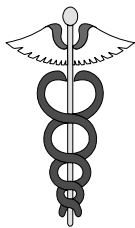
The logo features the letters "OEA" in a bold, sans-serif font, positioned to the left of a large, stylized "C" shape. The "C" is composed of two thick, black curved segments that meet at the top and bottom, creating a partial circle. To the right of the "C", the words "Choice Trust" are written in a bold, sans-serif font.

OEA Choice Trust



**Member Benefits Handbook
PPO Deductible Plan 2A**

THE **ODS** COMPANIES

Underwritten By
ODS Health Plan, Inc.

EMPLOYEE PLAN DESCRIPTION

OEA CHOICE TRUST
P.O. Box 23600
Tigard, Oregon 97281-3600

Telephone Numbers

Medical Customer Service Department

Portland (503) 620-3822
Toll-Free 1-800-452-0914

Service authorizations & Referrals

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

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

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Welcome

We are pleased that you have chosen OEA Choice Trust as your partner in healthcare. Our goal is to provide our members with excellent health care benefits and superior customer service.

We have written this booklet to give you a summary of the main features and benefits of your health care plan. It is important to take a little time to read through the material and familiarize yourself with your plan. By using the services offered by the Preferred Provider Organization (PPO) panel, you will receive quality healthcare and will have a higher level of benefits.

For additional information about OEA Choice Trust and our member services, visit our website at www.oeachoice.com. From our website you can search for a provider or email us for assistance. You can also access MyChoice, our customized member website, designed with you in mind. MyChoice allows you to check the status of your claim, review your claims history, order additional ID Cards, and access information to help you stay healthy and make good decisions about your healthcare. MyChoice also provides you access to board-certified, licensed physicians by e-mail where you can discuss your personal health related issues and receive a response within 24 hours.

For over 20-years OEA Choice Trust has been committed to providing service-oriented and cost effective health care benefits for Oregon's public school employees and their families. For more information contact us at (503) 620-3822 or toll free at (800) 452-0914. We look forward to hearing from you and assisting you with your health insurance needs.

Please note: This handbook may be changed or replaced at any time, by the group or the Plan, without the consent of any member. All plan provisions are governed by the company's agreement with the Plan. This plan description may not contain every plan provision.

Summary Plan Description

1. **Plan Name:**
OEA Choice Trust Benefit Plan
2. **Plan Sponsor:**
Oregon Education Association
6900 SW Atlanta Street, Building 1
Tigard, Oregon 97223
503-620-3822
3. **Employer Identification Number:** 93-0763726
4. **Agent for Legal Process:** The plan sponsor named above.
5. **Plan Number:** 501
6. **Type of Plan:** Employee Medical Benefit Plan.
7. **Plan Year:** October 1st through September 30th.
8. **Plan Administrator:**
OEA Choice Trust
6900 SW Atlanta Street, Building 2
Tigard, Oregon 97223
9. **Funding Medium and Type of Plan Administration:** This plan is partially insured by ODS. Benefits are provided under a group insurance contract entered into between OEA Choice Trust and ODS. Claims for benefits are sent to OEA Choice Trust. OEA Choice Trust is responsible for paying claims up to a specified amount, then ODS is responsible.

The Plan is funded by means of employer and/or employee contributions. The amount of total contributions is determined from time to time by the use of sound actuarial and underwriting methods. The portion an employee pays toward the total contribution is at a rate determined by the employer, or collective Bargaining Unit.
10. **Provider of Benefits:** Benefits are provided in accordance with a Policy of Insurance between ODS and OEA Choice Trust.
11. **Named Fiduciary:** Oregon Education Association.
12. Participants and beneficiaries may receive form the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the plan, and if the employer or employee organization is a plan sponsor, the plan sponsor's address.

This information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). This Member Handbook is the Summary Plan Description.

In furnishing this information, OEA Choice Trust is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Your Responsibility in This Plan

In a PPO plan you are responsible for the following:

- Selecting Providers in the ODS Network in order to receive the highest level of benefits;
- To work with your physician and make sure that the specialist, radiologist, pathologists, hospital or any facility that you are being referred to is in-network; and
- You have a responsibility to stay involved in these decisions related to your health. If you do not remain involved in the decisions, you may be responsible for part or all of the charges associated with the services provided out-of-network.

Summary of Benefits

This section summarizes your medical plan benefits. The details of the actual benefits and the conditions, limitations and exclusions of the Plan are contained in the sections that follow. PPO Benefits are those delivered by participating physicians and providers; Non-PPO Benefits are those delivered by non-participating physicians and providers.

By using the services offered by the PPO panel, you will receive quality healthcare and will have a higher level of benefits. You may choose a participating physician or provider from the ODS Network medical directory (which is also available on our website at www.oeachoice.com under "Providers").

Maximum Lifetime Benefit	\$2,000,000	
	<u>Preferred Option Benefits</u>	<u>Non-Preferred Option Benefits</u>
Annual Deductible per member	\$ 500	\$ 1,000
Maximum Annual Family Aggregate Deductible	\$1,500	\$ 3,000
Per Person Out-of-Pocket Maximum (does not include deductible)	\$3,000	\$ 6,000
Family Out-of-Pocket Maximum (does not include deductible)	\$6,000	\$12,000

BENEFITS

(All benefits are subject to deductible unless otherwise noted below)

CO-PAYMENT

(Amount You Pay)

	PPO	Non-PPO
Hospital - Inpatient Care		
Acute Care	20%	40%
Skilled Nursing Facility Care	20%	40%
Ambulatory Services		
Outpatient Surgery and Invasive Diagnostic Procedures (Facility Charges) These services require authorization	20%	40%
Diagnostic X-ray and Lab	20%	40%
Therapeutic X-ray	20%	40%
Imaging Procedures	20%	40%
Kidney Dialysis	20%	40%
Rehabilitation		
Inpatient Rehabilitation	20%	40%
Outpatient Rehabilitation	20%	40%
Professional Services		
Preventive Healthcare		
Periodic Health Exams (as per schedule on page 23)	\$15 co-pay/visit, ded waived	40%
Routine Diagnostic X-ray & Lab	20%	40%
Immunizations	No co-pay, ded applies	40%
Prostate Rectal Exam	\$15 co-pay/visit, ded waived	40%
Prostate Specific Antigen (PSA) Test	20%	40%

BENEFITS

(All benefits are subject to deductible unless otherwise noted below)

CO-PAYMENT

(Amount You Pay)

	PPO	Non-PPO
Sigmoidoscopy	20%	40%
Colonoscopy	20%	40%
Well Baby Exams	\$15 co-pay/visit, ded waived	40%
Women's Annual Exam	\$15 co-pay/visit, ded waived	40%
Women's Routine Mammogram	\$15 co-pay/visit, ded waived	40%
Outpatient Diabetic Instruction	20%	40%
Home and Office Visits	\$15 co-pay/visit, ded waived	40%
Anesthesiologist	20%	20%
Therapeutic Injections	20%	40%
Physician Hospital Visits	20%	40%
Surgery	20%	40%
Chiropractic, naturopathic & acupuncturist care (up to \$1,500 annual maximum)	\$15 co-pay/visit, deductible waived	\$15 co-pay/visit, deductible waived
Emergency Care		
Urgent Care Centers	\$15 co-pay/visit, ded waived	\$15 co-pay/visit, ded waived
Emergency Room Facility	\$100 per visit, then 20%	\$100 per visit, then 20%
Ambulance Transportation (\$5,000 calendar year maximum)	20%	20%
Other Services		
TMJ (up to a lifetime maximum of \$3,000. Must be authorized)	20%	40%
Maternity	20%	40%
Hospice Care	20%	40%
Home Healthcare	20%	40%
Infusion Therapy		
Home Infusion	20%	40%
Outpatient Infusion	20%	40%
Outpatient Durable Medical Equipment	20%	40%
Supplies and Appliances	20%	40%
Disposable Supplies (provided in a physicians office)	20%	40%
Injectable Medication		
Self-administered	See prescription drugs	See prescription drugs
Not self-administered	20%	40%
Prescription Drugs		
Participating Pharmacy	See Rx Card	See Rx Card
Mail Order Pharmacy	See Rx Card	See Rx Card
Mental Health and Chemical Dependency*		
Inpatient	20%	40%
Residential	20%	40%
Outpatient	\$15 co-pay/visit, ded waived	40%

*Subject to State mandated limits (see page 36)

Note: The \$100 emergency room facility co-payment will be waived if covered hospitalization immediately follows emergency room service.

COVERED EXPENSES

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

A. Hospital - Inpatient Care

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

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

B. Hospital - Outpatient Care

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

C. Skilled Nursing Facility

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

D. Ambulatory Services

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

E. Physicians and Professional Providers

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

F. Maternity

Services and supplies.

G. Ambulance

Transportation to the nearest facility that has the capability to provide the necessary treatment, up to \$5,000 maximum per calendar year. For a full explanation of covered expenses, see page 28.

H. Supplies, Appliances and Medications

Items that relate directly to the treatment of an illness or injury are covered.

DEDUCTIBLES

This Plan has a calendar year deductible. The deductible is the amount of Covered Expenses that are paid by the member before benefits are payable by the Plan. The amount of the deductible is shown in the Summary of Benefits. Services accumulated toward the PPO calendar year deductible can be used to satisfy the non-PPO calendar year deductible. Services accumulated toward the non-PPO calendar year deductible can be used to satisfy the PPO calendar year deductible. The deductible applies separately to each insured person, but no family will be required to satisfy more than the total family deductible as shown in the Summary of Benefits, no matter how many insured people are in the family. After the deductible has been satisfied, benefits will be paid according to the schedule of benefits.

If covered expenses are incurred in the last three months of a calendar year and applied toward the deductible for that year, they will be carried forward and applied toward the deductible for the following year.

Fixed dollar co-payments, prescription drug out-of-pocket expenses, and disallowed charges do not apply to the annual deductible. Expenses applied towards the annual deductible do not apply towards the out-of-pocket limit.

If this Plan replaces a group policy of the employer, any deductible amount satisfied under the prior policy during the calendar year, will be credited under this Plan.

ANNUAL MAXIMUM OUT-OF-POCKET COST

After you or your covered dependents have met a \$3,000 per person annual out-of-pocket maximum (\$6,000 per person annual out-of-pocket maximum for services rendered out-of-panel), the Plan will pay 100% for the remainder of the calendar year. Services accumulated toward the PPO out-of-pocket maximum can be used to satisfy the non-PPO out-of-pocket maximum. Services accumulated toward the non-PPO out-of-pocket maximum can be used to satisfy the PPO out-of-pocket maximum. The emergency room facility co-payment, the out-of-pocket expenses for prescription drugs, the out-of-pocket expenses for transplants performed at non-participating transplant facilities, the service authorization cost containment penalty, disallowed charges, and out-of-pocket expenses incurred by dependent children living outside the service area do not accrue toward the annual out-of-pocket maximum.

There is a maximum of \$6,000 annual out-of-pocket per family (\$12,000 for services rendered out-of-panel).

MAXIMUM LIFETIME BENEFIT

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

PAYMENT

Expenses allowed by OEA Choice Trust are based upon the Contracted Fees for services rendered by PPO physicians and providers and the maximum plan allowance for services of non-PPO physicians and providers. The maximum plan allowance for non-PPO physicians and providers is established, reviewed, and updated by a national database. Please see the Summary of Benefits on page 4 for further details.

Except for co-payments, deductibles, and policy benefit limitations, participating physicians and providers agree to look solely to OEA Choice Trust, if it is the paying Insurer, for compensation of covered services provided to enrollees. Nothing in this paragraph shall prohibit a physician or provider and a member from entering into an agreement for payment by a participant for medical services which are not covered by the Health Benefit Plan.

RESTORATION

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

HOW WE COORDINATE BENEFITS WITH MEDICARE

This plan coordinates benefits with Medicare Parts A and B as allowed under federal government rules and regulations (see page 71).

EMERGENCY CARE

You and your insured dependents are covered for emergency services worldwide. If you believe you have a medical emergency you should call 9-1-1 or seek care from the nearest appropriate physician or provider, such as a physician's office or clinic, urgent care facility or emergency room. See the Definitions section for the definition of emergency on page 15.

COVERAGE WHILE TRAVELING OUTSIDE THE SERVICE AREA

While you or your eligible dependents are traveling outside the service area we will extend Plan benefits, as if the care were rendered by participating physicians or providers, subject to the following limitations:

- Fees charged by out-of-area physicians and providers of care will be reimbursed at the maximum plan allowance for those services;
- Benefits and co-pays will apply as if the patient had been referred to a participating physician or provider; and
- All follow-up care will be paid at the out of plan benefit level.

COVERAGE FOR DEPENDENTS WHILE RESIDING OUTSIDE THE SERVICE AREA

When an insured eligible dependent child resides outside the service area, we will extend plan benefits for treatment of an illness or injury, preventive healthcare (including routine physicals and immunizations) and maternity services, as if the care were rendered by participating physicians or providers, subject to the following limitations:

- All non-emergency hospital confinements must be authorized;
- Fees charged by out of area physicians and providers of care will be reimbursed at the maximum plan allowance for those services;
- Benefits and co-pays will apply as if the patient had been referred to a participating physician or provider; and
- Out of pocket expenses for services performed by physicians and providers outside the service area will not accrue toward the annual out of pocket maximum.

