated physical, dental and mental health care
  - Coordinated care organization (CCOB), for coordinated physical and mental health care
  - Fully capitated health plan, physician care organization (PCO) or primary care manager (PCM), for physical health care
  - Dental care organization, for dental care
  - Mental health organization or coordinated care organization (CCOE), for mental health care
  - Coordinated care organization (CCOG), for dental and mental health care
- Managed care organizations may charge copayments. Pregnant clients or clients under age 19 do not pay copayments.
- Your managed care plan(s) or primary care manager are listed on your coverage letter (not your Medical Care ID). For each family member, match the Managed Care/TPR enrollments letter on page 2 with the information listed on page 3.

Page 33: Labor and delivery

Check page 2 of your coverage letter (not your Medical ID) to make sure your newborn is listed.

Page 34 - Problems with your health care services

Your managed care plan's phone number is listed on page 3 of your coverage letter (not on the Medical ID).

Pages 36 and 37: Hearing rights updated for managed care members

- Health plan members may now ask for a DMAP hearing and/or appeal with the plan at the same time.

Page 38: Advance Directives complaint address

- File Advance Directive non-compliance complaints with the State Survey and Certification office:

  Health Care Regulation and Quality Improvement
  Office of Community Health and Health Planning
  Oregon Health Authority
  800 NE Oregon Street, Suite 305
  Portland, OR 97232
  971-673-0546; fax 971-673-0556

Page 40: Who to call for help

Also call your worker if you have not received your coverage letter, or if the coverage letter is wrong.

Your worker's identification code and telephone number are listed on page 1 of your coverage letter (not on the Medical ID).

Page 42: Division of Child Support address, phone, and fax number

Find the address, phone and fax number of your local Child Support office on the Division's website at **www.oregonchildsupport.gov.**

- Toll free 1-800-850-0228
- TTY 1-800-735-2900

Page 42: Estates Administration Unit phone number

Their Salem phone number is now 503-378-2884.

Pages 44, 45, 46, 47 and 48: Notice of Privacy Practices revised

- The Notice of Privacy Practices now includes information about the Oregon Health Authority (OHA).
- The Notice of Privacy Practices will tell you how the Department of Human Services (DHS) and OHA may use and disclose health information about you.
- Your health information may be shared between DHS, OHA and your health care providers to determine eligibility, coordinate your care and for treatment, payment and health care operations.
- To get the Notice of Privacy Practices:
  - Find the form online at **https://apps.state.or.us/Forms/Served/me2090.pdf**
  - Pick one up at a DHS office (call 1-800-699-9075 for locations)
  - Call the OHP Central Processing Center at 1-800-699-9075, Monday to Friday, 7 a.m. to 6 p.m.

Your Oregon Health Plan (OHP) benefits

The chart below shows what benefits are available under your OHP coverage. Some CCOs may not provide all of your benefits listed below. Work with your CCO to find out if it covers a service you need.

Benefits covered under: OHP Plus, OHP with Limited Drug and Citizen/Alien-Waived Emergent Medical (CAWEM) Plus
Chemical dependency
Dental ▪ Basic services including cleaning, fillings and extractions ▪ Urgent or immediate treatment ▪ Limited other services*
Hearing aids and hearing aid exams
Home health; private duty nursing
Hospice care – not covered for CAWEM Plus clients
Hospital care ▪ Emergency treatment ▪ Inpatient and outpatient care
Immunizations
Labor and delivery
Laboratory and X-rays
Medical care from a physician, nurse practitioner or physician assistant
Medical equipment and supplies
Medical transportation
Mental health
Physical, occupational and speech therapy
Prescription drugs – only includes drugs that are not covered by Medicare Part D for OHP with Limited Drug clients
Vision ▪ Services for medical care ▪ Limited services for eye health*

*Additional benefits are available to pregnant adults and children who have OHP Plus.

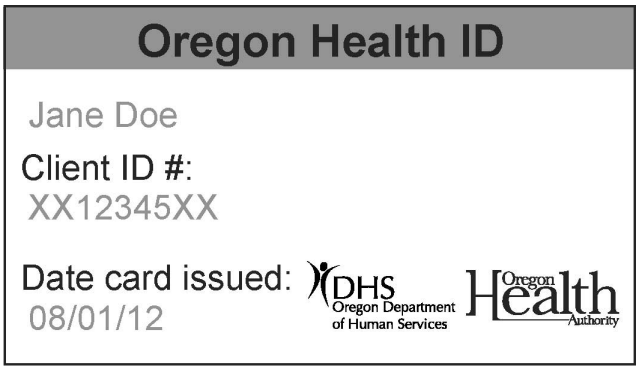
Other benefit packages:

- CAWEM – Covers emergency medical, emergency dental and emergency transport services.
- Qualified Medicare Beneficiary (QMB) – Only covers Medicare premiums and copayments (except for Medicare Part D) and deductibles.

Oregon Health Identification (ID)

The Oregon Health ID is the size of a business card. It lists your name, client ID number and the date it was issued.

Every person who is eligible in your household receives their own Oregon Health ID.



Front

Back

Take your Oregon Health ID to all health care appointments. Providers use the information on the card to check your eligibility.

A new ID card will not be sent unless your name changes, your ID number changes, or you ask for a replacement ID card.

Coverage letter

The coverage letter is for your information only. You do not need to take it to your health care appointments. You will get a new letter when:

- You are new to the Oregon Health Plan;
- You have a new managed care plan, Primary Care Manager or Third Party Resource (TPR - other health care coverage, such as Medicare);
- You get a new ID card; or
- Your benefits, address, or household members have changed.

Sample coverage letter

5503 XX#### XX P2 EN
AT
PO BOX #####
SALEM, OR 97309
DO NOT FORWARD: RETURN IN 3 DAYS

Branch name/Division: OHP/CAF

Worker ID/Telephone: XX/503-555-5555

JOHN DOE
123 MAIN ST

HOMETOWN OR 97000

Keep this letter!

This letter explains your Oregon Health Plan (OHP) benefits.

This letter is just for your information. You do not need to take it to your health care appointments.

We will only send you a new letter if you have a change in your coverage, or if you request one.

Welcome to the Oregon Health Plan (OHP). This is your **new coverage letter.**

This letter lists coverage information for your household. This letter does not guarantee you will stay eligible for services. This letter does not override decision notices your worker sends you.

We will send you a new letter and a Medical ID card any time you request one or if any of the information in this letter or on your Medical ID changes. To request a new letter or Medical ID, call your worker.

The enclosed yellow sheet includes a chart that describes the services covered for each benefit package and a list of helpful phone numbers.

We have listed the reason you are being sent this letter below. The date the information in this letter is effective is listed next to your name.

Reason for letter:

Managed care plan or Primary Care Manager enrollment changed for:
DOE, JOHN – 08/01/2012
DOE, JANE – 08/01/2012
DOE, TIMOTHY – 08/01/2012

How to read the sample coverage letter

Page 1 (sample on previous page)

This page shows your worker's ID and phone number, and why you got the letter.

Page 2 (sample below)

This page lists the benefit package, copayment requirements and managed care or TPR enrollment for everyone in your household who is eligible for benefits.

Name	Date of birth	Client ID#	Co pay?	Benefit Package	Managed Care/ TPR enrollments
John Doe	01/01/1968	XXXXXXXX	No	OHP Standard	A, B
Jane Doe	02/01/1968	XXXXXXXX	No	OHP with Limited Drug	B, C, E
Timothy Doe	03/01/2006	XXXXXXXX	No	OHP Plus	D

Page 3 – Managed Care/TPR Enrollment (sample below)

This page lists the names and phone numbers for managed care plans and TPR. TPR is other health coverage, such as private insurance, Medicare, or an assigned pharmacy.

A	CCOB - Mental and Physical COORDINATION INC 800-555-1212	**B**	Dental Care Organization QUALITY CARE 866-555-1212	**C**	Mental Health Organization HEALTHY MIND CARE 888-555-1234
D	Private Maj Med/Rx/Den BLUE CROSS OF OREGON Pol # 12345ABC789	**E**	Medicare Part - A MEDICARE NW - PART A	**F**	

The sample shows the following coverage information:

John – Does not pay copayments, has OHP Standard benefits and is enrolled in:

- **A** – Coordinated Care Organization: Coordination Inc., for physical and mental health care
- **B** – Dental Care Organization: Quality Care, for dental care

Jane – Does not pay copayments, has OHP with Limited Drug benefits and is enrolled in:

- **B** – Dental Care Organization: Quality Care
- **C** – Mental Health Organization: Healthy Mind Care
- **E** – Medicare Part A: Medicare NW, for hospital care

Timothy – Does not pay copayments, has OHP Plus benefits and is not enrolled in any OHP managed care plans because he has private health insurance:

- **D** – Private Health Insurance: Blue Cross of Oregon, for physical health care, dental health care and prescription coverage

Transportation Brokerages

Use the brokerage in your county to ask for approval and receive reimbursement for your medical transportation costs.

Counties served	Brokerage
Benton Linn Lincoln	**Cascades West Ride Line** Cascades West Council of Governments Phone: 541-924-8738 Toll-free: 866-724-2975
Baker* Crook* Deschutes* Grant* Harney* Jefferson* Malheur* Union* Wallowa*	**Cascades East Ride Center** Central Oregon Intergovernmental Council Phone: 541-385-8680 Toll-free: 866-385-8680
Lane	**RideSource Call Center** Lane Transit District Phone: 541-682-5566 Toll-free: 877-800-9899
Gilliam Hood River Morrow Sherman Umatilla Wasco Wheeler	**Transportation Network** Mid-Columbia Council of Governments Phone: 541-298-5345 Toll-free: 877-875-4657
Coos Curry Douglas Jackson Josephine Klamath Lake	**TransLink** Rogue Valley Transit District Phone: 541-842-2060 Toll-free: 888-518-8160
Marion* Polk* Yamhill*	**TripLink** Salem Area Mass Transit District Phone: 503-315-5544 Toll-free: 888-315-5544
Clatsop Columbia Tillamook	**Northwest Ride Center** Sunset Empire Transit District Phone: 503-861-7433 Toll-free: 866-811-1001
Clackamas* Multnomah* Washington*	**Transportation Services** Tri-Met Phone: 503-802-8700 Toll-free: 800-889-8726

**Note: The brokerage in these counties will not be providing client reimbursement on July 1, 2013. They may delay until January 1, 2014.*

For TTY/Relay Service, dial 711.

If you need this booklet in another language, large print, Braille, on tape, or another format, call 1-800-359-9517 or TTY 1-800-621-5260.

Si necesita este folleto en otro idioma, letra más grande, Braille, cinta de audio, o en otro tipo de formato, llame al 1-800-359-9517 o al 1-800-621-5260 (TTY).

Spanish

Если Вам нужна эта брошюра на другом языке, напечатная большими буквами, на брайле, на кассете или в каком-нибудь другом формате, пожалуйста, позвоните по телефону 1-800-359-9517 или TTY 1-800-621-5260.

Russian

Nếu quý vị cần tập tài liệu này bằng một ngôn ngữ khác, in khổ chữ lớn, chữ nổi (Braille), băng ghi âm, hoặc hình thức khác, xin gọi điện thoại số 1-800-359-9517 hoặc TTY (dành cho người bị điếc) 1-800-621-5260.

Vietnamese

Dacă doriţi această broşură în altă limbă, caractere mari, Braille, înregistrată pe casetă audio, sau în alt format, telefonaţi la 1-800-359-9517 sau TTY la 1-800-621-5260.

Romanian

បើអ្នកត្រូវការឯកសារនេះជាភាសាមួយទៀត ជាអក្សរពុម្ពធំៗ ជាប្រេល ជាខ្សែអាត់សម្លេង ឬតាមទំរង់ផ្សេងទៀត សូមទូរស័ព្ទលេខ 1-800-359-9517 ឬ TTY 1-800-621-5260 ។

Cambodian

ຖ້າທ່ານຕ້ອງການປຶ້ມນ້ອຍຫຼັ້ມນີ້ ເປັນພາສາອື່ນອີກ, ແບບຕົວພິມໃຫຍ່, ເປັນແບບໜັງສື ສຳຫຼັບຄົນຕາບອດ, ແບບເທບອັດສຽງ, ຫຼືແບບອື່ນໆອີກ, ໃຫ້ໂທຫາ 1-800-359-9517 ຫຼື TTY 1-800-621-5260.

Lao

Yog haistia koj xav tau phau ntawv no ua lwm yam lus, luam tus ntawv kom loj, ua Ntawv ig muag (Braille), kaw rau hauv kab xev, los yog lwm yam, hu rau 1-800-359-9517 los yog TTY 1-800-621-5260.

Hmong

Se gorngv meih qiemx zuqc longc naaiv buonv sou fiev dieh nyungc nzangc, fiev hlo nyei, Hluo nyei nzangc, siou waac hlaang, fai dieh nyungc, heuc 1-800-359-9517 fai TTY 1-800-621-5260

Mien

만일 다른 언어나 큰 활자, 점자, 녹음 테이프, 또는 다른 형식으로 된 이 안내서를 원하는 경우에는 전화 1-800-359-9517 또는 TTY 1-800-621-5260 번으로 연락하시기 바랍니다.

Korean

Accessible services

Do you have a disability that makes it hard for you to read printed material? Do you speak a language other than English? We can give you information in one of several ways:

- Large print
- Audio tape
- Braille
- Electronic format
- Oral presentation (face-to-face or on the phone)
- Sign language interpreter
- Translations in other languages

Let us know what you need. Tell your worker or, if you have no worker, call 503-373-0333 x 393 or TTY 503-373-7800.

Is access a problem?

Do barriers in buildings or transportation make it hard for you to attend meetings? To get state services?

- We can move our services to a more accessible place.
- We can provide the type of transportation that works for you.

You have a right to complain if:

- You keep getting DHS printed forms and notices, but you need them some other way.
- Our programs aren't accessible.

You have 60 days to make your complaint. Send your complaint to:

The Governor's Advocacy Office
500 Summer St NE, E17
Salem, OR 97301

1-800-442-5238
1-800-945-6214 TTY
503-378-6532 Fax

– or send to –

US Dept of Health & Human Services
Office for Civil Rights
2201 Sixth Avenue, Mail Stop RX-11
Seattle, WA 98121

1-800-362-1710
1-206-615-2296 TTY
1-206-615-2297 Fax
OCRComplaint@hhs.gov

Contents

Welcome to the Oregon Health Plan

The Oregon Health Plan (OHP) is a state program that provides health care coverage to eligible clients.

This booklet will help you understand:

- The different ways people receive care under OHP managed care and fee-for-service.
- How to read your Medical Care Identification.
- Health care coverage under OHP.
- The benefit packages under OHP.
- How to use the health services that are covered under OHP.
- What you need to know about managed care under OHP.

Keep this booklet to answer questions about your health care coverage.

What is the Oregon Health Plan?

In Oregon, the Medicaid program is called the Oregon Health Plan (OHP). Medicaid is a medical assistance program for low-income families. Both federal and state funds pay for the Medicaid program in states that choose to offer it. The federal government requires states that offer Medicaid to cover a set list of services for certain people, such as children. A state may decide, with federal approval, what other services they can afford to offer and who else is eligible.

Under OHP:

- Eligibility is expanded so more people can receive medical assistance.
- Health care services are provided depending on where they rank on the Prioritized List of Health Services.

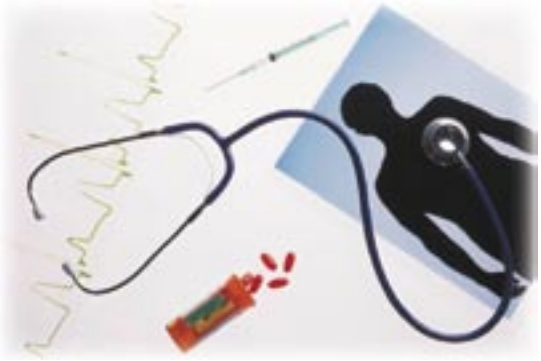
Medicaid is not the same as Medicare

Many people confuse the terms Medicaid and Medicare. Medicaid (OHP) serves qualified clients of any age who have limited income and assets. The Social Security Administration runs the Medicare health insurance program. Some people are eligible for both Medicaid and Medicare. They can receive benefits from both programs at once. Medicare serves people who fit at least one of the following descriptions, regardless of income:

- Age 65 or older
- Any age with kidney failure or long-term kidney disease
- People with permanent disabilities who are unable to work

Prioritized List of Health Services

Oregon Health Plan clients receive benefits based on where health care conditions and treatments are placed on a Prioritized List of Health Services. The Oregon Health Services Commission (HSC) developed the List. The HSC is made up of doctors, nurses, and others concerned about health care issues. The Governor appoints them.



To create the first Prioritized List of Health Services, the HSC held many public meetings throughout the state to find out what health issues were important to Oregonians. The HSC then used that information to rank all health care procedures in order of effectiveness.

The HSC meets regularly to update the list. The Oregon Legislature does not have enough money to pay for everything on the list, so they use the money that is available to pay for the most effective services.

All managed care plans and health care providers use this list to decide if they can provide a service under OHP.

OHP covers reasonable services for finding out what's wrong. That includes diagnosing a condition that is not currently funded. Once they decide on a diagnosis or treatment that's not funded, OHP will not pay for any more services for that condition.

