Oregon's Health CO-OP

Member Benefit Handbook

Oregon's Health CO-OP Oregon Standard Bronze Plan
99389OR0540001-00

Group Name (Employer):	[NAME]
Group Number (Employer):	[NUMBER]
Policy Effective Date:	[DATE]

Oregon's Health CO-OP

Member Benefit Handbook

Thank you for choosing health care coverage through Oregon's Health CO-OP! We are excited to have you join us as members. We look forward to providing you with comprehensive health care coverage and outstanding service. The values you have told us are very important to us!

Why We Are Special. Oregon's Health CO-OP is a Consumer Operated and Oriented Plan ("**CO-OP**"). The Patient Protection and Affordable Care Act of 2010 made CO-OPs available throughout the country beginning in 2014. A CO-OP is a nonprofit health plan with a member-based board of directors, designed to focus on member needs. CO-OPs are created with the input of consumers like you, and are for individuals and employers interested in offering their employees health insurance. Our board of directors is made up of members of the community who uniquely understand the health needs of individuals, families and our communities. We believe they can best determine the overall direction of the health plan.

How to Use this Member Benefit Handbook. We are providing you with this Member Benefit Handbook to help you understand how your health care coverage works. We think that most of your questions about your coverage will be answered in this Member Benefit Handbook. However, we also have trained customer service representatives at toll-free 1-844-509-4676 who are available to address your needs. Welcome to Oregon's first member directed health insurance plan, a model created with you!

Customer Service Department

Phone: Toll-free 1-844-509-4676
Email: OHCOOPhelp@valencehealth.com
Website: www.ohcoop.org
Address: 220 NW Second Avenue, Suite 600
Portland, OR 97209

TABLE OF CONTENTS

SECTION 1 WELCOME.

Thank you for choosing to obtain your coverage through Oregon's Health CO-OP. We look forward to providing you with the health care coverage described in this Member Benefit Handbook. We also welcome you to our community of Members. We are here to serve our Members, and hope you will be satisfied with the benefits we offer.

Health care should not be complicated. We strive for a simple model and a presentation of benefits that is easy to understand. We are providing you with this Member Benefit Handbook to help you understand how your health care coverage works. This Member Benefit Handbook provides a detailed summary of the Policy and should answer most of your questions.

Some of the words or phrases you see in this Member Benefit Handbook are capitalized. The word "Member" is an example. When you see a capitalized word or phrase that is not usually capitalized, the word or phrase has a special meaning. The definitions of those words are in Section 9.

Also, when we use the words "we," "us," and "our," we are referring to Oregon's Health CO-OP. When we use the words "you" and "your," we are referring to any Member entitled to health care coverage under the Policy.

1.1 Policy.

Your health care coverage is covered by the Policy. The Policy consists of: (a) this Member Benefit Handbook; (b) the Schedule of Benefits; (c) the Group Application; (d) the Group Contract; (e) the Group Contract Schedule of Terms; and (f) any endorsements, riders, and amendments.

You may ask your Group for a copy of the Schedule of Benefits, the Group Application, the Group Contract, and the Group Contract Schedule of Terms. "**Group**" means the employer or association group that entered into the Group Contract with us. We will furnish a summary statement of the essential features of the insurance coverage to the Group for distribution to the members.

Other information is available on our website at www.ohcoop.org

1.2 ID Cards.

Each Member will receive an ID Card. Your ID Card contains information about your coverage under the Policy. You should present this ID Card to Providers when receiving health care services. This will help Providers understand your coverage and where to submit claims for payment. You should also have your ID Card available when contacting our Customer Service Department.

1.3 Customer Service Department.

Our Customer Service Department is staffed with trained customer service representatives who specialize in helping you understand the Policy and who are available to answer your questions. They can also describe to you information that is available on our website, if you do not have internet access. You can contact our Customer Service Department by calling toll-free 1-844-509-4676 or by writing to us at:

Oregon's Health CO-OP, Customer Service, P.O. Box 3948, Corpus Christi, TX 78463

SECTION 2 ELIGIBILITY AND ENROLLMENT.

2.1 Eligible Employees.

The Policy was selected by the Group and covers Eligible Employees. An "**Eligible Employee**" is an employee who meets the qualifications in this Section 2.1. An Eligible Employee may be an individual employee, a sole proprietor, a partner in a partnership, and others that the Group includes as an employee in the Group's health benefit plan.

2.1.1. Minimum Hours Per Week.

An employee must work a minimum number of hours per week for the Group to be an Eligible Employee.

The Group establishes the minimum number of hours. The minimum number of hours per week may range between 17.5 and 40 hours per week. The Group must apply the minimum number of hours per week requirement uniformly to all employees. The Group may make changes to the minimum number of hours per week only with our prior approval. Any changes are effective on the first day of the first calendar month after approval.

The minimum number of hours per week requirement that applies to the Policy is in the Group Contract. You also can ask the Group or contact our Customer Service Department to determine the Group's minimum number of hours per week requirement.

2.1.2. New Employee Waiting Period.

New employees may be added in accordance with the terms of the policy. The Group may require new employees to work for the Group for a minimum amount of time before becoming covered under the Policy. That period is called the new employee waiting period.

The new employee waiting period may not exceed 90 days. The Group will apply the new employee waiting period uniformly to all employees. The Group may make changes in the new employee waiting period only with our prior approval. Any changes are effective on the first day of the first calendar month after approval.

If the Group selected a new employee waiting period, the period is in the Group Contract. You also can ask the Group or contact our Customer Service Department to determine the Group's new employee waiting period.

2.1.3. Initial Eligibility Date.

The date that an employee first becomes eligible to enroll in the Policy is the initial eligibility date.

The initial eligibility date is the first day of the first calendar month after the new employee waiting period ends. If the new employee waiting period ends on the first day of a calendar month, the initial eligibility date will be that day.

2.1.4. Excluded Employees.

The Policy is not available to employees who work on a temporary, seasonal, or substitute basis.

2.2 Eligible Family Members.

If an employee is eligible to enroll, the Group might also allow the employee's family members to enroll under the Policy.

The Group Contract says whether the Group allows family members to be covered. You also can ask the Group or contact our Customer Service Department to find out whether family members may enroll under the Policy.

The Group may allow enrollment of: (a) employees only and no family members; (b) employees and their spouses or Domestic Partners; (c) employees and their children; and (d) employees and their family members.

If the Group allows the enrollment of family members, the enrollment is limited to Eligible Family Members. An "**Eligible Family Member**" is one of the persons below.

- ***Spouse.*** A spouse is a lawfully married spouse of an Eligible Employee, including same-sex couples validly married in another state.

- ***Domestic Partner.*** A Domestic Partnership is a civil contract entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon. The Domestic Partner of an Eligible Employee is an Eligible Family Member.

- ***Dependent Child.*** A dependent child is a natural child, stepchild, or adopted child (or child placed for adoption) of an Eligible Employee, their spouse, or their Domestic Partner. The dependent child must be under 26 years of age. A dependent child does not include a grandchild.

- ***Disabled Dependent Child.*** A disabled dependent child is a natural child, stepchild, adopted child (or child placed for adoption) of an Eligible Employee or the Eligible Employee's spouse or Domestic Partner. The disabled dependent child must be over 25 years of age. A disabled dependent child does not include a grandchild. The child: (a) must have been continuously unable to secure self-sustaining employment since turning 26 years of age because of a mental disability or physical handicap; (b) must not be married or in a domestic partnership; and (c) must be primarily dependent on the enrolled Eligible Employee for financial support. We will require documentation from the child's Physician confirming the child's disability or handicap.

2.3 Enrollment.

You must enroll to be covered under the Policy. To enroll, you must submit a written application on a form approved by us. Enrollment forms are generally available from the Group. You may also contact our Customer Service Department to obtain a form. The names of all individuals enrolling for coverage must be provided. Enrollment forms must be signed and submitted to the Group, or to us if directed by the Group.

2.4 Initial Enrollment.

You may enroll for coverage under the Policy during your initial enrollment period. Your initial enrollment period begins on your initial eligibility date and ends 31 days after that date. For example, if you are an employee hired on January 15, and the Group has a 30-day waiting period, your initial eligibility date would be March 1. Therefore, your initial enrollment period would be from March 1 through March 31.

A late enrollee is an individual who enrolls in the group subsequent to the initial enrollment period during which the individual was eligible for coverage. If you do not enroll during the initial enrollment period, the next opportunity for you to enroll is during an annual open or special enrollment period. The late enrollee waiting period may not exceed 90 days.

2.5 Annual Open Enrollment.

The Group may establish an annual open enrollment period during which you may enroll for coverage under the Policy. This is a period of time immediately before the beginning of the next Group Contract Year. If you enroll during an annual open enrollment period, coverage will begin on the first day of the new Group Contract Year.

2.6 Special Enrollment.

If a special enrollment event occurs to an Eligible Employee or an Eligible Family Member: (a) the Eligible Employee may enroll for coverage under the Policy; and (b) Eligible Family Members may enroll for coverage under the Policy (assuming the Eligible Employee enrolls or is already enrolled). The Eligible Employee and Eligible Family Members may enroll for coverage during the 60-day period after the special enrollment event occurs.

2.6.1. Termination of Other Coverage.

The termination of other health care coverage is a special enrollment event. The special enrollment does not include a termination of coverage for failure to pay premiums or for cause, such as making a fraudulent claim.

2.6.2. New Family Member.

The addition of a new Eligible Family Member through marriage, birth, adoption, or placement for adoption is a special enrollment event.

2.6.3. Loss of Medicaid or CHIP Coverage.

The termination of health care coverage under Medicaid or CHIP is a special enrollment event.

2.6.4. Eligibility for Premium Assistance.

Becoming entitled to group health plan premium assistance through Medicaid or CHIP is a special enrollment event.

2.7 Change in Status.

If a change in status occurs that affects your eligibility under the Policy, you may make or revoke an election for coverage. You must make the election during the 60-day period after the change in status occurs. The events described below are changes in status.

