Benefits for Healthcare Coverage

The 2022 Oregon Benchmark Plan

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INTRODUCTION

The Oregon Benchmark Plan serves as a baseline for the minimum scope of benefits that most health benefit plans sold in Oregon's individual and small group markets must cover at equal or greater value. This plan document defines Oregon's Essential Health Benefits (EHB) Base Benchmark plan for plan years beginning on or after January 1, 2022.

To the extent the Oregon Benchmark Plan does not comply with current federal requirements, individual and small-group market issuers in Oregon may need to conform plan benefits to meet applicable EHB requirements when designing plans that are substantially equal to the EHB-benchmark Plan.

Consistent with federal guidance under 45 CFR § 156.110, this base benchmark plan will be supplemented with (1) the pediatric dental benefits described in the Dental Plan of the Oregon Health Plan Children's' Health Insurance Plan and (2) the pediatric vision benefits described in the vision provisions of the Federal Employee Dental and Vision Insurance Plan Blue Vision High Option.

Oregon will use the approach outlined in 45 CFR §156.122 for determining EHB drug benefits. EHB plans may design their own drug formularies but must cover the same number of prescription drugs in each United States Pharmacopeia (USP) category and class as the benchmark plan and, at a minimum, at least one drug in every USP category and class.

The State of Oregon has not included any additional EHB benefits pursuant to 45 CFR 155.170.

Nothing in this 2022 Benchmark plan should be construed as additional EHB requirements under Federal Law. At no time shall the set of benefits listed below be construed to allow an issuer to NOT cover any and all federal and state required benefits.

COVERED EXPENSES

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

Some medically necessary services and supplies may be excluded from coverage under this plan. Be sure you read and understand the Benefit Limitations and Exclusions section of this book, including the section on Preauthorization.

Medical Necessity

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

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

Healthcare Providers

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

Your Annual Out-of-Pocket Limit

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

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

PLAN BENEFITS

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

PREVENTIVE CARE SERVICES

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

- **Routine physicals** for members age 22 and older according to the following schedule:

  – Ages 22-34 One exam every four years

  – Ages 35-59 One exam every two years

  – Ages 60 and over One exam every year

  Only laboratory work tests and other diagnostic testing procedures related to the routine physical exam are covered by this benefit. Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a routine physical examination are not covered by this preventative care benefit. Please see Outpatient Services in this section.

- **Well woman visits**, including the following:

  − One **routine gynecological exam** each calendar year for women 18 and over.

Exams may include Pap smear, pelvic exam, breast exam, blood pressure check, and weight check. Covered lab services are limited to occult blood, urinalysis, and complete blood count.

- **Routine preventive mammograms** for women as recommended.
  - The deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for 'Preventive Care - Well Woman Visits' applies to mammograms that are considered 'routine' according to the guidelines of the U.S. Preventive Services Task Force.
  - The deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for 'Outpatient Services - Diagnostic and Therapeutic Radiology and Lab' applies to diagnostic mammograms related to the ongoing evaluation or treatment of a medical condition.
- **Pelvic exams and Pap smear exams** at any time upon referral of a women's healthcare provider; and pelvic exams and Pap smear exams annually for women 18 to 64 years of age with or without a referral from a women's healthcare provider.
- **Breast exams** annually for women 18 years of age or older or at any time when recommended by a women's healthcare provider for the purpose of checking for lumps and other changes for early detection and prevention of breast cancer.

- **Colorectal cancer screening** exams and lab work including the following:
  - A fecal occult blood test
  - A flexible sigmoidoscopy
  - A colonoscopy
    - The deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for 'Preventive Care - Routine Colonoscopy' applies to colonoscopies that are considered 'routine' according to the guidelines of the U.S. Preventive Services Task Force.
    - The deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for 'Professional Services - Surgery' and for 'Outpatient Services - Outpatient Surgery/Services' apply to colonoscopies related to ongoing evaluation or treatment of a medical condition.)
  - A double contrast barium enema
- **Prostate cancer screening,** including digital rectal examination and a prostate-specific antigen test.
- **Well baby/child care exams**, for members age 21 and younger according to the following schedule:
  - At birth: One standard in-hospital exam
  - Ages 0 - 2: 12 additional exams during the first 36 months of life
  - Ages 3 - 21: One exam per year