OHP only pays for treatments for a condition not on the currently funded part of the list if it is directly related to another condition whose treatment is funded. Your doctor will know if this applies to you. See page 9 to learn more about services that are not covered by OHP.

Benefit packages

The medical, dental or mental health services OHP covers for each client is called a "benefit package." Each client receives a benefit package based on certain things, such as age or condition. Members of your household may receive different benefit packages. Fields 9a and 9b of your Medical Care ID (see sample on page 17) show which benefit package each household member receives. An explanation of each benefit package appears below. A quick reference chart on page 10 lists the benefits for each benefit package at a glance.

OHP Plus benefit package

Eligibility

You receive the comprehensive OHP Plus benefit package if you are:

- Pregnant.
- Under the age of 19.
- Receiving SSI.
- Receiving Temporary Assistance to Needy Families (TANF) or Extended Medical Assistance.
- Age 65 or older, blind or disabled with income at or below the SSI standard.
- Age 65 or older, blind or disabled receiving state-paid long-term care services.

Coverage

OHP Plus covers medical, dental, mental health and chemical dependency services. OHP Plus covers on all the services listed on page 8-9 plus:

- Hearing services, hearing aids and batteries
- Home health
- Hospital stays
- Physical, occupational and speech therapy
- Private duty nursing
- Routine vision testing and eyeglasses
- Transportation to health care services

Copayments

Some OHP Plus clients are required to make copayments for outpatient services

and prescription drugs. If you are enrolled in a managed care plan, you don't have to pay the plan a copayment for their services.

Amounts of OHP Plus copayments are:

- $2 for generic and $3 for brand name prescription drugs (for each filled prescription).
- $3 for outpatient services (such as office visits to see a doctor, dentist or other health care provider). The copayment is only for the visit to the provider.

You do not have to pay a copayment for:

- Family planning services and supplies, such as birth control pills.
- Prescription drugs ordered through the OHP Home-Delivery Pharmacy Program. See page 25 for more information about this program.
- Emergency services.
- Lab tests, shots, durable medical equipment or x-rays.
- Services received from your OHP managed care organization.

If you cannot pay

If you cannot make a required copayment, you will still receive the drug product or health care service; however, you will still owe a debt to the pharmacy or health care provider for the copayment.

OHP with Limited Drug benefit package

OHP Plus with Limited Drug is a comprehensive package of services that focuses on preventive care (pages 8-10). Only the prescription drug coverage is limited.

Eligibility

You receive this benefit package if you are eligible for both Medicaid and Medicare Part D.

Coverage

The OHP with Limited Drug package covers all the same medical, dental and mental health benefits as the OHP Plus package. However, this package does not cover prescription drugs that Medicare Part D pays for. OHP does pay for some other drugs that Medicare does not cover.

Note: OHP will not pay for types of drugs that Medicare Part D would cover, even if you choose not to enroll in a Medicare drug plan. You will have to pay for them yourself.

Copayments

You may have to make a copayment for the outpatient services and prescription drugs you receive outside your managed care plan. Copayments are:

- $3 for outpatient services, such as office visits to see a doctor or other health care provider. You do not have to make copayments for treatments such as shots, lab tests or x-rays. You do not have to pay for emergency services.
- $2 for generic and $3 for brand name prescription drugs, for each filled OHP prescription.

Different, mandatory copayments of $1 to $5 apply to your Medicare Part D drugs. OHP does not pay Medicare premiums, deductibles or copayments for Medicare Part D drug plans or services.

OHP Standard benefit package

OHP Standard is a reduced benefit package. It is similar to private insurance because some clients with OHP Standard must pay monthly premiums to keep their coverage.

Eligibility

You receive OHP Standard benefits if you do not meet the requirements for OHP Plus or other benefit packages, but your income fits in the OHP Standard range. The department accepts new, qualified applicants into the OHP Standard package only when the program is open for enrollment. Presently OHP Standard is closed to new enrollees.

Your benefit package may change

Current OHP clients may transfer from another OHP benefit package into OHP Standard if they qualify. If you become pregnant, disabled, turn 65, or meet other qualifications, call your worker. You may be eligible for the OHP Plus or OHP with Limited Drug benefit packages.

Coverage

See pages 8-10 for the list of health services almost everyone may receive. OHP Standard is a reduced benefit package whose coverage is limited as follows:

- Acupuncture is covered only for chemical dependency treatment.
- Chemical dependency and mental health services are covered.
- Hospital care is limited to urgent or emergency services.
- Medical equipment and supplies coverage is limited to diabetic supplies, respiratory equipment, oxygen equipment, ventilators, suction pumps, tracheostomy supplies, urology and ostomy supplies.

- The only medical transportation covered is emergency ambulance (and only if the Division of Medical Assistance Programs [DMAP] considers it an emergency).
- Vision care covers only eye diseases or injury (no glasses or tests for glasses).

Copayments

Clients with the OHP Standard package are not required to pay copayments.

Premiums

Many clients who receive OHP Standard benefits must make a monthly payment for health care coverage. This monthly payment is called a premium. Premium amounts are based on a family's income and size at the time of enrollment. The amount will not increase during your enrollment period.

You don't have to pay premiums if:

- Your household income is ten percent or less of the Federal Poverty Level when you apply or reapply.
- You are American Indian or an Alaska Native.
- If you are eligible for services through an Indian Health Services program.

Your premium requirement will begin the date your coverage begins. If you are required to pay a premium, you will receive a bill in the mail each month. You owe monthly premiums even if you didn't see your health care provider.

Premiums must be paid in full

You will not lose coverage during your current enrollment period just because you have a past-due premium. However, when your enrollment period is ending and you reapply, you will need to pay all billed premiums before you can qualify for another six months of coverage.

You will receive a notice when it is time to reapply. When you reapply, your worker will tell you if you have past-due premiums and give you a deadline by which to pay them. **If you do not pay your past-due premiums by the deadline, you will not be able to enroll in OHP Standard again until:**

- The program is open to new clients, and
- You have paid all your billed premiums.

Any clients in the household (children, for example) who are not required to pay premiums may reapply as usual. If they are still eligible, these clients will continue to receive benefits even if others in the household do not renew their coverage.

How to pay your premiums

Send your check or money orders to the post office box below. A pre-addressed envelope comes with your bill. The billing office staff will accept cash only if presented in person at the Baker City address. Your local DHS office cannot accept premium payments in any form. A new company will run the OHP Premium Billing Office effective April 1, 2007.

Contact the OHP premium billing office to:

- Make sure they received your premium payment
- Find out your current premium balance
- Find out where or how to send payments
- Verify current premium due dates

OHP Premium Billing Office

Mailing address: PO Box 1120, Baker City, OR 97814-1120
Pay in person at: 1705 Main Street, Suite 300, Baker City
Local phone: 541-523-3602
Toll-free TTY: 1-800-264-6958
Fax: 1-800-261-3317
E-mail: Support@OHPbilling.com
Web site: <OHPbilling.com>
Phone: 1-800-261-3317

Qualified Medicare Beneficiary (QMB) benefit package

Eligibility

This program helps you if you are eligible to receive hospital benefits through Medicare. QMB clients have limited income but are not eligible for Medicaid.

Coverage

The state helps by paying for QMB clients' Medicare premiums, deductibles and coinsurance. However, OHP does not pay for premiums or copayments for Medicare Part D drug plans or services. If you have QMB-only, Medicare pays your health care costs, not OHP.

Clients may be eligible for more than one benefit package at once. For example, a person with QMB benefits may also be eligible for OHP with Limited Drug benefits.

Citizen Alien-Waived Emergency Medical Assistance (CAWEM) benefits

These clients are not citizens of the United States and do not have an immigration status that meets Medicaid requirements. Coverage is limited to emergency services and labor and delivery services.

Health care services

The health service you may receive are based on your assigned benefit package. See Fields 9a and 9b on your Medical Care ID to find out what type of coverage you have. Benefit packages are defined on pages 3 through 7.

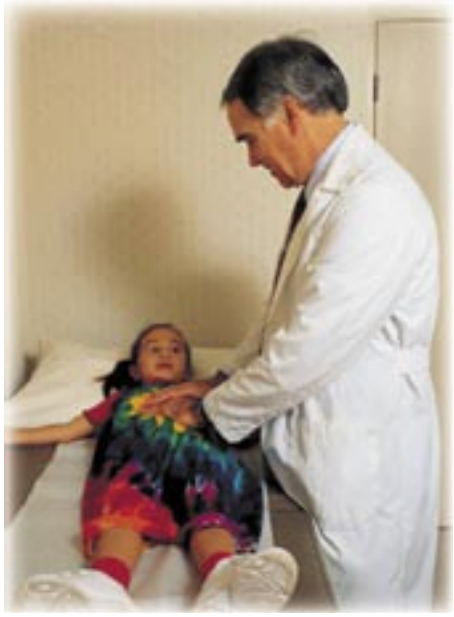
See the quick reference chart on page 10 that shows what services are covered for each benefit package.

Preventive services

Preventing health problems before they happen is an important part of your care.

Under OHP, you can get preventive services to help you stay healthy. Preventive services include check-ups and any tests to find out what is wrong. Be sure to discuss the recommended schedule for check-ups with your provider. Other preventive services include the following:

- Well-child exams
- Immunizations (shots) for children and adults (**not** for foreign travel or employment purposes)
- Routine physicals
- Pap smears
- Mammograms (breast x-rays) for women
- Prostate screenings for men
- Dental check-ups, exams and preventive dental care for children and adults
- Maternity and newborn care
- Maternity management (special services to help you have a safe pregnancy)



Some services have limits. Your provider can help answer your questions about limited services. There are some services that are not covered even if treatment may be important. If you get a health care service that is not covered, you may have to pay the bill. Your provider will tell you if a service is not covered and what choices you have.

Medical services

Services covered by OHP Plus, OHP with Limited Drug and OHP Standard all include the following:

- Preventive services
- An exam or test (laboratory or x-ray) to find out what is wrong, whether the treatment for the condition is covered or not
- Treatment for most major diseases
- 24-hour emergency care, x-ray, and lab services
- Chemical dependency (alcohol and drug) treatment
- Eye health care
- Hospice
- Labor, delivery and newborn care
- Some surgeries
- Most prescription drugs
- Family planning
- Specialist care and referrals
- Stop-smoking programs
- Diabetic supplies and education
- Medical equipment and supplies
- Emergency ambulance

If you are in managed care, you will need to get a referral from your provider to see a specialist.

Not covered services

OHP covers reasonable services for diagnosing conditions, including the office visit to find out what's wrong. However, once they know what's wrong, OHP may not cover follow-up visits if the condition or treatment is not funded on the Prioritized List of Health Services (see page 2).

For example, OHP does *not* pay for the following services:

- Treatment for conditions that get better on their own (such as colds or flu)
- Treatment for conditions for which home treatment works (such as sprains, allergies, corns, calluses or some skin conditions)
- Cosmetic surgeries or treatments
- Treatments that are not generally effective
- Services to help you get pregnant
- Weight loss programs
- Buy-ups – To "buy up" means you get an item that is not covered by OHP by paying the difference between the item OHP covers and a more expensive, non-covered model. For example, OHP may cover a basic pair of eyeglasses but the client may want a more expensive pair that is not covered by OHP. The client tries to "buy up" by paying the difference between the two. This is not allowed.

Quick reference benefits chart

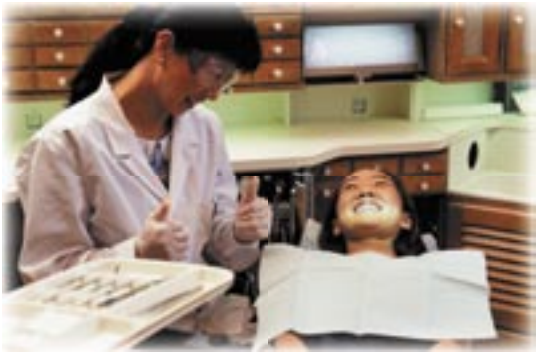
Covered Services	OHP Standard	OHP Plus	OHP with Limited Drug
Acupuncture	Limited	✓	✓
Chemical dependency services	✓	✓	✓
Dental	Limited	✓	✓
Emergency medical services	✓	✓	✓
Hearing aids and hearing aid exams		✓	✓
Home health		✓	✓
Hospice care	✓	✓	✓
Hospital care	Limited	✓	✓
Immunizations	✓	✓	✓
Labor and delivery	✓	✓	✓
Laboratory and X-ray	✓	✓	✓
Medical equipment and supplies	Limited	✓	✓
Medical transportation	Limited	✓	✓
Mental health services	✓	✓	✓
Physical, occupational & speech therapies		✓	✓
Physician services	✓	✓	✓
Prescription drugs	✓	✓	Limited*
Private duty nursing		✓	✓
Vision care	Limited	✓	✓
* **OHP with Limited Drug** does not pay for certain prescription drugs that Medicare Part D covers. OHP does pay for some other drugs that Medicare does not cover.			
QMB covers Medicare premiums, copayments (except on drugs), and deductibles.			
CAWEM clients receive only emergency or labor and delivery services.			

OHP offers more services and places more limitations than we can list here. This chart is meant to be a guide, not OHP policy.

If you have questions about what OHP will pay for, ask your managed care plan or the DMAP Client Advisory Services Unit (see CASU, page 41).

Dental services include the following:

- Preventive services (cleanings, fluoride treatments, sealants for children)
- Routine services (fillings, x-rays)
- Dental check-ups
- Tooth removal
- Dentures
- 24-hour emergency care
- Specialist care and referrals



NOTE: OHP Standard dental coverage is limited to emergency services only.

Mental health services include the following:

- Evaluations and consultations
- Therapy
- Case management
- Medication management
- Hospitalization
- Emergency services
- Programs to help with daily and community living

Chemical dependency treatment

The chemical dependency services you may receive are based on the benefit package you have been assigned to. Problems with alcohol or other drugs affect the whole family. You may need treatment if drinking alcohol or using other drugs causes problems such as these in your life:

- Fighting with your loved ones
- Missing work
- Getting sick
- Having trouble with the law

Identifying problems before they become worse will increase your chance of recovery. You do not need a referral to receive help for problems with alcohol or drugs. You can go to:

- Any provider who will take your Medical Care ID.
- Your primary care provider or primary care manager.

Outpatient treatment and methadone services

OHP covers outpatient treatment and methadone services. Outpatient treatment means you can stay at home with your family and keep working while getting treatment.

Residential services

Residential services include treatments provided in a 24-hour care facility. OHP does not cover residential services; however, if needed, you may get residential services from other programs.

For more information on residential services, call the Oregon Partnership Alcohol and Drug HelpLine at:

- 1-800-923-HELP (4357) or 1-877-553-TEEN (8336)—youth line
- 1-877-515-7848 for Spanish-speaking clients
- 503-945-5962—The DHS Addictions and Mental Health Medicaid Policy Unit can also answer your questions about these type services.

Stop smoking programs

OHP pays for services to help you stop smoking. Talk to your primary care provider for more information.

Oregon Quit Line: 1-877-270-STOP (7867)
TTY: 1-877-777-6534

Pregnancy care coverage

Pregnancy care is covered under the OHP. If you become pregnant, call your worker right away. Your worker will make sure you do not lose medical coverage before your baby is born. You also need to tell your worker if a pregnancy ends.

Pregnant clients:

- Receive services under OHP Plus or OHP with Limited Drug.
- Are not charged premiums or copayments.

If you are pregnant, or think you might be, it is important that you see a health care provider right away.

Remember!

- Regular check-ups are important to have a healthy baby. Keep your appointments and follow your provider's advice.
- Alcohol and drugs taken before or during pregnancy can harm your unborn baby. If you need help for alcohol and drug use, talk to your provider.
- Now is a good time to stop smoking cigarettes. Smoking during pregnancy can harm your baby. Talk to your provider to find out ways he or she can help you quit.
- If you need a specialist for your pregnancy care, your provider can refer you to one.
- Your provider can give you vitamins that will keep your baby healthy during your pregnancy and help prevent birth defects.

Newborn care coverage

Call your worker as soon as your baby is born—within two weeks is good. Your baby has medical coverage until his or her first birthday, even if you are no longer eligible for OHP.

When you call your worker, give the following information about your baby, and your baby's parents:

- Date of birth
- Name
- Sex
- Social Security number (or call again as soon as your baby gets one)
- Your primary care provider or primary care manager

Family planning and related services

The following family planning and related services are available to women, men and teens:

- Family planning visits (physical exam and contraceptive education)
- Contraceptive supplies, such as oral contraceptives and condoms
- Sterilization services (tubal ligations and vasectomies)

"Related services" include the following:

- Pap smear
- Pregnancy test
- Screenings for sexually transmitted diseases (STDs)
- Abortions
- Testing and counseling for AIDS and HIV

Even if you're in managed care, you can go to any one of the following places to receive family planning services.

- A county health department
- A family planning clinic
- Any provider who will take your Medical Care ID

There is no copayment for any of the family planning and related services or supplies.

Medical Care Identification (ID)

The state sends a Medical Care ID to OHP clients each month. Check your Medical Care ID to make sure the information is correct. If it is not, call your worker. Always carry your current Medical Care ID. Show it every time you get health care services.