- ***Legal Marital Status.*** This is a change in your marital status. This includes: (a) marriage; (b) death of a spouse; (c) divorce; (d) legal separation; and (e) annulment.

- ***Number of Dependents.*** This is a change in your number of dependents. This includes: (a) birth or death; (b) adoption; and (c) placement for adoption.

- ***Employment Status.*** This is a change in your employment status or the employment status of your spouse or dependent. The change must affect your eligibility under the Policy.

- ***Eligibility Requirements for Dependent***. This is an event that causes your dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of age or any similar circumstance.

- ***Residence.*** This is a change in the place of your, your spouse's, or your dependent's residence. The change must affect your eligibility under the Policy.

- ***Judgment, Decree, or Order.*** This is a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires you to provide health coverage for your child or dependent. This includes a judgment, decree, or order that releases you from such an obligation.

- ***Medicare or Medicaid.*** If you are enrolled for coverage under the Policy, this occurs when you or your spouse or dependent becomes entitled to coverage under Medicare or Medicaid.

2.8 Termination of Coverage.

We will notify the Group policyholder when the policy is terminated and the coverage is not replaced by the Group policyholder.

2.9 Qualified Medical Child Support Orders.

The Policy will comply with the terms of any qualified medical child support order. This is a child support order, judgment or decree (including a court-ordered marital settlement agreement) requiring a medical plan to allow you to enroll the child for medical coverage. A court order must meet certain legal requirements to be a qualified medical child support order. If these requirements are met, we must provide the coverage required by the court order. However, you will be required to make the same contributions for the coverage of the child that is otherwise payable for the coverage of a dependent. You will be notified if we receive a qualified medical child support order relating to you. You may request a copy of our qualified medical child support order review procedures by contacting our Customer Service Department.

SECTION 3 PROVIDERS AND NETWORKS.

This Section 3 explains the difference between a Network Provider and a Non-Network Provider. The difference affects your Copayment, your Coinsurance, and your other Out-of-Pocket expenses. In most cases, your Out-of-Pocket expenses will be lower if you use a Network Provider.

3.1 Deductibles, Copayments, Coinsurance, Allowed Amount, and Balance Billing.

3.1.1. Deductibles.

Your "**Deductible**" is the amount you must pay before you receive any benefits for specified Covered Services in a Calendar Year. You pay your Deductible directly to your Provider.

The Schedule of Benefits states your Deductible and indicates which specific Covered Services are subject to your Deductible. If you have chosen a plan with no deductible, your schedule of benefits will reflect a deductible of zero.

If you are the only person in your family covered under the Policy, a single "per person" Deductible applies to you.

If more than one person in your family is covered under the Policy, both a "per person" Deductible and a "per family" Deductible apply to you. Once any individual family member covered under the Policy pays the "per person" Deductible in a Calendar Year, the Deductible will be satisfied for that person for that Calendar Year. Once any combination of family members covered under the Policy pays the "per family" Deductible in a Calendar Year, the Deductible will be satisfied for all family members for that Calendar Year.

The following Out-of-Pocket expenses are not credited to your Deductible: (a) Copayments; (b) Coinsurance; (c) expenses for Covered Services provided by Non-Network Providers in excess of the Allowed Amount; and (d) expenses for services and supplies not covered by the Policy.

3.1.2. Copayment.

A "**Copayment**" is a fixed amount that you must pay for a specific Covered Service. The Schedule of Benefits states the Copayment (if applicable) for each Covered Service.

3.1.3. Coinsurance.

"**Coinsurance**" is an amount that you must pay for a specific Covered Service, expressed as a percentage of the Allowed Amount. The Schedule of Benefits states the Coinsurance (if applicable) for each Covered Service.

3.1.4. Allowed Amount.

The Allowed Amount for a Covered Service may vary depending on whether you use a Network Provider or a Non-Network Provider.

For a Network Provider, the "**Allowed Amount**" for a Covered Service is the discounted maximum fee that the Network Provider has agreed to accept for the Covered Service.

For a Non-Network Provider, the "**Allowed Amount**" for a Covered Service means a percentage of the amount for the Covered Service that Providers in the relevant geographical area usually charge for the same or similar service or supply. For Non-Network Providers, we determine the Allowed Amount. We base our determination in part on national data containing information about provider charges across the United States. We may utilize the services of a third party to assist us with our determination of the Allowed Amount. However, we are not bound by any determination by any third party.

3.1.5. Balance Billing.

If you use a Non-Network Provider for a Covered Service, you will be subject to Balance Billing by the Non-Network Provider. "**Balance Billing**" is the amount by which the Non-Network Provider's charge for the Covered Service exceeds the Allowed Amount for the Covered Service. You are responsible for paying all charges from Balance Billing.

Network Providers have agreed to never Balance Bill our Members for any Covered Service. You will never be subject to Balance Billing if you only use Network Providers.

3.2 Network Providers.

A "**Network Provider**" is a Provider who is in the Network. If you receive Covered Services from a Network Provider, you are responsible only for any applicable Deductible, Copayments or Coinsurance. We will pay the Network Provider directly for all other charges. Except for Deductibles, Copayments and Coinsurance, a Network Provider will not charge you for Covered Services. Network Providers may charge you for services or supplies that are not Covered Services.

Under some categories of services, you must receive the service from a Network Provider to be a Covered Service. These categories include Durable Medical Equipment, Prescription Drugs, Preventive Care, Primary Care, and Planned Home Births as set forth in the Policy.

The Policy complies with the Patient Protection and Affordable Care Act of 2010 by not discriminating against Providers acting within the scope of their own licensure or certification.

3.2.1. Out-of-State Network Providers.

We have Network Providers throughout the United States. Your Deductible, Copayments and Coinsurance will be the same regardless of the location of the Network Provider.

3.2.2. Selecting a Network Provider.

To select a Network Provider, or to verify if a Provider is in the Network, please see the Provider Directory on our website at www.ohcoop.org. You can also contact our Customer Service Department.

3.2.3. Primary Care Provider.

We encourage you to work closely with one Provider who acts as your Primary Care Provider. Primary Care Providers can provide all of your routine care, refer you to Specialists, and arrange for any Urgent Care or other care that you may require. In most cases, your Copayment and Coinsurance will be lower if you use a Primary Care Provider rather than a Specialist.

Primary Care Providers must be Network Providers. The following Network Providers can be Primary Care Providers: (a) physicians who specialize in family medicine, general practice, internal medicine, osteopathic medicine, or pediatrics; (b) nurse practitioners who specialize in adult practice, family practice, pediatrics, or women's health care; (c) physician assistants; and (d) naturopathic doctors.

To determine whether a Network Provider is a Primary Care Provider, please see the Provider Directory on our website at www.ohcoop.org. You can also contact our Customer Service Department.

3.3 Emergency Care and Urgent Care.

If you or a member of your family needs immediate assistance for a medical emergency, call 9-1-1 or go to the nearest emergency room or appropriate Facility.

For an Emergency Medical Condition, we treat all Providers as Network Providers, regardless of whether you are at a Network Facility or a Non-Network Facility. This means that for an Emergency Medical Condition: (a) we will not impose any administrative requirement or limitation on coverage that is more restrictive than those that apply to Network Providers; (b) we will not impose a copayment amount or coinsurance rate that exceeds the amount or rate for Network Providers; (c) we will not impose a deductible unless it applies generally to Non-Network Providers; and (d) such services are subject only to an out-of-packet maximum that applies to all services from Non-Network Providers. If you are admitted to a Facility as an inpatient, your Provider should contact us at toll-free 1-844-509-4676 as soon as possible to make a benefit determination on your admission. If you are admitted to a Non-Network Facility as an inpatient, we may require you to transfer to a Network Facility when your condition stabilizes.

For Urgent Care, we do not treat Non-Network Providers as Network Providers. We encourage you to contact your Primary Care Provider for Urgent Care matters.

3.4 Specialists.

We encourage you to contact your Primary Care Provider before you see a Specialist. In most cases, your Copayment and Coinsurance will be higher if you use a Specialist rather than a Primary Care Provider.

If you see a Specialist on your own, you should: (a) inform your Primary Care Provider; and (b) provide the Specialist with the name and contact information of your Primary Care Provider.

3.5 Non-Network Providers.

A "**Non-Network Provider**" is a Provider who is not in the Network. In most cases, your Copayment, Coinsurance, and Out-of-Pocket expenses will be higher if you use a Non-Network Provider rather than a Network Provider. As stated in Section 3.2, the Policy does not cover some services if obtained through Non-Network Providers.

Additionally, you will be subject to Balance Billing if you use a Non-Network Provider. Non-Network Providers often charge more for a Covered Service than the Allowed Amount for the Covered Service. In that situation, you will be responsible for paying the Non-Network Provider the amount by which the Non-Network Provider's charge for the Covered Service exceeds the Allowed Amount for the Covered Service.

3.6 Non-Network Provider in a Network Facility.

Not all of the Providers who practice in a Network Facility are Network Providers. Even though you receive treatment in a Network Facility, a Non-Network Provider could perform some service for you. In this situation, we treat the Non-Network Provider as a Network Provider. If you receive a bill from a Non-Network Provider in this situation, please contact our Customer Service Department. You will still be responsible for a Non-Network Provider's services that are not Covered Services.

3.7 Out-of-Pocket Maximums.

Your "**Out-of-Pocket Maximum**" is the maximum amount of aggregate Out-of-Pocket expenses you must pay in a Calendar Year for your Deductible, all Copayments, and all Coinsurance. Once you pay your Out-of-Pocket Maximum in a Calendar Year, the Policy will pay all Allowed Amounts for all Covered Services for the remainder of that Calendar Year, subject to the other terms, conditions, and limitations of the Policy.

The Policy provides for one Out-of-Pocket Maximum for Network Providers and a separate Out-of-Pocket Maximum for Non-Network Providers.