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

- Standard age-appropriate childhood and adult **immunizations** for primary prevention of infectious diseases as recommended by and adopted by the Centers for Disease Control and Prevention, American Academy of Pediatrics, American Academy of Family Physicians, or similar standard-setting body. Benefits do not include immunizations for more elective, investigative, unproven, or discretionary reasons (e.g. travel). Covered immunizations include, but may not be limited to the following:
  - Diphtheria, pertussis, and tetanus (DPT) vaccines, given separately or together
  - Hemophilus influenza B vaccine
  - Hepatitis A vaccine
  - Hepatitis B vaccine
  - Human papillomavirus (HPV) vaccine
  - Influenza vaccine
  - Measles, mumps, and rubella (MMR) vaccines, given separately or together
  - Meningococcal (meningitis) vaccine
  - Pneumococcal vaccine
  - Polio vaccine
  - Varicella (chicken pox) vaccine

- **Tobacco use cessation program services** are covered only when provided by an approved program. Approved programs are covered at 100% of the cost up to a maximum lifetime benefit of two quit attempts. Specific nicotine replacement therapy will only be covered according to the program's description. Tobacco use cessation program will be covered to the same extent this policy covers other prescription medications.

- Any plan deductible, co-payment, and/or co-insurance amounts stated in your Medical Benefit Summary are waived for the following recommended preventive care services when provided by a participating provider:
  - Services that have a rating of "A" or "B" from the U.S. Preventive Services Task Force (USPSTF);
  - Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
  - Preventive care and screening for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA);
  - Preventive care and screening for women supported by the HRSA that are not included in the USPSTF recommendations.

A and B list for preventive services can be found at:
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations

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

PROFESSIONAL SERVICES

This plan covers the following professional services when medically necessary:

- Services of a **physician** (M.D. or D.O.) for diagnosis or treatment of illness or injury
- Services of a licensed **physician assistant** under the supervision of a physician
- Services of a certified **surgical assistant, surgical technician, or registered nurse** (R.N.) when providing medically necessary services as a surgical first assistant during a covered surgery
- Services of a **nurse practitioner**, including certified registered nurse anesthetist (C.R.N.A.) and certified nurse midwife (C.N.M.), for medically necessary diagnosis or treatment of illness or injury
- **Urgent care services** provided by a physician. 'Urgent care' means services for an unforeseen illness or injury that requires treatment within 24 hours to prevent serious deterioration of a patient's health. Urgent conditions are normally less severe than medical emergencies. Examples of conditions that could need urgent care are sprains and strains, vomiting, cuts, and severe headaches.

- **Outpatient habililitative services** provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide physical, occupational, or speech therapy. Services must be prescribed in writing by a licensed physician, dentist, podiatrist, nurse practitioner, or physician assistant. The prescription must include site, modality, duration, and frequency of treatment. Total covered expenses for outpatient rehabilitative services is limited to a combined maximum of 30 visits per calendar year subject to preauthorization and concurrent review for medical necessity. Only treatment of neurologic conditions (e.g. stroke, spinal cord injury, head injury, pediatric neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which rehabilitative services would be appropriate) may be considered for additional benefits, not to exceed 30 visits per condition, when criteria for supplemental services are met.

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

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

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

- Services of a physician or a licensed certified nurse midwife for **pregnancy**. Services are subject to the same payment amounts, conditions, and limitations that apply to similar expenses for illness..

- **Routine nursery care** of a newborn while the mother is hospitalized and eligible for pregnancy-related benefits under this plan if the newborn is also eligible and enrolled in

this plan.

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

HOSPITAL AND SKILLED NURSING FACILITY SERVICES

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

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

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

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

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

childbirth, your provider does not need to preauthorize your hospital stay.

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

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

OUTPATIENT SERVICES

This plan covers the following outpatient care services:

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

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

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

  Emergency room charges for services, supplies, or conditions excluded from coverage under this plan are not eligible for payment. Please see the Benefit Limitations and Exclusions section of this handbook.
- **Surgery** and other outpatient services. Benefits are based on the setting where services are performed.
  - For surgeries or outpatient services performed in a physician's office, the benefit stated in your Medical Benefit Summary for Professional Services - Office Procedures and Supplies applies.