Your Medical Care ID shows your branch office name, phone number, your worker's code, and the benefit package and copayment information for everyone on the ID. See the sample ID and explanations on pages 16 and 17.

Changes to your Medical Care ID

If your name or address changes, let your worker know. The post office will not forward your Medical Care ID to your new address. You could lose your OHP benefits if your worker does not have your correct address.

It is illegal to use your Medical Care ID for health services for anyone not listed on your ID.

How to read your Medical Care ID

The sample on the next page gives us the following information about John Doe, who has a permanent disability.

- John finds "AB" written in Field 7b, "copayments." Field 7a at the top of the page tells him how much he will pay for outpatient services and OHP prescription drugs.
- John's ID shows an "FG" in Field 8b. Boxes "F" and "G" in Field at the top of the page show that John is enrolled in Medicare Parts A, B and D.
- Field 9b, Benefit Package, shows a "CD." Field 9a explains that "C" means QMB and "D" is OHP with Limited Drug.

The sample ID gives us the following information about Janie Doe, who was born in 1984:

- Field 7b for Janie spells out "NO COPAYS," so Janie knows she will not have to make copayments.
- Field 8b has the letters "ABC" in it. Field 8a shows that Janie is enrolled in a DMAP medical plan ("A"), a DMAP dental plan ("B") and a DMAP mental health plan ("C").
- The "B" in Field 9b shows that Janie receives OHP Plus benefits.

Young Jacob's information on the sample ID shows the following:

- He has "NO COPAYS" 7b and has the OHP Plus benefit package 9b.
- He is enrolled in DMAP medical (A) and dental (B) plans. He also has private vision, mental health and medical insurance coverage "C, D,E" in 8a.
- His Medicaid ID and date of birth are listed in Fields 11 and 12.
- Field 13 shows Jacob is covered for the month of January.

(1) (2)

5503 XX#### EF P2
P.O. BOX 14520
SALEM, OR
97309-5044
DO NOT FORWARD: RETURN IN 3 DAYS

(3)

DMAP Medical Care Identification (ID)

(4) Branch Name	Division	(5) Worker	(6) Phone
OHP Branch	AFS	EF	(503) 378-2666 1-800-699-9075

John Doe
Street Name

City State Zip

(7a) Copy Requirements
A $3 for outpatient services not paid for by your Plan (listed in 8a)
B $2 Generic/$3 Brand – for drugs not paid for by your Medical Plan (listed in 8a)

(8a) Managed Care/TPR
A DMAP MEDICAL PLAN MEDICAL PLAN NAME PH # 1-800-555-1234 GRP #
B DMAP DENTAL PLAN DENTAL PLAN NAME PH # 1-800-555-1234 GRP #
C DMAP MENTAL HEALTH PLAN MENTAL HEALTH PLAN NAME PH # 1-800-555-1234 GRP #
D PRIVATE MAJOR MED/DRUGS MEDICAL PLAN NAME PH # 1-800-555-1234 GRP #
E PRIVATE VISION COVERAGE VISION PLAN NAME PH # 1-800-555-1234 GRP #
F MEDICARE PART A AND B MEDICARE PLAN NAME PH # 1-800-555-1234 GRP #
G MEDICARE PART D HAS PART D
H
I

(9a) Benefit Package	
A – OHP Plus	**D – OHP with limited drug**
B – OHP Standard	**E – CAWEM Emergency Medical**
C – QMB	

All non-emergency care must be approved by applicable Managed Care/TPR shown in field 8a. See DMAP General Rules OAR 410-120-1210 for specific benefit package limitations. All DMAP administrative rules can be found on the DMAP Web site at: www.oregon.gov/DHS/healthplan/

(10) Name of Eligible Person(s)	(11) Recipient ID	(12) Date of Birth	(13) Dates of Coverage	(7b) Copy Req	(8b) ManagedCare/TPR	(9b) Benefit Package
DOE, JOHN	XX#####X	10/13/62	6/01-6/30/07	A	FG	CD
DOE, JANIE	XX#####X	08/10/74	6/01-6/30/07	NO COPAYS	ABC	B
DOE, JACOB	XX#####X	01/26/99	6/01-6/30/07	NO COPAYS	ABCD	A

IMPORTANT:

- **This is your new DMAP Medical Care ID. Issued on:** 6/1/07
- **Show this ID to all providers, even if you have a Managed Care Plan card.**
- **Not valid outside the United States or US Territories.**

(14)

Agency Message - 45 characters - 6 Lines - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message - Agency Message

DMAP Message - 45 characters - 6 Lines - DMAP Message76

State of Oregon Department of Human Services Division of Medical Assistance Programs DMAP 1417 (Rev 05/07)

Medical transportation

You must find a way to get to your health care appointments. If you transport yourself, ask your worker if OHP can reimburse you for your expenses . If transportation is a problem, you might:

- Take the bus.
- Ask a friend or relative to drive you.
- Find a volunteer from a community service agency.
- Call the transportation call center that serves OHP clients free of charge in your county.

If you cancel or change your appointment, call right away to cancel or change your ride.

Brokerages include:

Cascades East Ride Center (Baker, Crook, Deschutes, Grant, Harney, Jefferson, Malheur, Union and Wallowa Counties)	541-385-8680	TTY: 800-735-2900
Cascades West Ride Line (Benton, Linn, Lincoln Counties)	541-924-8738	TTY: 541-928-1775
Lane Transit (Lane County)	Pending	
Northwest Ride Center (Columbia, Clatsop, Tillamook Counties)	503-861-7433	TTY: 7-1-1
TransLink (Coos, Curry, Douglas, Jackson, Josephine, Klamath, Lake Counties)	541-842-2060	TTY: 7-1-1
Transportation Network (Hood River, Gilliam, Morrow, Sherman, Wasco, Wheeler, Umatilla Counties)	541-298-5345	TTY: 7-1-1
Transportation Services (Tri-Met) (Clackamas, Multnomah, Washington Counties)	503-802-8700	TTY: 7-1-1
Trip Link (Marion, Polk, Yamhill Counties)	503-315-5544	TTY: 7-1-1

Service delivery

There are two ways to receive health care through the Oregon Health Plan. They are fee-for-service (FFS) and managed care. Be sure to look your Medical Care ID for "Dates of Coverage" (Field 13) and "Managed Care/TPR" (Field 8) to see if you are enrolled in a managed care plan.

Depending on where you live and other factors, you may be enrolled in a managed care plan for some kinds of health care and receive health care from any provider who will take your Medical Care ID for other services. For instance, you may be in a medical plan and a mental health plan, but not a dental plan. For information about managed care services, please turn to page 28.

Some clients receive health care from FFS providers for the first part of a month and then are enrolled in a managed care plan for the remainder of the month. Check the "Dates of Coverage" and "Managed Care/TPR" fields of your ID every month to make sure nothing has changed. If you have questions about the information on your ID, call your worker. Your worker's phone number is located in Field 6 on your Medical Care ID.

Reasons why clients may not be enrolled in a plan include:

- There are no managed care plans (medical, dental or mental health) available in the area in which they live.
- Clients who are American Indian, Alaska Natives or are eligible for services through an Indian Health Services program are not required to enroll in an OHP managed care plan. These clients can choose to be in a managed care plan or receive health care from any provider who will take their Medical Care ID.
- New clients with the following conditions don't have to enroll in a managed care plan if they:
  - Are scheduled for surgery. Enrollment in a plan may be delayed until after surgery.
  - Are in the last three months of a pregnancy. If not already enrolled in a DMAP plan, enrollment in a plan may be delayed until after the birth of the baby.
  - Have End Stage Renal Disease or receive routine dialysis treatment, or have received a kidney transplant within the last 36 months.

Fee-for-service

Fee-for-service (FFS) means that you are not enrolled in a managed care plan. If you are not enrolled in managed care, you can receive health care from any provider who will take your Medical Care ID. You may need to call doctors' offices to find out if they accept OHP clients. That provider will bill DMAP directly for any services provided and will receive a "fee" for his or her "service." Some people call this an "open card."

If you are a fee-for-service client, the "Managed Care/TPR" Field 8 on your Medical Care ID will not show an OHP managed care plan. However, if you have private insurance, that insurance will be listed in this column. (TPR stands for Third Party Resource.)

Problems with health care services

If you have a complaint about the way you were treated at a health care appointment (such as staff rudeness or unresolved billing):

- Call the DMAP Client Advisory Services Unit (CASU) at 1-800-273-0557 (TTY 1-800-375-2863).
- Fill out an OHP complaint form (OHP 3001). You can get this form from CASU, from your worker or on the DHS Web site: <http://dhsforms.hr.state.or.us/Forms/Served/HE3001.pdf>.
- If you disagree with a decision about your health care made by DMAP, complete an Administrative Hearing Request form (DHS 443). Your worker can give you the form. See page 36 for more information about your rights to a hearing.

24-hour health care advice

Sometimes when you or your child gets sick or hurt, you can't tell if you need to see a doctor or not. Other times, you know you need medical care, but you don't know if you should wait to see your regular provider or go to an urgent care center or hospital emergency room.

If you receive care on a fee-for-service basis, you may call the nurse advice line at 1-800-711-6687. The nurse will ask some questions, then help you decide where to get treatment. Maybe you do not need a trip to the hospital. The nurse may even call back later to see how you are.

The nurses are available 24 hours a day, seven days a week. This service is free.

Emergency medical care

An emergency is a serious injury or sudden illness, including severe pain, that you believe might cause death or serious bodily harm if left untreated. If you are pregnant, emergency services also include your unborn baby's health. If you believe you have an emergency, call 9-1-1 or go to the nearest emergency room. Emergency care is covered 24 hours a day, 7 days a week.

Take your ID

At the emergency room, show your Medical Care ID. The emergency room staff will call your provider if they need to know more about you.

Emergency care when you're away from home

If you are traveling and have an emergency, go to the nearest emergency room or call 9-1-1. Emergency services are only authorized for as long as the emergency exists. Call your primary care provider to arrange for further care if it is needed while you are gone. Also, call for follow-up or transfer of your care.

If it's not really an emergency

If you use an ambulance or the emergency room for something that DMAP does not consider an emergency, you may have to pay the bill. Emergency room care is very expensive. Do not go to the emergency room for care that should take place in your provider's office. Care for sore throats, colds, flu, back pain or tension headaches is not considered an emergency. Call your provider or the 24-hour nurse advice line instead.

Urgent care

An urgent medical condition is serious enough to be treated right away, but does not require emergency room care. For urgent care, call your provider. They will give you advice on what to do. If you cannot reach your provider, call the 24-hour nurse advice line, 1-800-711-6687, or go to an urgent care center. If you have a mental health crisis, call your mental health plan.

Follow-up to emergency or urgent care

After you are released from the emergency room or from an urgent care clinic, call your primary care provider (PCP) as soon as possible. Tell your provider where you were treated and why. Your PCP will handle all your follow-up care and schedule another appointment, if it is needed.

Dental emergency and urgent care

A dental "emergency" is dental care requiring **immediate** treatment. Examples of dental emergencies include:

- Severe tooth pain
- A tooth knocked out
- Serious infection

"Urgent" dental care is dental care requiring prompt but not immediate treatment. Examples of urgent conditions include:

- A toothache
- Swollen gums
- A lost filling

If you have a dental emergency or urgent care need, call your regular dentist.

Disease or Case Management Program

You may be placed in a special program if you have certain chronic conditions, such as:

- Diabetes
- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)

You may also be placed in the case management program if you have certain multiple medical needs. The goal of the program is to keep you healthier longer.

If you are part of the program, you receive extra help, advice or visits from nurses about how to care for yourself. You will also learn how to work with your providers to coordinate your care among all of your health care professionals.

You may call the 24-hour nurse advice line at 1-800-711-6687 any time you have questions about your condition. The program also provides a library of resources to learn more about your health condition.

Care away from home

If you travel outside of Oregon, OHP only covers emergency services. You may be billed for out-of-state emergent care if the provider does not enroll as a DMAP provider.

After you receive emergency treatment, call your primary care provider to arrange for further care if it is needed while you are gone. Also, call for follow-up or transfer of your care.

Travel outside of the United States

If you travel outside the United States (including Canada and Mexico), OHP will not cover any health care services you get in another country.

Pharmacy Management Program

If you are in the Pharmacy Management Program, you must go to one pharmacy for your prescription drugs.

You will not be in the Pharmacy Management Program if you:

- Are enrolled in a medical plan.
- Have Medicare drug coverage in addition to OHP FFS and no other third party pharmacy insurance coverage;
- Are an American Indian, Alaska Native or eligible for benefits through an Indian Health Services program.
- Are a child in the care and custody of the Department of Human Services.
- Are an inpatient or resident in a hospital, nursing facility, or other medical institution, or receiving services under the Home and Community Based or Developmental Disability waivers.

How the program works

When your first prescription is filled, you will be enrolled with the pharmacy that fills the prescription. DMAP will send you a new Medical Care ID showing the enrolled pharmacy in Field 8, Managed Care/TPR, on the ID.

You will have 30 days to change pharmacies if you do not want to be enrolled in the pharmacy listed on the Medical ID. To change pharmacies, call the DMAP Client Advisory Services Unit (CASU) at 1-800-273-0557 or TTY at 1-800-375-2863.

Exceptions allowed

You may receive drugs from a different pharmacy if:

- You have an urgent need to fill a prescription and your enrolled pharmacy is not available (for example, it is closed or you are out of the area).
- Your pharmacy does not have the prescribed drug in stock.

You may change your pharmacy enrollment:

- If you move.
- When you reapply for the OHP.
- If you are denied services by your enrolled pharmacy.

OHP home-delivery pharmacy services

This program lets fee-for-service clients order and receive medications in the mail at home or at your clinic. You do not have to make copayments for drugs provided through the DMAP Home-Delivery Pharmacy. You can:

- Order ongoing prescriptions for the entire family.
- Order refills by mail or phone.
- Be guaranteed quality and safety.
- Have delivery within eight to ten days.
- Order up to a three-month supply at one time.

You can use these services even if you are restricted to one walk-in pharmacy through the Pharmacy Management Program. Your doctor can send your prescription to the home-delivery service or you can enroll yourself by calling 1-877-935-5797 toll-free. Customer service representatives are available Monday through Friday from 8 a.m. to 5 p.m.

When you need help

If you get a bill

Copayments are your responsibility. Providers may bill you for unpaid copayments. If you get a bill (other than for a copayment) from a provider, call OHP Client Advisory Services Unit at 1-800-273-0557 (TTY 1-800-375-2863) if you are fee-for-service or you have a PCM.

NOTE: If you pay a medical, dental, or mental health bill yourself, DMAP will *not* pay you back.

Client access to clinical records

An OHP client may have access to his or her own clinical records. A client may also ask to have his or her medical records corrected. More client rights and responsibilities follow on the next two pages.

More helpful numbers

Starting on page 40, read when to call your worker or how CASU can help you with other questions you may have. We have listed more services available to you and your family in the back of this booklet.

OHP client rights

- To be treated with dignity and respect
- To be treated by providers the same as other people seeking health care benefits to which you are entitled
- To obtain covered substance abuse treatment, family planning, or related services without a referral
- To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines
- To be actively involved in the development of your treatment plan
- To receive information about your condition and covered and non-covered services, to allow an informed decision about proposed treatment(s)
- To consent to treatment or refuse services and be told the consequences of that decision, except for court-ordered services
- To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency
- To receive written materials explained in a manner that is understandable to you
- To receive necessary and reasonable services to diagnose the presenting condition
- To receive covered services under the OHP which meet generally accepted standards of practice and are medically appropriate
- To obtain covered preventive services
- To receive a referral to specialty providers for medically appropriate, covered services
- To have a clinical record maintained which documents conditions, services received and referrals made.
- To have access to your own clinical record, unless restricted by statute
- To transfer a copy of your clinical record to another provider
- To make a statement of wishes for treatment (Advance Directive) and obtain a power of attorney for health care
- To receive written notice before a denial of, or change in, a service level or benefit is made, unless such notice is not required by federal or state regulations
- To know how to make a complaint, grievance or appeal and receive a response
- To request an Administrative Hearing with the Department of Human Services
- To receive a notice of an appointment cancellation in a timely manner.
- To receive adequate notice of DHS privacy practices

OHP client responsibilities

- To treat all providers and personnel with respect
- To be on time for appointments made with providers
- To call in advance if you are going to be late or have to cancel your appointment
- To seek periodic health exams, check-ups, and preventive services from your medical, dental or mental health providers
- To use your PCP or clinic for diagnostic and other care, except in an emergency
- To obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist, unless self-referral is allowed
- To use emergency and urgent care services appropriately
- To give accurate information for inclusion in the clinical record
- To help the provider or clinic obtain clinical records from other providers. This may include signing a release of information form
- To ask questions about conditions, treatments and other issues related to your care that you don't understand
- To use information to make informed decisions about treatment before it is given
- To help in the creation of a treatment plan with your provider
- To follow prescribed, agreed-upon treatment plans
- To tell your provider you have OHP coverage and to show your Medical Care ID when asked.
- To tell your DHS worker of a change of address or phone number
- To tell your DHS worker if someone in the family becomes pregnant
- To tell your DHS worker of the birth of a child
- To tell your DHS worker if any family members move in or out of the household
- To tell your DHS worker if there is any other insurance available and to report any changes in insurance in timely manner
- To pay for non-covered services you receive
- To pay the monthly OHP premium on time, if required
- To assist DMAP to find any other insurance to which you are entitled and to pay DMAP the amount of benefits you received as a result of an accident or injury
- To notify DMAP of issues, complaints or grievances
- To sign a release so that DHS and your plan can get information that is pertinent and needed to respond to an Administrative Hearing request in an effective and efficient manner

Managed care

In managed care, a managed care plan or primary care manager (PCM) coordinates your health care needs.