If you are the only person in your family covered under the Policy, the following applies:

- A single "per person" Out-of-Pocket Maximum for Network Providers.
- A single "per person" Out-of-Pocket Maximum for Non-Network Providers.

If more than one person in your family is covered under the Policy, the following applies:

- A "per person" Out-of-Pocket Maximum for Network Providers.
- A "per family" Out-of-Pocket Maximum for Network Providers.
- A "per person" Out-of-Pocket Maximum for Non-Network Providers.
- A "per family" Out-of-Pocket Maximum for Non-Network Providers.

Once any individual family member covered under the Policy pays the "per person" Out-of-Pocket Maximum in a Calendar Year, the Out-of-Pocket Maximum will be satisfied for that person for that Calendar Year. Once any combination of family members covered under the Policy pays the "per family" Out-of-Pocket Maximum in a Calendar Year, the Out-of-Pocket Maximum will be satisfied for all family members for that Calendar Year.

The Schedule of Benefits states all applicable Out-of-Pocket Maximums.

The following Out-of-Pocket expenses are not credited to your Out-of-Pocket Maximums; (a) expenses for Covered Services provided by Non-Network Providers in excess of the Allowed Amount; and (b) expenses for services and supplies not covered by the Policy.

The Policy complies with the Patient Protection and Affordable Care Act of 2010 by limiting your Out-of-Pocket Maximums for Network Providers.

3.8 Midyear Policy Renewals.

Your Deductible and Out-of-Pocket Maximums are based on a Calendar Year. The Policy is renewed on a Policy Year. The Policy Year may not coincide with a Calendar Year.

The renewal of the Policy in the middle of a Calendar Year will not affect your Deductible or Out-of-Pocket Maximums unless the Deductible or Out-of-Pocket Maximums increase for the new Policy Year. In that case, the increased Deductible or Out-of-Pocket Maximums (as applicable) will apply for the remainder of the Calendar Year. You will still be credited with all amounts paid toward your Deductible and Out-of-Pocket Maximums during that Calendar Year.

3.9 Comparison.

The example below shows the potential differences in Out-of Pocket expenses for a Covered Service performed by a Network Provider and a Non-Network Provider. The example is for illustration purposes only. Your actual Out-of-Pocket expenses will be different in each case.

For the purposes of this example only, assume that: (a) a Covered Service is charged at $220; (b) no Copayment is required; and (c) the Deductible has been paid or is not required.

Covered Service	**Network Provider**	**Non-Network Provider**
Provider's usual charge	$220	$220
Oregon's Health CO-OP negotiated discount	$20	$0
Allowed Amount	$200	$200

Percentage paid by Oregon's Health CO-OP from Schedule of Benefits	80% ($160)	70% ($140)
Coinsurance paid by you from Schedule of Benefits	20% ($40)	30% ($60)
Balance Billing	$0	$20
Your total payment to Provider	$40	$80
Percent of Provider's usual charge you must pay	18%	36%

3.10 Changes to Network Providers.

If you see a Provider after the Provider leaves the Network, we will treat the Provider as a Non-Network Provider. You are responsible for making sure that your Provider is still in the Network. To verify if a Provider is in the Network, please see the Provider Directory on our website at www.ohcoop.org. You can also contact our Customer Service Department.

3.11 Indian Health Services Providers.

Native Americans may access Covered Services from Indian Health Services facilities, a Tribe, or Tribal organization. Such Covered Services have no Copayments or Coinsurance. For a list of Indian Health Services facilities, please visit the Indian Health Services website at www.ihs.gov, or contact the regional Indian Health Services office:

Portland Area Indian Health Service
1414 NW Northrup Street
Suite 800
Portland, OR 97209
Telephone: 503-414-5555

3.12 No Liability for Health Care.

All Providers are independent contractors. We are not responsible for the quality of any health care that you receive. We are not liable for your death, injuries, or damages as a result of receiving any health care services or supplies from any Provider.

SECTION 4 COVERED BENEFITS.

The Policy generally covers health care services and supplies that are Medically Necessary to diagnose or treat an illness or injury.

"**Medically Necessary**" or "**Medical Necessity**" means health care services or supplies that we believe are reasonably needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, and that we believe meet all of the following criteria: (a) are consistent with the generally accepted standards for the practice of medicine in Oregon; (b) are consistent in type and frequency with the scientifically based guidelines of nationally-recognized medical or health care organizations or governmental agencies that are acceptable to us; (c) are needed to meet the reasonable health needs of the Member; (d) are not for the Member's or Provider's convenience; (e) are expected to produce clinically significant benefits that significantly exceed the attendant health risks; (f) are superior to alternative services or to no services; (g) are the least costly of alternatives that can be safely provided; and (h) are rendered in the most cost-efficient setting where the services can be safely provided. Even if your Provider recommends a particular service or supply, it may not be Medically Necessary. We may review any service or supply for Medical Necessity either before, during, or after treatment.

We cover all of the following "**Essential Health Benefits**," as required by the Patient Protection and Affordable Care Act of 2010: (a) ambulatory patient services; (b) emergency services; (c) hospitalization; (d) maternity and newborn care; (e) mental health and substance use disorder services, including behavioral health treatment; (f) prescription drugs; (g) rehabilitative and habilitative services and devices; (h) lab services; (i) preventive and wellness services and chronic disease management; and (j) pediatric services, including vision care. This policy DOES NOT provide pediatric dental coverage that meets the requirements of the Affordable Care Act. The Group was able to purchase this Policy from us because the Group separately affirmed to us that the Group has obtained or will obtain dental coverage that meets the requirements of the Affordable Care Act through a certified dental plan.

A "**Covered Service**" is a health care service or supply that is covered as a benefit under the Policy in accordance with the terms and conditions of the Policy.

Although the Covered Services are comprehensive, we do not cover all heath care services and supplies. For example, Section 5.1 excludes certain services and supplies from coverage. The Policy also provides for limitations on certain Covered Services. Additionally, certain Covered Services require you to pay a Deductible, a Copayment, or Coinsurance. See the Schedule of Benefits.

The Policy does not apply Preexisting Condition Exclusions. There are no annual dollar limits or lifetime maximums on Essential Health Benefits.

4.1 Preventive Care.

Being healthy is vital to the enjoyment of life. We encourage you to obtain preventive care services to help avoid illness. Preventive care services must be obtained from a Network Provider. In this Section 4.1, we describe those services to help you make informed decisions about your care.

4.1.1. Preventive Services.

The Patient Protection and Affordable Care Act of 2010 identified preventive services as vitally important. We agree. For these preventive services, you do not have any cost-sharing payments. For example, you do not pay any Deductible, Copayment, or Coinsurance to a Provider when receiving preventive services from a Network Provider. Instead, preventive services are covered from the first dollar.

Preventive services include the services below.

- ***Services With a Rating of "A" or "B" by the USPSTF.*** The USPSTF recommends certain preventive services and assigns the services with a grade. For example, the organization recommends screening for high blood pressure in adults 18 years of age and older with a grade of "A." You can see a complete list of these preventive services at: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/, or call the Customer Service Department.

- ***Immunizations Recommended by the Advisory Committee on Immunization Practices.*** You can see a complete list of these preventive services at: http://www.cdc.gov/vaccines/acip/index.html, or call the Customer Service Department.

- ***Care and Screenings for Children Supported by the Health Resources and Services Administration.*** The Health Resources and Services Administration recommends certain preventive care and screenings for infants, children and adolescents.

- ***Care and Screenings for Women Supported by the Health Resources and Services Administration.*** The Health Resources and Services Administration recommend certain preventive care and screenings for women. You can see a complete list of these preventive services at: http://www.hrsa.gov/womensguidelines/, or call the Customer Service Department.

4.1.2. Routine Physical Exams.

We recommend you see a Primary Care Provider for routine care. For Members 22 years of age and older, we cover routine physical exams according to the schedule below.

- 22 through 34 years of age: One exam every four years.
- 35 years of age and over: One exam every year.

Lab and diagnostic testing related to a routine physical exam are covered. Other testing ordered during, but not related to, a routine physical exam is covered as an outpatient service benefit in Section 4.6.5.

4.1.3. Well Baby and Well Child.

We cover well baby and well child exams as follows.

- At birth: One standard in-hospital exam.
- 0 through 2 years of age: Twelve exams.
- 3 through 21 years of age: One exam per year.

Lab and diagnostic testing related to a well baby or well child exams are covered. Other testing ordered during, but not related to, a well baby or well child care exam is covered as an outpatient service benefit in Section 4.6.5.

4.1.4. Immunizations.

We cover standard immunizations for the primary prevention of infectious diseases, as recommended by the CDC or a similar standard-setting body. Some Retail Pharmacies in the Network may administer covered immunizations.

Immunizations for elective, investigative, or unproven reasons are not covered.

4.1.5. Well Woman Services.

We cover the well woman services below.

- ***Gynecological Exam.*** We cover one routine gynecological exam each Calendar Year. Certain related services are also covered. Related services include: (a) breast exam; (b) Pap smear; (c) pelvic exam; (d) weight check; and (e) blood pressure check. Breast exams are available annually for women 18 years of age and older and at any time at the recommendation of the woman's health care provider. Occult blood, urinalysis, and complete blood count lab services are covered. Other services are covered as an outpatient service benefit in Section 4.6.

- ***Routine Mammogram***. We cover routine screening mammograms. For women 40 years of age and older, one mammogram is available each calendar year. Other mammograms, such as those provided for the treatment of a medical condition, are covered as an outpatient service benefit in Section 4.6.

- ***Contraceptives.*** We cover, without cost sharing, all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a Provider.

4.1.6. HPV.

We cover human papillomavirus vaccines, as recommended by the CDC.