COVERAGE FOR RETIREE'S WHILE RESIDING OUTSIDE THE SERVICE AREA

When an insured eligible retiree resides outside the service area, we will extend plan benefits for treatment of an illness or injury, preventive healthcare (including routine physicals and immunizations) and maternity services, as if the care were rendered by participating physicians or providers, subject to the following limitations:

- All non-emergency hospital confinements must be authorized;
- Fees charged by out of area physicians and providers of care will be reimbursed at the maximum plan allowance for those services; and
- Benefits and co-pays will apply as if the patient had been referred to a participating physician or provider.

Cost Containment

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

SERVICE AUTHORIZATION REQUIREMENTS

A. Hospital Pre-admission Authorization

All non-emergency hospital confinements must be authorized in order for maximum plan benefits to be payable. By non-emergency, we mean any confinement which can be scheduled in advance. The Plan will authorize a normal length of stay, based upon the medical condition. Additional hospital days are covered only upon medical evidence of need.

In the case of an emergency admission to the hospital, authorization must be obtained by calling the Plan within 48 hours of the emergency hospital admission (or as soon as reasonably possible).

Please Note:

If an insured person fails to obtain Pre-Admission Authorization for inpatient stays, a co-payment penalty of 50%, up to a maximum deduction of \$2,500 per occurrence, will be applied to covered charges before regular Plan benefits are figured. You will be responsible for payment of any charges not covered because of non-compliance. The co-payment penalty does not apply to the plan's deductible or out-of-pocket maximum. This penalty will not apply in the case of an emergency admission.

Pre-admission authorization involves the following steps:

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

To obtain Pre-admission Authorization by phone, contact the Plan at (503) 243-4496 (in Portland) or 1-800-258-2037 (toll-free, outside of Portland).

Inpatient and Residential (overnight residential, day treatment, or partial hospitalization) stays for Mental Health or Chemical Dependency are also subject to service authorization. Call Cascade Behavioral Health at 1-800-799-9391.

B. Ambulatory Surgery

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

Authorization involves the following steps:

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

C. Mandatory Second Surgical Opinion

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

Please Note:

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

D. Mental Health/Chemical Dependency Program

Cascade Behavioral Health provides specialty management services for Mental Health and Alcohol/Drug treatment. Call Cascade Behavioral Health at (503) 624-9382 or toll-free at 1-800-799-9391.

Please Note:

If an insured person fails to obtain Pre-Admission Authorization for inpatient and residential Mental Health and Chemical Dependency stays, a co-payment penalty of 50%, up to a maximum deduction of \$2,500 per occurrence, will be applied to covered charges before regular Plan benefits are figured. You will be responsible for payment of any charges not covered because of non-compliance. The co-payment penalty does not apply to the plan's deductible or out-of-pocket maximum. This penalty will not apply in the case of an emergency admission.

COST EFFECTIVENESS SERVICES

In limited circumstances, the Plan will pay benefits for cost containment services. These are procedures, medical supplies or other medically-related expenses that are not ordinarily covered by the Plan. Cost effectiveness services will be covered, if and only if, the Plan's medical director, in the medical director's sole opinion, determines:

- (1) The cost effectiveness services are medically necessary; and
- (2) Providing those services will result in an immediate cost savings to the Plan.

Each claim for cost effectiveness services will be reviewed based on its own unique facts and circumstances. The fact that a particular cost effectiveness service was provided for one person does not mean it will automatically be provided for others. Nor does it mean that once cost effectiveness services have been approved for a person that they will continue to be approved for that person.

The cost effectiveness services provision is just one of the Plan's cost-containment measures. It does not operate as an overriding exception to the Plan's exclusions.

Any amounts the Plan pays for cost effectiveness services will be included in calculating any limitations, co-pays or co-insurance under the Plan.

Care Coordination

CARE COORDINATION

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

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

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

DISEASE MANAGEMENT

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

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

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

IF CALLING FROM PORTLAND AREA 503-948-5561

OUTSIDE THE PORTLAND AREA 1-800-592-8083

Office Hours – Monday through Friday
7:00 AM to 5:30 PM (Pacific Time)

Definitions

The following are definitions of some important terms used in this member handbook.

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

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

Authorization or **Authorized** refers to obtaining approval by the Plan prior to the date of service for services that have been ordered by the attending physician.

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

Cascade Behavioral Health provides specialty management services for Mental Health and Alcohol/Drug treatment (see page 34).

Chemical dependency (including alcoholism and mental illness) is defined in the Treatment for Chemical Dependency and Mental Illness section (see page 34).

Condition means a medical condition.

Co-payment means the fixed dollar amounts or percentages of covered expenses to be paid by the eligible person.

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

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

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

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

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

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

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

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

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

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

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

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

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

Emergency services means those healthcare items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required for the stabilization of the patient.

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

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

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

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

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

The **Group** is the organization whose members are covered by this Plan.

Group eligibility waiting period means the period of employment or membership with the group that a prospective enrollee must complete before coverage begins.

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

Hospice Care is defined in the Hospice Care section on page 28.

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

Implant means a material inserted or grafted into tissue.

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

Insured dependent means an eligible dependent of an insured employee of the Group, whose application has been accepted by the Plan and who is insured by this Plan.

Insured employee means an employee of the Group, who is insured by this Plan following acceptance by the Plan of that person's application.

Late enrollee means an individual who enrolls subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. If you decline coverage for yourself and/or your dependents when initially eligible, you will not be allowed to enroll yourself and or your dependents until the next open enrollment period. (See page 54 or complete details.)

An individual is not a late enrollee if:

- The individual qualifies for special enrollment as described on page 54;
- The individual applies for coverage during an open enrollment period;
- A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order;

- The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or
- The individual's coverage under Medicaid, Medicare, CHAMPUS, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan, has been involuntarily terminated within 63 days prior to applying for coverage in a group health benefit plan.

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

For a service by a non-participating physicians/providers, the Plan will process charges for those services as follows: maximum amount is the lesser of the amount payable under any supplemental provider fee arrangements and the seventy-fifth (75th) percentile of fees commonly charged for a given procedure in a given area, based on a national database.

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

Maximum Plan Allowance for prescription benefits is the maximum amount which the Plan will reimburse physicians and providers for medications. For a participating physician or provider, the maximum amount is the contracted fee. For non-participating physicians and providers, the maximum amount is no more than the prevailing pharmacy network fee based on Average Wholesale Price (AWP) determined by First Data Bank minus a percentage discount. AWP is a figure that is reported by commercial publishers of drug pricing data, based on wholesale pricing information provided to them by drug manufacturers.

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

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

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

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

Medically necessary care does not include custodial care.

Please Note:

The fact that a physician or provider prescribes, orders, recommends, or approves a service or supply does not, of itself, make the service medically necessary or a covered service. Refer to the "General Exclusions" section starting on page 41 for further information regarding medical necessity. Also see "Transplants" on page 37.

Mental illness is a psychological disorder that results in pain or distress and substantial impairment of basic or normal functioning.

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

Non-participating and Non-PPO refers to hospitals, physicians, providers, professionals, and facilities that have not contracted with us to provide benefits to persons covered under this Plan. They will be reimbursed at the maximum plan allowance for the service provided.

ODS refers to ODS Health Plan, Inc.

ODS Network is the Preferred Provider Organization (PPO) selected by your employer. ODS Network Preferred Participating Physicians and Providers are physicians, hospitals and medical suppliers who contract to provide healthcare to you and your covered dependents. By using a Participating Physician or Provider, your covered medical expenses will be paid at a higher rate (see page 4).

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

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

Participating and PPO refers to hospitals, physicians, providers, professionals, and facilities that have contracted with us to provide benefits to persons covered under this Plan.

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

Physician means a doctor of medicine or osteopathy.

The **Plan** is the agreement between the Group and OEA Choice Trust which contains all the conditions of the Plan. The Employee Plan Description is a part of the Plan.

Policyholder means the group or employer for whose members or employees medical benefits are being provided.

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

- A certified nurse practitioner;
- A podiatrist;
- A chiropractor;

- An acupuncturist;
- A naturopath;
- A dentist (doctor of medical dentistry or doctor of dental surgery), but only for treatment of accidental injury to natural teeth, or for surgery that does not involve repair, removal or replacement of teeth, gums, or supporting tissue;
- A licensed psychologist;
- A State-licensed physician assistant;
- A State-licensed clinical social worker, or M.A.;
- A registered physical, occupational, or speech therapist, but only for rehabilitative services provided upon the written referral of a doctor of medicine or osteopathy;
- A registered nurse or licensed practical nurse, but only for those services for which nurses customarily bill patients;
- A registered nurse first assistant; and
- An optometrist.

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

The Plan's **service area** is the geographical area where the participating physicians and providers provide their services.

Service authorization refers to obtaining approval by the Plan prior to the date of service for services that have been ordered by the attending physician.

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

Waiting period means the period that must pass before the individual is eligible to enroll for benefits under the terms of the plan.

Benefit Description

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

MEMBERSHIP CARD

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

If you lose your identification card, we will issue a replacement. Contact us at (503) 620-3822 or toll-free at (800) 452-0914.

WHEN BENEFITS ARE AVAILABLE

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

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

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

HOSPITAL CARE

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

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

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

A. Hospital Benefits

Covered expenses consist of the following:

- The actual daily charge for a **hospital room**, but not to exceed the hospital's most common rate for a 2-bed room;

- The charge for **isolation care**, when we agree it is necessary to protect other patients from contagion or to protect you from contracting the illness of another person;
- The charge for an **intensive care unit**. Using the criteria of the Joint Commission on Accreditation of Hospitals as a guide, we reserve the right to decide whether a unit in a particular hospital qualifies as an intensive care unit;
- The **facility charges** for surgery performed in a hospital outpatient department;
- Charges for **other hospital services and supplies** that are necessary for treatment and are ordinarily furnished by a hospital; and
- Charges for **routine nursery care** of a well-newborn infant, including one in-nursery physician's visit, while the mother is confined in the hospital and receiving maternity benefits under this Plan. The Plan deductible is waived for routine nursery care.

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

All inpatient stays require service authorization. Please contact Cascade Behavioral Health at (503) 624-9382 or toll-free at 1-800-799-9391 for hospitalization related to chemical dependency or mental illness. See the Cost Containment section, page 10, for additional information regarding service authorization.

B. Inpatient Days Covered

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

C. Inpatient Rehabilitative Hospital Care

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

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

D. Emergency Room Care

The Plan will pay 80 percent of covered expenses, after a \$100 co-payment for each hospital emergency room visit. The \$100 co-payment does not accrue to the annual out-of-pocket maximum. However, the \$100 emergency room facility co-payment will be waived if covered hospitalization immediately follows emergency room service.

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

E. Pre-admission Testing

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

SKILLED NURSING FACILITY CARE

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

Skilled Nursing Facility Benefits

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

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

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

- Senile deterioration;
- Alzheimer's disease;
- Mental deficiency or retardation; or
- Mental illness.

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

AMBULATORY SERVICES

Many ambulatory services require service authorization. Failure to obtain required service authorization can result in denial of benefits.

A. Outpatient Surgery

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

Certain surgical procedures are covered only when performed as outpatient surgery. Please ask your participating physician or professional provider if this applies to your surgery, or contact our Customer Service Department at (503) 620-3822 or toll-free at (800) 452-0914.

B. Diagnostic X-rays and Laboratory Tests

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

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

Covered expenses include:

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

D. Imaging Procedures

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

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

PET and SPECT scans require service authorization.

PHYSICIAN AND PROFESSIONAL PROVIDER SERVICES

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

A. Preventive Healthcare

The Plan covers the following preventive healthcare benefits:

1. **Periodic Health Exams.** The Plan covers periodic health exams limited to the following schedule:
 - Newborn: One hospital visit.
 - Infants: Six well-baby visits to a physician's office during the first year of life.
 - Children:
 - Age 1: Two exams during the year.
 - Age 2-6: One exam every year.
 - Age 7-17: One exam every two years.
 - Adults:
 - Age 18-34: One exam every four years.
 - Age 35-59: One exam every two years.
 - Age 60 and above: One exam every year.

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

Routine diagnostic x-ray and lab work related to a periodic health exam are also covered and are subject to the applicable deductible and standard co-insurance.

Please Note:
Periodic health exams are calculated from the date of the previous health exam.

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

3. Preventive Women’s Healthcare

The Plan will cover the following preventive women’s healthcare. These services are covered when performed by a PPO or non-PPO physician or provider.

- a A complete and thorough physical examination of the breast, including but not limited to a clinical breast examination, performed by a healthcare provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer as follows:
 - i. Annually for women 18 years of age and older; and
 - ii At any time at the recommendation of the women’s health care provider.

- b. Mammograms are covered as follows:
 - Age 35 through 39 1 mammogram
 - Age 40 and older 1 mammogram per year

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

- c. Pelvic Exam/Pap Smears are covered annually for women of all ages, and at any time upon referral of the woman’s healthcare provider.
4. **Routine Prostate Rectal Exam & Prostate Specific Antigen (PSA) Test.** For men age 50 and over, the Plan covers one rectal examination and one PSA test every calendar year or as determined by the treating physician. For men younger than 50 years of age who are at high risk for prostate cancer, including African-American men and men with a family medical history of prostate cancer, prostate rectal exam and PSA test are covered as determined by the treating physician.
 5. **Colorectal cancer screening.** The Plan will cover the following colorectal cancer screening exams and laboratory tests:
 - a. The Plan covers one flexible sigmoidoscopy every 5 years for men and women age 50 and over.
 - b. The Plan covers one colonoscopy every 10 years for men and women age 50 and over. The preventive benefit also applies to the related facility and anesthesia fees.
 - c. The Plan covers one double contrast barium enema every 5 years for men and women age 50 and over.
 - d. The Plan covers one fecal occult blood test every calendar year for men and women age 50 and over.