- For surgeries or outpatient services performed in an ambulatory surgical center or outpatient hospital setting, both the benefits stated in your Medical Benefit Summary for Professional Services - Surgery and the Outpatient Services - Outpatient Surgery/Services apply.

- Therapeutic **radiology services, chemotherapy, and renal dialysis** provided or ordered by a physician. Covered services include a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Benefits for members who are receiving services for **end-stage renal disease (ESRD),** who are eligible for Medicare, are limited to 125% of the current Medicare allowable amount for participating and non-participating ESRD service providers.

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

EMERGENCY SERVICES

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

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

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

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

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

MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

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

Providers Eligible for Reimbursement

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

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

Eligible mental and/or chemical healthcare providers are:

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

Medical Necessity and Appropriateness of Treatment

- As with all medical treatment, mental health and chemical dependency treatment is subject to review for medical necessity and/or appropriateness. Review of treatment may involve pre-service review, concurrent review of the continuation of treatment, post-treatment review, or a combination of these. The plan will notify the patient and patient's provider when a treatment review is necessary to make a determination of medical necessity.

Benefits for long-term residential mental health programs exceeding 45 days of treatment per calendar year will not be authorized.

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

HOME HEALTH AND HOSPICE SERVICES

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

Only the following hospice services are covered:

- Home nursing visits.
- Home health aides when necessary to assist in personal care.
- Home visits by a medical social worker.
- Home visits by the hospice physician.
- Prescription medications for the relief of symptoms manifested by the terminal illness.
- Medically necessary physical, occupational, and speech therapy provided in the home.
- Home infusion therapy.
- Durable medical equipment, oxygen, and medical supplies.
- Respite care provided in a nursing facility to provide relief for the primary caregiver,

subject to a maximum of five consecutive days and to a lifetime maximum benefit of 30 days. A member must be enrolled in a hospice program to be eligible for respite care benefits.

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

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

DURABLE MEDICAL EQUIPMENT

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

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

− The durable medical equipment benefit also covers one hearing aid per hearing impaired ear if prescribed, fitted, and dispensed by a licensed audiologist with the approval of a licensed physician. Coverage will be provided every 36 months as medically necessary for the treatment of a member's hearing loss.

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

− Wigs following chemotherapy or radiation therapy are covered once per calendar year.

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

TRANSPLANT SERVICES

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

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

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

- Kidney
- Kidney - Pancreas
- Pancreas whole organ transplantation (under certain criteria)
- Heart
- Heart -Lung
- Lung
- Liver (under certain criteria)

- Bone marrow and peripheral blood stem cell
- Pediatric bowel

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

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

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

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

Payment of Transplant Benefits

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

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

OTHER COVERED SERVICES, SUPPLIES, AND TREATMENTS

- This plan covers up to 12 visits for **acupuncture** per plan year.
- This plan covers services of a state certified ground or air **ambulance** when private transportation is medically inappropriate because the acute medical condition requires paramedic support. Benefits are provided for emergency ambulance service and/or transport to the nearest facility capable of treating the condition. Air ambulance service is covered only when ground transportation is medically or physically inappropriate. Reimbursement to non-participating air ambulance services are based on 125% of the Medicare allowance. In some cases Medicare allowance may be significantly lower than the provider's billed amount. The provider may hold you responsible for the amount they bill in excess of the Medicare allowance, as well as applicable deductibles and co-insurance.
- This plan covers **biofeedback** to treat migraine headaches or urinary incontinence when provided by an otherwise eligible practitioner. Benefits are limited to a lifetime maximum of ten sessions.
- This plan covers **blood transfusions**, including the cost of blood or blood plasma.
- This plan covers removal, repair, or replacement of an internal **breast prosthesis** due to a contracture or rupture, but only when the original prosthesis was for a medically necessary mastectomy. Preauthorization is required, and eligibility for benefits is subject to the following criteria:
  - The contracture or rupture must be clinically evident by a physician's physical examination, imaging studies, or findings at surgery.
  - This plan covers removal, repair, and/or replacement of the prosthesis; a new reconstruction is not covered.
  - Removal, repair, and/or replacement of the prosthesis is not covered when recommended due to an autoimmune disease, connective tissue disease, arthritis, allergenic syndrome, psychiatric syndrome, fatigue, or other systemic signs or symptoms.
  - The Plan may require a signed loan receipt/subrogation agreement before providing coverage for this benefit.
- This plan covers **breast reconstruction** in connection with a medically necessary mastectomy. Coverage is provided in a manner determined in consultation with the attending physician and patient for:

  − All stages of reconstruction of the breast on which the mastectomy was performed;

  − Surgery and reconstruction of the other breast to produce a symmetrical

  appearance; − Prostheses; and

  − Treatment of physical complications of the mastectomy, including lymphedema

  Benefits for breast reconstruction are subject to all terms and provisions of the plan, including deductibles, co-payments and/or co-insurance stated in your Medical Benefit Summary.
- This plan covers **cardiac rehabilitation** as follows:

- − Phase I (inpatient) services are covered under inpatient hospital benefits.
- − Phase II (short-term outpatient) services are covered subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for outpatient hospital benefits. Benefits are limited to services provided in connection with a cardiac rehabilitation exercise program that does not exceed 36 sessions and that are considered reasonable and necessary.
- − Phase III (long-term outpatient) services are not covered.

- This plan covers IUD, diaphragm, and cervical cap **contraceptive devices** along with their insertion or removal. Contraceptive devices that can be obtained over the counter or without a prescription, such as condoms are not covered.
- This plan covers **corneal transplants**. Preauthorization is not required.
- In the following situations, this plan covers one attempt at **cosmetic or reconstructive surgery:** − When necessary to correct a functional disorder; or
  - − When necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury; or
  - − When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery

  Preauthorization is required for all cosmetic and reconstructive surgeries covered by this plan. For information on breast reconstruction, see 'breast prosthesis' and 'breast reconstruction' in this section.
- This plan covers dental and orthodontic services for the treatment of **craniofacial anomalies** when medically necessary to restore function. Coverage includes but is not limited to physical disorders identifiable at birth that affect the bony structures of the face or head, such as cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome. Coverage is limited to the least costly clinically appropriate treatment. Cosmetic procedures and procedures to improve on the normal range of functions are not covered. See the exclusions for cosmetic/reconstructive services, dental examinations and treatment, jaw surgery, and orthognathic surgery under the 'Excluded Services' section.
- This plan provides coverage for certain **diabetic supplies and training** as follows:
  - − Diabetic supplies other than insulin and syringes (such as lancets, test strips, and glucostix) are covered subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment. You may purchase those supplies from any retail outlet and send your receipts to the plan, along with your name, group number, and member ID number. We will process the claim and mail you a reimbursement check.
  - − Diabetic insulin and syringes are covered under your prescription drug benefit, if your plan includes prescription coverage. Lancets and test strips are also available under that prescription benefit in lieu of those covered supplies under the medical plan.
  - − This plan covers one diabetes self-management education program at the time of diagnosis, and up to three hours of education per year if there is a significant change in your condition or its treatment. To be covered, the training must be provided by an accredited diabetes education program, or by a physician, registered nurse, nurse practitioner, certified diabetes educator, or licensed dietitian with expertise in diabetes.

- This plan covers medically necessary telemedical health services provided in connection with the treatment of diabetes (see Professional Services in this section).

- This plan covers **dietary or nutritional counseling** provided by a registered dietitian under certain circumstances. It is covered under the diabetic education benefit, or for management of inborn errors of metabolism (excluding obesity), or for management of anorexia nervosa or bulimia nervosa (to a lifetime maximum of five visits).
- This plan covers nonprescription **elemental enteral formula** ordered by a physician for home use. Formula is covered when medically necessary to treat severe intestinal malabsorption and the formula comprises a predominant or essential source of nutrition. Coverage is subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment.
- This plan covers routine **foot care** for patients with diabetes mellitus.
- **Hospitalization for dental procedures** is covered when the patient has another serious medical condition that may complicate the dental procedure, such as serious blood disease, unstable diabetes, or severe cardiovascular disease, or the patient is physically or developmentally disabled with a dental condition that cannot be safely and effectively treated in a dental office. Coverage requires preauthorization, and only charges for the facility, anesthesiologist, and assistant physician are covered. Hospitalization because of the patient's apprehension or convenience is not covered.