4.1.7. Colorectal Screening.

We cover the following colorectal cancer screening exams for individuals 50 years of age and older: (a) one fecal occult blood test per year plus one flexible sigmoidoscopy every five years; (b) one colonoscopy every 10 years; or (c) one double contrast barium enema every five years. We cover colorectal cancer screening examinations and laboratory tests as recommended by the treating physician for members with a high risk for colorectal cancer.

4.1.8. Prostate Cancer Screening.

We cover digital rectal exams.

4.1.9. Tobacco Cessation.

We cover tobacco use cessation only when provided by a program approved by us. Tobacco use is use of tobacco on average four or more times per week within the past six months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Approved programs are covered at 100% of the cost. Specific nicotine replacement therapy will only be covered according to the program's description.

4.1.10. Maternity Office Appointments.

We cover, without cost sharing, routine prenatal office appointments.

4.1.11. Diabetes Management for Pregnant Women.

From conception through six weeks postpartum, covered health services, medications and supplies medically necessary for a woman to manage her diabetes are covered. Diabetic Supplies are covered, without cost sharing, as listed in Section 4.7.6.

4.2 Professional Services.

4.2.1. Primary Care Provider.

We cover services of a Network Primary Care Provider for diagnosis and treatment of an illness or injury, subject to the terms and conditions of the Policy.

4.2.2. Specialist.

We cover services of a Specialist for diagnosis and treatment of an illness or injury, subject to the terms and conditions of the Policy.

4.2.3. Surgical.

We cover supplies, equipment, inpatient and outpatient surgical services, subject to the terms and conditions of the Policy. Surgical services must be provided by a: (a) Physician; (b) certified surgical assistant; (c) surgical technician; (d) or registered nurse, if providing services as a surgical first assistant.

4.2.4. Diabetes Self-Management Program.

We cover supplies, equipment, and a diabetes self-management program prescribed to you by a Provider legally authorized to prescribe such items. A diabetes self-management program means one program of assessment and training after the diagnosis of diabetes. The program also includes up to three hours per Calendar Year of additional assessment and training if there is a material change of condition, medication, or treatment. The program must be provided by: (a) an education program credentialed or accredited by a state or national entity accrediting such programs; (b) a Physician; (c) a naturopathic doctor; (d) a nurse

practitioner; (e) a registered nurse; (f) a certified diabetes educator; (g) a licensed dietitian with demonstrated expertise in diabetes; or (h) a pharmacist.

4.2.5. Non Face-to-Face Services.

We cover the following services that may occur when you are not physically present "face-to-face" with your Provider.

- ***Telephone, Email, Skype Visit.*** We cover services provided to you by a Provider via two-way electronic communication, such as telephone, e-mail, video, or Skype if: (a) the service would be covered if the service was provided to you in person; and (b) the service is provided in lieu of a service that is available to you in person.

- ***Telemedical (Provider to Provider).*** We cover medically necessary telemedical health services for health services when provided by a qualified Provider. The telemedical health service may not duplicate or replace a health service that is available to the Member in person. Members may receive telemedical health services in Hospitals; rural health clinics; federally qualified health centers; Physicians' offices; community mental health centers; skilled nursing facilities; renal dialysis centers; senior centers and public community centers; and sites where public health services are provided. Coverage includes telemedical health services for diabetes as required by law.

4.2.6. Obesity.

We cover screening for obesity and will cover office visits to a Network registered dietician for nutritional counseling.

4.3 Inpatient Services.

The following inpatient services are covered in accordance with the terms and conditions of the Policy.

4.3.1. Inpatient Hospital Services.

We cover inpatient hospital services, subject to the terms and conditions of the Policy. We must Preauthorize the services.

We cover inpatient room and board charges at the hospital's semi-private room rate, subject to limited exceptions. Inpatient room and board charges are covered at the hospital's private room rate only if: (a) the hospital does not offer semi-private rooms; or (b) the attending Physician orders Hospitalization in an intensive care unit, a coronary care unit, or a private room for Medically Necessary isolation.

We do not cover charges for: (a) rental of telephones, radios, or televisions; (b) guest meals; or (c) other personal items.

The Policy does not exclude from payment or reimbursement any Covered Service merely because the service was rendered at any hospital owned or operated by the State of Oregon or any state approved community mental health program or community developmental disabilities program.

4.3.2. Skilled Nursing Facility.

We cover services provided by a skilled nursing facility. We must Preauthorize the services. The services are limited to 60 days per Calendar Year. Confinement for custodial care is not covered.

4.3.3. Inpatient Rehabilitation.

We cover inpatient Rehabilitation Services that are Medically Necessary to restore or improve a lost body function resulting from an illness or injury. A Physician must prescribe the services as part of a treatment program. We must Preauthorize the services.

The services are limited to 30 days per Calendar Year except as follows. The services for neurologic conditions (e.g. stroke, spinal cord injury, head injury, pediatric neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which rehabilitative services would be appropriate for children under 18 years of age) are limited to 60 days per Calendar Year. Recreation therapy is covered only if it is part of an inpatient rehabilitation admission.

4.3.4. Inpatient Habilitation.

We cover inpatient Habilitation Services that are Medically Necessary to help a person keep, learn or improve skills and functioning for daily living. A Physician must prescribe the services as part of a treatment program. We must Preauthorize the services.

The services are limited to 30 days per Calendar Year except as follows. The services for neurologic conditions (e.g. spinal cord, brain, pediatric neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which habilitative services would be appropriate for children under 18 years of age) are limited to 60 days per Calendar Year. Recreation therapy is covered only if it is part of an inpatient habilitation admission.

4.3.5. Delivery and Inpatient Services for Maternity.

We cover delivery and inpatient services for maternity care in accordance with the Newborns' and Mothers' Health Protection Act of 1996. The services cover: (a) at least 48 hours after a vaginal delivery; and (b) at least 96 hours after a Caesarean section. We must Preauthorize services for any extended period of time. The attending Provider may decide to discharge the mother and the newborn earlier. However, the Provider must consult with the mother and the mother must agree.

If the newborn requires any additional inpatient services after the mother is discharged, the newborn will incur a separate copay or coinsurance.

4.4 Emergency and Urgent Care.

If you have an Emergency Medical Condition, call 9-1-1 or go to the nearest emergency room or appropriate Facility. We encourage you to contact your Primary Care Provider for Urgent Care matters.

4.4.1. Emergency Room.

We cover services and supplies provided in an emergency room, subject to the terms and conditions of the Policy. We also cover related services routinely provided in an emergency room. The services and supplies must be necessary to stabilize an Emergency Medical Condition.

The Policy also covers Emergency Medical Conditions resulting from an eye injury or illness.

4.4.2. Urgent Care.

We cover services and supplies provided in connection with Urgent Care. We also cover related services routinely provided in an Urgent Care setting. The services and supplies must be necessary to stabilize the Urgent Care matter.

4.4.3. Emergency Transportation.

We cover services for Emergency Medical Transportation by state certified ambulance and certified air ambulance transportation. The ambulance services must provide transportation to the nearest Facility capable of providing the necessary care or to a Facility specified by us. We will generally make payments directly to the Provider of the ambulance care and transportation. If payments cannot be made directly to the Provider, you may submit a claim under Section 6.1 for reimbursement of expenses you paid.

4.5 Mental Health and Chemical Dependency.

We cover expenses incurred for the treatment of Mental Health, Nervous Conditions, and Chemical Dependency. Coverage is subject to the terms and conditions in this Section 4.5, and other terms, conditions, and exclusions of the Policy.

We may require a second opinion to determine whether any services covered in this Section 4.5 are Medically Necessary. We will notify you if we require a second opinion. You must notify us of an emergency admission to a Facility within one business day after admission. The treatment of substance abuse and related disorders is subject to placement criteria established by the American Society of Addiction Medicine. The Policy complies with the Mental Health Parity and Addiction Equality Act of 2008.

A Mental Health Provider is eligible for reimbursement under this Section 4.5 if: (a) the Mental Health Provider is approved by the United States Department of Health and Human Services; (b) the Mental Health 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; (c) you are staying overnight at the Facility and are involved in a structured program at least eight hours per day, five days per week; or (d) the Mental Health Provider is providing a Covered Service.

Eligible Mental Health Providers under this Section 4.5 are: (a) a program licensed, approved, established, maintained, contracted with, or operated by the Mental Health Division for Alcoholism; (b) a program licensed, approved, established, maintained, contracted with, or operated by the Mental Health Division for Drug Addiction; (c) a program licensed, approved, established, maintained, contracted with, or operated by the Mental Health Division for Mental or Emotional Disturbance; (d) a medical or osteopathic Physician licensed by the State Board of Medical Examiners; (e) a psychologist licensed by the State Board of Psychologists' Examiners; (f) a nurse practitioner registered by the State Board of Nursing; (g) a clinical social worker licensed by the State Board of Clinical Social Workers; (h) a professional counselor licensed by the State Board of Licensed Professional Counselors and Therapists; (i) a marriage and family Therapist licensed by the State Board of Licensed Professional Counselors and Therapists; and (j) a Facility licensed for inpatient or residential care and treatment of Mental Health or Chemical Dependency.

4.5.1. Outpatient Mental Health.

We cover outpatient services for the treatment of Mental Health or Nervous Conditions Health.

4.5.2. Inpatient Mental Health.

Inpatient services for the treatment of Mental Health or Nervous Conditions Health are covered. We must Preauthorize the services.

4.5.3. Mental Health Residential Care.

Services provided by a Mental Health or Nervous Conditions Health residential facility are covered. We must Preauthorize the services.

4.5.4. Outpatient Chemical Dependency.

Outpatient services for the treatment of Chemical Dependency are covered.

4.5.5. Inpatient Chemical Dependency.

Inpatient services for the treatment of Chemical Dependency are covered. We must Preauthorize the services.

4.5.6. Chemical Dependency Residential Care.

Services provided by a Chemical Dependency residential facility are covered. We must Preauthorize the services.