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

B. Family Planning

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

C. Home, Office or Hospital Visits

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

D. Diabetes Self-Management Programs

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

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

E. Therapeutic Injections

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

See Injectable Medication for additional information.

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

F. Surgery

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

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

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

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

G. Circumcision

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

H. Reconstructive Surgery Following A Mastectomy

The Plan covers reconstructive surgery following a mastectomy for:

- All stages of Reconstruction of the breast on which the mastectomy has been performed, including but not limited to nipple reconstruction, skin grafts and stippling of the nipple and areola;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses; and

- Treatment of physical complications for all stages of the mastectomy, including lymphedemas; and
- Inpatient care related to the mastectomy and post-mastectomy services.

Your physician must contact the Plan to receive authorization in advance.

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

I. Cochlear Implants

Cochlear implants are covered when determined medically necessary and authorized.

J. Cosmetic and Reconstructive Surgery

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

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

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

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

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

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

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

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

K. Inborn Errors of Metabolism

We will provide coverage, subject to Plan benefits and limitations, for treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which standard methods of diagnosis, treatment and monitoring exist. Coverage includes diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.

L. Maxillofacial Prosthetic Services

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

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

M. Temporomandibular Joint Syndrome

The Plan covers expense for treatment of temporomandibular joint syndrome (TMJ) for medical reasons only. All TMJ related services, including but not limited to diagnostic and surgical procedures, must be authorized, and will be covered only when medically necessary as established by a history of advanced pathologic process (arthritic degeneration) documented in a physician's medical record, or in cases involving severe acute trauma. Benefits for TMJ are limited to a \$3,000 lifetime maximum. Treatment of dental diseases or injuries is excluded.

N. Chiropractors, Naturopaths and Acupuncturists

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

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

There is a combined calendar year maximum of \$1,500 for chiropractic, naturopathic and acupuncturist services. Office visits for alternative care providers are reimbursed at the same rate as office visits of participating physicians and professional providers.

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

Office supplies and remedies provided by a naturopath are also covered. Physical therapy ordered by a Naturopath is also covered. Reimbursement is at the plan's standard reimbursement rate for the type of service rendered. For physical therapy services, see Outpatient Rehabilitation on page 30. Physical therapy services are not subject to the \$1,500 maximum for alternative care.

To be covered, a remedy must be approved by the Board of Naturopathic Examiners.

Vitamins and minerals, whether in injectable or other form, are not covered.

MATERNITY CARE

Pregnancy care, childbirth and related conditions are covered under this Plan. This benefit includes voluntary abortions.

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

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

EMERGENCY CARE

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

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

If the patient's condition requires hospitalization in a non-PPO facility, the attending physician and our medical director will monitor your condition and determine when the transfer to a PPO facility can be made. The Plan does not provide PPO-level benefits for care beyond the date the attending physician and our medical director determine the patient can be safely transferred.

PPO-level benefits will not be available if you go to a non-PPO provider for care other than emergency medical care. The following are not emergency medical conditions and are not eligible for PPO-level benefits (this list is not inclusive of all such services):

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

AMBULANCE TRANSPORTATION

Ambulance transportation, including local ground transportation, is covered up to a maximum of \$5,000 per calendar year for medically necessary transport to the nearest facility that has the capability to provide the necessary treatment. Benefits will be paid to you and the provider or directly to the provider.

Certified air ambulance transportation is covered when medically necessary and is not subject to the \$5,000 calendar year maximum.

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

HOSPICE CARE

Definitions:

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

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

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

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

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

A. Hospice Home Care

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

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

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

B. Hospice Inpatient Care

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

C. Respite Care

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

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

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

D. Exclusions

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

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

OTHER SERVICES

A. Home Healthcare

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

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

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

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

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

Maximum Visits

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

Service authorization

Home healthcare requires service authorization. Contact our Customer Service Department at (503) 620-3822 or toll-free at (800) 452-0914 before receiving such care.

B. Outpatient Rehabilitation

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

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

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

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

C. Supplies, Appliances, and Durable Medical Equipment

Outpatient supplies, appliances and durable medical equipment are covered. If you receive these services from non-participating physicians or providers, the service will be reimbursed at the non-PPO rate.

Covered supplies include the following:

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

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

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

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

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

Durable medical equipment is equipment and related supplies which we determine are used primarily to serve a medical purpose, are not generally useful to a person in the absence of illness, injury or disease, are appropriate for use in the patient's home and are designed to withstand repeated use. Examples of durable medical equipment include a wheelchair, a hospital-type bed, and oxygen.

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

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

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

- Those used primarily for comfort, convenience, or cosmetic purposes;
- Wigs and toupees;
- Those used for education or environmental control, such as ramps, hand rails, bath benches, telephones, humidifiers, air filters, air conditioners, heat lamps, tanning lights, seasonal lights, whirlpool or hot tubs;
- Therapeutic devices, except for transcutaneous nerve stimulators; and
- Incontinence supplies that do not require a prescription to purchase.

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

D. Infusion Therapy

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

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

Infusion therapy benefits are limited to the following:

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

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

- solutions, medications, and pharmaceutical additives;
- pharmacy compounding and dispensing services;
- durable medical equipment for the infusion therapy;
- ancillary medical supplies;

- nursing services associated with:
 - patient and/or alternative care giver training;
 - visits necessary to monitor Intravenous therapy regimen;
 - emergency services;
 - administration of therapy; and
- collection, analysis, and reporting of the results of laboratory testing services required to monitor response to therapy.

Service authorization

Infusion therapy requires service authorization. Contact our Customer Service Department at (503) 620-3822 or toll-free at (800) 452-0914 before receiving such care.

E. Nonprescription Enteral Formula For Home Use

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

F. Injectable Medication

Medications that are given by injection or infusion (intravenous administration) in the provider’s office, infusion center or home infusion (e.g., allergens, Remicade) are covered as a supply. If the pharmaceutical is available in an oral dosage form, the Plan will not cover it in the form of an injectable medication unless we agree that it is medically necessary that the enrollee use the injectable form. In addition, infusion and in-office injectables may require prior authorization by the Plan or be subject to specific benefit limitations. The following self-injectable medications are examples of medications covered under the Prescription Drugs section of your plan. This list is not to be considered all-inclusive of covered drug supplies. For more information on covered drug supplies please refer to page 48:

Ana-guard	Aranesp	Avonex	Betaseron
Copaxone	Enbrel	Epipen	Epogen
Fragmin	Imitrex	Infergen	Innohep
Insulin	Kineret	Lovenox	Neumega
Neupogen	Pegasys	Procrit	Rebif
Glucagon Emergency Kits			

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

General Limitations

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

TREATMENT FOR CHEMICAL DEPENDENCY AND/OR MENTAL ILLNESS

A. Treatment Review

Authorization is required before beginning any mental health and/or chemical dependency inpatient and residential (overnight residential, day treatment, or partial hospitalization) treatment program. Please contact Cascade Behavioral Health at (503) 624-9382 or toll-free at 1-800-799-9391 to initiate the authorization process. Participating facilities are responsible to obtain authorization on the member's behalf.

For outpatient services, members are not required to obtain authorization. Participating physicians and providers will authorize services through the Plan on your behalf for outpatient mental health and/or chemical dependency services. Non-authorized services performed by a participating physician or provider will be denied. Members are only responsible to pay the PPO level of out-of-pocket expenses for the denied services. Outpatient services performed by non-participating physicians or providers do not require authorization.

If a member uses a non-participating physician or provider, benefits will be paid at the non-PPO level.

Cascade Behavioral Health is available (at (503) 624-9382 or toll-free at 1-800-799-9391) to assist you in locating providers and facilities within a specific geographical area and clinical specialty.

Please note that it is your responsibility to keep track of the number of visits you have used. An authorization issued by Cascade Behavioral Health only authorizes the necessity of the services. It is not a guarantee that services will be covered. If you have used your maximum number of visits, additional visits, even if authorized, will be denied.

B. Emergency Treatment

Emergency treatment will be reimbursed at the PPO benefit level whether the care is provided by a PPO or non-PPO physician or provider. Prior authorization by Cascade Behavioral Health is not required for emergency treatment. Authorization for emergency treatment should be obtained at the earliest opportunity by contacting Cascade Behavioral Health during regular business hours. Once the emergency medical condition has stabilized, continued care must be authorized to be a covered benefit. We may require transfer to a participating facility/program which is medically appropriate based on the necessary level of care. (See the Emergency section on page 28 for additional information about emergency treatment.)

C. Definitions

In addition to the definitions in the Definition section, the following apply to the Mental Health and Chemical Dependency section.

Chemical dependency means drug and alcohol related disorders, as defined by the most recent version of the Diagnostic and Statistical Manual, as published by the American Psychological Association. For purposes of this plan, chemical dependency does not include addiction to, or dependency on foods, tobacco, or tobacco products.

Dual diagnosis means a condition marked by diagnosis of both a mental illness and chemical dependency that requires simultaneous treatment such that one condition cannot be treated independent of the other.

Health facility means a facility licensed to provide full-day or part-day acute treatment for chemical dependency or mental illness.

Mental illness is a covered Axis I diagnosis listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Outpatient service means a program or service providing treatment by appointment. Such a program or service shall be licensed, approved, established, maintained, contracted with or operated by the Oregon Office of Mental Health & Addiction Services, or is provided by one of the following:

- a physician;
- a licensed clinical psychologist;
- a psychiatric mental health nurse practitioner; or
- a licensed clinical social worker.

Residential facility or day or partial hospitalization program means a program or facility providing an organized full-day or part-day program of treatment. Residential services occur in a program or facility licensed, approved, established, maintained, contracted with or operated by the Office of Mental Health & Addiction Services.

D. Treatment Settings

Covered expenses for treatment of mental illness and/or chemical dependency are limited to services which are provided in the least costly treatment setting that is medically appropriate for the individual patient's condition. The following criteria will be used to determine the appropriate setting for the treatment of mental illness and/or chemical dependency:

- Expenses for inpatient health facility care will be covered only when the medical records reflect that the patient's medical circumstances require 24-hour skilled nursing supervision and physician assessment not readily available in a less costly setting.
- Expenses for residential care will be covered only when the facility records reflect that the patient required non-medical supervision, protection, assistance and treatment for at least 4 hours per day. In determining the patient's need for residential care, the following factors will be taken into consideration:
 - The patient's existing social, occupational and living situations which could adversely affect outpatient treatment;
 - Potential for physical harm to the patient or others; and
 - The patient's ability and willingness to participate consistently in treatment.
- Expenses for outpatient services will be covered when treatment is justified considering the patient's history and current medical, occupational, social and psychological situation and overall prognosis.

If services are provided in a treatment setting that is inappropriate based on the above criteria, benefits will be limited to the amount that would have been paid if those services had been provided in the least costly treatment setting appropriate to provide that care.

Note:

Cascade Behavioral Health provides specialty management services for Mental Health and Alcohol/Drug treatment. Call Cascade Behavioral Health at (503) 624-9382 or toll-free at 1-800-799-9391. In order to receive preferred rates for mental health and/or chemical dependency services, you need to have care authorized and referred.

E. Benefits for Chemical Dependency

For services received as an inpatient in a health facility, benefits are limited to 19 days in any 2 calendar year period for enrollees 17 years of age or younger, and 14 days in any 2 calendar year period for enrollees 18 years of age or older.

For services received in a residential program or facility or in a day or partial hospitalization program, benefits are limited to 24 days in any 2 calendar year period for enrollees 17 years of age or younger, and to 19 days in any 2 calendar year period for enrollees 18 years of age or older.

Benefits for outpatient services are limited to 42 visits in any 2 calendar year period for enrollees 17 years of age or younger, and to 32 visits in any 2 calendar year period for enrollees 18 years of age or older.

F. Benefits for Mental Illness

During any 2 calendar year period, benefits for services received as an inpatient in a health facility are limited to 15 days for enrollees 17 years of age or younger, and to 14 days for enrollees 18 years of age or older.

For services received during any 2 calendar year period in a residential program or facility, or in a day or partial hospitalization program, benefits are limited to 19 days for enrollees 17 years of age or younger, and to 19 days for enrollees 18 years of age or older.

For outpatient services, benefits are limited to 29 visits in any 2 calendar year period for enrollees of all ages.

Please note: For purposes of calculating the number of outpatient visits, each session of therapy is counted as one visit. For example, if an individual receives individual therapy and group therapy on the same day, the individual will have utilized two outpatient visits, even if the services were performed by the same provider.

G. Benefits for Combined Chemical Dependency and Mental Illness Diagnosis

If an enrollee receives covered services and supplies for a combined diagnosis of both chemical dependency and mental illness, benefits will be calculated on the basis that such services and supplies were for the treatment of mental illness alone. Benefits in a 2 calendar year period for both mental illness and a combined diagnosis of chemical dependency and mental illness will not exceed the maximum days or visits for mental illness alone.

Note: A single 2 calendar year benefit period begins with the first date of treatment for a mental health and/or chemical dependency condition. When the 2 calendar year period expires, the member will be eligible for a new 2 calendar year benefit period.