- This plan covers treatment for **inborn errors of metabolism** involving amino acid, carbohydrate, and fat metabolism for which widely accepted standards of care exist for diagnosis, treatment, and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage includes expenses for diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. Nutritional supplies are covered subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for durable medical equipment.
- **Injectable drugs and biologicals** administered by a physician are covered when medically necessary for diagnosis or treatment of illness or injury. This benefit does not include immunizations (see Preventive Care Services in this section) or drugs or biologicals that can be self-administered or are dispensed to a patient.
- This plan covers **maxillofacial prosthetic services** when prescribed by a physician as necessary to restore and manage head and facial structures. Coverage is provided only when head and facial structures cannot be replaced with living tissue, and are defective because of disease, trauma, or birth and developmental deformities. To be covered, treatment must be necessary to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing. Coverage is limited to the least costly clinically appropriate treatment, as determined by the physician. Cosmetic procedures and procedures to improve on the normal range of functions are not covered. Dentures, prosthetic devices for treatment of TMJ conditions, and artificial larynx are also not covered.

- This plan provides certain benefits related to **opioid use disorder** as follows:
  - Benefits for **Buprenorphine** products or brand equivalent products for medically assisted treatment (MAT) of opioid use disorder without prior authorization, dispensing limits, fail

first policies, or lifetime limit requirements.

- − Benefits will be provided for at least **one intranasal opioid reversal agent prescription** for initial prescriptions of opioids with dosages of 50 MME or higher.

- The **routine costs of care associated with qualifying clinical trials** are covered. Benefits are only provided for routine costs of care associated with qualifying clinical trials. Expenses for services or supplies that are not considered routine costs of care are not covered. The plan is not, based on the coverage provided, liable for any adverse effects of a clinical trial. For more information, see 'routine costs of care' in the Definitions section of this handbook.
- **Sleep studies** are covered when ordered by a pulmonologist, neurologist, otolaryngologist, or certified sleep medicine specialist, and when performed at a certified sleep laboratory.
- This plan covers up to 20 visits for **spinal manipulation** per plan year.
- This plan covers medically necessary therapy and services for the treatment of **traumatic brain injury.**
- This plan covers **tubal ligation and vasectomy** procedures.

BENEFIT LIMITATIONS AND EXCLUSIONS

Least Costly Setting for Services

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

EXCLUDED SERVICES

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

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

- Chelation therapy, unless preauthorized for certain medical conditions or heavy metal toxicities
- Day care or custodial care, including help with daily activities such as walking, getting in or out of bed, bathing, dressing, eating, and preparing meals
- Dental examinations and treatment, which means any services or supplies to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures
- Eye examinations (routine)
- Fitness or exercise programs and health or fitness club memberships
- Foot care (routine), unless you are being treated for diabetes mellitus. Routine foot care includes services and supplies for corns and calluses, toenail conditions other than infection, and hypertrophy or hyperplasia of the skin of the feet
- Genetic (DNA) testing, except for tests identified as medically necessary for the

diagnosis and standard treatment of specific diseases

- Homeopathic treatment
- Infertility - Services or supplies to diagnose, prevent, or treat sterility, infertility, erectile dysfunction, frigidity, or sexual dysfunction
- Instructional or educational programs, except diabetes self-management programs
- Jaw - Services or supplies for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants, or improving placement of dentures
- Massage, massage therapy, or neuromuscular re-education, even as part of a physical therapy program
- Motion analysis, including physician review
- Myeloablative high dose chemotherapy, except when the related transplant is covered
- Naturopathic treatment
- Obesity (including all categories) or weight control treatment or surgery, even if there are other medical reasons for you to control your weight. Food supplementation programs, behavior modification and self-help programs, and other services and supplies for weight loss are also excluded from coverage.
- Physical or eye exams required for administrative purposes, such as participation in athletics, admission to school, or employment
- Private nursing service
- Programs that teach a person to use medical equipment, care for family members, or self-administer drugs or nutrition (except for the diabetic education benefit)
- Screening tests, imaging, and exams solely for screening, and not associated with a specific diagnosis, sign of disease, or abnormality on prior testing (including but not limited to total body CT imaging, CT colonography, and bone density testing), except as allowed under the preventive care benefit
- Self-help or training programs
- Snoring - Services or supplies for the diagnosis or treatment of snoring or upper airway resistance disorders, including somnoplasty
- Speech therapy - Oral/facial motor therapy for strengthening and coordination of speech-producing muscles and structures, except as medically necessary in the restoration or improvement of speech following a traumatic brain injury or for members diagnosed with a pervasive developmental disorder.
- Temporomandibular joint (TMJ)-related services, or treatment for associated myofascial pain, including physical or oromyofacial therapy
- Vocational rehabilitation, functional capacity evaluations, work hardening programs, community reintegration services, and driving evaluations and training programs, except as medically necessary in the restoration or improvement of speech following a traumatic brain injury or for members diagnosed with a pervasive developmental disorder.