If you are in managed care, you may be enrolled in any or all of the following:

- Medical plan or PCM (for physical health care)
- Dental plan
- Mental health plan
- Chemical dependency plan (available in Deschutes County only)

What are the benefits of managed care?

- You will not have to pay copayments.
- You and your family will have guaranteed access to health care 24 hours a day, 7 days a week.

Interpreter services

If you are in managed care and need an interpreter for doctor visits or to assist you with questions, contact your plan. Interpreters can be available either by telephone or in person.

Identification cards

Your medical and dental plans will send you identification cards. They tell you what to do in an emergency. It is important to show both your DMAP Medical Care ID and your plan ID when you seek health care. Call the plan's member services department to replace lost plan ID cards.

Managed care plan or primary care manager

The managed care plans or primary care manager (PCM) you are enrolled with are listed on your Medical Care ID. For each family member, match Field 8b with Field 8a.

Primary care provider in a medical plan

When you enroll in a medical plan, your medical plan will ask you to choose a primary care provider (PCP). Each family member may choose a different PCP. Your PCP will provide or coordinate your medical services and treatments. Your medical plan will give you 30 days to choose a PCP. After 30 days, your medical plan may choose

a PCP for you. Ask your plan for a list of providers if you don't have one.

Primary care manager (PCM)

Medical plans are not available in all areas of the state, or to all clients. In order to make sure OHP clients can still receive the advantages of managed care, DMAP also contracts with individual providers to coordinate and manage your health care. These providers are called primary care managers (PCMs). Each family member may choose a different PCM. If you are enrolled with a PCM, your PCM will provide and coordinate your medical services and treatments.

To coordinate your medical care, your PCP or PCM will:

- Keep your medical records in one place to give you better service.
- Provide access for you to medical care 24 hours a day, 7 days a week.
- Be your first contact when you need medical care, unless it's an emergency.
- Arrange for your specialty or hospital care when needed.

If you receive non-emergency or non-urgent care services from providers who are not part of your plan, you may be responsible for charges, including Medicare deductibles and coinsurances.

You may change your managed care plan or PCM

- When you reapply for OHP coverage.
- If you move out of your plan's service area, or away from the PCM.
- For any important reason that DMAP approves.
- To change your plan or PCM, call your DHS worker.

Ask your medical plan when the change will go into effect. If you need medical care before the change goes into effect, call your medical plan. Your medical plan can help you get the care you need.

Special services

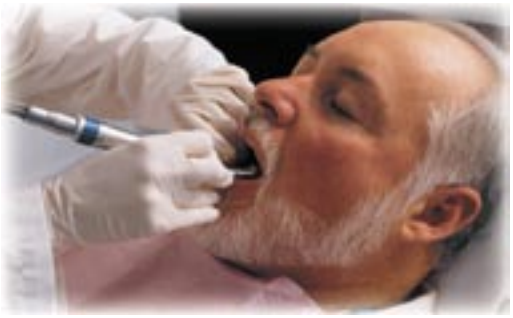
- You must have a referral from your plan or PCM before you see a specialist. If you do not have a referral, OHP may not pay for the care you receive. You may have to pay the specialist's bill.
- However, you do not need a referral from your PCP or PCM to get family planning and related services. You may seek this type of help from anyone who will take your Medical Care ID.
- You will get your prescription drugs at the pharmacies your managed health plan contracts with. Ask your plan for a list.

Exceptional Needs Care Coordinator (ENCC)

Each medical plan has an ENCC to assist members who have complex medical or special needs. ENCCs help coordinate health care services for members age 65 or older and members with disabilities. Members who have special medical supply or equipment needs, or who will require support services in obtaining care, may ask for help from an ENCC by calling your medical plan.

Dental plans

If you are enrolled in a dental plan, your dental plan will ask you to choose a dentist from their list of providers. Each family member may choose a different dentist. Your dentist will provide and coordinate your dental services and treatments.



To coordinate your dental care, your dentist will:

- Keep your dental records in one place to give you better service.
- Provide access for you to dental care 24 hours a day, 7 days a week.
- Be your first contact when you need dental care, except in an emergency.
- Arrange for specialty dental care, if you need it.

Mental health plans

If you are enrolled in a mental health plan, your mental health plan will provide and coordinate your mental health services and treatments.

Mental health services include an assessment, case management, therapy, medication management and inpatient psychiatric care from the appropriate mental health plan.

You must get your mental health drugs at the pharmacy your medical plan contracts with.

To coordinate your mental health care, your mental health plan will:

- Keep your records in one place to give you better service.
- Provide access for you to mental health care 24 hours a day, 7 days a week.
- Be your first contact when you need mental health care.
- Arrange for your speciality or psychiatric hospital care when needed.

24-hour health care advice

Your plan's client handbook tells you what to do if you need emergency or urgent care services. Sometimes when you or your child gets sick or hurt, you can't tell if it is an emergency or not. Call your managed care plan and ask where to get treatment. Someone is available to give you advice 24 hours a day, seven days a week. Speak to the provider on call, even if he or she is not your usual provider.

If you go to the emergency room

If you go to an emergency room or urgent care clinic, show both your Medical Care ID **and your medical plan card**. The emergency room staff will call your provider if they need to know more about you.

Follow-up to emergency or urgent care

After you are released from the emergency room or from an urgent care clinic, call your primary care provider as soon as possible. Tell your provider where you were treated and why. Your PCP or PCM will handle all your follow-up care and schedule another appointment, if it is needed.

Care away from home

If you need health care services while you are traveling, call your PCP or PCM for advice. Your plan may not pay for services it does not authorize first. If you travel outside the United States (including Canada and Mexico), OHP will not cover any health care services you get in another country. If you have Medicare coverage and you are in managed care, contact your medical plan to find out about your coverage while traveling.

Labor and delivery

If at all possible, try to stay within your medical plan's service area during the last 30 days of your pregnancy.

However, if you must leave your medical plan's service area, your plan is only responsible for emergency care outside the plan's service area. The plan will cover the delivery and the baby's newborn check-up in the hospital but not the prenatal care. The plan will also pay for any other emergency care involving you or your baby.

Newborn enrollment

Your managed care medical plan will cover your newborn child at the time of birth. However, you will still need to call your DHS worker to enroll your baby in your plan as soon as possible (within two weeks is best). Check your next Medical Care ID to make sure your baby is listed. If not, call your worker.

Managed care member rights

In addition to the rights shown on page 26, as a member of a managed care plan, you also have the right to:

- Select or change your primary care provider (PCP).
- Have the plan's written materials explained in a manner that is understandable.
- Know how to make a complaint with the plan and receive a response from the plan.

Client access to clinical records

An OHP client may have access to his or her own clinical records. A client may also ask to have his or her medical records corrected.

For clients in managed care, plans and their providers must provide copies within ten working days of the request from the member. Plans and their providers may charge the DMAP member reasonable copying costs.

Problems with your health care services

If you have a complaint about the way you were treated at a health care appointment (such as staff rudeness or unresolved billing), choose one of the following:

- Call your managed care plan at the number shown on your Medical Care Identification.
- Call the Client Advisory Services Unit at 1-800-273-0557 (TTY 1-800-375-2863) to discuss your problem.
- Fill out an OHP complaint form (OHP 3001). You can get this form from the DMAP Client Advisory Services Unit, from your worker or on the DHS Web site: <http://dhsforms.hr.state.or.us/Forms/Served/HE3001.pdf>. Your plans also have complaint forms.
- See also your Hearing Rights on page 36.

Managed care member responsibilities

In addition to the responsibilities listed on page 27, as a member of a prepaid health plan, you also have the responsibility to:

- Choose your provider or clinic, once enrolled.
- Obtain services only from your PCP (except in an emergency) or through plan providers upon referral from your PCP.
- Obtain a referral to a specialist from your PCP or clinic before seeking care from a specialist unless self referral to the specialist is allowed.
- Notify the plan or PCP within 72 hours of an emergency.
- Assist the plan in pursuing any third party resources available and to pay the plan the amount of benefits it paid for an injury from any recovery received from the injury.
- Bring issues or complaints to the attention of the plan.

When to call your managed care plan

If you are in managed care, call your plan:

- To change your PCP.
- To ask which providers are taking new patients.
- If you have a problem with your plan's services.
- If you get or lose other health insurance.
- If you need urgent care.
- If you get emergency care.
- To ask what services are covered and not covered.
- To find out which hospital, pharmacy, or vision provider to use.
- To get special help for a disability.

If you get a bill

If you get a bill from a provider, call the medical, dental, or mental health plan responsible for your care.

NOTE: If you pay a health care bill yourself, the plan will not pay you back.

If your health plan does not resolve the billing problem, call the OHP Client Advisory Services Unit for help at 1-800-273-0557.

Hearing rights

If you do not agree with a decision made on your request for OHP/Medicaid services, you have the right to ask for a hearing.

You may ask for a hearing through any local DHS branch office. If you do not have a caseworker/case manager, contact OHP at 1-800-699-9075 or TTY (503) 373-0354.

At the hearing, you can explain why you do not agree with the decision made in your case. You can have a lawyer or someone else assist you with the hearing. We cannot pay for the cost of a lawyer; however, you may be able to get a lawyer for free by contacting Legal Aid. The hearing will be held before an impartial person called an Administrative Law Judge (ORS Chapter 183).

Managed care

If you are enrolled in a managed health care plan or dental plan, you may only ask for a hearing after you have appealed the decision with your plan.

If you are not satisfied with the outcome of that appeal, you may then ask for a DMAP hearing by completing an Administrative Hearing Request form (DHS 443) and returning it to DMAP or any local DHS branch office WITHIN 45 DAYS from the date of Notice of Appeal Resolution. Please include a copy of the Notice of Appeal Resolution when submitting your request for hearing.

Medicare

If you are enrolled in managed care and also have Medicare benefits, you may have more appeal rights. Contact your plan's member services unit.

Fee-for-service

If you are an open card (fee-for-service) client, you may ask for a DMAP hearing by completing an Administrative Hearing Request form (DHS 443) and returning it to DMAP or any local DHS branch office WITHIN 45 DAYS from the date of the decision notice.

If you want your benefits to remain the same while waiting for the outcome of the hearing, you must submit the completed DHS 443 form by the date of action or WITHIN 10 DAYS of the date of the decision notice. If the hearing decision is in favor of the agency, you may then have to repay the cost of continued health services. Please include a copy of the decision notice when submitting your request for hearing.

Expedited hearings

If you have an urgent medical problem that cannot wait for a regular hearing, you can ask for an "Expedited Fair Hearing." The DMAP Medical Director will review your medical records and decide if your medical problem cannot wait for the regular hearing process.

DMAP hearing request mailing address

Send completed hearing request forms (DHS 443) to:

Division of Medical Assistance Programs
Attention: Hearings Unit
500 Summer Street NE, E49
Salem, OR 97301-1079

Your right to make health care decisions

If you are an adult, you have the right to know about any medical treatment your doctor recommends for you and to refuse it if you choose. However, a serious illness or sudden injury could leave you unable to make decisions or express your wishes. In such a situation, your relatives would have to decide what you would want.

Oregon has a law that allows you to say in writing, ahead of time, how you would want to be treated if you were seriously ill or injured. The legal documents used to do this are called Advance Directives. The Advance Directive lets you name a person to direct your health care when you cannot do so. This person is called your health care representative. Your health care representative does not need to be a lawyer or health care professional. It should be someone with whom you have discussed your wishes in detail. Your health care representative must agree in writing to represent you.

The Advance Directive allows you to give instructions for health care providers to follow if you become unable to direct your care. The Advance Directive lets you tell your doctor to stop life-sustaining help if you are near death. This tells your doctor that you do not want your life prolonged if you have an injury or illness or disease that two doctors agree you will not recover from. You will get care for pain and to make you comfortable no matter what choices you make.

The Advance Directive is only valid if you voluntarily sign it when you are of sound mind. Unless you limit the duration of the Advance Directive it will not expire. You also may revoke your Advance Directive at any time. You have the right to decide your own health care as long as you are able to, even if you have completed the Advance Directive. Completing the Advance Directive is your choice. If you choose not to fill out and sign the Advance Directive form, it will not affect your health plan coverage or your access to care.

The Oregon Advance Directive forms are available at no cost from your medical plan (if you are in managed care) or by contacting your local hospital. For more information about Advance Directives, call your medical plan (if you are in managed care) or Oregon Health Decisions in Portland at 503-241-0744 or 1-800-422-4805.

Health care professionals

The following is a list of identified health care professionals licensed in the State of Oregon.

Not all managed care plans cover the services of all healing arts professionals.

You may need a referral from your Primary Care Provider (PCP) or Primary Care Manager (PCM) to see a healing arts professional. If you do not have a referral, you may have to pay the bill. No referral is needed for covered chemical dependency (alcohol and drug) treatment, family planning or related services.

- Acupuncturists
- Audiologists
- Chiropractic Physicians
- Clinical Social Workers
- Counselors, Professional
- Dental Hygienists
- Dental Specialists
- Dentists, General
- Denturists
- Dieticians
- Hearing Aid Dealers
- Marriage and Family Therapists
- Massage Technicians
- Midwives, Licensed Direct Entry (LDEM)
- Naturopathic Physicians
- Nurses, Licensed Practical
- Nurse Practitioners
- Nurses, Registered

** Not all psychiatric social workers are licensed.*

- Occupational Therapists
- Occupational Therapy Assistants
- Optometrists
- Osteopathic Physicians
- Physical Therapist Assistants
- Physicians, MD
- Physician Assistants
- Podiatrists
- Pharmacists
- Physical Therapists
- Psychiatric Social Workers*
- Psychologists
- Psychologist Associates
- Radiologic Technologists (Full License)
- Radiologic Technologists (Limited Permit)
- Respiratory Therapists
- School Counselors
- School Psychologists
- Speech Pathologists

Who to call for help

If you have a question or problem with your health care coverage or provider, there are ways to resolve it.

The following pages show different offices that may be able to answer your questions. Please read carefully how each office can help you.

These phone lines are very busy, so you may have to re-dial several times before you get through.

Call your worker if you:

- Get pregnant or a pregnancy ends.
- Have a baby.
- Move.
- Have questions about your eligibility.
- Get or lose other health insurance.
- Want to change your plans or PCM.
- Want to ask for a hearing.
- Have not received your Medical Care ID, or if it is wrong.
- Have family members move in or out of your home.
- Need this booklet in another language, large print, Braille, on tape, computer disk, or in an oral presentation.
- Become eligible for health insurance through an employer.
- Become disabled or determined eligible for SSI.
- Do not have transportation to or from a health care appointment.

Your worker may tell you to report other changes as well. You DHS worker's identification code and telephone number are on your Medical Care ID in Fields 5 and 6.

The OHP Statewide Processing Center is 1-800-699-9075 or TTY 503-373-7800. They can answer questions until you have an assigned worker.

OHP Client Advisory Services Unit (CASU) **1-800-273-0557**
500 Summer St NE, E44 TTY 1-800-375-2863
Salem, Oregon 97301 FAX 503-945-6898

Like any insurance company, the Oregon Health Plan has a group of customer service representatives to help you understand and use your coverage. Call CASU if you need a client advisor to:

- Provide you general information about your medical and dental coverage.
- Coach you on how to resolve problems involving access or quality of care.
- Help you resolve what you consider to be an inappropriate denial of covered benefits.
- Explain the OHP managed care system and help you navigate through that system.
- Research and resolve medical billings from your health care providers or collection agencies.
- Send you another client handbook or other written materials you need.
- Take your request for changing an assigned pharmacy.
- Advise you about OHP premiums.
- Advise you about OHP copayments.
- Send you or your new health insurance company a "certificate of creditable coverage" when you leave the OHP and need to provide proof of prior coverage.

NOTE: CASU advisors cannot send you a list of health care providers or refer you to any specific doctor.

Certificate of creditable coverage (after you leave OHP)

Many private health insurance companies temporarily deny or reduce benefits for prior (pre-existing) medical conditions. However, they can't do this if you had health insurance coverage:

- For at least 18 months in the past two years
- With no breaks longer than 63 days.

The new insurance company may require a certificate of creditable coverage as proof of previous insurance.

If you need a certificate to verify your OHP coverage, contact CASU at 1-800-273-0557. Upon your request, that unit will mail or fax the certificate to you or to your new insurance company.

Division of Child Support

The Division of Child Support (DCS) will set up and enforce child support orders or medical support orders for families who receive public assistance. These support payments:

- Help children in need.
- Encourage family self-sufficiency.
- Return money to the state treasury.
- Reduce the state's costs in providing public assistance.

Assignment of rights

When you applied for OHP services, you gave the state permission to establish paternity and pursue health care coverage from parent(s) not living in your household. DHS is now paying for your child's health care, so the department will keep any money it collects for health care from the absent parent(s) or other insurance companies.