H. Exclusions

In addition to exclusions listed in the Exclusion section, services, supplies, and treatment related to the following are not covered:

- Psychological enrichment or self-help programs for mentally healthy individuals.
- Behavior modification programs, including: assertiveness training, image therapy, sensory movement groups, marathon group therapy, and sensitivity training;
- Counseling or treatment in the absence of illness, including individual or family counseling or treatment for marital, social, behavioral, family, occupational or religious problems, or treatment of "normal" transitional response to stress;
- Level 0.5 education-only programs related to DUII violation;
- Education-only, court-mandated Anger Management classes;
- Voluntary mutual support groups, such as Alcoholics Anonymous;
- Family education or support groups;
- Sexual disorders (except paraphilias); and
- Personality Disorders, defined as a pattern of behavior causing impairment in social or occupational functions.

TRANSPLANTS

We will pay benefits for medically necessary and appropriate transplant procedures which in our judgment conform to accepted medical practice and are not experimental or investigational. (See "Experimental or Investigational Procedures" in General Exclusions section which begins on page 41).

A. Definitions

Participating Transplant Facility means a healthcare facility with which the Plan has contracted or arranged to provide facility transplant services for the group's enrollees.

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

Transplant means:

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

Transplant does not include:

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

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

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

B. Covered Benefits

Benefits for transplants are limited as follows:

- We will waive any otherwise applicable deductible, or co-payments of the Plan and pay 100 percent of the contracted amount for facility fees when a transplant is performed at a participating transplant facility;
- If a transplant procedure is performed at a facility other than a participating transplant facility, we will pay 60% of the amount we would have paid had the services been rendered at a participating transplant facility. The patient will be responsible for the balance. The deductible and co-payment will not accumulate toward the out-of-pocket maximum amount under the Plan. If the provider's billed charge is less than the amount that would have been paid if the service had been rendered at a participating transplant facility, reimbursement will not exceed the billed charge. **Note:** Services not performed at a participating transplant facility will be paid at 60% even if the patient has met the Plan's out-of-pocket maximum;
- If the Recipient or Self-Donor is enrolled under this Plan, we will pay for donor costs related to a covered transplant. "Donor costs" means the covered expense of removing the tissue from the donor's body and preserving or transporting it to the site where the transplant is performed as well as any other necessary charges directly related to locating and procuring the organ. If the donor is insured under this Plan and the recipient is not, we will not pay any benefits toward donor costs. Expenses incurred by an enrolled donor which result from complications and unforeseen effects of the donation will be covered as any other sickness. Expenses incurred by a donor not enrolled in the Plan which result from complications and unforeseen effects of the donation will not be covered.
- Covered transplants are medically necessary and appropriate when they meet the ODS Medical Necessity Criteria for the following organs or tissues:
 - Heart;
 - Heart/lung or lung;
 - Liver;
 - Kidney;
 - Kidney and pancreas when transplanted together in the same operative session;
 - Pancreas (this includes pancreas alone and pancreas after kidney transplantation);
 - Small bowel;
 - Autologous bone marrow or stem cell transplant for the treatment of:
 - acute leukemias;
 - chronic leukemias;
 - lymphoproliferative disorders;
 - germ cell tumors of the testes, ovaries, mediastinum and retroperitoneum;
 - plasma cell disorders;
 - solid tumors of childhood;
 - neuroductal tumors;
 - other malignancies.
- Homogenic/allogenic bone marrow or stem cell transplant for the treatment of:
 - acute leukemia;
 - chronic leukemias;
 - myelodysplastic syndromes;
 - stem cell disorders;
 - myeloproliferative disorders;
 - lymphoproliferative disorders;

- inherited metabolic disorders;
 - inherited erythrocyte abnormalities;
 - inherited immune system disorders;
 - other inherited disorders;
 - plasma cell disorders;
 - other malignancies.
- We will pay for physician and professional provider transplant services according to the benefits for physicians and professional providers under the Plan;
 - We will pay for anti-rejection drugs following the covered transplant, we will pay according to the benefits for prescription drugs, if any, under the Plan.

Please Note:
All transplant related procedures and services, including the pre-transplant evaluation, must be authorized and be medically necessary and appropriate according to criteria established by the Plan. To receive maximum Plan benefits, the transplant related procedure must be performed at a participating transplant facility.

C. Service Authorization Requirement

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

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

Mail:	Medical Intake Unit The ODS Companies P.O. Box 40384 Portland, Oregon 97240
Telephone:	(503) 948-5561 - Portland Area
Toll-free:	1-800-592-8283 - Nationwide

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

D. 24-Month Exclusion Period

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

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

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

E. Exclusions

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

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

BIOFEEDBACK THERAPY

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

PODIATRY SERVICES

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

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

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

General Exclusions

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

Behavior Modification

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

Benefits Not Stated

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

Charges Over the Maximum Plan Allowance

Any charge over the maximum plan allowance for services or supplies will be excluded.

Comfort and First-Aid Supplies

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

Cosmetic/Reconstructive Surgery

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

Counseling or Treatment in the Absence of Illness

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

Custodial Care

Routine care and hospitalization for assistance with activities of daily living, including, but not limited to, bathing, dressing, feeding, and administration of medications.

Dental Examinations and Treatment; Orthodontia

Dental examination and treatment and orthodontia are not covered.

Dental Implants

Experimental or Investigational Procedures

Services and supplies are excluded that, in our judgment:

- Are not rendered by an accredited institution, physician or provider within the United States or by one that has not demonstrated medical proficiency in the rendering of the service or supplies;
- Are not recognized by the medical community in the service area in which they are received;

- Involve a treatment for which the approval of one or more government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered;
- Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established; and
- Are available in the United States only as part of clinical trial or research program for the illness or condition being treated.

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

Eye Examinations

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

Faith Healing

Family Planning

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

Financial Counseling Services

Food Services

“Meals on Wheels,” and similar programs are not covered.

Gender Changes

Services or supplies in connection with gender change procedures and complications resulting from gender change procedures.

Guest Meals in a Hospital or Skilled Nursing Facility

Hearing Aids

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

Homemaker or Housekeeping Services

Hospice Services

The following hospice services are excluded:

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

Immunizations

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

Infertility

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

Inmates

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

Legal Counseling**Massage or Massage Therapy (performed by a LMT)**

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

Mental Examination and Psychological Testing and Evaluations

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

Mental Retardation/Learning Disabilities

Treatment related to mental retardation and learning disabilities is not covered. Services or supplies provided by an institution for the mentally retarded are not covered.

Missed Appointments**Necessities of Living**

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

Nutritional Counseling (except DSM)**Orthopedic Shoes**

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

Orthognathic Surgery

This includes services and supplies associated with orthognathic surgery.

Pastoral and Spiritual Counseling**Personality Disorders**

This includes services and supplies for the treatment of a pattern of behavior causing significant impairment in social or occupational functioning.

Physical Examinations

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

Physical Exercise Programs

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

General Exclusions

Private Nursing Services

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

Rehabilitation Services

Rehabilitation services are not covered, except as provided in the Rehabilitation section on pages 21 and 30.

Reports and Records

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

Routine Foot Care

We will not cover the following services:

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

Services Otherwise Available

This exclusion includes:

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

Services Provided By a Member of Your Immediate Family

The Plan will not reimburse services provided by you or any member of your family. Family members would include a spouse, child, brother, sister, or parent of you or your spouse.

Services Provided By Volunteer Workers

Service Related Conditions

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

Services and Supplies Provided for Obesity or Weight Reduction

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

- Gastric restrictive procedures with or without gastric bypass, or the revision of the same.

- Weight management services such as weight loss programs, exercise programs, counseling, hypnosis, biofeedback, neurolinguistic programming, guided imagery, relaxation training and subliminal suggestion used to modify eating behaviors.
- Any drug or formula related to or resulting from the treatment of weight loss or obesity even if prescribed by your physician.

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

Sexual Disorders

This Plan does not cover services or supplies for the treatment of sexual dysfunction or inadequacy.

Support Education

This includes the following:

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

Supportive Environmental Materials

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

Surgery to Alter Refractive Character of the Eye

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

Taxes

TeleHealth and TeleMedicine

Telephone Visits or Consultations, and Telephone Psychotherapy

Telephones and Televisions in a Hospital or Skilled Nursing Facility

Therapies

Hippotherapy, services or supplies related to learning disabilities or development delay, and maintenance therapy and programs are not covered.

Transportation

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

Treatment After Coverage Terminates

This Plan does not cover services or supplies that you or your insured dependent receive after coverage ends. The only exception is if you are hospitalized at the time of termination. See “When Benefits Are Available” on page 20.

Treatment for Admissions Prior to Coverage

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

Treatment Not Medically Necessary

This Plan does not cover:

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

Please Note:

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

Treatment Prior to Enrollment

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

Vitamins and Minerals

This plan does not cover vitamins and minerals unless they are medically necessary for treatment of an illness or injury and only if they bear the legend "Caution – Federal law prohibits dispensing without a prescription" and a dosage form of equal or greater strength of the medication is not available without a prescription under federal law. This applies whether the vitamin or mineral is oral, injectable, or transdermal.

Wigs, Toupees, Hair Transplants

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

Work-Related Conditions

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

Prescription Drug Expense Benefit

Prescription Drug Expense benefits provide payment for eligible prescription drug charges. The Plan will pay 100% of covered expense after a co-payment per prescription (see Prescription Drug ID card for co-payment amount).

DEFINITIONS

Generic drug means a drug determined by the Food and Drug Administration to be therapeutically equivalent to the brand-name version. Generic drugs must contain the same active ingredients as their brand-name counterpart and be identical in strength, dosage form and route of administration.

Brand name drug means a prescription medication that has a patent and is marketed and sold by only one source or is listed in widely accepted references as a brand name medication based on manufacturer and price.

Non-preferred brand drug means a drug that has been reviewed by the Plan and found not to have a significant advantage over preferred brands, but usually costs more. Drugs that have alternative treatment modalities are also considered high-cost brand drugs.

Preferred brand drug means a brand drug that has been reviewed by the Plan and found to be clinically effective at favorable costs.

GENERIC DRUGS

Both generic and brand name medications are covered benefits. Regardless of the reason or medical necessity, if you request a brand name drug or your physician prescribes a brand name drug when a generic equivalent is available, you will be responsible for the brand co-payment plus the difference in cost between the generic and the brand name drug. (The following drugs may be filled with the brand name without any additional cost to you other than the co-payment: Coumadin, Dilantin, Lanoxin, Levothyroxine branded products, Norpace CR, Premarin, Procanbid, Quinaglute, Quinidex, Tegretol, Tegretol XR and Theodur.)

COVERED EXPENSES

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

- It is for a covered drug supply that is prescribed for a covered person;
- The expense is incurred while the covered person is eligible for the Prescription Drug Expense Benefit. A charge is considered to be incurred at the time the drug or medicine is furnished for which the charge is made; and
- The prescribed drug is not excluded under the Plan.

COVERED DRUG SUPPLY

A covered drug supply:

- Is a supply of a drug or medicine that is medically necessary for the treatment of an illness or injury that cannot legally be dispensed without a prescription, and that by law must bear the legend "Caution -- Federal law prohibits dispensing without prescription";
- Includes insulin (up to a maximum of 100 insulin syringes per 30 days and a maximum of 200 disposable needles per 30 days), insulin pens for premeasured insulin cartridges (up to 4 per year), insulin cartridges for pens, blood glucose test strips, glucose tablets, and ketone test strips for urinalysis (separate co-pays are applied to a supply of insulin and to diabetic supplies);
- Selected over-the-counter (OTC) medications, when available in prescription strength and with a valid prescription will be covered under the prescription benefit. The same benefit parameters such as co-pay and days supply restrictions will apply to covered over-the-counter medications. Examples of covered OTC medications include Claritin OTC and Prilosec OTC. For a list of OTC covered medications please visit our website at www.oechoice.com or call us at (503) 620-3822 or toll free 1-800-452-0914.
- Is limited to a 34-day supply of medication;
- Includes the following self-injectable medications:

Ana-guard	Aranesp	Avonex	Betaseron
Copaxone	Enbrel	Epipen	Epogen
Fragmin	Imitrex	Infergen	Innohep
Insulin	Kineret	Lovenox	Neumega
Neupogen	Pegasys	Procrit	Rebif
Glucagon Emergency Kits			

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

- Includes contraceptive drugs and devices used for medical reasons and birth control but only if they cannot legally be dispensed without a prescription, and by law must bear the legend "Caution – Federal law prohibits dispensing without prescription."
- Certain prescription drugs or medicines, including most self-injectables and infusion drugs (e.g., Enbrel, Copaxone, Avonex), must be purchased through our Specialty Pharmacy Provider to be a covered benefit. In addition, these drugs may require prior authorization by ODS or be subject to specific benefit limitations (visit our website at www.oechoice.com for more information). Your pharmacist, physician and other medical providers will advise you if your prescription requires a prior authorization or requires delivery by our Specialty Pharmacy Provider.