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

- Abdominoplasty
- Artificial insemination, in vitro fertilization, or GIFT procedures

- Cosmetic or reconstructive services, except as specified in the Covered Expenses - Other Covered Services, Supplies, and Treatments section
- Electronic Beam Tomography (EBT)
- Eye refraction procedures, orthoptics, vision therapy, or other services to correct refractive error
- Jaw surgery - Treatment for abnormalities of the jaw, malocclusion, or improving the placement of dentures and dental implants
- Orthognathic surgery - Treatment to augment or reduce the upper or lower jaw, except for reconstruction due to an injury (see the Covered Expenses - Professional Services section)
- Panniculectomy
- Surgery to reverse voluntary sterilization
- Transplants, except as specified in the Covered Expenses - Transplants section

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

Treatment programs, training, or therapy as follows:

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

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

- Drugs and biologicals that can be self-administered (including injectables), other than those provided in a hospital, emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered

- Growth hormone injections or treatments, except to treat documented growth hormone deficiencies
- Immunizations or other medications or supplies for protection while traveling or at work
- Over-the-counter medications or nonprescription drugs

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

- Computer or electronic equipment for monitoring asthmatic, diabetic, or similar medical conditions or related data
- Equipment commonly used for nonmedical purposes, or marketed to the general public, or intended to alter the physical environment. This includes appliances like adjustable power beds sold as furniture, air conditioners, air purifiers, room humidifiers, heating and cooling pads, home blood pressure monitoring equipment, light boxes, conveyances other than conventional wheelchairs, whirlpool baths, spas, saunas, heat lamps, tanning lights, and pillows. It also includes orthopedic shoes and shoe modifications. Mattresses and mattress pads are only covered when medically necessary to heal pressure sores.
- Equipment used primarily in athletic or recreational activities. This includes exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal problems.
- Eyeglasses or contact lenses
- Modifications to vehicles or structures to prevent, treat, or accommodate a medical condition
- Replacement costs for worn or damaged durable medical equipment that would otherwise be replaceable without charge under warranty or other agreement
- Personal items such as telephones, televisions, and guest meals during a stay at a hospital or other inpatient facility

Experimental or Investigational Treatment

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

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

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

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

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

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

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

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

Other Items - This plan does not cover the following:

- Services or supplies that are not medically necessary
- Charges for inpatient stays that began before you were covered by this plan
- Services or supplies received before this plan's coverage began
- Services or supplies received after enrollment in this plan ends. (The only exception is that if this policy is replaced by another group health policy while you are hospitalized, the plan will continue paying covered hospital expenses until you are released or your benefits are exhausted, whichever occurs first.)
- Care and related services designed essentially to assist a person in maintaining activities of daily living, e.g. services to assist with walking, getting in/out of bed, bathing, dressing, feeding, preparation of meals, homemaker services, special diets, rest cures, day care, and diapers. Custodial care is only covered in conjunction with respite care allowed under this policy's hospice benefit (see Covered Expenses - Hospital, Skilled Nursing Facility, Home Health, and Hospice Services).
- Treatment of any illness or injury resulting from an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement authority
- Services or supplies available to you from another source, including those available through a government agency
- Services or supplies with no charge, or which your employer would have paid for if you had applied, or which you are not legally required to pay for. This includes services provided by yourself or an immediate family member.
- Charges that are the responsibility of a third party who may have caused the illness or injury or other insurers covering the incident (such as workers' compensation insurers, automobile insurers, and general liability insurers)
- Services or supplies for which you are not willing to release the medical or eligibility