Oregon Department of Justice
Division of Child Support
1495 Edgewater Street NW, Suite 170
Salem, Oregon 97304

Phone: 503-986-6090
Fax: 503-986-6297

Estates Administration Unit

When a Medicaid client dies, Oregon law requires DHS to recover money spent on their care from the "estate" of the client. Money recovered is usually for assistance provided after the client turned 55. However, if the client received General Assistance or was institutionalized at the time of his or her death, assistance that was paid prior to age 55 may be recovered. The money recovered is put back into DHS programs to help other people.

DHS will not make a claim against an estate until the surviving spouse dies. The department will not recover from the estate if the client is survived by a minor child, or a child who is blind or permanently and totally disabled. The child must be a natural or legally adopted.

DHS Estates Administration Unit
P O Box 14021
Salem, OR 97301

1-800-826-5675 (toll-free inside Oregon)
503-947-9975 (Salem)

Personal injury or accident liens

If you, as a Medicaid client, have an accident or injury, you need to tell DHS. Someone else might be responsible to pay for the medical bills that result. When you applied for OHP, you agreed to let DHS have any medical payments you receive, or have the right to receive, from private health insurance or other sources to repay DHS for assistance paid due to the accident or injury. This applies from the date of your injury to the date of a settlement.

If you do not notify DHS of your accident, the department, or your managed care plan, can take legal action (pursue a lien) against you to collect the cost of medical services you received as a result.

DHS Personal Injury Liens Unit
P O Box 14512
Salem, OR 97309

Toll Free 1-800-377-3841
503-378-4514 (Salem)

Domestic violence

This is a list of some of the warning signs of an abusive relationship. You may be in an abusive relationship, if your current or past partner or spouse:

- Puts you down.
- Stops you from getting or keeping a job.
- Makes threats against you or your children.
- Makes you afraid for your safety.
- Keeps you from seeing your friends or family.
- Shoves, grabs, slaps, punches, pinches, strangles, kicks, hits or chokes you.
- Tries to hurt you in any other way.

Call one of these phone numbers for confidential help in creating a safety plan and to get support and information:

Portland Women's Crisis Hotline
1-888-235-5333
503-235-5333 (Portland)
503-419-4357 (TTY)

National Domestic Violence
1-800-799-SAFE (7233)
1-800-787-3224 (TTY)
(Serves both men and women)

DHS NOTICE OF PRIVACY PRACTICES

Effective Date: June 1, 2005

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This publication will be furnished in a format for individuals with disabilities upon request by telephoning (503) 945-5780, Fax (503) 947-5396 or TTY (503) 945-5928.

Available formats include:

- Large Print
- Braille
- Audio Tape Recording
- Electronic Format, and
- Oral Presentation.

The Department of Human Services (DHS) Notice of Privacy Practices will tell you how DHS may use or disclose health information about you. This information is called Protected Health Information (PHI). Not all situations will be described. DHS is required to protect health information by federal and state law. DHS is required to follow the terms of the notice currently in effect.

DHS may use and disclose information without your authorization

For Treatment. DHS may use or disclose PHI with health care providers who are involved in your health care. For example, information may be shared to create and carry out a plan for your treatment.

For Payment. DHS may use or disclose PHI to get payment or to pay for the services you receive. For example, DHS may provide PHI to bill your health plan for health care provided to you.

For Health Care Operations. DHS may use or disclose PHI in order to manage its programs and activities. For example, DHS may use PHI to review the quality of services you receive.

DHS may use or disclose health information without your authorization for the following purposes under limited circumstances:

Appointments and Other Health Information. DHS may send you reminders for medical care or checkups. DHS may send you information about health services that may be of interest to you.

For Public Health Activities. DHS is the public health agency that keeps and updates vital records, such as births and deaths. DHS is the public health agency that tracks and takes action to control some diseases.

For Health Oversight. DHS may use or disclose PHI for government health care oversight activities. Examples are audits, investigations, inspections, and licenses.

For Law Enforcement and As Required by Law. DHS will use and disclose PHI for law enforcement and other purposes as required or allowed by federal or state law.

For Disputes and Lawsuits. DHS will disclose PHI in response to a court order. DHS will disclose PHI in response to an administrative order. If you are involved in a lawsuit or dispute, DHS may share your information in response to legal requirements.

Worker's Compensation. DHS may disclose PHI as allowed by law to worker's compensation or like programs.

For Abuse Reports and Investigations. DHS is required by law to receive reports of abuse. It is also required to investigate reports of abuse.

For Government Programs. DHS may use and disclose PHI for public benefits under other government programs. An example would be to figure out Supplemental Security Income (SSI) benefits.

To Avoid Harm. DHS may disclose PHI to law enforcement in order to avoid a serious threat to the health and safety of a person or the public.

For Research. DHS uses PHI for studies and to develop reports. These reports do not identify specific people.

For Reporting Death. DHS may disclose information of a deceased person to a coroner. DHS may also share information about a deceased person to a medical examiner or to a funeral director.

Disclosures to Family, Friends, and Others. DHS may disclose PHI to your family or other persons who are involved in your health care. You have the right to object to the sharing of this information.

For Disaster Relief. Should there be a disaster, DHS may disclose information about you to any agency helping in relief efforts. DHS may share information about you to tell your family about your condition or location.

Other Uses and Disclosures Require Your Written Authorization. For other purposes, DHS will ask for your written permission before using or disclosing PHI. You may cancel this permission at any time in writing. DHS cannot take back any uses or disclosures already made with your permission.

Other Laws Protect PHI. Many DHS programs have other laws for the use and disclosure of health information about you. For example, usually you must give your written permission for DHS to use and disclose your mental health and chemical dependency treatment records.

Your PHI privacy rights

When information is kept by DHS for its work as a public health agency, other state and federal laws govern the public health records. The public health records are not subject to the rights described below.

Right to See and Get Copies of Your Records. In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

Right to Request a Correction or Update of Your Records. You may ask to change or add missing information to health records DHS created about you, if you think there is a mistake. You must make the request in writing, and provide a reason for your request. DHS may deny your request in certain circumstances.

Right to Get a List of Disclosures. You have the right to ask DHS for a list of your PHI disclosures made after April 14, 2003. You must make the request in writing. This list will not include the times that information was disclosed for treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your authorization. If you request a list more than once during a 12-month period, you may be charged a fee.

Right to Request Limits on Uses or Disclosures of PHI. You have the right to ask that DHS limit how your information is used or disclosed. You must make the request in writing and tell DHS what information you want to limit and to whom you want the limits to apply. DHS is not required to agree to the restriction. You can request in writing or verbally that the restrictions be ended.

Right to Revoke Permission. If you are asked to sign an authorization to use or disclose PHI, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared.

Right to Choose How We Communicate with You. You have the right to ask that DHS share PHI with you in a certain way or in a certain place. For example, you may ask DHS to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request.

Right to File a Complaint. You have the right to file a complaint if you do not agree with how DHS has used or disclosed health information about you.

Right to Get a Copy of This Notice. You have the right to ask for a copy of this notice at any time.

How to contact DHS to use your privacy rights

To use any of the privacy rights listed above, you may contact your local DHS office. You may also contact the Governor's Advocacy Office at the address listed at the end of this notice. DHS may deny your request.

If DHS denies your request, DHS will send you a letter that tells you the reason. DHS will tell you how you can ask for a review of the denial.

How to file a privacy complaint or report a privacy problem

You may contact any of the people listed below if you want to file a privacy complaint. You may also contact them to report a problem with how DHS has used or disclosed your health information.

Your benefits will not be affected by any complaints you make. DHS cannot hold it against you if you file a complaint. DHS cannot hold it against you if you refuse to agree to something that you believe to be unlawful.

Oregon Department of Human Services
Governor's Advocacy Office
500 Summer St NE, E17
Salem, OR 97301-1097

Phone: 1-800-442-5238
Fax: 503-378-6532 (Salem)
E-mail: GAO.info@state.or.us
TTY: 503-945-6214

Office for Civil Rights
Medical Privacy Complaint Division
US Dept. of Health & Human Services
200 Independence Avenue SW
HHH Building, Room 509 H
Washington DC 20201

Phone: 1-800-627-7748
TTY: 1-866-788-4989
E-mail: OCRcomplaint@hhs.gov

For more information on this Notice of Privacy Practices

You can contact the DHS Privacy Officer if you have any questions about this notice. You can contact the DHS Privacy Officer if you need more information on privacy.

Oregon Department of Human Services
Privacy Officer
500 Summer St NE, E24
Salem, OR 97301

Phone: 503-945-5780 (Salem)
Fax: 503-947-5396 (Salem)
E-mail: DHS.privacyhelp@state.or.us

In the future, DHS may change its Notice of Privacy Practices. Any changes will apply to information DHS already has. It will also apply to information DHS receives in the future.

A copy of the new notice will be posted at each DHS site and facility. A copy of the new notice will be provided as required by law. You may ask for a copy of the current notice anytime you visit a DHS facility. You can also get a copy of the current notice online at <http://dhsforms.hr.state.or.us/forms/Served/DE2090.pdf>.

My OHP phone list

DHS worker_____ **Phone**_____

OHP Client Advisory Services Unit (CASU) **Phone** 1-800-273-0557
TTY 1-800-375-2863
FAX 503-945-6898

OHP Premium Billing Office **Phone 1-800-261-3317**

Medical plan customer service_____ **Phone**_____

Doctor's name _____ **Phone**_____

Doctor's name _____ **Phone**_____

Doctor's name _____ **Phone**_____

Dental plan_____ **Phone**_____

Dentist's name _____ **Phone**_____

Mental health plan_____ **Phone**_____

Practitioner's name _____ **Phone**_____

Department of Human Services
Division of Medical Assistance Programs
500 Summer St NE, E35
Salem, OR 97301-1077

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FEP BlueVision®

http://www.fepblue.org

Exhibit 3 to OAR 836-053-0012

BlueCross BlueShield | FEPBlueVision

2014

A Nationwide Vision PPO Plan

Who may enroll in this plan: All Federal employees and annuitants in the United States and overseas who are eligible to enroll in the Federal Employees Dental and Vision Insurance Program.

Enrollment Options for this Plan:

- **High Option – Self Only**
- **High Option – Self Plus One**
- **High Option – Self and Family**
- **Standard Option – Self Only**
- **Standard Option – Self Plus One**
- **Standard Option – Self and Family**

The FEP BlueVision credentialing process was constructed to meet and exceed NCQA requirements.

The FEP BlueVision fabrication system has received full certification from the COLTS Laboratories "Quality First" program, a leading, independent ophthalmic testing organization.

The FEP BlueVision laboratories have ISO 9001:2008 certification. The International Organization for Standardization with ISO 9001 is the international reference for quality management requirements.

FEDVIP
Federal Employees
Dental and Vision Insurance Program

Authorized for distribution by the:

United States
Office of Personnel Management

Heathcare and Insurance
http://www.opm.gov/healthcare-insurance/

Introduction

On December 23, 2004, President George W. Bush signed the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Public Law 108-496). The Act directed the Office of Personnel Management (OPM) to establish supplemental dental and vision benefit programs to be made available to Federal employees, annuitants and their eligible family members. In response to the legislation, OPM established the Federal Employees Dental and Vision Insurance Program (FEDVIP). OPM has contracted with dental and vision insurers to offer an array of choices to Federal employees and annuitants.

This brochure describes the benefits of FEP BlueVision under the Blue Cross and Blue Shield Association's contract OPM01-FEDVIP-01AP-7 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

FEP BlueVision
711 Troy Schenectady Road, Suite 301
Latham, New York 12110
1-888-550-BLUE (2583)
TTY: 1-800-523-2847
www.fepblue.org

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations and exclusions of this brochure. It is your responsibility to be informed about your benefits. You, and your family members, do not have a right to benefits that were available before January 1, 2014 unless those benefits are also shown in this brochure.

If you are enrolled in this plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One, you and your designated eligible family member are entitled to these benefits. If you are enrolled in Self and Family coverage, each of your eligible family members is also entitled to these benefits.

OPM negotiates benefits and rates with each carrier annually. Rates are shown at the end of this brochure.

FEP BlueVision is responsible for the selection of in-network providers in your area. Contact us at 1-888-550-2583 or TTY: 1-800-523-2847 for the names of participating providers or to request a provider directory. You may also request or view the most current directory via our website at **www.fepblue.org**. Continued participation of any specific provider cannot be guaranteed. Thus, you should choose your plan based on the benefits provided and not on a specific provider's participation. When you phone for an appointment, please remember to verify that the provider is currently in-network. If your provider is not currently participating in the provider network, you can nominate him or her to join. Nomination forms are available on our web site, or call us and we will take your nomination over the phone. You cannot change plans, outside of Open Season, because of changes to the provider network.

Provider networks may be more extensive in some areas than others. **Please be aware that the FEP BlueVision network is different from the network of your health plan.**

This FEP BlueVision plan and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program.

We want you to know that protecting the confidentiality of your individually identifiable health information is of the utmost importance to us. To review full details about our privacy practices, our legal duties, and your rights, please visit our website, www.fepblue.org and click on the link to FEP BlueVision, and then click on the "Privacy Policies" link at the bottom of the page. If you do not have access to the internet or would like further information, please contact us by calling 1-888-550-2583 or TTY: 1-800-523-2847.

Table of Contents

FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several nationwide, and in some areas, regional dental Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO) plans, and high and standard coverage options. You can also select from several nationwide vision plans. You may enroll in a dental plan or a vision plan, or both. Visit www.opm.gov/healthcare-insurance/dental-vision/ for more information.
Enroll Through BENEFEDS	You enroll through the Internet at www.BENEFEDS.com. Please see Section 2, Enrollment, for more information.
Dual Enrollment	If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) can not be covered by two FEDVIP dental plans or two FEDVIP vision plans.
Coverage Effective Date	If you sign up for a dental and/or vision plan during the 2013 Open Season, your coverage will begin on January 1, 2014. Premium deductions will start with the first full pay period beginning on/after January 1, 2014. You may use your benefits as soon as your enrollment is confirmed.
Pre-Tax Salary Deduction for Employees	Employees automatically pay premiums through payroll deductions using pre-tax dollars. Annuitants automatically pay premiums through annuity deductions using post-tax dollars.
Annual Enrollment Opportunity	Each year, an Open Season will be held, during which you may enroll or change your dental and/or vision plan enrollment. This year, Open Season runs from November 11, 2013 through December 9, 2013. You do not need to re-enroll each Open Season unless you wish to change plans or plan options; your coverage will continue from the previous year. In addition to the annual Open Season, there are certain events that allow you to make specific types of enrollment changes throughout the year. Please see Section 2, Enrollment, for more information.
Continued Group Coverage After Retirement	Your enrollment or your eligibility to enroll may continue after retirement. You do not need to be enrolled in FEDVIP for any length of time to continue enrollment into retirement. Your family members may also be able to continue enrollment after your death. Please see Section 1, Eligibility, for more information.

Section 1 Eligibility

Federal Employees

If you are a Federal or U.S. Postal Service employee, you are eligible to enroll in FEDVIP, if you are eligible for the Federal Employees Health Benefits (FEHB) Program or the Health Insurance Marketplace (Exchange) and your position is not excluded by law or regulation. Enrollment in the FEHB Program or the Health Insurance Marketplace (Exchange) is not required.

Federal Annuitants

You are eligible to enroll if you:

- retired on an immediate annuity under the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS), or another retirement system for employees of the Federal Government;
- retired for disability under CSRS, FERS, or another retirement system for employees of the Federal Government.

Your FEDVIP enrollment will continue into retirement, if you retire on an immediate annuity or for disability under CSRS, FERS or another retirement system for employees of the Government, regardless of the length of time you had FEDVIP coverage as an employee. There is no requirement to have coverage for 5 years of service prior to retirement in order to continue coverage into retirement, as there is with the FEHB Program.

Your FEDVIP coverage will end if you retire on a Minimum Retirement Age (MRA) + 10 retirement and postpone receipt of your annuity. You may enroll in FEDVIP again when you begin to receive your annuity.

Advise BENEFEDS of your new payroll office number.

Survivor Annuitants

If you are a survivor of a deceased Federal/U.S. Postal Service employee or annuitant and you are receiving an annuity, you may enroll or continue the existing enrollment.

Compensationers

A compensationer is someone receiving monthly compensation from the Department of Labor's Office of Workers' Compensation Programs (OWCP) due to an on-the-job injury/ illness who is determined by the Secretary of Labor to be unable to return to duty. You are eligible to enroll in FEDVIP or continue FEDVIP enrollment into compensation status.

Family Members

Eligible family members include your spouse and unmarried dependent children under age 22. This includes legally adopted children and recognized natural children who meet certain dependency requirements. This also includes stepchildren and foster children who live with you in a regular parent-child relationship. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

FEDVIP rules and FEHB rules for family member eligibility are **NOT** the same. For more information on family member eligibility visit the website http://www.opm.gov/healthcare-insurance/dental-vision/eligibility/ or contact your employing agency or retirement system.