EXCLUSIONS

No Prescription Drug Expense Benefit will be paid for any charge excluded by the General Limitations or General Exclusions sections of the medical insurance program or for any:

- Devices, including, but not limited to therapeutic devices and appliances, hypodermic needles and syringes (however, hypodermic needles and syringes for use with insulin will be a covered benefit up to a maximum of 100 insulin syringes per 30 days and a maximum of 200 disposable needles per 30 days). For contraceptive devices, please see Covered Drug Supply;

- Charge for administration or injection of a drug or medicine;
- Drug that is determined by the Plan to be experimental or investigational or that is labeled: "Caution -- Limited by federal law to investigational use";
- Any drug or medicine that is used for an experimental or investigational purpose, even if it is otherwise approved by the federal government or recognized as neither experimental or investigative for other uses or health conditions (e.g., progesterone suppositories);
- Hair growth legend drugs;
- Charge in excess of the maximum plan allowance for a covered drug;
- Drug or medicine that is to be taken by or administered to a covered person in whole or in part while the covered person is a patient in a hospital, a sanitarium, a rest home, a skilled nursing facility, an extended care facility, a nursing home, or a similar institution;
- Prescription refills or quantities of medications that are in excess of the number prescribed by the physician or the number established by the Plan;
- Drug or medicine that is dispensed more than one year after the order of a physician;
- Biological sera, blood, blood products, or immunization agents other than allergy sera;
- Drug or medicine to treat an addiction to or dependence on a drug or chemical (e.g., Nicorette);
- Medication that by law must bear the legend "Caution – Federal law prohibits dispensing without prescription" if a dosage form of equal or greater strength of the medication is available without a prescription under federal law;
- Drug prescribed or used for cosmetic purposes;
- Drug prescribed for or used for non-FDA approved indications, unless approved by the Health Resources Commission;
- Drug or device prescribed or used to treat sexual dysfunction;
- Drug prescribed to treat a medical condition that is not covered under this Plan;
- Drug prescribed for purposes other than treating disease;
- Charge in excess of the maximum plan allowance for a covered drug;
- Drug prescribed for preventive purposes, unless such preventive services are specifically covered by this Plan; or
- Drug that is covered under another benefit (i.e. hospice, home health, medical, etc.).

CLAIMS PROCEDURES

Participating Pharmacy refers to a pharmacy that has contracted with us to provide prescription drug benefits to persons covered under this Plan. Non-participating Pharmacy refers to a pharmacy that has not contracted with us to provide prescription drug benefits to persons covered under this Plan.

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

Certain prescription drugs and/or quantities of prescription drugs may require prior authorization by the Plan.

Any new drug approved by the FDA after the date this policy goes into effect is not covered until approved by the Plan.

If you go to a Participating Pharmacy:

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

If you go to a Non-Participating Pharmacy:

- Pay the pharmacy, in full, for the prescription drugs;
- Obtain an OEA Choice Trust Pharmacy form by contacting OEA Choice Trust;
- Mail the completed form to:

OEA Choice Trust
P.O. Box 23600
Tigard, Oregon 97281-3600

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

Please Note:
Claims questions should be addressed to:

OEA Choice Trust
P.O. Box 23600
Tigard, Oregon 97281-3600

(503) 620-3822 or 1-800-452-0914

MAIL ORDER PHARMACY

You also have the option of obtaining prescriptions for covered drugs and medicines through the Mail Order Pharmacy. If you use the Mail Order Pharmacy, we will pay 100% of the covered expense after a co-payment for each brand name or generic prescription (see Prescription Drug ID card for co-payment amount). Note, however, that the brand name drugs will be covered as described on page 47 when a generic drug is available. To use the Mail Order Pharmacy, obtain a mail order pharmacy form from OEA Choice Trust.

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

Please Note:
Unless your doctor requires the use of a brand name drug, your prescription will be filled with a generic when available and permissible by Oregon law.

Mail Order Pharmacy phone number is 1-800-635-3070.

Eligibility

This section describes who is eligible to enroll under the Plan. Please be aware that the date you become eligible may be different than the date insurance begins. See "When Insurance Begins" for more specific information. This is located in the "Enrollment" section beginning on page 54.

EMPLOYEES

You are eligible to enroll under the Plan if you work the minimum of hours required by your Collective Bargaining Agreement. You are eligible to remain enrolled if you are on an approved leave of absence under the Family and Medical Leave Act of 1993.

DEPENDENTS

If you are married, your legal spouse is eligible for insurance. Your domestic partner is eligible for coverage if he or she meets the eligibility criteria on the Domestic Partner Affidavit provided by your employer. Your unmarried dependent children will continue to be eligible if they are under age 26 and are dependent on you for full or partial support, or if a court or administrative order requires you to provide health insurance. (See Loss of Eligibility By Dependents on page 58 for the date coverage will end.)

Please Note:

Some school districts may not offer domestic partner coverage or may offer same gender only coverage. Check with your school district's group administrator to determine if domestic partner coverage is available.

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

- Your natural child;
- Your spouse's or domestic partner's child, foster or adopted child;
- Children placed for adoption with you;
- Children of a covered dependent child, until the dependent child is no longer eligible under the plan; and
- Children related to you by blood or marriage for whom you are the legal guardian. You will need to provide a court order showing legal guardianship.

If you have a child who has sustained a disability rendering him/her physically or mentally incapable of self-support, that child may be eligible for insurance even though he or she is over 26 years old. To be eligible, the child must be unmarried and principally dependent on you for support. The incapacity must have arisen before the child's 26th birthday. You must provide us with a written physician's statement that confirms that these conditions existed continuously prior to the child's 26th birthday. Documentation of the child's medical condition must be reviewed and approved by the Plan's medical consultant. Periodic review by the medical consultant will also be required on an ongoing basis.

Dependents on active military status are not eligible.

Qualified Medical Child Support Order (QMCSO)

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

The effective date of coverage for a child added to the plan under a QMCSO is the date specified in the court order, or if none, the date of the court order.

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

NEW DEPENDENTS

If you marry while you are insured under this Plan, your spouse and his or her children are eligible to enroll as of the date of the marriage. A complete and signed application must be submitted within 31 days of the date of the marriage. (See "When Insurance Begins.") All dependents must meet eligibility requirements.

Your domestic partner is eligible if he or she meets the criteria on the Affidavit of Domestic Partnership supplied by your employer. The domestic partner and his or her dependents are eligible to enroll and must complete a signed application within 31 days of when you and your partner have met the requirements outlined in the affidavit. The effective date of the insurance will be the first of the month following approval of the application. All children must meet eligibility requirements.

Your newborn child or your covered dependent's newborn child will automatically be insured for 31 days after birth. To continue insurance, the insured employee must submit a complete and signed application within those 31 days listing the new child as a dependent. If we do not receive the application, insurance for the child will end 31 days following birth.

Adopted children are automatically insured for the first 31 days from the date of the adoption decree. If a child is placed with you pending the completion of adoption proceedings, that child will be insured for the first 31 days from the date of placement. To extend insurance beyond the first 31 days, the insured employee must submit a complete and signed application within those 31 days listing the child as a dependent.

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

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

Employee Eligibility

Those employees eligible for early retirement under ORS 243.303 and the eligibility rules of the Oregon Public Employees Retirement System (PERS), will be allowed to continue their OEA CHOICE Trust Medical Plan coverage after retirement as long as they apply within 60 days of retirement. Coverage may continue provided the member has been participating in the program for a minimum period of **24 consecutive months** immediately prior to their retirement. (An exception is made for those retirees whose district has been with the OEA CHOICE Trust program less than 24 months.) Benefits and coverage will be the same as for active employees.

Dependent Eligibility

If a dependent is carried on a member's insurance immediately prior to the member's retirement, the dependent is allowed to continue on the member's insurance during retirement. If a dependent does not enroll at the time of retirement, they lose their "Special Enrollment" rights and may not re-enroll in the plan. New eligible dependents acquired after an employee's retirement must be enrolled within 31 days of first becoming eligible to receive coverage, or they will not be able to enroll in the future.

When Retiree Eligibility Ends

Eligibility for a retiree will end on the last day of the monthly period in which he or she:

- Dies;
- Reaches age 65;
- Voluntarily terminates enrollment for him or herself and all enrolled dependents;
- Or, on the first of the month during which the retiree becomes eligible for Medicare.

A retiree and his or her spouse who voluntarily terminate coverage may not re-enroll.

Eligibility for a spouse will end on the last day of the monthly period in which:

- A decree of divorce is final (may then be eligible for COBRA continuation);
- He/she voluntarily terminates enrollment, either individually or through the retiree;

Eligibility for a dependent child will end on the last day of the monthly period in which the child:

- Is no longer eligible according to the terms of the contract;
- Voluntarily terminates enrollment, either individually or through the retiree.

Refer to Continuation of Coverage section of the Benefit Handbook for COBRA and portability information.

Medicare Supplement Program for Retirees

OEA CHOICE Trust has available to retirees a Medicare Supplement program. This program is designed to coordinate with Medicare coverage and is available to members when they reach age 65 and are eligible for Medicare. The member must be enrolled in both Parts A and B of Medicare and have been a participating member in an OEA CHOICE Trust Medical Plan for a period of 24 consecutive months. For information regarding this program, members may contact us at (503) 620-3822 or (800) 452-0914.

Enrollment

This section explains how to enroll under the Plan.

WHEN YOU FIRST BECOME ELIGIBLE

You must file a complete and signed application for yourself and any dependents you want insured within 31 days of when you become eligible to apply for insurance. Employees become eligible to apply on the day you are hired or the end of any required waiting period. File the application with your employer's payroll or personnel office.

You must notify your employer and the Plan whenever you change your address.

ENROLLING NEW DEPENDENTS

You may obtain insurance for newly acquired or newly eligible dependents by submitting a complete and signed application within 31 days of their eligibility. To continue insurance for newborn children, you must submit a complete and signed dependent application before the child is 31 days old. To continue insurance for an adopted child or a child placed for adoption, you must submit a complete and signed dependent application within 31 days of adoption or placement.

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

OPEN ENROLLMENT

If you do not enroll yourself and/or your eligible dependents within 31 days of first becoming eligible, you will be considered a "late enrollee" and must wait for the next Open Enrollment period to enroll. Open Enrollment occurs once a year at renewal. However, an eligible individual shall not be considered a late enrollee if he or she meets one of the exceptions under "Late Enrollee" on page 16, including eligibility under "Special Enrollment Rights" as described below.

SPECIAL ENROLLMENT RIGHTS

If you decline coverage for yourself or your dependent(s) when eligible to enroll because of other health coverage, you may enroll yourself or your dependent(s) in this plan outside of the open enrollment period provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

A. Mid-Year Loss of Other Coverage

For this special enrollment period to apply, an employee (or dependent of an employee) must be eligible for coverage but not be currently enrolled in the plan because of previous coverage under another group health plan (or through health insurance) at the time of the initial enrollment period. This special enrollment right is only available to current employees and their dependents. The following conditions apply to this provision:

- The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or individual;
- The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason enrollment was declined;

- The employee requests such enrollment not later than 31 days after the previous coverage ended; and
- One of the following events occurred:
 1. The employee's or dependent's prior coverage was under COBRA continuation provision and the coverage under such provision was exhausted, this includes reaching the lifetime maximum while on COBRA coverage;
 2. The employee's or dependent's prior coverage was terminated as a result of loss of eligibility for the coverage. Examples of when the coverage under a plan may be lost include:
 - legal separation or divorce;
 - loss of dependent status per plan terms;
 - death;
 - termination of employment;
 - reduction in the number of hours of employment;
 - reaching the lifetime maximum on all benefits;
 - the plan ceasing to offer coverage to a group of similarly situated individuals;
 - moving out of an HMO service area that results in termination of coverage and no other option is available under the plan;
 - termination of the benefit packet option, unless a substitute option is offered.
 3. The employer contributions toward the employee's or dependent's other coverage were terminated. (If employer contributions cease, the employee or dependent does not have to terminate coverage under the prior plan in order to be eligible for special enrollment.)

This special enrollment right, as described above, applies:

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

B. New Dependents

When an enrollee gains a new dependent through birth, marriage, domestic partnership, adoption or placement for adoption, special enrollment rights will allow for enrollment outside the open enrollment period, but only if special enrollment is requested within thirty-one (31) days after the event (e.g., marriage, domestic partnership, birth, adoption, or placement for adoption) that caused the enrollee to gain a new dependent. When such special enrollment rights are triggered, the following individuals are eligible to enroll in the plan:

- An employee who is eligible but not enrolled;
- The spouse or domestic partner of such employee; and
- The new dependent.

Note that when the employee, spouse/domestic partner and new dependent have special enrollment rights, other existing dependents do not.

When the new dependent results from marriage/domestic partnership, coverage is effective on the day of marriage or, for domestic partnership, on the first of the month following acceptance of the application. When the new dependent results from birth, coverage is effective on the date of birth. When the dependent results from an adoption or placement for adoption, coverage is effective on the date of the adoption or placement.

WHEN INSURANCE BEGINS

Insurance coverage begins for you and any enrolled dependents on the first day of the month following your date of hire. When the new dependent results from marriage, coverage is effective on the day of the marriage. When the new dependent results from domestic partnership, coverage is effective on the first of the month following the acceptance of the application. Newborn children are eligible to begin coverage on the date of their birth, adopted children or children placed for adoption are eligible to begin coverage on the date of adoption or placement, court ordered coverage is effective on the date specified by the court order, or if you are enrolled under a Collective Bargaining Agreement which states otherwise. The necessary premiums for your coverage must also be paid for insurance to become effective.

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

WHEN INSURANCE ENDS

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

A. Group Plan Termination

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

If the Group has not paid the premium by the premium due date, the Plan will issue a notice to the Group advising that if the premium is not received by the end of the grace period, the policy will be terminated. The notice will be issued at least 10 days prior to the end of the grace period, and will explain eligible employees' rights to continuation or portability coverage under federal and/or state law. If the policy is subsequently terminated due to nonpayment of premium, it is the duty of the Group to send the eligible employee notice of termination.