4.6 Outpatient Services.

Outpatient services may be delivered in a hospital, ambulatory surgery center, or other setting not requiring an overnight stay. They must be ordered by a qualified health care professional. Certain outpatient services, set forth in Section 5.2.3, require Preauthorization by us.

4.6.1. Outpatient Facility Fees for Surgery.

Outpatient Facility fees at an outpatient surgical facility are covered by the Policy. "Outpatient surgical facility" means any licensed public or private establishment that has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery.

This benefit does not include services or accommodations for patients to stay overnight.

4.6.2. Physician Fees for Outpatient Surgery.

The fees for professional services related to outpatient surgery provided or ordered by a Provider are described in Section 4.2.3.

4.6.3. Outpatient Rehabilitation Services.

We cover outpatient Rehabilitation Services that are Medically Necessary to restore or improve a lost body function resulting from an illness or injury. The Rehabilitation Services must be performed by a licensed physical therapist, occupational therapist, speech language pathologist, Physician, or other practitioner licensed to provide physical, occupational, or speech therapy. The services include but are not limited to services for the treatment of traumatic brain injury, or pervasive developmental disorders for children under 18. The services must be prescribed by a licensed Physician, naturopathic doctor, nurse practitioner, physician assistant, dentist, podiatrist or other Specialist. The prescription must include site, modality, duration, and frequency of treatment.

Benefits for outpatient Rehabilitative Services are limited to a combined maximum of 30 visits per calendar year except as follows. The services for neurologic conditions (e.g. stroke, spinal cord injury, head injury, pediatric neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which rehabilitative services would be appropriate for children under 18 years of age) are limited to 60 visits per Calendar Year. We must Preauthorize the services.

We cover speech therapy services only for: (a) voice deficits related to the peripheral speech mechanism, whether congenital or acquired; (b) phonological and language deficits due to hearing loss (but not including recurrent otitis media unless chronic significant hearing loss is documented); (c) stuttering; or (d) phonological and language deficits arising from neurological disease or injury of known cause.

We cover speech and cognitive therapy for acute illnesses and injuries for up to one year post injury if the services do not duplicate those provided by other eligible Providers.

We cover outpatient pulmonary rehabilitation programs when prescribed by a Physician. You must have a severe chronic lung disease that interferes with the normal activities of daily living despite optimal management with medications.

4.6.4. Outpatient Habilitation Services.

Outpatient Habilitation Services that are Medically Necessary to help a person keep, learn or improve skills and functioning for daily living are covered. The Habilitation Services must be performed by a licensed physical therapist, occupational therapist, speech language pathologist, Physician, or other practitioner licensed to provide physical, occupational, or speech therapy. The services include but are not limited to services for the treatment of the brain, or pervasive developmental disorders for children under 18. The services must be prescribed by a licensed Physician, naturopathic doctor, nurse practitioner, physician assistant, dentist, podiatrist or other Specialist. The prescription must include site, modality, duration, and frequency of treatment.

Benefits for outpatient Habilitative Services are limited to a combined maximum of 30 visits per Calendar Year except as follows. The services for neurologic conditions (e.g. spinal cord, brain, pediatric neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which habilitative services would be appropriate for children under 18 years of age) are limited to 60 visits per Calendar Year. We must Preauthorize the services.

4.6.5. Diagnostic Tests.

Medically Necessary diagnostic services, including testing or observation to diagnose the extent of a medical condition is covered by the Policy.

Services or materials provided or ordered by a Physician, nurse practitioner, naturopathic doctor, or physician assistant for diagnostic radiology and lab procedures are covered by the Policy. This includes services performed or provided by: (a) laboratories; (b) radiology facilities; (c) hospitals; and (d) Physicians.

4.6.6. Imaging.

We cover diagnostic imaging procedures ordered by a Provider for the diagnosis of illness or injury. We must Preauthorize any Advanced Diagnostic Imaging that occurs in a Provider's office or in an outpatient setting.

4.6.7. Therapy.

Services or materials provided or ordered by a licensed health care professional for therapeutic radiology services, chemotherapy, or renal dialysis are covered by the Policy. The services include a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells. This benefit includes services performed or provided by Physicians (including services in conjunction with office visits) and other facilities.

4.7 Prescription Drugs and Pharmacies.

4.7.1. Prescription Drugs.

We cover Prescription Drugs and other items in this Section 4.7. To obtain a current list of covered Prescription Drugs, please see the Formulary on our website at www.ohcoop.org. You can also contact our Customer Service Department.

You must use a pharmacy in the Network to obtain a covered Prescription Drug or other items in this Section 4.7, except in cases of an Emergency Medical Condition or Urgent Care situations. Prescription Drugs we cover are listed in the Formulary. We only cover Prescription Drugs listed in the Formulary, unless you obtain Preauthorization from us.

4.7.2. Pharmacies.

We have three types of pharmacies in the Network. There are Retail Pharmacies, Mail Order Pharmacies, and Specialty Pharmacies. To select a Network Pharmacy, or to verify if a Pharmacy is in the Network, please see the Provider Directory on our website at www.ohcoop.org, or contact our Customer Service Department.

You can obtain up to a 30-day supply of a Prescription Drug from a Retail Pharmacy in the Network.

We have selected some Retail Pharmacies that may provide up to a 90-day supply of Maintenance Drugs. These selected pharmacies are designated in the Network pharmacy list: www.ohcoop.org.

You can obtain up to a 90-day supply of a Prescription Drug from a Mail Order Pharmacy in the Network.

You can obtain up to a 30-day supply of a prescribed Specialty Drug from a Specialty Pharmacy in the Network.

4.7.3. Emergency and Urgent Care.

In the case of an Emergency Medical Condition or Urgent Care situation, you can obtain up to a 30-day supply of a Prescription Drug from a Non-Network pharmacy.

Non-Network pharmacy charges are not eligible for reimbursement unless you have an Emergency Medical Condition that prevents you from using a Network pharmacy. If this occurs, you will need to pay full price for your prescription at the time of purchase and submit a reimbursement form to us. Reimbursement forms are available online. You can also contact our Customer Service Department.

4.7.4. Drugs or Medications Not Listed in the Formulary.

You are financially responsible for the full cost of any drugs or medications not listed in the Formulary.

A Provider prescribing a drug or medication not listed in the Formulary can request an exception for you. We must Preauthorize any drug or medication not listed in the Formulary. When the use of a non Formulary drug or medication is approved via Preauthorization, you are responsible for either the non-preferred brand tier or specialty tier copay/coinsurance based on the tier level the drug or medication falls.

4.7.5. Brand Name Drugs.

Prescriptions for Brand Name Drugs can increase your Out-of-Pocket expenses. You should discuss these prescriptions with your Provider.

If your Provider prescribes a Brand Name Drug, the Network pharmacy will substitute the appropriate Generic Drug automatically if available and permissible. When a generic version of a Brand Name Drug is available on the market, the Brand Name Drug will be removed from the Formulary.

4.7.6. Diabetic Supplies.

We cover insulin, diabetic supplies including insulin syringes, needles, lancets, glucose test strips and glucose monitor devices listed in the Formulary. The Policy also covers glucagon recovery kits. In addition, diabetic supplies are covered by Durable Medical Equipment under Section 4.9.5.

4.7.7. Anticancer Medications.

We cover cancer chemotherapy treatment. Coverage includes prescribed orally-administered anticancer medication used to kill or slow the growth of cancerous cells. We cover the medication on the same basis as our coverage for intravenously administered or injected cancer medications.

4.7.8. Tobacco Cessation.

We cover tobacco cessation Prescription Drugs if used in an approved tobacco cessation program. See Section 4.1.9.

4.7.9. Oral Contraceptives.

We cover oral contraceptives listed in the Formulary. Other Food and Drug Administration (FDA) approved contraceptive methods, such as, but not limited to, hormone injections, implant(s) or intrauterine device(s) (IUD) are covered under your medical benefit. All FDA approved contraceptive methods as prescribed by a Network Provider are covered without Cost sharing. Subject to reasonable medical management, services related to follow-up and management of side effects, counseling for continued adherence, and device removal are covered.

4.7.10. Immunizations

Some Retail Pharmacies in the Network may provide immunizations. For a list of retail network pharmacies, please check our website at www.ohcoop.org. You can also contact our Customer Service Department.

4.7.11. Limitations.

To be covered, except as provided in the next paragraph, all Prescription Drugs must be FDA-approved, Medically Necessary, and required by law to be dispensed with a prescription. Not all FDA-approved drugs are covered under the Policy. Newly approved drugs will be reviewed within 90 days after FDA approval and coverage decisions are made within six months of market release.

The Policy does not exclude coverage of a drug for a particular indication solely on the grounds that the indication has not been approved by the United States Food and Drug Administration if: (a) the Health Evidence Review Commission established under ORS 414.688; or (b) the Pharmacy and Therapeutics Committee established under ORS 414.353 determines that the drug is recognized as effective for the treatment of that indication in accord with the requirements of ORS 743A.062.

We must Preauthorize any exceptions to the Formulary.

We cover self-injectable Prescription Drugs only if they are: (a) in the Formulary; (b) intended for self-administration; and (c) labeled by the FDA.

Some Prescription Drugs in the Formulary: (a) require Preauthorization; (b) have special rules for using them; (c) are subject to age limitations for safety reasons; or (d) are subject to quantity limitations on the number of doses allowed. All such limitations will be designated or indicated in the Formulary.

There are limitations on early refills due to, but not limited to, lost or stolen medication or vacation according to our policies. Please call our Customer Service Department if you need assistance.

4.7.12. Exclusions.

We do not cover Experimental or Investigational drugs, or drugs used by you in a research study or in another similar investigational environment.

We do not cover: (a) over-the-counter (OTC) drugs or medications or vitamins that may be purchased without a prescription with the exception of those required to be covered per USPSTF A and B List and the HRSA; or (b) prescribed drugs that are available in an OTC therapeutically similar form.