Not Eligible

The following persons are not eligible to enroll in FEDVIP, regardless of FEHB eligibility or receipt of an annuity or portion of an annuity:

- Deferred annuitants
- Former spouses of employees or annuitants
- FEHB Temporary Continuation of Coverage (TCC) enrollees
- Anyone receiving an insurable interest annuity who is not also an eligible family member

Section 2 Enrollment

Enroll Through BENEFEDS

You must use BENEFEDS to enroll or change enrollment in a FEDVIP plan. BENEFEDS is a secure enrollment website (www.BENEFEDS.com) sponsored by OPM. If you do not have access to a computer, call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680 to enroll or change your enrollment.

If you are currently enrolled in FEDVIP and do not want to change plans or options, your enrollment will continue automatically. Please note: your plans' premiums may change for 2014.

Note: You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, PostalEase, EBIS, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

Enrollment Types

Self Only: A Self Only enrollment covers only you as the enrolled employee or annuitant. You may choose a Self Only enrollment even though you have a family; however, your family members will not be covered under FEDVIP.

Self Plus One: A Self Plus One enrollment covers you as the enrolled employee or annuitant plus one eligible family member whom you specify. You may choose a Self Plus One enrollment even though you have additional eligible family members, but the additional family members will not be covered under FEDVIP.

Note: A Self Plus One enrollment option does not exist under the FEHB Program.

Self and Family: A Self and Family enrollment covers you as the enrolled employee or annuitant and all of your eligible family members. You must list all eligible family members when enrolling.

Dual Enrollment

If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) can not be covered by two FEDVIP dental plans or two FEDVIP vision plans.

Opportunities to Enroll or Change Enrollment

Open Season

If you are an eligible employee or annuitant, you may enroll in a dental and/or vision plan during the November 11 through December 9, 2013 Open Season. Coverage is effective January 1, 2014.

During future annual Open Seasons, you may enroll in a plan, or change or cancel your dental and/or vision coverage. The effective date of these Open Season enrollments and changes will be set by OPM. If you want to continue your current enrollment, do nothing. **Your enrollment carries over from year to year, unless you change it.**

New hire/Newly eligible

You may enroll within 60 days after you become eligible as:

- a new employee;
- a previously ineligible employee who transferred to a covered position;
- a survivor annuitant if not already covered under FEDVIP; or
- an employee returning to service following a break in service of at least 31 days.

Your enrollment will be effective the first day of the pay period following the one in which BENEFEDS receives and confirms your enrollment.

Qualifying Life Event

A qualifying life event (QLE) is an event that allows you to enroll, or if you are already enrolled, allows you to change your enrollment outside of an Open Season.

The following chart lists the QLEs and the enrollment actions you may take:

Qualifying Life Event	From Not Enrolled to Enrolled	INCREASE: Enrollment Type	DECREASE: Enrollment Type	Cancel	CHANGE: From One Plan to Another
Acquiring an eligible family member	No	Yes	No	No	No
Losing a covered family member	No	No	Yes	No	No
Losing other dental/ vision coverage (eligible or covered person)	Yes	Yes	No	No	No
Moving out of regional plan's service area	No	No	No	No	Yes
Going on active military duty, non-pay status (enrollee and spouse)	No	No	No	Yes	No
Returning to pay status from active military duty (enrollee and spouse)	Yes	No	No	No	No
Annuity/ compensation restored	Yes	Yes	Yes	No	No
Transferring to an eligible Federal position*	No	No	No	Yes	No

*Position must be in a Federal agency that provides dental and/or vision coverage with 50 percent or more employer-paid premium.

The timeframe for requesting a QLE change is from 31 days before to 60 days after the event. There are two exceptions:

- There is no time limit for a change based on moving from a regional plan's service area; and
- You cannot request a new enrollment based on a QLE before the QLE occurs, except for enrollment because of a loss of dental or vision insurance. You must make the change no later than 60 days after the event.

Generally, enrollments and enrollment changes made based on a QLE are effective on the first day of the pay period following the one in which BENEFEDS receives and confirms the enrollment or change. BENEFEDS will send you confirmation of your new coverage effective date.

Once you enroll in a plan, your 60-day window for that type of plan ends, even if 60 calendar days have not yet elapsed. That means once you have enrolled in either a dental or a vision plan, you cannot change or cancel that particular enrollment until the next Open Season, unless you experience a QLE that allows such a change or cancellation.

Canceling an enrollment

You may cancel your enrollment only during the annual Open Season. An eligible family member's coverage also ends upon the effective date of the cancellation.

Your cancellation is effective at the end of the day before the date OPM sets as the Open Season effective date.

When Coverage Stops

Coverage ends when you:

- no longer meet the definition of an eligible employee or annuitant;
- begin a period of non-pay status or pay that is insufficient to have your FEDVIP premiums withheld and you do not make direct premium payments to BENEFEDS;
- are making direct premium payments to BENEFEDS and you stop making the payments; or
- cancel the enrollment during Open Season.

Coverage for a family member ends when:

- you as the enrollee lose coverage; or
- the family member no longer meets the definition of an eligible family member.

Continuation of Coverage

Under FEDVIP, there is no 31-day extension of coverage. The following are also NOT available under the FEDVIP plans:

- Temporary Continuation of Coverage (TCC);
- spouse equity coverage; or
- right to convert to an individual policy (conversion policy).

FSAFEDS/High Deductible Health Plans and FEDVIP

If you are planning to enroll in an FSAFEDS Health Care Flexible Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA), you should consider how coverage under a FEDVIP plan will affect your annual expenses, and thus the amount that you should allot to an FSAFEDS account. Please note that insurance premiums are not eligible expenses for either type of FSA.

Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense and file a claim in the time period permitted. This is known as the "Use-it-or-Lose-it" rule. Carefully consider the amount you will elect.

Current FSAFEDS participants must re-enroll to participate in 2014. See www.fsafeds.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-800-952-0450.

If you enroll or are enrolled in a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA), you may use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB and FEDVIP plans.

Using your FSA pre-tax dollars for your eyecare and eyewear needs is a great way to get more out of your benefit dollar. And FEP BlueVision will submit your eligible FSAFEDS out-of-pocket expenses electronically, so you don't have to.

Using your FSAFEDS account for your eyecare and eyewear expenses is simple:

- Visit your provider for your routine eye examination and eyewear
- Pay any out-of-pocket expenses
- FEP BlueVision will submit your expenses for reimbursement for you.

Section 3 How You Obtain Care

Identification Cards/ Enrollment Confirmation

Two ID cards are issued for each member, regardless of coverage option. If additional cards are needed, you may request them through our website, www.fepblue.org, or call us at 1-888-550-2583 or TTY: 1-800-523-2847. All eligible dependents listed on your enrollment share your identification number. You do not need an ID card for each member of your family.

Plan Providers

We list in-network plan providers in the provider directory, which is updated frequently. The most current list can be found on our website at www.fepblue.org and click on the link for FEP BlueVision. It is your responsibility to ensure that the provider chosen is an active participant in the program, at the time you receive services. The FEP BlueVision network is specific to routine vision care and is different from the network for your medical plan.

In some cases, due to local regulations or business practices, the doctor may be independent of the retail location. You should confirm that both the doctor and the retail location are participating prior to seeking services.

In-Network

In-network providers are referred to as participating providers. The FEP BlueVision in-network benefit is paperless and extremely user-friendly for members. When scheduling an appointment, you should identify yourself as a member of FEP BlueVision and provide your name and identification number. The provider is then responsible for verifying eligibility by contacting FEP BlueVision either by telephone or via the web.

Under Standard Option, you must stay in-network for covered services. If you receive care from a non-participating provider, we will not pay for any services unless you reside in a limited access area. Please see Section 4, Your Cost For Covered Services.

Out-of-Network

Out-of-network providers are referred to as non-participating providers. High Option: We will provide fee schedule allowances as described in Section 4, Your Cost For Covered Services, for covered services performed by non-participating providers. However, since these providers do not participate with FEP BlueVision, you may be responsible for any amounts over the fee schedule allowances. Please see Section 8, Claims Filing and Disputed Claims Processes, for information.

Under Standard Option, you must stay in-network for covered services. If you receive care from a non-participating provider, we will not pay for any services unless you reside in a limited access area. Please see Section 4, Your Cost For Covered Services.

Pre-Authorization

Pre-authorization is only required for:

- Medically necessary contact lenses in the treatment of certain eye health conditions and is obtained by the participating provider.
- The treatment of low vision and is obtained by the participating provider.
- Discounts for laser vision correction and is obtained by the member.

First Payor

When you visit a provider who participates with both your FEHB plan and your FEDVIP plan, the FEHB plan will pay benefits first. The FEDVIP plan allowance will be the prevailing charge in these cases. You are responsible for the difference between the FEHB and FEDVIP benefit payments and the FEDVIP plan allowance.

Coordination of Benefits

We do not coordinate benefits with non-FEHB health plans.

Limited Access Areas

If you live in an area that does not have adequate access to an FEP BlueVision network provider and you receive covered services from an out-of-network provider, we will pay up to 100% of our Plan Allowance. You are responsible for any difference between the amount billed and our payment. To determine if you are in a limited access area call us at 1-888-550-2583 or TTY: 1-800-523-2847. Please see Section 4, Your Cost for Covered Services, for more information. Please see Section 8, Claims Filing and Disputed Claims Processes, for information.

Section 4 Your Cost for Covered Services

This is what you pay out-of-pocket for covered care:

Copayment

There are no copayments for covered eye examinations, standard eyeglass lenses, plan frames, or contact lenses in lieu of eyeglasses. There may be copayments for optional lens types and treatments.

Annual Benefit Maximum

- Standard Option: one routine eye examination every calendar year; one pair of standard eyeglass lenses or contact lenses every calendar year; one frame every other calendar year. (Contact lens benefit available in lieu of eyeglasses.)
- High Option: one routine eye examination every calendar year; one pair of standard eyeglass lenses or contact lenses every calendar year; one frame every calendar year. (Contact lens benefit available in lieu of eyeglasses.)

In-Network Services

Members are only responsible for any cost that exceeds the Plan Allowances (as described in Section 5, Vision Services and Supplies) and copayments for optional lenses and treatments (as described in Section 5, Vision Services and Supplies). To receive covered benefits, you must stay in-network if you are enrolled in Standard Option.

Out-of-Network Services

If you are enrolled in Standard Option, you must stay in-network for covered services. If you receive care from a non-participating provider, we will not pay for any services unless you reside in a limited access area.

If you are enrolled in High Option and you choose to visit a non-participating provider, you will be reimbursed according to the following fee schedule allowances shown in the chart below. You are responsible for charges billed over the amounts shown.

Services/Materials	We Pay
Exam	Up to $30
Single Vision Lenses	Up to $25
Bifocal Lenses	Up to $35
Trifocal Lenses	Up to $45
Lenticular Lenses	Up to $45
Elective Contact Lenses	Up to $75
Medically Necessary Contact Lenses	Up to $225
Frames	Up to $30

Please see Section 3, How You Obtain Care, for more information.

Limited Access Areas

Members who reside in areas not meeting access standards* can visit an out-of-network provider, pay billed charges and then be reimbursed based on the Plan Allowance.

***NOTE: Access Standards**

Urban zip codes: at least 90% of Federal eligibles (employees and annuitants) in a network access area (zip code plus 15 driving-miles) must have access to a vision care preferred provider.

Rural zip codes: at least 80% of Federal eligibles (employees and annuitants) in a network access area (zip code plus 35 driving-miles) must have access to a vision care preferred provider.

Plan Allowance: The maximum benefit payment for services provided in areas not meeting the access standards are shown in the chart below. You are responsible for charges billed over the amounts shown.

Services/Materials	Standard Option We Pay	High Option We Pay
Exam	Up to $50	Up to $50
Single Vision Lenses	Up to $72	Up to $72
Bifocal Lenses	Up to $109	Up to $109
Trifocal Lenses	Up to $136	Up to $136
Lenticular Lenses	Up to $136	Up to $136
Contact Lenses	Up to $130	Up to $150
Medically Necessary Contact Lenses	Up to $600	Up to $600
Frames	Up to $130	Up to $150

Section 5 Vision Services and Supplies

Important things you should keep in mind about these benefits:

Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted protocols.

Benefit Description	You Pay	
Diagnostic	**Standard Option**	**High Option**
Eye exam: covered in full every calendar year. Includes dilation, if professionally indicated. 92002/92004 New patient exams 92012/92014 Established patient exams S0620 Routine ophthalmologic exam w/refraction - new patient S0621 Routine ophthalmologic exam w/refraction - established patient	In-Network: Nothing Out-of-Network: All charges	In-Network: Nothing Out-of-Network: Expenses in excess of the fee schedule allowance of $30
Eyewear	**Standard Option**	**High Option**
You may choose prescription glasses or contacts.		
Lenses: one pair covered in full every calendar year. V2100-2199 Single Vision V2200-2299 Conventional (Lined) Bifocal V2300-2399 Conventional (Lined) Trifocal V2121, V2221, V2321 Lenticular Note: Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, ultraviolet protective coating, oversized and glass-grey #3 prescription sunglass lenses. Note: Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions ≥ +/- 6.00 diopters. Note: All lenses include scratch resistant coating with no additional copayment. There may be an additional charge at Sam's Club and Walmart.	In-Network: Nothing Out-of-Network: All charges	In-Network: Nothing Out-of-Network: Expenses in excess of fee schedule allowance of: $25 single vision $35 lined bifocal $45 lined trifocal $45 lenticular
Frame: *High Option:* covered once every calendar year. *Standard Option:* covered once every other calendar year. V2020 Frame *Note: Additional discounts are available from participating providers except Costco, Sam's Club and Walmart.	In-Network: Collection Frame: Nothing Non-Collection Frame: Expenses in excess of a $130 allowance. Additionally, a 20% discount applies to any amount over $130* Out-of-Network: All charges	In-Network: Collection Frame: Nothing Non-Collection Frame: Expenses in excess of a $150 allowance. Additionally, a 20% discount applies to any amount over $150*

Eyewear - continued on next page

Benefit Description	You Pay	
Eyewear (cont.)	**Standard Option**	**High Option**
Note: Your eyewear will be delivered to your provider from the FEP BlueVision laboratory generally within five to seven calendar days. More delivery time may be needed when out-of-stock frames, AR (anti-reflective) Coating, specialized prescriptions or a non-collection frame is selected. Note: "Collection" frames with retail values up to $225 are available at no cost at most participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	In-Network: Collection Frame: Nothing Non-Collection Frame: Expenses in excess of a $130 allowance. Additionally, a 20% discount applies to any amount over $130* Out-of-Network: All charges	In-Network: Collection Frame: Nothing Non-Collection Frame: Expenses in excess of a $150 allowance. Additionally, a 20% discount applies to any amount over $150* Out-of-Network: Expenses in excess of fee schedule allowance of $30
Contact Lenses	**Standard Option**	**High Option**
Contact Lenses: covered once every calendar year – in lieu of eyeglasses. V2500-V2599 Contact Lenses *Note: Additional discounts are available from participating providers except Costco, Sam's Club and Walmart. ****Note: Pre-authorization is required.**	In-Network: Expenses in excess of a $130 allowance (may be applied toward the cost of evaluation, materials, fitting and follow-up care). Additionally, a 15% discount applies to any amount over $130.* Participating providers usually charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. When this occurs and the value of the Contact Lenses received is less than the allowance, you may submit a claim for the remaining balance (the combined reimbursement will not exceed $130). Expenses in excess of $600 for medically necessary contact lenses.** Out-of-Network: All charges	In-Network: Expenses in excess of a $150 allowance. Additionally, a 15% discount applies to any amount over $150.* The evaluation, fitting and follow-up care is covered in full for regular contact lenses. For Specialty lenses (including, but not limited to, toric, multifocal and gas permeable lenses), you receive $60 toward the contact lens evaluation and fitting, plus a 15% discount off the balance over $60*. Participating providers will bill you for anything over the $60 less the discount so you do not have to file a claim. Expenses in excess of $600 for medically necessary contact lenses.** Out-of-Network: Expenses in excess of fee schedule allowance of: $75 elective contact lenses $225 medically necessary contact lenses

Benefit Description	You Pay	
Other Vision Services	**Standard Option**	**High Option**
Optional Lenses and Treatments:	**In-Network Only**	**In-Network Only**
Ultraviolet Protective Coating	No Copay	No Copay
Polycarbonate Lenses (if not child, monocular or prescription ≥+/-6.00 diopters)	$30	$30
Blended Segment Lenses	$20	$20
Intermediate Vision Lenses	$30	$30
Standard Progressives	$50	No Copay
Premium Progressives (Varilux®, etc.)	$90	$90
Photochromic Glass Lenses	$20	$20
Plastic Photosensitive Lenses (Transitions®)	$65	No Copay
Polarized Lenses	$75	$75
Standard Anti-Reflective (AR) Coating	$35	$35
Premium AR Coating	$48	$48
Ultra AR Coating	$60	$60
Hi-Index Lenses	$55	$55
Extra Discounts and Savings	**Standard Option**	**High Option**
Prescription glasses		
• Optional Lens Treatments (only available from FEP BlueVision providers)		
- **Progressive Lens Options:** Members may receive a discount on additional progressive lens options:		
Select Progressive Lenses	$70	$70
Ultra Progressive Lenses	$195	$195

Replacement Contact Lens Program: FEP BlueVision offers a contact lens replacement program to members. This exclusive mail order program provides you with the guaranteed lowest prices on contact lens replacement materials. Members may call 1-800-536-7123 with a current prescription.