In the event the Group Policy is terminated for a reason other than nonpayment of premium and the Group does not replace the insurance, we will mail a notice of termination to the Group Policyholder. Group plan termination includes termination of an employer's participation in or termination of a multiple employer trust policy. Our notice will be mailed within 10 working days of the date of termination. The notice will explain your rights under federal and state law regarding portability, conversion and continuation of coverage. It is the responsibility of the group policyholder to send you the information contained in the notice.

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

B. Termination By Insured Employee

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

C. Death

If you die, insurance for your insured dependents ends on the last day of the month in which your death occurs. Note that your insured dependents may extend their insurance for up to 3 years if the requirements for continuation of coverage are met (see page 80 for details). The Group must notify us of any continuation of coverage and appropriate premiums must be paid along with the Group's regular monthly payment.

D. Dependent Survivor Benefits

If you die, insurance for your insured dependents ends on the last day of the monthly period in which your death occurs. However, your insured dependents may extend their insurance for up to 3 years, without premium, provided they are not enrolled in another group health insurance plan at the time of your death. This benefit will end at the earliest of the following dates: a) the date the covered person would cease to be your dependent if you were living; (b) the date your widowed spouse remarries; (c) the date the group policy terminates; and (d) the date on which your dependent(s) become eligible for other group health insurance coverage.

E. Loss of Eligibility

If your employment terminates, your insurance will end for you and your insured dependents on the last day of the month in which termination occurred, unless you choose to continue coverage through "COBRA" (see page 80 for details).

F. Family and Medical Leave

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

- You and your enrolled dependents will remain eligible for coverage during your FMLA leave.
- If you and/or your enrolled dependents elect not to remain enrolled during FMLA leave, you (and/or your enrolled dependents) will be eligible to reenroll under the Plan on the date you return from leave. To reenroll, you must submit a complete and signed application within 60 days of your return to work. All of the terms and conditions of the contract will resume at the time of reenrollment as if there had been no lapse in coverage. You will receive credit for any exclusion period served prior to the FMLA leave and you will not have to re-serve any group eligibility-waiting period under the Plan. However, you will receive no exclusion period credits for the period of the leave.
- Your rights under FMLA will be governed by that statute and its regulations.

G. Leave of Absence

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

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

H. Strike or Lockout

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

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

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

I. Termination of Employment

If your employment terminates, your insurance will end for you and all insured dependents on the last day of the month in which termination occurs, unless you choose to continue coverage (see page 80).

If you are laid-off by your employer and return to active work within six months of being laid off, you and any previously insured dependents may re-enroll under the Group Plan on the date you are rehired. Your coverage will begin on the date of rehire.

If you experience a reduction in hours that causes you to lose coverage, and within six months your hours increase and you again qualify for benefits, you and any previously insured dependents may re-enroll under the Group Plan on the date you qualify. Your coverage will begin on the first day of the month after you qualify.

All contract provisions will resume at the time you re-enroll whether or not there was a lapse in your insurance. Any exclusion period for pre-existing conditions that you did not complete at the time you were laid off or had a reduction in hours must be satisfied. However, the period of your layoff will be counted toward the exclusion period. At the time you re-enroll in the Plan, you do not have to re-serve any waiting period required by the Plan. All plan limits will resume as though you never left. For example, if you satisfied your calendar year deductible when your insurance ended and you re-enrolled within the same calendar year, you will not need to satisfy a new deductible.

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

J. Loss Of Eligibility By Dependent

A covered child will lose eligibility when he or she marries, reaches age 26, is no longer dependent on the eligible employee, or when the eligible employee is no longer legally required to provide insurance for the child. Coverage will end on the last day of the month in which the child's eligibility ends, unless the child continues coverage as provided under this Plan (see page 80).

Insurance ends for an insured spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), unless the divorced spouse continues coverage as provided under this Plan (see page 80).

Insurance ends for a domestic partner on the last day of the month in which the domestic partnership ends. A domestic partner may continue coverage as provided under this Plan (see page 80).

K. Coverage For Spouses Over Age 55

If a legal spouse is age 55 or older and his or her eligibility for insurance ends due to legal separation, termination of marriage or your death, the spouse will be entitled to continue his or her coverage (including coverage for dependent children) under this Plan. Continuation under this section is not available for any dependent electing coverage under the Continuation of Coverage section beginning on page 80.

In order to be eligible for continued coverage under this section, the spouse must give written notice of the legal separation, termination of marriage or your death to the Plan Administrator within:

- Thirty days of the date of your death;
- Sixty days of the date of legal separation; or
- Sixty days of the date of entry of the divorce decree.

Within 14 days of receipt of the above notice, the Plan Administrator shall notify the spouse that coverage can be continued, and provide an election form to the spouse. The spouse must return the election form within 60 days after the Plan Administrator mails it. Failure of the spouse to exercise the election within 60 days of the notification shall terminate the right to continued benefits under this section.

If the Plan Administrator fails to notify the spouse within the required 14 days, premiums shall be waived until the date notice is received by the spouse.

The monthly premium rate for continued coverage will be the monthly rate that would have been charged if the spouse was an Individual under this Plan plus the premium for coverage of dependent children, if any. Each monthly premium (except the initial premium) must be paid by the spouse to the Plan Administrator within 30 days of the premium due date. The initial premium must be paid by the spouse to the Plan Administrator within 45 days of the date the election to continue coverage is made.

Coverage will be continued until the earliest of:

- The date the spouse becomes covered under any other group health plan;
- The date the spouse becomes eligible for federal Medicare coverage;
- The last day of the month for which premiums were paid to us if coverage terminates due to non-payment of premiums; or
- The date the Plan terminates or the date the employer terminates participation under this Plan.

L. Uniformed Services Employment And Reemployment Rights Act (USERRA)

Coverage will terminate if an employee is called to active duty by any of the armed forces of the United States of America. However, if an employee requests to continue coverage under USERRA on or after December 10, 2004, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, if the employee pays any required contributions toward the cost of the coverage during the leave. Employees who request this benefit prior to December 10, 2004, are eligible for up to 18 months of continued coverage or the period of uniformed service leave, whichever is shortest. If the leave is 30 days or less, the contribution rate will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

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

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

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

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

M. Certificates of Creditable Coverage

Certificates of Creditable coverage will be issued when coverage ends, unless your employer has replaced your group coverage with a new insurance carrier, when COBRA coverage ends, and when an individual requests a certificate within two years of losing coverage.

N. Other

See "Health Insurance Continuation" section starting on page 80. See also "Individual Portability Plan" which begins on page 86.

Claims Administration & Payment

The following section explains how claims are administered.

SUBMISSION AND PAYMENT OF CLAIMS

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

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

A. Hospital Claims

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

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

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

- The name of the insured person who was treated;
- Your name and group and identification numbers;
- A description of the diagnosis or symptoms treated; and
- A description of the services and the dates on which they were provided.

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

B. Physician and Professional Provider Claims

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

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

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

C. Ambulance Claims

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

D. Explanation of Benefits (EOB)

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

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

E. Claim Inquiries

If you have any questions about how to file a claim, the status of a pending claim, or any action taken on a claim, please call us at (503) 620-3822 or toll-free at (800) 452-0914 or write to our Customer Service Department. We will respond to your inquiry within 30 days of receipt.

F. Plan Time Frames for Processing Claims

If your claim is denied, we will send an EOB to you with an explanation of the denial within 30 days after we receive your claim. If we need additional time to process your claim for reasons beyond our control, we will send a notice of delay to you explaining those reasons within 30 days after we receive your claim. We will then complete our processing and send an EOB to you within 45 days after we receive your claim. If we need additional information to complete our processing of your claim, our notice of delay will describe the information needed and the party responsible for providing the additional information will have at least 45 days to submit the additional information. Once we receive the additional information, we will complete our processing of the claim within 15 days. Submission of information necessary to process a claim is subject to the plan's claim submission period explained under Submission and Payment of Claims.

If the delay notice we send requests coordination of benefits information, we will issue an EOB within 44 days after receiving the claim.

If a service must be authorized for you to receive maximum plan benefits, we will respond to the authorization request within two business days. The response time will be expedited if the patient has an urgent medical condition.

GRIEVANCE AND APPEALS

A. Definitions

For purposes of this section, the following definitions apply:

Complaint means an expression of dissatisfaction about a specific problem encountered by an enrollee or about a decision by an insurer or an agent acting on behalf of OEA Choice Trust and that includes a request for action to resolve the problem or change the decision. A complaint does not include an inquiry.

Grievance means a written complaint submitted by or on behalf of an enrollee regarding:

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

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

Post-service claim means any claim for a benefit under a group health plan that is not a pre-service claim.

Pre-service claim means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A “**claim involving urgent care**” means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- (A) Could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function, or,
- (B) In the opinion of a physician with knowledge of the enrollee’s medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

B. Time Limit for Submitting Grievance and Appeals

If a written complaint is not submitted within the appropriate timeframes as outlined in this section, you will lose your rights to the grievance and appeals process. If you do not submit your written complaint on time, you may lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

You have **180 days** to submit a written grievance regarding an adverse determination. **An adverse determination** is a written notice from the Plan, in the form of a letter or an Explanation of Benefits (EOB), that has set forth the following:

- the specific reason or reasons for the benefit denial;
- the specific Plan provision on which the denial was based;
- a description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary; and
- appropriate information as to the steps to be taken if you wish to appeal the Plan Administrator’s determination, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim.

C. The Review Process

The Plan has a multi-level review process. The first level of review is called a Grievance. The second level of review is a First Level Appeal. You must exhaust these two levels of review before you can exercise your right to file a lawsuit in court under ERISA Section 502(a). The remaining review levels are voluntary and are not required prior to exercising your right to sue under ERISA Section 502(a).

However, if you are not satisfied with the outcome of the Grievance and First Level Appeal, you may request a Second Level Appeal. **If you are not satisfied with the outcome of the Second Level Appeal, and your complaint meets the specifications outlined under External Review, you may request that the complaint be reviewed by an independent review organization.** You will need to exhaust the Grievance and the First and Second Levels of Appeal to proceed to External Review, unless the Plan agrees otherwise. If you choose to enter into the voluntary levels of review described below, the Plan:

1. waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to any of the voluntary levels of review described below.
2. agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any appeal is pending in the voluntary review process described below.
3. will provide, upon request, information relating to the voluntary levels of review described below in order to enable you to make an informed decision whether to use these levels of review.

Note:

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

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

D. Grievance

If you have a **grievance**, you may submit it in writing to the Plan and ask for a review. If you need assistance on filing a grievance, contact our Customer Service at (503) 620-3822 or toll-free at (800) 452-0914 to discuss the issue as it may be possible to resolve it with a phone call. You may submit written comments, documents, records, and other information relating to the claim for benefits. Upon request, and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The Plan's response time to your grievance is based on the nature of the claim.

A grievance related to an **urgent care claim** will be entitled to expedited review upon request. The request may be made orally or in writing. A grievance related to an **urgent care claim** will be responded to not later than 72 hours after receipt of the grievance by the plan, unless the enrollee fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the Plan shall notify the enrollee as soon as possible, but no later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. The enrollee shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan shall notify the enrollee of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (a) the plan's receipt of the specified information, or (b) the end of the period afforded the enrollee to provide the specified additional information.

For all other claims, we will acknowledge receipt of the written grievance within 7 days of receipt and conduct an investigation. The grievance will receive a full investigation by persons who were not involved in the initial determination.

The investigation of a grievance of a **pre-service claim** will be completed within 15 days of receipt of the appeal.

The investigation of a grievance of a **post-service claim** will be completed within 30 days of receipt of the grievance.

When an investigation has been completed, you may expect a written notice of the disposition of your grievance, including the basis for the decision, along with information on your right to a First Level Appeal.

E. Appeals

If you disagree with our decision made in response to a grievance, you may appeal the decision. Your appeal must be made within 60 days of the date of our action on your initial grievance. You may also call our Customer Service Department at (503) 620-3822 or toll-free at (800) 452-0914 to discuss the issue as it may be possible to resolve your situation with a phone call.

First Level Appeal If you request a First Level Appeal, you should submit your appeal in writing. A First Level Appeal of an **urgent care claim** is subject to expedited review and time provisions described above with respect to grievances related to an **urgent care claim**. The Plan will acknowledge receipt of a written appeal, in writing, within 7 days. The Plan will conduct an investigation by persons who were not involved in the review of your grievance. Investigations and responses to your appeal will follow the same timelines outlined under the Grievance subsection. The Plan will keep you informed of the progress, including if additional time or investigation is required for a full and complete review. You will receive a written notice of the disposition of your appeal, including the basis for the decision, along with information on your right to a Second Level of Appeal.

Second Level Appeal If you disagree with our decision made in response to a First Level Appeal, you may voluntarily request a review of the decision by the OEA Choice Trust Board of Trustees. Your second appeal must be made in writing, within 60 days of the date of our action on your First Level Appeal. The Board will acknowledge receipt of a written appeal, in writing, within 7 days and conduct an investigation. The Board will keep the enrollee informed of the progress, including if additional time or investigation is required for a full and complete review. Within 30 days of receipt of the appeal, the Board will notify the enrollee in writing of the action taken.