information the plan needs to determine the benefits payable under this plan

- Treatment of any condition caused by a war, armed invasion, or act of aggression, or while serving in the armed forces
- Treatment of any work-related illness or injury, unless you are the owner, partner, or principal of the employer group insured by the plan, injured in the course of employment of the employer group insured by the plan, and are otherwise exempt from, and not covered by, state or federal workers' compensation insurance. This includes illness or injury caused by any for-profit activity, whether through employment or self-employment.
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports the plan needs to process claims
- Any amounts in excess of the allowable fee for a given service or supply
- Services of providers who are not eligible for reimbursement under this plan. An individual, organization, facility, or program is not eligible for reimbursement for services or supplies, regardless of whether this plan includes benefits for such services or supplies, unless the individual, organization, facility, or program is licensed by the state in which services are provided as an independent practitioner, hospital, ambulatory surgical center, skilled nursing facility, durable medical equipment supplier, or mental and/or chemical healthcare facility. And, to the extent the plan maintains credentialing requirements the practitioner or facility must satisfy those requirements in order to be considered an eligible provider.
- Scheduled and/or non-emergent medical care outside of the United States.
- Any services or supplies not specifically listed as covered benefits under this plan

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Complaint means an expression of dissatisfaction directly to the plan that is about a specific problem encountered by a member, or about a benefit determination by the plan or an agent acting on behalf of the plan, and that includes a request for action to resolve the

problem or change the benefit determination. Complaint does not include an inquiry.

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

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

Co-payment or co-insurance is the out-of-pocket amount a member is required to pay to a provider. **Creditable coverage** means a member's prior health coverage that meets the following criteria:

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

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

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

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

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

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

Emergency medical condition means a medical condition:

- That manifests itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson possessing an average knowledge of health and medicine would

reasonably expect that failure to receive immediate medical attention would:

- − Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;
- − Result in serious impairment to bodily functions; or
- − Result in serious dysfunction of any bodily organ or part; or

- With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.

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

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

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

Employee means any individual employed by an employer.

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

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

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

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

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

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

Generic drugs are drugs that, under federal law, require a prescription by a licensed physician (M.D. or D.O.) or other licensed medical provider and are not a brand name medication. By law, generic drugs must have the same active ingredients as the brand name medication and are subject to the same standards of their brand name counterpart.

Grievance means:

- A request submitted by a member or an authorized representative of a member;
  - − In writing, for an internal appeal or an external review; or
  - − In writing or orally, for an expedited internal review or an expedited external review; or
- A written complaint submitted by a member or an authorized representative of a member regarding: − The availability, delivery, or quality of a healthcare service;

- Claims payment, handling, or reimbursement for healthcare services and, unless the member has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or
- Matters pertaining to the contractual relationship between a member and the plan.

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

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

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

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

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

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

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

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

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

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

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

Lifetime maximum or lifetime benefit means the maximum benefit that will be provided

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

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

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

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

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

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

Member means an individual insured under a health policy.

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

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

Mental and/or chemical healthcare provider means a person that has met the credentialing

requirements of the plan, is otherwise eligible to receive reimbursement under the policy and is:

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

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

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

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

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

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

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

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

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

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

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

and Licensed Massage Therapist.

Preferred is a list of approved brand name medications used to treat various medical conditions.

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

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

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

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

- The drug, device, or service being tested in the clinical trial unless the drug, device, or service would be covered for that indication by the policy if provided outside of a clinical trial;
- Items or services required solely for the provisions of the drug, device, or service being tested in the clinical trial;
- Items or services required solely for the clinically appropriate monitoring of the drug, device, or service being tested in the clinical trial;
- Items of services required solely for the prevention, diagnosis, or treatment of complications arising from the provision of the drug, device, or service being tested in the clinical trial;
- Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- Items or services customarily provided by a clinical trial sponsor free of charge to any participant in the clinical trial; or
- Items or services that are not covered by the policy if provided outside of the clinical trial.

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

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

Specialized treatment facility means a facility that provides specialized short-term or long-term care. The term specialized treatment facility includes ambulatory surgical centers, birthing centers, chemical dependency/substance abuse day treatment facilities, hospice facilities,

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

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

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

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

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

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

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

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

Surgical procedure means any of the following operative procedures:

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

Telemedical means medical services delivered through a two-way video communication that

allows a provider to interact with a patient who is at a different physical location than the provider.

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

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

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