Laser Vision Correction: FEP BlueVision members can realize substantial discounts on laser correction procedures (LASIK and PRK). Members are entitled to savings of up to 25% off the provider's usual and customary fees, or a 5% discount on any advertised special, from participating physicians and affiliated laser centers. (Some centers provide a flat fee equating to these discount levels.) To ensure that the discount is applied correctly, the member must obtain pre-authorization for this service.

Contact us at 1-888-550-2583 for the names of participating providers and to receive a pre-authorization number.

Additional Benefits

Medically Necessary Contact Lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions:

Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism.

Medically necessary contact lenses are dispensed in lieu of other eyewear. Participating providers will obtain the necessary pre-authorization for these services.

Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision. After pre-authorization by FEP BlueVision, covered low vision services (both in- and out-of-network) will include one comprehensive low vision evaluation every 5 years, with a maximum charge of $300; maximum low vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period, with a maximum charge of $100 each visit. Participating providers will obtain the necessary pre-authorization for these services.

Warranty: FEP BlueVision “Collection” frames and all eyeglass lenses manufactured in FEP BlueVision laboratories are guaranteed for one year from the original date of dispensing. Warranty limitations may apply to provider – or retailer – supplied frames and/or eyeglass lenses. Please ask your provider for details of the warranty that is available to you.

Discount: All FEP BlueVision independent providers are required to extend a 20% discount to all members that purchase additional frames, and/or spectacle lenses and/or daily wear contact lenses, and a 10% discount when purchasing additional disposable contact lenses. This discount can either be in conjunction with their benefit (pair 2, 3, etc.) or at any other time. The materials portion of the member’s benefit does not need to be exhausted first in order for the member to receive this discount.

NOTE: Retail locations are not required to provide this discount.

Section 6 International Services and Supplies

If you travel or live outside the United States and Puerto Rico, you are still entitled to the benefits described in this brochure. Unless otherwise noted in this section, the same definitions, limitations, and exclusions also apply.

Please note that pre-authorization does not apply when you receive care outside of the United States and Puerto Rico. You or your provider must submit an explanation of medical necessity for the services listed in Section 3, How You Obtain Care, when you receive these services outside of the United States and Puerto Rico.

International Claims Payment

For professional care you receive overseas, we provide benefits as indicated below. You are responsible for any difference between our payment and the amount billed, in addition to any copayment amounts. You must also pay any charges for noncovered services.

Finding an International Provider

We do not maintain a network of providers outside the United States and Puerto Rico. You may visit any international provider of your choice.

Filing International Claims

International providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement.** Claim forms are available at www.fepblue.org. To file a claim for covered vision care services received outside the United States and Puerto Rico, send completed claim forms and itemized bills to:

FEP BlueVision

P.O. Box 2010

Latham, New York 12110-2010

Or you may fax your claim to 518-220-6555. Please contact us at fepmemberhelp@davisvision.com to let us know if you would like to submit your claim via email. We will respond with instructions on how to securely submit your claim.

Customer Service Website and Phone Numbers

www.fepblue.org or 1-888-550-2583, TTY: 1-800-523-2847 or call collect 1-518-220-2583.

Laser Vision Correction

The discount on laser correction procedures (LASIK and PRK) is only available through network providers. Therefore, the discount on these procedures is not available for services received overseas.

International Plan Allowances

You may need to pay the provider in-full at the time of service and you will be reimbursed up to the amounts shown below:

Services/Materials	We Pay	We Pay
	Standard Option	High Option
Exam	Up to $60	Up to $60
Single Vision Lenses	Up to $72	Up to $72
Bifocal Lenses	Up to $109	Up to $109
Trifocal Lenses	Up to $136	Up to $136
Lenticular Lenses	Up to $136	Up to $136
Contact Lenses	Up to $130	Up to $150
Medically Necessary Contact Lenses	Up to $600	Up to $600
Frames	Up to $130	Up to $150

Section 7 General Exclusions – Things We Do Not Cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is necessary for the prevention, diagnosis, care or treatment of a covered condition.**

We do not cover the following:

- Services provided by non-participating providers for Standard Option members;
- Any vision service, treatment or materials not specifically listed as a covered service;
- Services and materials that are experimental or investigational;
- Services or materials which are rendered prior to your effective date;
- Services and materials incurred after the termination date of your coverage unless otherwise indicated;
- Services and materials not meeting accepted standards of optometric practice;
- Services and materials resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services or materials provided as a result of intentionally self-inflicted injury or illness;
- Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;
- State or territorial taxes on vision services and materials;
- Medical treatment of eye disease or injury;
- Visual therapy;
- Special lens designs or coatings other than those described in this brochure;
- Replacement of lost/stolen eyewear;
- Non-prescription (Plano) lenses;
- Two pairs of eyeglasses in lieu of bifocals;
- Services not performed by licensed personnel;
- Prosthetic devices and services;
- Insurance of contact lenses;
- Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

If your vision care provider is in the participating network, he or she will file the claim for you, and payment will be sent directly to the vision care provider.

If you live in a limited access area, overseas or if you obtain services from a non-participating provider (High Option only), you are responsible for filing the claim. You can obtain claim forms at www.fepblue.org or call 1-888-550-2583 or TTY: 1-800-523-2847.

After services have been received, submit an out-of-network claim form along with copies of the provider's bills to:

FEP BlueVision

P.O. Box 2010

Latham, New York 12110-2010

Deadline for Filing Your Claim

Participating providers will file your claim for you.

For international claims, those incurred in limited access areas and out-of-network claims*, the standard time limit for filing a claim is up to one year from the date of service.

* High Option Only

Disputed Claims Process

Follow this disputed claims process if you disagree with our decision on your claim or request for services. **The FEDVIP law does not provide a role for OPM to review disputed claims.**

Disputed Claim Steps:

1. The provider, member or patient may appeal any decision to deny services before, during or after the service is provided. Ask us in writing to reconsider our initial decision. You must send written notice of disputed claims via U.S. Mail, fax or email to:

Reconsideration Department

FEP BlueVision

P.O. Box 2010

Latham, New York 12110-2010

FAX: 1-800-403-1783

Email: fepmemberhelp@davisvision.com

2. We will acknowledge receipt of your request within five business days from the date we receive it and will give you a decision within 30 days.

3. If the dispute is not resolved through the reconsideration process, you may request a review of the denial. We will make a decision within 35 days of the date we receive your request in writing.

4. If you do not agree with our final decision, you may request an independent third party, mutually agreed upon by us and OPM, review the decision. The decision of the independent third party is binding on us and is the final administrative review of your claim. This decision is not subject to judicial review.

Section 9 Definitions of Terms We Use in This Brochure

Annual Benefit Maximum	The maximum annual benefit that you can receive, per person, under this plan.
Annuitants	Federal retirees (who retired on an immediate annuity), and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.
Enrollee	The Federal employee or annuitant enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Plan Allowance	The maximum benefit payment for services received. Please refer to Section 4, Your Cost for Covered Services, for the maximum benefit payment for services received in limited access areas or out-of-network and Section 6, International Services and Supplies, for services received outside the United States or Puerto Rico.
Pre-Authorization	This is the procedure used by the plan to pre-approve services and the amount that the plan will cover.
We/Us	FEP BlueVision.
You	Enrollee or eligible family member.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Dental and Vision Insurance Program premium.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, plan, BENEFEDS or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-888-550-BLUE (2583) or TTY: 1-800-523-2847 and explain the situation.
- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self-support).

If you have any questions about the eligibility of a dependent, please contact BENEFEDS.

Be sure to review Section 1, Eligibility, of this brochure, prior to submitting your enrollment or obtaining benefits.

Fraud or intentional misrepresentation of material fact is prohibited under the plan. You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEDVIP benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the plan, or enroll in the plan when you are no longer eligible.

Summary of Benefits

- **Do not rely on this chart alone**. This page summarizes specific expenses we cover; for more detail, please review the individual sections of this brochure.
- If you want to enroll or change your enrollment in this plan, please visit www.BENEFEDS.com or call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680.

Covered Services In-Network	High Option You Pay	Standard Option You Pay	Page
Routine Eye Exams (including dilation, if professionally indicated)	Nothing	Nothing	12
Standard Eyeglass Lenses (Contact lenses may be obtained in lieu of glasses)	Nothing	Nothing	12
Optional Lens Treatments	Some additional copays	Some additional copays	14
Frames			
Collection Frames	Nothing	Nothing	12-13
Non-Collection Frame	Any amount over the $150 Plan allowance after a 20% discount	Any amount over the $130 Plan allowance after a 20% discount	12-13
Contact Lenses	Any amount over the $150 plan allowance after a 15% discount Evaluation, Fitting and Follow-up care are covered in full at network providers.	Any amount over the $130 plan allowance after a 15% discount	13
Laser Vision Correction	The provider's charge after the negotiated discount	The provider's charge after the negotiated discount	14

See Section 4, Your Cost for Covered Services, for the Out-of-Network benefits available under High Option.
See Section 5, Vision Services and Supplies, for complete benefit information.

Rate Information

These rates apply nationwide and internationally.

Monthly Rates

High Option Self Only	High Option Self Plus One	High Option Self and Family	Standard Option Self Only	Standard Option Self Plus One	Standard Option Self and Family
$10.12	$20.28	$30.42	$8.00	$16.01	$24.01

Bi-Weekly Rates

High Option Self Only	High Option Self Plus One	High Option Self and Family	Standard Option Self Only	Standard Option Self Plus One	Standard Option Self and Family
$4.67	$9.36	$14.04	$3.69	$7.39	$11.08

AMEND: 836-053-0320

NOTICE FILED DATE: 10/27/2022

RULE SUMMARY: Adds LGBTQ+ as a category in which insurers must report on their efforts to address enrollees network adequacy needs, including various types of essential community providers in its network.

CHANGES TO RULE:

836-053-0320
Annual Report Requirements for Network Adequacy ¶

(1) An insurer offering individual or small group health benefits plans must submit its annual report for each network required under ORS 743B.505 no later than March 31 of each year.¶
(2) Beginning March 31, 2020, the annual report shall include at least the following information for networks associated with health benefit plans currently in force and networks associated with health benefit plans being marketed at the time the report is submitted:¶
(a) Identification of the insurer's network, including plans to which the network applies, how the use of telemedicine or telehealth or other technology may be used to meet network access standards;¶
(b) The insurer's procedures for making and authorizing referrals within and outside its network, if applicable;¶
(c) The insurer's procedures for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;¶
(d) The factors used by the insurer to build its provider network, including a description of the network and the criteria used to select or tier providers;¶
(e) The insurer's efforts to address the needs of enrollees, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, gay, lesbian, bisexual, transgender, and any other minority gender identity or sexual orientation, physical or mental disabilities, and serious, chronic ~~or,~~ complex medical or behavioral health conditions. This information must include the insurer's efforts, when appropriate, to include various types of essential community providers in its network;¶
(f) The insurer's process for ensuring networks for plans sold outside of the marketplace provide enrollees who reside in low-income zip code areas or who reside in health professional shortage areas with adequate access to care without delay; ¶
(g) The insurer's methods for assessing the health care needs of enrollees and their satisfaction with services;¶
(h) The insurer's method of informing enrollees of the plan's covered services and features, including but not limited to:¶
(A) The plan's grievance and appeals procedures;¶
(B) Its process for choosing and changing providers;¶
(C) Its process for updating its provider directories for each of its network plans;¶
(D) A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and¶
(E) Its procedures for covering and approving emergency, urgent and specialty care, if applicable.¶
(i) The insurer's system for ensuring the coordination and continuity of care:¶
(A) For enrollees referred to specialty physicians; and¶
(B) For enrollees using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning.¶
(j) The insurer's process for enabling enrollees to change primary care professionals, if applicable;¶
(k) The insurer's proposed plan for providing continuity of care in the event of contract termination between the insurer and any of its participating providers, or in the event of the insurer's insolvency or other inability to continue operations. The description shall explain how enrollees will be notified of the contract termination, or the insurer's insolvency or other cessation of operations, and transitioned to other providers in a timely manner; and¶
(l) The insurer's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at their participating hospitals.
Statutory/Other Authority: ORS 731.244, ORS 743B.505
Statutes/Other Implemented: ORS 743B.505

AMEND: 836-053-1403

NOTICE FILED DATE: 10/27/2022

RULE SUMMARY: Updates statutory citations.

CHANGES TO RULE:

836-053-1403
Definitions of Coordinated Care and Case Management for Behavioral Health Care Services
~~As used in ORS 743A.168:¶~~
(1) The definitions set forth in ~~section 5 of Section 4, Chapter 273, Oregon Laws 2017~~ORS 743A.168 apply to the use of those terms in these rules.¶
(2) "Caring contacts" mean brief communications with a patient that start during care transition such as discharge or release from treatment, or when a patient misses an appointment or drops out of treatment, and continues as long as a qualified mental health professional deems necessary.¶
(3) "Case management" means the management of services that are provided to assist an individual in accessing medical and behavioral health care, social and educational services, public assistance and medical assistance and other needed community services identified in the individual's patient-centered care plan.¶
(4) "Coordination of care" means the process of coordinating patient care activities as well as the facilitation of ongoing communication and collaboration with lay caregivers by community resource providers, health care providers, and agencies to meet the multiple needs of a patient by:¶
(a) Organizing and participating in team meetings; and¶
(b) Ensuring continuity of care during each transition of care.¶
(5) "Crisis stabilization plan" means an individually tailored plan provided to a patient and the patient's lay caregiver that:¶
(a) Is based on the patient's behavioral health assessment and physical health assessment; and¶
(b) Describes the patient's specific short-term rehabilitation objectives and proposed crisis interventions.¶
(6) "Lay caregiver" means:¶
(~~A~~a) For a patient who is younger than 14 years of age, a parent or legal guardian of the patient.¶
(~~B~~b) For a patient who is at least 14 years of age or older, an individual designated by the patient or a parent or legal guardian of the patient to the extent permitted under ORS 109.640 and 109.675.¶
(~~C~~c) For a patient who is at least 14 years of age or older, and who has not designated a caregiver, an individual to whom a health care provider may disclose protected health information without a signed authorization under ORS 192.567.¶
(7) "Lethal means counseling" means counseling strategies designed to reduce the access by a patient who is at risk for suicide to lethal means, including but not limited to firearms.¶
(8) "Medically appropriate treatment" means the services and supports necessary to diagnose, stabilize, care for and treat a behavioral health condition.¶
(9) "Patient centered care" means care provided in a manner that:¶
(a) Is respectful of and responsive to a patient's preferences, needs and values; and¶
(b) Ensures that all clinical decisions are guided by the patient's values.¶
(10) "Peer delivered services" means an array of support services provided by agencies or community--based organizations to patients or family members of patients:¶
(a) Using peer support specialists; and¶
(b) That are designed to support the needs of patients and their families.¶
(11) "Peer support specialist" means a Peer Wellness Specialist or a Peer Support Specialist, including Family Support Specialist and Youth Support Specialist, as defined in ORS 414.025 and 414.665 and certified under OAR 410-180-0310 to 410-180-0312.¶
(12) "Qualified mental health professional" means an individual meeting the minimum qualification criteria adopted by the Oregon Health Authority by rule for a qualified mental health professional.¶
(13) "Safety plan" means a written plan developed by a patient in collaboration with the patient's lay caregiver, if any, as facilitated by a health care provider that identifies strategies for the patient or lay caregiver to use when the patient's risk for suicide is elevated or following a suicide attempt.¶
(14) "Transition of care" means the process of transferring a patient from one provider or care setting to another provider or care setting.¶
(15) Coordination of Care and Case Management processes shall ensure coordination and management of services when indicated by a behavioral health assessment conducted by a behavioral health clinician, including, but not limited to:¶
(a) A best practices risk assessment and, if indicated, a safety plan and lethal means counseling;¶

(b) A determination of the patient's clinical needs and recommendations, if within the scope of the provider's practice, for medically appropriate treatment including but not limited to one or more of the following:¶
(A) Adjusting or prescribing medication;¶
(B) Therapeutic services;¶
(C) Other medically appropriate treatment; or¶
(D) Peer delivered services.¶
(c) Caring contacts.¶
(d) Recommendations as required or permitted under ORS 192.567, 441.~~196~~054 and 441.~~198~~051 to the patient, lay caregiver and health care provider.¶
(e) Informing the patient, lay caregiver and health care provider of the practitioners who can provide the recommended services and how to access the practitioners and other community-based resources.¶
(f) Explaining to the patient and the lay caregiver crisis stabilization planning and patient centered care and establishing a goal of convening a care team.¶
(g) Identifying a person to provide coordination of care who:¶
(A) Is part of a ~~patient centered~~ behavioral health home, as defined in ORS 414.025, a patient centered primary care home, as defined in ORS 414.025, or a patient centered medical home recognized by the National Committee for Quality Assurance; ¶
(B) Is appropriately licensed or certified;¶
(C) Will communicate directly with the patient and the lay caregiver; and¶
(D) When possible or requested, will meet personally with the patient and the lay caregiver.¶
(h) Creating with the patient and the lay caregiver a plan for the transition of care and sharing the plan with the patient's health care providers and care team.
Statutory/Other Authority: ORS 731.244, O~~L 2017, Ch. 273 5~~5RS 743A.168
Statutes/Other Implemented: O~~L 2017, Ch. 273 5~~5RS 743A.168

AMEND: 836-053-1404

NOTICE FILED DATE: 10/27/2022

RULE SUMMARY: Removes the definition of “chemical dependency." Adds definitions for “Behavioral health condition” and “Generally accepted standards of care."