You have the option to appear before the Board in person or by conference call or other appropriate technology. The Board will allow your representative to act on your behalf in the appeal process if you choose. Your appeal will be reviewed and a written decision will be sent out to you within 30 working days of its receipt, including the basis for decision, along with information on your right to file suit under ERISA 502(a).

F. External Review

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

1. The dispute must relate to an adverse decision on one or more of the following:
 - whether a course or plan of treatment is medically necessary;
 - whether a course or plan of treatment is experimental or investigational; or
 - whether a course or plan of treatment that a covered individual is undergoing is an active course of treatment for purposes of continuity of care under this Plan (see page 66 for additional information);
2. The enrollee must apply in writing for external review, and not later than the 180th day after receipt of the Plan's final written decision following the grievance and appeal process as described in this section;
3. The enrollee must sign a waiver granting the independent review organization access to the medical records of the enrollee;
4. The enrollee must have exhausted the grievance and appeal process described in this section. However, the Plan may waive the requirement of compliance with exhausting the process and have a dispute referred directly to the external review upon the enrollee's consent; and
5. An enrollee who applies for external review of an adverse decision shall provide complete and accurate information to the independent review organization in a timely manner.

The Plan agrees to be bound by the decision of the independent review organization with respect to whether a course or plan of treatment is medically necessary, notwithstanding the definition of medical necessity in the plan; whether a course or plan of treatment is experimental or investigational; or whether a course or plan of treatment that a covered individual is undergoing is an active course of treatment for purposes of continuity of care under this Plan (see page 66 for additional information).

G. Additional Enrollee Rights

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

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

or through the Internet at <http://www.cbs.state.or.us/external/ins/>

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

CONTINUITY OF CARE

A. Continuity of Care

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

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

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

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

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

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

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

The Plan will not provide continuity of care if the enrollee leaves the Plan or if the policyholder discontinues the plan in which the enrollee is enrolled.

B. Length of Continuity of Care

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

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

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

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

C. Notice Requirement

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

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

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

BENEFITS AVAILABLE FROM OTHER SOURCES

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

A. Coordination of Benefits (COB)

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

B. Third-Party Liability

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

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

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

Definitions:

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

1. "Covered Individual" means an individual covered by us, including a dependent of a Member/Insured. "Covered Individual" also includes the estate, heirs, guardian or conservator of the individual for whom benefits have been paid or may be paid by us, and includes any trust established for the purpose of receiving "Recovery Funds" and paying for the future income, care or medical expenses of such individual.
2. "Benefits" means any amount paid by us, or submitted to us for payment to or on behalf of the Covered Individual. Bills, statements or invoices submitted to us by a provider of services, supplies or facilities to or on behalf of a Covered Individual are considered requests for payment of "Benefits" by the Covered Individual.

3. "Third Party Claim" means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a Third Party (or any right to assert the foregoing) by or on behalf of a Covered Individual, regardless of the characterization of the claims or damages of the Covered Individual, and regardless of the characterization of the Recovery Funds. (For example, a Covered Individual who has received payment of medical expenses from us, may file a Third Party claim against the party responsible for the Covered Individual's injuries, but only seek the recovery of non-economic damages. In that case, we are still entitled to recover Benefits as described herein.)
4. "Third Party" means any individual or entity responsible for the injury or illness, or the aggravation of an injury or illness, of the Covered Individual. "Third Party" includes any insurer of such individual or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the Covered Individual including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, PIP coverage, and workers' compensation insurance.
5. "Recovery Funds" means any amount recovered from a Third Party.

Subrogation

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

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

Right of Recovery

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

1. The Covered Individual holds any rights of recovery against the Third Party in trust for us, but only for the amount of Benefits we paid for that illness or injury.
2. We are entitled to receive the amount of Benefits we have paid for that illness or injury out of any settlement or judgment which results from exercising the right of recovery against the Third Party. This is so regardless of whether the Third Party admits liability or asserts that the Covered Individual is also at fault. In addition, we are entitled to receive the amount of Benefits we have paid whether the health care expenses are itemized or expressly excluded in the Third Party recovery.
3. If, and only if, we ask the Covered Individual, and his or her attorney, to protect our reimbursement rights under this sub-section, then the Covered Individual may subtract from the money to be paid back to us, as an expense for collecting from the other party, a proportionate share of reasonable attorney fees.
4. We may ask the Covered Individual to sign an agreement to abide by the terms of this Right of Recovery sub-section. If we elect to proceed under this sub-section we will not be required to pay benefits for the illness or injury until the agreement is properly signed and returned.

5. This right of recovery includes the full amount of the Benefits paid, or pending payment by us, out of any recovery made by the Covered Individual from the Third Party, including, without limitation, any and all amounts from the first dollars paid or payable to the Covered Individual (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or medical expenses of the Covered Individual), regardless of the characterization of the recovery, whether or not the Covered Individual is made whole, or whether or not any amounts are paid or payable directly by the Third Party, an insurer or another source. Our recovery rights will not be reduced due to the Covered Individual's own negligence.
6. If it is reasonable to expect that the Covered Individual will incur future expenses for which Benefits might be paid by us, the Covered Individual shall seek recovery of such future expenses in any Third Party Claim.

Additional Third Party Liability Section Provisions

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

- a. If the Covered Individual seeks payment by us of any Benefits for which there may be a Third Party Claim, the Covered Individual shall notify us of the potential Third Party Claim. The Covered Individual has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to us by a Provider to the Covered Individual.
- b. Upon request from us, the Covered Individual shall provide to us all information available to the Covered Individual, or any representative, or attorney representing the Covered Individual, relating to the potential Third Party Claim. The Covered Individual and his or her representatives shall have the obligation to notify us in advance of any claim (written or oral) and/or any lawsuit made against a Third Party seeking recovery of any damages from the Third Party, whether or not the Covered Individual is seeking recovery of Benefits paid by us from the Third Party.
- c. In order to receive an advance payment of Benefits pursuant to this Section, we require that any Covered Individual seeking payment of Benefits by us, and if the Covered Individual is a minor or legally incapable of contracting, then the Covered Person's parent or guardian, must fill out, sign and return to our office a Third-Party Recovery Questionnaire and Agreement that includes a questionnaire about the accident and the potential Third-Party claim. If the Covered Individual has retained an attorney to represent the Covered Individual with respect to a Third-Party Claim, then the attorney must sign the Third-Party Recovery Agreement, acknowledging the obligations described in that Agreement.
- d. The Covered Individual shall cooperate with us to protect our recovery rights under this Section, and in addition, but not by way of limitation, shall:
 - i. Sign and deliver such documents as we reasonably require to protect our rights;
 - ii. Provide any information to us relevant to the application of the provisions of this Section, including medical information (including doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments; and
 - iii. Take such actions as we may reasonably request to assist us in enforcing our right to be reimbursed from Third Party recoveries.

- e. By accepting the payment of benefits by us, the Covered Individual agrees that we have the right to intervene in any lawsuit or arbitration filed by or on behalf of a Covered Individual seeking damages from a Third Party.
- f. The Covered Individual agrees that we may notify any Third Party, or Third Party's representatives or insurers of our recovery rights set forth herein.
- g. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of this Section.
- h. This Section applies to any Covered Individual for whom advance payment of Benefits is made by us whether or not the event giving rise to the Covered Individual's injuries occurred before the individual became covered by us.
- i. If the Covered Individual continues to receive medical treatment for an illness or injury after obtaining a settlement or recovery from a Third Party, we will provide Benefits for the continuing treatment of that illness or injury only to the extent that the Covered Individual can establish that any sums that may have been recovered from the Third Party for the continuing medical treatment have been exhausted for that purpose.
- j. If the Covered Individual or the Covered Individual's representatives fail to do any of the foregoing acts at our request, then we have the right to not advance payment of Benefits or to suspend payment of any Benefits for or on behalf of the Covered Individual related to any sickness, illness, injury or medical condition arising out of the event giving rise to, or the allegations in, the Third Party Claim. In exercising this right, we may notify medical providers seeking authorization or pre-authorization of payment of Benefits that all payments have been suspended, and may not be paid.
- k. Coordination of Benefits, where the Covered Individual has healthcare coverage under more than one Plan or health insurance policy, is not considered a Third Party Claim.
- l. If any term, provision, agreement or condition of this Section is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

C. Motor Vehicle Insurance

We will not pay benefits for health care costs that are actually paid or would have been paid by motor vehicle insurance. This means that in the event that a Covered Individual, including an insured dependent, who does not carry motor vehicle insurance as required by state law, that this Plan will estimate the amount of Personal Injury Protection that would have been paid and reduce its benefits based on the estimate. But we will pay expenses over the amount covered by the motor vehicle insurance, subject to the Third Party Recovery Section above. If we have paid benefits first, we are entitled to any reimbursement from the motor vehicle insurer, under the Third Party Recovery Section above.

You must give us information about any medical insurance payments available to the Covered Individual or the Covered Individual's insured dependents.

MEDICARE

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

Coordination of Benefits

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

DEFINITIONS

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

Plan means any of the following coverages, including Plan coverages which provide benefit payments or services to an insured person for hospital, medical, surgical or dental care:

- Group, blanket or franchise insurance (except student accident insurance);
- Prepayment coverage on a group basis, including HMO (Health Maintenance Organization) coverage;
- Coverage under a labor-management trusteeship plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Coverage under government programs, other than Medicaid, and any other coverage required or provided by law; or
- Other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type hospital indemnity coverage, Plan also means that amount of indemnity benefits that exceeds \$100 a day.

Each contract or other arrangement for coverage described above is a separate Plan.

Claimant means the insured person for whom the claim is made.

Claim Period means part or all of a calendar year during which the claimant is insured under the Plan.

An **Allowable Expense** means any expense which is covered by at least one Plan during a Claim Period. Where a Plan provides benefits in the form of a service rather than cash payments, the cash value of the service during a Claim Period will also be considered an Allowable Expense.

This Plan is the part of this group contract that provides benefits for healthcare expenses.

HOW COB WORKS

If the claimant is covered by another Plan or Plans, the benefits under this Plan and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, then the other Plan(s) pay(s).

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

The Secondary Plan (the Plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the Primary Plan will not exceed the greater of:

- 100% of total Covered Expense; or
- The amount of benefits it would have paid had it been the Primary Plan.

WHICH PLAN PAYS FIRST?

When another Plan does not have a COB provision, that Plan is primary, and therefore determines and pays its benefits first. When another Plan does have a COB provision, the first of the following rules that applies will govern:

- **Non-dependent/Dependent.** If a Plan covers the claimant as an employee, member or non-dependent, then that Plan will determine its benefits before a Plan which covers the person as a dependent.
- **Dependent Child/Parents Not Separated or Divorced.** If the claimant is a dependent child whose parents are not divorced or separated and the claimant is eligible for benefits under both parents' plans, then the Plan of the parent whose birthday falls earlier in the calendar year will determine its benefits before the Plan of the parent whose birthday falls later in that year. If both parents' birthdays are on the same day, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. If another Plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that Plan's COB rule will determine the order of benefits.
- **Dependent Child/Separated or Divorced Parents.** If two or more plans cover the claimant as a dependent child of divorced or separated parents, then the following rules apply:
 - First the Plan of the parent with custody of the child, then the Plan of the spouse of the parent with custody of the child, and finally the Plan of the parent without custody.
 - However, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of the benefits, this rule is ignored.
- **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or non-dependent longer are determined before those of the plan which covered that person for the shorter time.

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

CREDIT SAVINGS

Where the Plan does not have to pay its full benefits because of COB, the savings will be credited to the claimant for the Claim Period. These savings would be applied to any unpaid Allowable Expense during the Claim Period.

COB AND PLAN LIMITS

If COB reduces the benefits payable under more than one Plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those Plan provisions.

OUR RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, the claimant must give the insurer any information which is needed to coordinate benefits. With the claimant's consent, the insurer may release to or collect from any person or organization any needed information about the claimant.

FACILITY OF PAYMENT

If benefits that this Plan should have paid are instead paid by another Plan, this Plan may reimburse the other Plan. Amounts reimbursed are policy benefits and are treated like other policy benefits in satisfying policy liability.

RIGHT OF RECOVERY

If this Plan pays more for an Allowable Expense than is required by this provision, the excess payment may be recovered from:

- The claimant;
- Any person to whom the payment was made; or
- Any insurance company, service plan or any other organization which should have made payment.

CORRECTION OF PAYMENTS

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

If we make payments that should have been made by another plan, we will have the right to recover them from the person to or for whom they were made, or from insurance companies or other organizations. The person involved must sign any documents that are necessary to enforce our rights under this provision.

General Plan Information

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

REQUEST FOR INFORMATION

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

DISCLOSURE OF BENEFIT REDUCTION

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

CONFIDENTIALITY OF MEMBER INFORMATION

The confidentiality of your protected health information is of extreme importance to the Plan. Your protected health information includes, but is not limited to enrollment, claims, and medical and dental information. We use your information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. We do not sell your information. For more complete detail about how the Plan uses your information, please refer to the Notice of Privacy Practices. A copy of the notice is available on our website at www.oechoice.com or by calling the Plan at 503-620-3822.