We do not cover Prescription Drugs for any condition not covered under the Policy. Items not covered under the Policy include but are not limited to treatments for the following: (a) fertility; (b) obesity; (c) weight loss; (d) cosmetics; (e) hair growth; (f) drugs used as a preventive against the hazards of travel; or (g) sexual dysfunction or disorder in either men or women.

Equipment, devices, and supplies referenced in this Section 4.7 are covered under Section 4.9(e).

We do not cover: (a) any compound prescriptions containing an ingredient that is not approved by the FDA; (b) any drug designated as “less than effective” by the FDA; (c) any drug or medication dispensed

from a pharmacy outside the United States; (d) growth hormone injections or treatments, except to treat documented growth hormone deficiencies; or (e) immunizations or other medications or supplies for protection while traveling or at work.

4.8 Pediatric Vision Services.

We cover the below pediatric vision services for children 19 years of age and under.

4.8.1. Routine Eye Exams.

We cover one pediatric eye exam per Calendar Year only when performed by a Network Provider.

4.8.2. Eyeglasses.

We cover one pair of prescription eyeglasses per Calendar Year only when obtained from a Network Provider. Polycarbonate, glass or plastic lenses are covered. All lenses include scratch resistant coating.

4.8.3. Contact Lenses.

We cover one set of contact lenses per Calendar Year, provided the contact lenses are in lieu of eyeglasses, and are obtained only from a Network Provider.

We also cover contact lenses that are Medically Necessary to treat certain eye conditions. Medically Necessary contact lenses must be obtained from a Network Provider. We must Preauthorize any Medically Necessary contact lenses.

4.9 Other Services and Supplies.

We cover the below other services and supplies, subject to the terms and conditions of the Policy.

4.9.1. Hospice Services.

We cover Hospice Services provided by a Medicare-certified or state-certified hospice program.

Only the following Hospice Services are covered: (a) home nursing visits; (b) home health aides when necessary to assist in personal care; (c) home visits by a medical social worker; (d) home visits by the hospice Physician; (e) prescription medications for the relief of symptoms manifested by the terminal illness; (f) Medically Necessary physical, occupational, and speech therapy provided in the home; (g) home infusion therapy; (h) Durable Medical Equipment, oxygen, and medical supplies; (i) respite care provided in a skilled 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; (j) 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; and (k) pastoral care and bereavement services.

To qualify for Hospice Services: (a) your Physician must certify that you are terminally ill with a life expectancy of less than six months; (b) a non-salaried primary caregiver must be available and willing to provide custodial care to you on a daily basis; and (c) you must not be undergoing treatment of the terminal illness other than for direct control of adverse symptoms.

We must Preauthorize all Hospice Services.

4.9.2. Home Health Services.

We cover the following home health services: (a) skilled nursing services performed by a registered nurse or licensed practical nurse; (b) rehabilitative therapy performed by a physical, occupational, and speech therapist; (c) in-home services provided for a homebound Member by a medical social worker or Medicare-certified or state-certified home health agency; and (d) home infusion services, including parenteral nutrition, medications, and biologicals (other than immunizations) that cannot be self-administered.

We must Preauthorize any home health services.

Private duty nursing is not covered.

4.9.3. Reconstructive Surgery.

We cover reconstructive surgery. "Reconstructive surgery" means surgery that restores features damaged as a result of illness or injury or corrects a congenital deformity or anomaly that results in a functional impairment.

We do not cover cosmetic surgery. "Cosmetic surgery" means services or surgery performed to reshape structures of the body for the purpose of improving your appearance or self-esteem.

We may cover certain reconstructive surgery that may be partially cosmetic in nature.

Coverage is limited to one effort at reconstructive surgery when necessary: (a) to correct a functional disorder; (b) because of an accidental injury or to correct a scar or defect that resulted from treatment of an accidental injury; or (c) to correct a scar or defect on the head or neck that resulted from a covered surgery.

The reconstructive surgery must take place within 18 months after the disorder, injury, surgery, scar, or defect first occurred. The 18 month limitation may be waived where there is medical necessity.

We must Preauthorize any reconstructive surgery.

4.9.4. Breast Reconstructive Surgery.

We cover mastectomy-related services that are part of your course of treatment, including all stages of reconstruction. Breast reconstructive surgery must be in connection with a Medically Necessary mastectomy. "Mastectomy" means the surgical removal of all or part of a breast or a breast tumor suspected to be malignant.

Coverage is provided in a manner determined in consultation with the attending Physician and you for: (a) all stages of reconstruction of the breast on which the mastectomy was performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; (c) prostheses; and (d) treatment of physical complications of the mastectomy, including lymphedema.

We must Preauthorize any breast reconstructive surgery.

4.9.5. Durable Medical Equipment, Prosthetic Devices, Orthotic Devices, and Medical Supplies.

We cover Durable Medical Equipment, Prosthetic Devices, Orthotic Devices, and Medical Supplies when required for the treatment of illness or injury. This benefit is only available through Network Providers. The equipment, devices, and supplies must be prescribed by a Physician or a licensed nurse practitioner, dentist, physician assistant, or doctor of podiatric medicine. Supplies, equipment, and appliances that are marketed to the general public and are available without a prescription are not covered. Coverage includes the Prosthetic and Orthotic Devices contained in the list adopted by, and annually updated by, the Director of the Department of Consumer and Business Services. That list may not be more restrictive than the list of Prosthetic and Orthotic Devices and Medical Supplies in the Medicare fee schedule.

- "**Durable Medical Equipment**" means equipment that: (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose rather than convenience or comfort; (c) is generally not useful to a person in the absence of an illness or injury; and (d) is appropriate for use in the home.

  Examples of Durable Medical Equipment include but are not limited to: (a) hospital beds; (b) non-motorized wheelchairs; (c) crutches, canes, walkers; (d) nebulizers, (e) commodes; (f) suction

machines; (g) traction equipment; (h) respirators, (i) TENS units; (j) hearing aids; and (k) other similar equipment.

We must Preauthorize the purchase, rental, repair, lease, or replacement of a power-assisted wheelchair (including batteries and other accessories). If we cover a power-assisted wheelchair for you, we will not also cover a manual wheelchair for you. Members 19 years of age or older are limited to one power-assisted wheelchair every seven years.

We must Preauthorize the purchase or Durable Medical Equipment for sleep apnea and other sleeping disorders. Coverage of oral devices includes charges for consultation, fitting, adjustment, and follow-up care.

The benefit for lenses and frames is available only 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).

Breastfeeding pumps, manual and electric, are covered at no cost per pregnancy if obtained from a Network Provider. Breastfeeding pumps, manual and electric, obtained from a Non-Network Provider requires Preauthorization from us.

- "**Prosthetic Devices**" 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.

- "**Orthotic Devices**" means rigid or semi-rigid 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 coverage of 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 or rehabilitates existing body parts.

  We cover Prosthetic Devices 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 you in the use of the device.

  Benefits also include coverage for any repair or replacement of a prosthetic device 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.

- "**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: (a) syringes and needles; (b) splints and slings; (c) ostomy supplies; (d) sterile dressings; (e) elastic stockings; (f) enteral foods; (g) drugs or biologicals that must be put directly into Durable Medical Equipment to achieve the benefit of the Durable Medical Equipment; and (h) contraceptive devices.

4.9.6. Hearing Aids and Devices.

We cover up to a maximum benefit of two Hearing Aids every 48 months for: (a) Members 18 years of age and younger; and (b) Members 19 to 25 years of age if the Member is enrolled in secondary school or an accredited educational institution.

"Hearing aids and devices" means: (a) any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing; and (b) any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords.

A Physician must examine the Member before a hearing aid or device is prescribed. A licensed audiologist or hearing aid specialist must prescribe, fit, and dispense the aid or device.

4.9.7. Sleep Studies.

We cover: (a) sleep studies performed at a sleep lab, and (b) treatments for sleep apnea and other sleeping disorders. We must Preauthorize the sleep studies and the treatments.

We cover oral devices, including tongue-retaining appliances, if the devices are: (a) used to treat obstructive sleep apnea; and (b) prescribed by a Physician specializing in the evaluation and treatment of obstructive sleep apnea. Coverage includes charges for consultation, fitting, adjustment, and follow-up relating to the devices.

4.9.8. Organ Transplants.

We cover the following organ and tissue transplants: (a) kidney; (b) kidney – pancreas; (c) pancreas whole organ transplant; (d) heart; (e) heart – lung; (f) liver; (g) bone marrow and peripheral blood stem cell; and (h) small bowel.

We only cover transplants of human body organs, tissues, bone marrow, and peripheral blood stem cells. We do not cover transplants of artificial, animal, or other non-human organs and tissues.

We must Preauthorize the transplant. We review transplant benefit requests on a case-by-case basis to determine if the transplant is: (a) Medically Necessary; and (b) reasonable by nationally-recognized standards in reputable transplant centers.

If transplant services are available at a Network Facility but performed by Member choice at a Non-Network Facility, the benefits are limited to $100,000 per transplant.

We cover expenses for the acquisition of organs and tissues for transplant only if we cover the transplant itself. Expenses for the acquisition of organs and tissues are limited as follows: (a) the testing of related or unrelated donors for a potential living related organ donation are payable at the same percentage that would apply to the same testing of an insured recipient; (b) the expense for the acquisition of cadaver organs is payable at the same percentage and subject to the same maximum dollar limitation, if any, as the transplant itself; (c) the medical services required for the removal and transportation of the organs or tissues from living donors are covered; and (d) transplant related services, including human leukocyte antigen typing, sibling tissue typing, and evaluation costs, are accumulate toward any transplant benefit limitations and are subject to Provider contractual agreements.

Expenses for the donation of organs and tissues are limited to $8,000 per transplant. Travel and housing expenses for the recipient and one caregiver are limited to $5,000 per transplant.