CHANGES TO RULE:

836-053-1404
Definitions; Noncontracting Providers; Co-Morbidity Disorders ¶

(1) As used in ORS 743A.168 and OAR Chapter 836:¶
(a) "~~Mental or nervous~~Behavioral health condition~~s~~" means any mental or substance use disorder covered by diagnostic categories listed in the "Diagnostic and Statistical Manual of Mental Disorders, ~~DSM-IV-TR, Fourth Edition" (DSM-IV) or the "Diagnostic and Statistical Manual of Mental Disorders, Fifth Edit~~Fifth Edition, Text Revision (DSM-5-TR), the International Classification of Diseases, 10th Revision (ICD-10), or the International Classification of Diseases, 11th Revision~~"~~ (~~DSM-5~~ICD-11).¶
(b) "~~Chemical dependency" means an addi~~Generally accepted standards of care" means;¶
(A) Standards of care and clinical practi~~v~~ce ~~relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interfere~~guidelines that:¶
(i) Are generally recognized by health care providers practicing in relevant clinical specialties; and¶
(ii) Are based on valid, evidence-based sources; and¶
(B) Products and services that:¶
(i) Address the specific needs o~~nf~~ a ~~recurring basis with an individual's social, psychological or physical adjustm~~patient for the purpose of screening for, preventing, diagnosing, managing or treating an illness, injury or condition or symptoms of an illness, injury or condition;¶
(ii) Are clinically appropriate in terms of type, frequency, extent, site and duration; and¶
(iii) Are not primarily for the economic benefit of an insurer or payer or for the convenience of a patient, t~~o~~ ~~common problems.¶~~
~~(c) "Chemical dependency" does not mean an addiction to, or dependency on:~~reating physician or other health care provider.¶
(c) "Valid, evidence-based sources" includes but is not limited to:¶
(A) Peer-reviewed scientific studies and medical literature;¶
(~~A~~B) ~~Tobacco;¶~~
~~(B) Tobacco products; or¶~~
~~(C) Food~~Recommendations of nonprofit health care provider professional associations, and;¶
(C) Specialty societies.¶
(2) A non-contracting provider must cooperate with a ~~group~~ health insurer's requirements for review of treatment in ORS 743A.168(~~10~~2) and (~~11~~3) to the same extent as a contracting provider in order to be eligible for reimbursement.¶
(3) The exception of a disorder in the definition of "~~mental or nervous conditions" or "chemical dependency~~behavioral health condition" in section (1) of this rule does not include or extend to a co-morbidity disorder accompanying the excepted disorder.
Statutory/Other Authority: ORS 731.244, ORS 743A.168
Statutes/Other Implemented: ORS 743A.168

AMEND: 836-053-1405

NOTICE FILED DATE: 10/27/2022

RULE SUMMARY: Updates requirements for coverage of behavioral health conditions to comply with statute, and adds additional requirements for medical necessity, utilization or other clinical review, including level of care placement decisions.

CHANGES TO RULE:

836-053-1405
General Requirements for Coverage of ~~Mental or Nervous Conditions and Chemical Dependency~~ Behavioral Health Conditions ¶

(1) A group health insurance policy or an individual health benefit plan issued or renewed in this state shall provide coverage or reimbursement for medically necessary treatment of ~~mental or nervous conditions and chemical dependency~~behavioral health conditions, including ~~alcoholism~~but not limited to prescription drugs, at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for medically necessary treatment for ~~other~~ medical conditions.¶
(2a) ~~For the purposes of ORS 743A.168,~~The coverage may be made subject to provisions of the ~~f~~pol~~lowing standards apply in determining whether coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions is provided at the same level as, and~~icy that apply to other benefits under the policy, including but not limited to provisions relating to copayments, deductibles and coinsurance. Copayments, deductibles and coinsurance for behavioral health treatment may not be greater than those under the policy for medical conditions.¶
(b) The coverage of behavioral health treatment may not be made subject to treatment limitations ~~no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other~~, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of medical conditions~~:~~.¶
(a~~c~~) The ~~co-payment, coinsurance, reimbursement, or other cost sharing, including, but not limited to, deductibles for~~ parity requirements in subsections (1)(a) and (b) must comply with the "predominant" and "substantially all" tests in the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 29 U.S.C. 1185a and implementing regulations at 45 CFR 146.136 and 45 CFR 147.160.¶
(d) If annual or lifetime limits apply for treatment~~al or nervous conditions and chemical dependency, including alcoholism, may be no more than the co-payme~~ of behavioral health conditions the limits must comply with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 29 U.S.C. 1185a and implementing regulations at 45 CFR 146.136 and 147.160.¶
(e) Classification of prescription drugs into o~~r coinsurance~~pen, closed, or tiered drug benefit formularies, for ~~other cost sharing, including, but not limited to, deductible~~drugs intended to treat behavioral health conditions must be by the same process as drug selection for formulary status applied for drugs intended to treat medical conditions, regardless of whether such drugs are intended to treat behavioral health conditions for medical ~~and surgical services otherwise provided under the health insurance policy~~conditions.¶
(f) The coverage of behavioral health treatment may not limit coverage for treatment of pervasive or chronic behavioral health conditions to short-term or acute behavioral health treatment at any level of care or placement.¶
(b~~g~~) The co~~-payment,~~verage of behavioral health treatment must include co~~l~~in~~surance, reimbursement, or other cost sharing, including~~ically indicated outpatient coverage including follow-up in-home services or other outpatient services. The policy may limit coverage only if clinically indicated under any medical necessity, ~~but not limited to, deductibles for wellness and preventive services for~~ ilization or other clinical review conducted for the diagnosis, prevention or treatment~~al or nervous conditions and chemical dependency, including alcoholism, may be no more than the co-payment or coinsurance, or other cost sharing, including, but not limited to, deductibles for wellness and preventive services otherwise provided under the health insurance policy.¶~~
~~(c) If annual or lifetime limits apply for treatment of mental or nervous conditions and chemical dependency, including alcoholism the limits must comply with the "predominately equal" to and "substantially all" tests the federal Paul Wellstone and Pete Domenici Mental Health Parity and Ad~~ of behavioral health conditions or relating to service intensity, level of care placement, continued stay or discharge. Utilization and clinical review policies and procedures must meet the requirements of OAR 836-053-1405(9), (10), (11), and (12), as well as comply with the entire definition of "generally accepted standards of care" in OAR 836-053-1404.¶
(2) A group health insurer or an issuer of an individual health benefit plan issued of renewed in this state must use the same methodology to set reimbursement rates paid to behavioral health treatment providers that the group

health insurer or issuer of an individual health benefit plan uses to set reimbursement rates for medical and surgical treatment providers.¶
(3) A group health insurer or an issuer of an individual health benefit plan issued or renewed in this state must update the methodology and rates for reimbursing behavioral health treatment providers in a manner equivalent to the manner in which the group health insurer or issuer of an individual health benefit plan updates the methodology and rates for reimbursing medical and surgical treatment providers, unless otherwise required by federal law.¶
(4) A group health insurance policy or an individual health benefit plan issued or renewed in this state must contain a single definition of medical necessity that applies uniformly to all medical and behavioral health condiction ~~Equity Act, 29 U.S.C. 1185a and implementing regulations at 45 CFR 146.136 and 147.160.¶~~
~~(d) The co-payment, coinsurance, reimbursement, or other cost sh~~s.¶
(5) A group health insurance policy or an individual health benefit plan in this state shall have policies and procedures in place to ensure uniform application of the policy's definition of medical necessity to all medical and behavioral health conditions.¶
(6) Subject to subsection (5) of ORS 743A.168 and OAR 836-053-1405(7) through (12) coverage for expenses arising from treatment for behavioral health conditions may be managed through common methods designed to limit eligible expenses to treatment that is medically necessary only if similar limitations or requirements are imposed on coverage for expenses ari~~ng, including~~sing from a medical condition. Common methods include, but are not limited to, ~~deductibles expenses for prescription drugs intended to treat mental or nervous conditions and chemical dependency, including alcoholism, may be no more than the co-payment or coinsurance, or other cost sharing expenses for prescription drugs prescribed f~~selectively contracted panels, health policy benefit differential designs, preadmission screening, prior authorization of services, case management, utilization review, or other mechanisms designed to limit eligible expenses to treatment that is medically necessary.¶
(7) Any medical necessity, utilization or other clinical review, not related to level of care placement decisions, must be based on:¶
(a) The current generally accepted standards of care; or ¶
(b) Treatment criteria guidelines developed by the nonprofit professional association for the relevant clinical specialty.¶
(8) For medical necessity, utilization or other ~~med~~clinical ~~services provided under the health insurance policy~~review not related to level of care placement decisions, other criteria may be utilized as long as it is based on the current generally accepted standards of care including valid, evidence-based sources.¶
(e9) ~~Classification of prescription drugs into open, clo~~Any medical necessity, utilization or other clinical review relating to level of care placement decisions must be based~~, or tiered drug benefit formularies, for drugs intended to treat mental or nervous conditions and chemical dependency, including alcoholism, must be by the same process as drug selec~~n:¶
(a) The current generally accepted standards of care; and¶
(b) The version available in 2021 of the levels of care placement criteria developed by the nonprofit professional association for the relevant clinical specialty.¶
(10) In instances where there are no guidelines or criteria from the nonprofit professional association for the relevant clinical specialty, other criteria may be utilized if the criteria are based on the generally accepted standards of care, and may include advancements in technology of types of care. Other criteria utilized must be made available to the department upon request.¶
(11) For purposes of medical necessity, utilization for ~~formulary status applied for drugs intended to treat other medical conditions, regardless of whether such drugs are intended to t~~other clinical review relating to level of care placement decisions the following guidelines or criteria will be considered compliant:¶
(a) For a primary substance use disorder diagnosis in adolescents and adults, the ASAM Criteria: Treat-ment~~al or nervous conditions, chemical dependency, including alcoholism, or other medical con~~ Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd Edition (2013), by the American Society of Addiction Medicine (https://www.asam.org/asam-criteria).¶
(b) For a primary mental health diagnosis in adults nineteen (19) years of age and older, the Level of Care Utilization System for Psychiatric and Addictions~~.¶~~
~~(3) A group health insurance policy issued or renewed~~ Services (LOCUS), Adult Version 20, by the American Association American Association for Community Psychiatry (https://sites.google.com/view/aacp123/resources/locus).¶
(c) For a primary mental health diagnosis in ~~t~~chi~~s state must contain a single definition of~~ ldren six (6) to eighteen (18) years of age, the Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) by the American Association for Community Psychiatry and the Amedrica~~l necessity that applies uniformly to all medical, mental or nervous conditions, and chemical dependency, including alcoholism~~n Academy of Child and Adolescent Psychiatry

(https://www.aacap.org/aacap/Member_Resources/Practice_Information/CALOCUS_CASII.aspx).¶
(d) For a primary mental health diagnosis in children five (5) years of age and younger, Early Child Service Intensity Instrument (ECSII) by the American Academy of Child and Adolescent Psychiatry (https://www.aacap.org/aacap/Member_Resources/Practice_Information/ECSII.aspx).¶
(412) A ~~group health insurer that~~ll level of care placement decisions must be authorized at the level of care consistent with the is~~n~~sue~~s or renews a group health insurance policy in this state shall have policies and procedures in place to ensure uniform application of the policy's definition of medical necessity to all medical, mental or nervou~~red's score or assessment using generally accepted standards of care and the relevant level of care placement criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty. If the level of care indicated by the criteria and guidelines is not available, the insurer shall authorize the next highest level of care based on the generally accepted standards of care. If there is disagreement about the appropriate level of care, the insurer shall provide to the provider of the service the full details of the insurer's s~~conditions, and chemical dependency, including alcoholism.¶
~~(5) Coverage for expenses arising from treatment for mental or nervous conditions and chemical dependency, including alcoholism, may be managed through common methods designed to limit eligible expenses to treatment that is~~ring or assessment using the relevant level of care placement criteria and guidelines including information on the generally accepted standards of care or other criteria used to make the level of care decision.¶
(13) A group health insurer or an individual health benefit plan shall provide, at no cost:¶
(a) A one-time formal education program for the insurer and insurer staff who conduct medical necessity, utilization and other clinical reviews on the proper use of such reviews. The training must be presented by nonprofit clinical specialty associations or other entities authorized by the department.¶
(b) Medical necessity, utilization or other clinical review criteria used by the insurer, and any education or training materials regarding medical~~ly~~ necess~~ary only if similar limitations or requirements are imposed on coverage for expenses aris~~ity, utilization or other clinical review criteria to stakeholders, including participating providers and enrollees.¶
(c) Nothing in this section prohibits a group health insurer or an issuer of an individual health benefit plan from requiring ~~f~~pro~~m other medical condi~~viders to bill in accordance with generally accepted coding standards including the Nation~~.~~al Co~~mmon methods include, but are not limited to, selectively contracted panels, health policy benefit differential designs, preadmission screening, prior authorization of services, case management, utilization review, or other mechanisms designed to limit eligible expenses to treatment that is medically necessary~~rrect Coding Initiative.¶
(14) A group health insurer or an individual health benefit plan may not require providers to bill using a specific billing code or to restrict the reimbursement paid for particular billing codes other than on the basis of medical necessity.¶
(15) This rule does not:¶
(a) Prohibit an insured from receiving behavioral health treatment from an out-of-network provider or prevent an out-of-network behavioral health provider from billing the insured for any unreimbursed cost of treatment, to the extent permitted under state and federal law.¶
(b) Prohibit the use of value-based payment methods, including global budgets or capitated, bundled, risk-based or other value-based payment methods.¶
(c) Require that any value-based payment method reimburse behavioral health services based on an equivalent fee-for-service rate.¶
(16) Nothing in this rule prevents a group health insurance policy or an individual health benefit plan from providing coverage for conditions or disorders excepted under the definition of "~~mental or nervous~~behavioral health condition" in OAR 836-053-1404.¶
(17) The ~~D~~director shall review OAR 836-053-1404 to 836-053-1408 and any other materials every two years to determine whether the requirements set forth in the rules are uniformly applied to all medical~~, mental or nervous conditions, and chemical dependency, including alcoholism~~ and behavioral health conditions.
Statutory/Other Authority: ORS 731.244, ORS 743A.168, Or Laws 2021, ch 629
Statutes/Other Implemented: ORS 743A.168, Or Laws 2021, ch 629

AMEND: 836-053-1407

NOTICE FILED DATE: 10/27/2022

RULE SUMMARY: Amends terminology to replace the word “mental” with “behavioral” and remove the terms “nervous” and “chemical” from the rule.

CHANGES TO RULE:

836-053-1407
Prohibited Exclusions ¶

(1) An insurer may not deny benefits for a medically necessary treatment or service for a ~~mental or nervous~~behavioral health condition based solely upon:¶
(a) The enrollee's interruption of or failure to complete a prior course of treatment; ¶
(b) The insurer's categorical exclusion of such treatment or service when applied to a class of ~~mental or nervous~~behavioral health conditions; or¶
(c) The fact that a court ordered the enrollee to receive or obtain the treatment or service for a ~~mental or nervous~~behavioral health condition, unless otherwise allowed by law.¶
(2) Nothing in this section: ¶
(a) Requires coverage of a treatment or service that is or may be specifically excluded from coverage under state law.¶
(b) Prohibits an insurer from including a provision in a contract related to the insurer's general responsibility to pay for any service under the plan such as an exclusion for third party liability.¶
(c) Requires an insurer to pay for services provided to an enrollee by a school or halfway house or received as part of an educational or training program. However, an insurer may be required to provide coverage of treatment or services related to the enrollee's education that are provided by a provider and that are included in a medically necessary treatment plan.
Statutory/Other Authority: ORS 731.244, ORS 743A.168
Statutes/Other Implemented: ORS 743A.168

AMEND: 836-053-1408

NOTICE FILED DATE: 10/27/2022

RULE SUMMARY: Requires insurers to provide enrollees with the process and guidelines used to conduct medical necessity, utilization or other clinical determinations of benefits for behavioral health conditions.

CHANGES TO RULE:

836-053-1408
Required Disclosures ¶

(1) Insurers must provide an enrollee or an enrollee's authorized representative reasonable access to and copies of all documents, records, and other information relevant to an enrollee's claim or request for coverage.¶
(2) Insurers must provide the criteria, guidelines, processes, standards and other factors used to ~~make~~conduct medical necessity ~~determin~~, utilization~~s of benefits for mental or nervous~~r other clinical reviews for behavioral health conditions. This information must be made available free of charge by the insurer to any current or potential enrollee, beneficiary, or contracting provider upon request, within a reasonable time and in a manner that provides reasonable access to the requestor.¶
(3) Compliance with these disclosure requirements is not determinative of compliance with any other provisions of applicable federal or state law.
Statutory/Other Authority: ORS 731.244, ORS 743A.168
Statutes/Other Implemented: ORS 743A.168