TRANSFER OF BENEFITS

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

RECOVERY OF BENEFITS PAID BY MISTAKE

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

CONTRACT PROVISIONS

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

REPLACING ANOTHER PLAN

If this Plan replaces an earlier group plan, we will apply benefits and deductibles as follows:

- Except as provided for pre-existing conditions, we will apply the benefits under this Plan reduced by any benefits payable by the prior plan, subject to other provisions of this Plan relating to termination of coverage. This provision does not apply to any individual excluded under this Plan because the individual is otherwise covered under another policy with similar benefits.
- In the case of pre-existing conditions, we will apply the benefits available under the prior plan reduced by any benefits actually paid or payable by the prior plan.
- In either case, this Plan shall give credit for the satisfaction or partial satisfaction for any deductibles actually paid under the prior plan for the same or overlapping benefit periods with this Plan, but the credit shall apply or be given only to the extent that the expenses are recognized under the terms of this Plan and are subject to a similar deductible provision.

RESPONSIBILITY FOR QUALITY OF MEDICAL CARE

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

WARRANTIES

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

GUARANTEED RENEWABILITY

Insurers in the group health market are required to renew coverage at the option of the Plan Sponsor. Coverage may only be discontinued or non-renewed:

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

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

NO WAIVER

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

GROUP IS THE AGENT

The Group is your and your enrolled dependents' agent for all purposes under this contract. The Group is not the agent of ODS.

GOVERNING LAW

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

WHERE ANY LEGAL ACTION MUST BE FILED

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

TIME LIMIT FOR FILING A LAWSUIT

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

EVALUATION OF NEW TECHNOLOGY

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

Health Insurance Continuation (COBRA)

EXPLANATION OF BENEFIT

IMPORTANT NOTICE

The following section on continuation of coverage (COBRA) may apply to you. Please check with your employer's benefits manager to find out whether you qualify for this coverage. Both you and your spouse/domestic partner should read this notice carefully.

INTRODUCTION

OEA Choice Trust will provide benefits only to those qualified beneficiaries who elect coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), subject to the following limitations: (i) The Plan will offer no greater COBRA rights than the COBRA statute requires; (ii) The Plan will not be responsible for COBRA coverage if the covered employee or other qualified beneficiary does not comply with any of the notice, election or other requirements outlined below; and (iii) The Plan will not be responsible for COBRA coverage if the Plan Administrator has not distributed election notices and COBRA election forms within the required time periods, or if the Plan Administrator otherwise fails to comply with any of the requirements outlined below.

On behalf of your employer, we have set forth the following summary of your rights and obligations, and the obligations of the Plan Administrator, with respect to COBRA coverage. Note: the Plan Administrator will typically be the employer.

COBRA is a federal law requiring most employer-sponsored group health plans to offer qualified beneficiaries the opportunity to elect a temporary extension of health insurance coverage if coverage is lost due to a qualifying event (see below). A qualified beneficiary is someone who is covered under the Plan the day before a qualifying event and can include the covered employee (or retired employee), the covered employee's spouse/domestic partner, and the dependent children of the covered employee.

A covered employee or the spouse/domestic partner may elect continuation coverage for eligible family members. However, each family member has an independent right to elect COBRA coverage. This means that a spouse/domestic partner or child may elect continuation coverage even if the employee does not.

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

QUALIFYING EVENTS

A. Employee

As an employee covered by this Plan, you may elect continuation coverage if you lose coverage because of termination of employment (other than termination for gross misconduct on your part), a reduction in hours, or, if you are a retiree, your employer files for reorganization under Chapter 11 of the bankruptcy code.

B. Spouse or Domestic Partner

If you are the spouse or domestic partner of an employee (or of a retiree for reason 5 below) covered by the Plan, you have the right to choose continuation coverage for yourself if you lose coverage for **any** of the following six qualifying Events:

- (1) The death of your spouse or domestic partner ;
- (2) The termination of your spouse's or domestic partner's employment (for reasons other than gross misconduct) or reduction in your spouse's or domestic partner's hours of employment with the Policyholder;
- (3) Divorce or legal separation from your spouse;
- (4) Termination of domestic partnership;
- (5) Your spouse or domestic partner becomes entitled to Medicare; or
- (6) Your spouse's or domestic partner's employer files for Chapter 11 reorganization.

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

C. Children

A dependent child of an employee (or of a retiree for reason 6 below) covered by the Plan, has the right to continuation coverage if coverage is lost for **any** of the following six qualifying events:

- (1) The death of the employee parent;
- (2) The termination of the employee parent's employment (for reasons other than gross misconduct) or reduction in an employee parent's hours of employment with the Policyholder;
- (3) Parents' divorce or legal separation or termination of domestic partnership;
- (4) Employee parent becomes entitled (that is, covered) under Medicare;
- (5) The dependent ceases to be a "dependent child" under the Plan; or
- (6) The employee parent's employer files for Chapter 11 reorganization.

OTHER COVERAGE

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

NOTICE REQUIREMENTS

Qualifying Event Notice. The Plan provides that your family member's coverage terminates as of the last day of the month in which a divorce or legal separation occurs (spouse's coverage is lost), termination of domestic partnership (domestic partner's coverage is lost), or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the employee or a family member has the responsibility to notify the Plan Administrator if one of these events occurs by mailing or hand-delivering a written notice to the Plan Administrator. The notice must include the following information: 1) The name of the employer for this plan; 2) the name and social security number of the enrollee(s); 3) The affected beneficiary(ies); 4) The event (i.e., divorce); and 5) The date the event occurred. Notice must be given no later than 60 days after the loss of coverage under the Plan. When the Plan Administrator receives timely notice, you, your spouse or domestic partner, and/or dependent child will be notified of your right to continuation coverage within 14 days after the Plan Administrator receives notice. If notice of the event is not timely given, continuation coverage will not be available.

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

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

LENGTH OF CONTINUATION COVERAGE

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

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

36-Month Continuation Period.

In the case of losses of coverage due to an employee's death, divorce or legal separation, termination of domestic partnership, a dependent child ceasing to be a dependent under the terms of the Plan, or the bankruptcy of the Policyholder (applies to retiree plans only), coverage under the Plan may be continued for up to a total of 36 months.

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

EXTENDING THE LENGTH OF COBRA COVERAGE

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

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

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

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

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

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

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

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

Note: Longer continuation coverage may be available under Oregon Law for an employee's spouse age 55 and older who loses coverage due to the employee's death, or due to legal separation or divorce. See page 58 for details.

NEWBORN OR ADOPTED CHILD

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

SPECIAL ENROLLMENT AND OPEN ENROLLMENT

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

WHEN CONTINUATION COVERAGE ENDS

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

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes to Medicare benefits (under Part a, Part B, or both) after electing COBRA;

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

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

When COBRA continuation coverage ends, you and/or your insured dependents *may* be eligible to enroll in an individual portability plan provided by the Plan.

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

TRADE ACT OF 2002

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

A. Second Election Period for Certain Trade-Displaced Individuals

Certain covered employees who did not elect COBRA coverage are entitled to elect COBRA coverage during a special second election period. Covered employees who are eligible to make a COBRA election during this special second election period (Trade Adjustment Assistance (TAA) Eligible Employees) must satisfy each of the following requirements:

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

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

B. Duration of COBRA Coverage Elected During the Special Second Election Period

COBRA coverage elected during the special second election period is not retroactive – coverage commences on the day that the special second election period began, and the maximum COBRA coverage period will terminate on the same day that it would have terminated if COBRA coverage had been elected during the regular 60-day election period.

C. COBRA Tax Credit

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

Individual Portability Insurance

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

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

ELIGIBILITY FOR PORTABILITY COVERAGE

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

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

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

Domestic partners are not eligible dependents under a portability health plan. Domestic partners who otherwise meet the eligibility criteria above will need to enroll in a Portability plan as a subscriber. A domestic partner will not be able to enroll in a portability plan as the former employee's dependent.

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

PURPOSE OF PORTABILITY

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

ISSUANCE AND RENEWABILITY

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

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

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

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

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

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

You may select COBRA or State Continuation (whichever applies to your group situation) or select Portability.

Please Note:

If you choose Portability rather than COBRA or State Continuation, you will not be eligible to select COBRA or State Continuation at a later date. (COBRA is for employee groups of 20 or more. State Continuation is for employee groups consisting of less than 20 employees.)

PORTABILITY OPTIONS

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

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

The Plan offers two options for portability coverage:

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

Please contact the Plan's Portability Coordinator at (503) 219-3664 in the Portland area or toll-free 1-888-393-2940 for further information regarding the Prevailing and Low Cost Plans.

ERISA Duties

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”).

INFORMATION ABOUT YOUR PLAN AND BENEFITS

- You may examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, collective bargaining agreements (if applicable), updated summary plan description, 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 (if any). This information can be obtained by written request. The Plan Administrator may make a reasonable charge for the copies.
- You are entitled to receive a summary of the Plan’s annual financial report, if any is required by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUATION OF GROUP HEALTH PLAN COVERAGE

You are entitled to continue healthcare 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 COBRA continuation coverage rights (if applicable to your plan).

You are entitled to reduction or elimination of exclusionary periods of coverage for 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 COBRA continuation coverage, when your COBRA continuation coverage ceases, upon request before loss of coverage, or upon request up to 24 months after loss of coverage. Without evidence of creditable coverage, you may be subject to exclusion periods under the Plan.

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 this Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants.

No one, including the Employer or any other person, may fire you or discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a benefit is denied or no action is taken, in whole or in part, you have a right to receive an explanation, to obtain without charge copies of documents relating to the decision, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in 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 Plan Administrator. If you have a claim for benefits which is denied or no action is taken, in whole or in part, you may file suit in state or Federal court (see Grievance and Appeals for additional information). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If 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 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, (e.g., if it finds your claim is frivolous).

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the Employee Benefits Security Administration, U.S. Department of Labor, 1111 Third Avenue, Room 860, Seattle, Washington, 98101, Telephone (206) 553-4244, or the Office of Participant Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Patient Protection Act

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

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

Enrollees have the right to:

- Be treated with respect and recognition of their dignity and need for privacy.
- Have access to urgent and emergency services, 24 hours a day, 7 days a week.
- Know what their rights and responsibilities are. Enrollees will be given information about their health plan and how to use it. Enrollees will be given information about the physicians and providers who will care for them. This information will be provided in a way that enrollees can understand.
- Participate in decision making regarding their healthcare.
- Refuse care. Enrollees have the right to be advised of the medical result of their refusal.
- Receive services as described in their plan booklets.
- Have their medical and personal information remain private. Personal information will be handled in compliance with state and federal law, and will be given to third parties only as necessary to administer the plan, as required by law, or as permitted by the enrollee.
- Change to a new Primary Care Physician (PCP) up to two times in a 12-month period. (Not all plans require enrollees to choose a PCP.)
- File a complaint or appeal about any aspect of the plan. Enrollees have a right to a timely response to their complaint or appeal. Enrollees are welcome to make suggestions to the plan.
- Enrollees have the right to have a statement of wishes for treatment on file with your physician. A statement of wishes for treatment is known as an Advanced Directive. Enrollees also have the right to have a power of attorney filed. A power of attorney allows the enrollee to give someone else the right to make healthcare choices when the enrollee is unable to make these decisions.

Enrollees have the responsibility to:

- Read the plan booklet to make sure they understand the plan. Enrollees are advised to call Medical Customer Service Department with any questions.
- Select a PCP for those plans that require it.
- Treat all physicians and providers and their staff with courtesy and respect.
- Provide all the information needed for their physician or provider to provide good healthcare.
- Participate in making decisions about their medical care and forming a treatment plan.
- Follow instructions for care they have agreed to with their physician or provider.
- To the extent required by the plan, seek medical services only from their PCP.
- If required by the plan, obtain approval from their PCP before going to a specialist.
- Present their medical identification card when seeking medical care.
- Notify physicians and providers of any other insurance policies that may provide coverage.
- Reimburse OEA Choice Trust from any third party payments you may receive.

- Keep appointments and be on time. If this is not possible, enrollees must call ahead to let the physician or provider know they will be late or cannot keep their appointment.
- Seek regular health checkups and preventive services.
- Provide adequate information to the plan to properly administer benefits and resolve any issues or concerns that may arise.

If you have any questions about these rights and responsibilities, please call the Customer Service Department at (503) 620-3822 or toll-free at (800) 452-0914.

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

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

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

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

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

You can file a grievance or appeal by contacting our Customer Service Department at (503) 620-3822, or toll-free at (800) 452-0914, or by writing a letter to OEA Choice Trust, (P.O. Box 23600, Tigard, Oregon 97281-3600). See the booklet section titled “Grievance and Appeals” for complete information.

You may also contact the Oregon Insurance Division:

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

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

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

Prior authorization, also known as service authorization, is the process we use to determine whether a service is covered under the plan (including whether it is medically necessary) prior to the service being rendered. Contact our customer service department at (503) 620-3822, or toll-free at (800) 452-0914 for a list of services that require service authorization. Many types of treatment may be available for certain conditions; the service authorization process helps determine which treatment is covered under the plan.

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

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

For a written summary of information that may be included in our utilization review of a particular condition or disease, call the customer service at (503) 620-3822, or toll-free at (800) 452-0914.

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

The Plan protects your information in several ways:

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

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

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

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

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

8. How can non-English speaking members get information about the plan?

Call our customer service department at (503) 620-3822, or toll-free at (800) 452-0914. One of our representatives will coordinate the services of an interpreter over the phone.

9. What additional information can I get upon request?

The following documents are available by calling a medical customer service representative:

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

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

The following information regarding the health benefit plans of OEA Choice Trust is available from the Oregon Insurance Division:

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

Contact:

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



PO Box 23600, Tigard, OR 97281-3600
(503) 620-3822 - (800) 452-0914



www.oeachoice.com

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