4.9.9. Pregnancy and Childbirth.

We cover services and supplies associated with pregnancy care and childbirth. Pregnancy care means the care necessary to support a healthy pregnancy and care related to labor and delivery. There is no exclusion period or waiver for pregnancy and childbirth expenses. The services include: (a) pregnancy and delivery care by a Network Provider; (b) delivery at an approved Facility, birthing center or home; (c) postnatal care, including Complications of Pregnancy; and (d) emergency treatment for Complications of Pregnancy and unexpected pre-term birth.

We cover services associated with planned home births that are provided by Network Providers. To find a Network Provider for planned home birth services, please see the Provider Directory on our website at www.ohcoop.org. You can also contact our Customer Service Department.

4.9.10. Routine Foot Care.

We cover routine foot care only if you are being treated for diabetes mellitus.

4.9.11. Biofeedback.

We cover biofeedback treatments. The coverage is limited to: (a) the treatment of migraine headaches or urinary incontinence when provided by or under the supervision of a Provider; and (b) ten treatments per lifetime.

4.9.12. Cardiac Rehabilitation.

We cover phase I inpatient services for cardiac rehabilitation. We cover phase II short-term outpatient services for cardiac rehabilitation. Short-term outpatient services are limited to 36 sessions.

We do not cover other phases of cardiac rehabilitation.

4.9.13. Hospitalization for Dental Procedures.

We cover Hospitalization for dental procedures if the Member: (a) has another serious medical condition that may complicate the dental procedure, such as serious blood disease, unstable diabetes, or severe cardiovascular disease; or (b) is physically or developmentally disabled with a dental condition that cannot be safely and effectively treated in a dental office.

We do not cover Hospitalization for apprehension or convenience.

We only cover charges for the Facility, anesthesiologist, and assistant Physician. We do not cover the actual dental procedure unless otherwise covered under this Policy.

4.9.14. Inborn Errors of Metabolism.

We cover treatments for inborn errors of metabolism that involve amino acids, carbohydrates, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist. This includes quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. The coverage includes: (a) expenses for diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment; (b) clinical visits; (c) biochemical analysis; and (d) medical foods used in the treatment of such disorders.

4.9.15. Maxillofacial Prosthetic Services.

We cover maxillofacial prosthetic services necessary for adjunctive treatment. The treatment must be: (a) prescribed by a Physician; (b) necessary to restore and manage head and facial structures; and (c) necessary to control or eliminate pain or infection, or to restore functions, such as speech, swallowing, or chewing.

The coverage is only provided when head and facial structures: (a) cannot be replaced with living tissue; and (b) are defective because of disease, trauma, or birth and developmental deformities. The coverage is limited to the least costly clinically appropriate treatment, as determined by the Physician.

We do not cover: (a) cosmetic procedures to improve the normal range of functions; (b) dentures; (c) Prosthetic Devices for treatment of TMJ disorder conditions; or (d) artificial larynx.

4.9.16. Qualifying Clinical Trials.

In accord with Section 2709 of the Public Health Service Act, we cover routine costs of care associated with qualifying clinical trials. Routine patient costs include items and services provided under this Policy to Members who are not enrolled in any clinical trials. A qualifying clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is: (a) Funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs; (b) Supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs; (c) Conducted as an investigational new drug application, an investigational device exemption or a biologics license application subject to approval by the United States Food and Drug Administration; or (d) Exempt by federal law from the requirement to submit an investigational new drug application to the United States Food and Drug Administration.

Expenses for services or supplies that are not considered routine costs of care are not covered. Routine patient costs do not include, and we do not cover: (a) the investigational item, device, or service, itself; (b) items and 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; (c) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis, or (d) any services or supplies provided under an investigational protocol. We do not cover treatments that fall outside the designated class of approved clinical trials.

4.9.17. Tubal Ligations and Vasectomies.

We cover tubal ligations and vasectomies. We do not cover surgery to reverse a voluntary sterilization procedure.

4.9.18. Allergy Injections.

We cover allergy injections.

4.9.19. Nonprescription Enteral Formula for Home Use.

We cover nonprescription elemental enteral formula for home use if: (a) the formula is Medically Necessary for the treatment of severe intestinal malabsorption; (b) a Physician issues a written order for the formula; and (c) the formula comprises the sole or essential source of nutrition.

4.9.20. Cochlear Implants.

We cover bilateral cochlear implants. We must Preauthorize the implants.

4.9.21. Craniofacial Anomalies.

We cover treatments of craniofacial anomalies identifiable at birth that affect the bony structures of the face or head. This includes: (a) cleft palate; (b) cleft lip; (c) craniosynostosis; (d) craniofacial microsomia; and (e) Treacher Collins syndrome.

We do not cover developmental maxillofacial conditions that result in: (a) overbite; (b) crossbite; (c) malocclusion or similar developmental irregularities of the teeth; or (d) TMJ disorder.

4.9.22. Pervasive Developmental Disorders.

We cover medical services that are medically necessary and that are otherwise covered under the Policy, for Members under 18 years of age who have been diagnosed with a pervasive developmental disorder. Rehabilitation and Habilitation Services are subject to the visit limits set forth in Section 4.6.3 and Section 4.6.4.

4.9.23. Services Provided by an Optometrist.

If the Policy elsewhere covers any service that is within the lawful scope of practice of a licensed optometrist, we cover that service, whether the service is performed by a physician or a licensed optometrist.

4.9.24. Prescription Eye Drops.

We cover one early refill of a prescription for eye drops to treat glaucoma if you meet all of the following criteria: (a) you request the refill less than 30 days after the later of: the date the original prescription was dispensed or the date that the last refill of the prescription was dispensed; (b) the prescriber indicates on the original prescription that a specific number of refills will be needed; (c) the refill does not exceed the number of refills that the prescriber indicated; and (d) the prescription has not been refilled more than once during the 30-day period prior to the request for an early refill.

4.9.25. Nurse Practitioner.

If the Policy elsewhere covers any service that is within the lawful scope of practice of a duly licensed and certified nurse practitioner, including prescribing or dispensing drugs, we cover that service whether it is performed by a physician or by a duly licensed nurse practitioner.

4.9.26. Diethylstilbestrol Use by a Mother.

We will not deny or cancel the Policy solely because the mother of a Member used drugs containing diethylstilbestrol prior to the Member's birth.

4.9.27. Dentist.

If the Policy elsewhere covers any service that is within the lawful scope of practice of a duly licensed dentist, we cover that service whether it is performed by a physician or by a dentist.

4.9.28. Physician Assistant.

If the Policy elsewhere covers any service that is within the lawful scope of practice of a duly licensed physician assistant, we cover that service whether it is performed by a physician or by a physician assistant.

4.9.29. Unmarried Women and their Children.

The Policy does not discriminate against unmarried women, and provides the same coverage for maternity care to married and unmarried women. The Policy provides the same coverage for the child of an unmarried woman and a married person.

4.9.30. Termination of Pregnancy.

The Policy covers the termination of pregnancy.

4.9.31. Treatment while in Custody of a Local Supervisory Authority Pending Disposition of Charges.

Services or supplies for members in the custody of a local supervisory authority pending disposition of charges, with the exception of diagnostic tests or health evaluations required for all individuals in the custody of a local supervisory authority pending disposition of charges, are covered as specified in the Policy. A supervising authority means the state or local corrections agency or official designated in each county by that county's board of county commissioners or county court to operate corrections supervision services, custodial facilities, or both.

SECTION 5 EXCLUSIONS, LIMITATIONS, AND CASE MANAGEMENT.

5.1 Exclusions.

The services and supplies below are excluded from coverage under the Policy.

5.1.1. General.

We do not cover: (a) any services or supplies not specifically covered in the Policy; (b) any services or supplies that are specifically excluded under another section of the Policy; (c) any services or supplies not Medically Necessary to diagnose or treat an illness or injury; (d) any services or supplies that are not in accordance with our medical policies; or (e) any amounts in excess of a specified limit for a particular service or supply.

5.1.2. Specific.

The services and supplies below are specifically excluded from coverage under the Policy.

- ***Abdominoplasty.*** The procedure commonly known as a "tummy tuck" is not covered.

- ***Acupuncture***. Acupuncture is excluded from the Policy.

- ***Cosmetic Procedures.*** Except for the procedures covered under Section 4.9.3 (relating to reconstructive surgery), Section 4.9.4 (relating to breast reconstructive surgery), and Section 4.9.15 (relating to maxillofacial prosthetic services), services and supplies for cosmetic procedures, including Prescription Drugs and complications arising from cosmetic procedures, are not covered. For example, we do not cover: (a) lipectomy; (b) liposuction; and (c) hair removal.

- ***Criminal Acts.*** Except for Emergency Services, services or supplies relating to any illness or injury for which a contributing cause was your commission of or attempt to commit a felony are not covered. We do not cover illness or injury for which a contributing cause was engaging in an illegal occupation.

- ***Custodial Care.*** Custodial care and related services designed primarily to assist you in performing daily living activities are not covered, unless specifically covered under the Policy's Hospice Services in Section 4.9.1. We do not cover services to assist with: (a) getting in or out of bed; (b) bathing; (c) dressing; (d) walking; (e) feeding; (f) administration of medications; (g) preparing meals and other homemaker services; (h) special diets; (i) rest cures; (j) diapers; and (k) day care. We also do not cover care that is primarily for the purpose of separating you from others, or for preventing you from harming yourself.

- ***Dental for Adults.*** Services and supplies to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures for adults are not covered. In addition, we do not cover dental treatment: (a) necessitated by disease; (b) to repair defects resulting from tooth loss; or (c) to restore the ability to chew.

- ***Durable Medical Equipment From Non-Network Providers***. In the case of Durable Medical Equipment, Prosthetic Devices, Orthotic Devices, and Medical Supplies, the Policy does not cover any

items procured through Non-Network Providers. However, coverage is provided as described in Section 4.9.5 when procured through Network Providers.

- ***Equipment Commonly Used for Nonmedical Purposes.*** Supplies, equipment, and appliances that are marketed to the general public and are available without a prescription are not covered. We do not cover supplies, equipment, and appliances that are intended to alter the physical environment or that are used primarily in athletic or recreational activities. The exclusion also includes: (a) adjustable power beds sold as furniture; (b) air conditioners; (c) air purifiers; (d) blood pressure monitoring equipment; (e) compression or cooling combination units; (f) computer and electronic devices; (g) computer software for monitoring, recording, or reporting asthmatic, diabetic, or similar tests or data; (h) conveyances, including scooters (other than conventional wheelchairs); (i) cooling pads; (j) equipment purchased on the Internet; (k) exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal symptoms; (l) heating pads; (m) humidifiers; (n) light boxes; (o) mattresses and mattress pads (except for the healing of pressure sores); (p) orthopedic shoes; (q) pillows; (r) replacement costs for worn or damaged Durable Medical Equipment that would otherwise be replaceable without charge under a warranty or other agreement; (s) spas; (t) saunas; (u) shoe modifications (except when incorporated into a brace or prosthesis); (v) structural alternations to prevent, treat, or accommodate a medical condition, including grab bars and railings; (w) vehicle alterations to prevent, treat, or accommodate a medical condition; and (x) whirlpool baths.

- ***Examinations for Administrative Purposes*.** Physical and eye exams for administrative purposes are not covered. For example, we do not cover exams: (a) for participation in athletics; (b) for admission to school; or (c) for an employer.

- ***Experimental or Investigational Procedures.*** Except for coverage under Section 4.9.16 (relating to qualifying clinical trials) procedures or services that are Experimental or Investigational in nature are not covered. The exclusion applies even if your Provider determines that the procedure or service is the most likely procedure or service to help you.

- ***Eye Examinations for Adults.*** Eye exams for adults that are routine in nature are not covered. Pediatric vision services are covered as described in Section 4.8.

- ***Eyeglasses and Eye Refraction for Adults.*** Eyeglasses and eye refraction for adults are not covered, except under Section 4.9.5. We do not cover: (a) the fitting, provision, or replacement of eyeglasses, lenses, frames, contact lenses, or subnormal vision aids; (b) eye exercises; (c) orthoptics; (d) vision therapy; and (e) eye refraction procedures to correct refractive error. Pediatric vision services and supplies are covered in Section 4.8.

- ***Foot Care.*** Foot care that is routine in nature is not covered, except for patients being treated for diabetes mellitus. We do not cover services and supplies for: (a) corns; (b) calluses; (c) non-infectious conditions of the toenails; and (d) hypertrophy or hyperplasia of the skin of the feet.

- ***Homeopathy.*** Homeopathy is a system of medicine that involves treating a person with diluted substances. Such services, supplies and remedies are not covered.

- ***Infertility.*** Services and supplies to diagnose, prevent, or cure infertility or to induce fertility are not covered. We do not cover: (a) artificial insemination; (b) in vitro fertilization; (c) the diagnosis and treatment of infertility; or (d) surgery to reverse voluntary sterilization. However, Medically Necessary medication to preserve fertility during treatment with cytotoxic chemotherapy is covered. Infertility for males means low sperm counts or the inability to fertilize an egg. Infertility for females means the inability to conceive or carry a pregnancy to 12 weeks.

- ***Jaw Surgery.*** Procedures, services, and supplies for developmental or degenerative abnormalities of the jaw, malocclusion, or improving the placement of dentures, including dental implants, are not covered, unless specifically covered under the Policy in Section 4.2 (relating to professional services).

- ***Massage or Massage Therapy.*** We do not cover massage or massage therapy.

- ***Mental Health and Chemical Dependency.*** We do not cover treatment for the following diagnoses: (a) mental retardation; (b) paraphilias; (c) learning disorders; (d) urinary incontinence; (e) the current edition of diagnostic codes V15.81 through V71.09, except V61.20, V61.21, and V62.82 when used with children five years of age or younger; (f) food dependencies; or (g) nicotine-related disorders.

  We do not cover the following treatment programs, training, and therapy: (a) educational or correctional services or sheltered living provided by a school or halfway house; (b) psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present; (c) court-ordered sex offender treatment programs; (d) court-ordered screening interviews or drug or alcohol treatment programs; (e) marital or partner counseling; (f) support groups; (g) sensory integration training; (h) biofeedback (other than as specifically noted); (i) hypnotherapy; (j) academic skills training; (k) equine or animal therapy; (l) narcosynthesis; (m) aversion therapy; (n) social skill training; or (o) recreation therapy outside an inpatient or residential treatment setting.

- ***Motion Analysis.*** Motion analysis is not covered. We do not cover: (a) videotaping; (b) 3-D kinematics; (c) dynamic surface and fine wire electromyography; or (d) any Provider review of motion analysis.

- ***Myeloablative High Dose Chemotherapy.*** Myeloablative high dose chemotherapy is not covered, unless specifically covered under the Policy's transplantation services in Section 4.9.8.

- ***Orthognathic Surgery.*** Services and supplies to augment or reduce the upper or lower jaw are not covered.

- ***Panniculectomy.*** The procedure involves the removal of excess tissue and skin from the abdomen and is not covered.

- ***Providers (Ineligible).*** Services and supplies provided by Providers not properly licensed by the state in which services or supplies are provided are not covered.

- ***Self-Administered or Provided by Family Member.*** We do not cover any services or supplies that are self-administered, provided by a member of your family, or provided by a person who ordinarily resides in your home.

- ***Services and Supplies for Which a Third Party is Liable.*** Services and supplies for illness or injury for which a third party is liable are not covered. We do not cover services and supplies which are payable by a third party or pursuant to applicable workers' compensation laws, motor vehicle liability, uninsured motorist, underinsured motorist, or personal injury protection insurance, or any other liability or voluntary medical payment insurance, to the extent of any recovery from or on behalf of the third party or source.

- ***Services and Supplies for Which No Charge is Made.*** Services and supplies for which no charge is made (or deemed to be made) are not covered. We do not cover: (a) services and supplies for which you are not legally required to pay; (b) services and supplies provided by a Provider or Facility that was not properly licensed to provide the services or supplies; and (c) services and supplies provided by you or by an immediate family member.

- ***Services and Supplies for Which the Member is Unwilling to Release Information.*** Services and supplies for which you are unwilling to release medical or eligibility information necessary to determine the benefits payable under the Policy are not covered.

- ***Services and Supplies Routine in Nature.*** Services and supplies that are not for the primary purpose of diagnosis or treatment are not covered. We do not cover: (a) services and supplies provided primarily for the comfort, convenience, environmental control, or education of a patient; (b) services and supplies that are cosmetic in nature; (c) services and supplies provided for the processing of records or claims; (d) charges for completion of claim forms and charges for reports requested by us to process claims; (e) charges for missed appointments; (f) private nursing services; (g) personal items, such as telephones, televisions, and guest meals; and (h) supplies, equipment, and appliances not unique to medical care, such as air conditioners, humidifiers, air filters, whirlpools, hot tubs, heat lamps, and tanning lights.

- ***Sexual Disorders.*** Services and supplies for the treatment of sexual dysfunction or inadequacy (including erectile dysfunction) are not covered.

- ***Sex Reassignment.*** Procedures, services, and supplies for sex reassignment are not covered unless (1) medically necessary, and (2) the procedures are otherwise covered under this Policy for different reasons.

- ***Snoring.*** Services and supplies for snoring are not covered. For example, we do not cover somnoplasty.

- ***Speech Therapy.*** Speech therapy services are not covered, except for services: (a) that are Medically Necessary to restore or improve speech after a traumatic brain injury (including a stroke); or (b) for a child under the age of 18 diagnosed with a pervasive developmental disorder. We do not cover oral and facial motor therapy for strengthening and coordination of speech-producing musculature and structures.

- ***Spinal Manipulations.*** Spinal manipulation services are not covered, unless specifically Preauthorized by us.

- ***TMJ.*** TMJ services are not covered. We do not cover advice, treatment, physical therapy, and oromyofacial therapy, either directly or indirectly, for TMJ dysfunction, myofascial pain, or any related appliances.

- ***Training or Self-Help Programs.*** Training or self-help programs are not covered. We do not cover general fitness exercise programs, and programs that teach a person how to use Durable Medical Equipment or care for a family member. The exclusion also includes health or fitness club services or memberships and instruction programs, including instruction programs to self-administer drugs or nutrition.

- ***Transplants.*** Services or supplies for the transplantation of bone marrow, peripheral blood stem cells, or a human body organ or tissue are not covered, unless specifically covered under Section 4.9.8.

- ***Treatment After Coverage Ends.*** Services and supplies received by you after coverage under the Policy ends are not covered. An exception exists if you are in the hospital on the day the Policy terminates. In that case, we will continue to cover expenses for that Hospitalization until you are discharged from the hospital.

- ***Treatment Before Coverage Begins.*** Services and supplies received by you before coverage under the Policy begins are not covered.

- ***Treatment While in the Armed Forces.*** Services and supplies received while in the service of the armed forces are not covered. Conditions caused by active participation in war or insurrection are not covered. Conditions incurred in or aggravated while in the uniformed services are not covered. Services that relate to a civil revolution or riot are not covered.

- ***Treatment While Incarcerated.*** Services and supplies received while in the custody of any local, state, or federal law enforcement authority or while incarcerated in any jail or prison are not covered except as provided in Section 4.9.32. This Policy does not provide coverage for treatment of injuries resulting from a violation of law.

- ***Treatment Outside the United States.*** Services and supplies for any scheduled or non-emergency care outside of the United States are not covered.

- ***Unlicensed and Other Providers.*** We do not cover services provided by any unlicensed providers. We do not cover the services of homeopaths; faith healers; or lay, or direct entry midwives.

- ***Weight Control.*** We do not cover services and supplies provided for weight loss programs, such as food supplementation, behavior modification, self-help, and training programs. This exclusion applies regardless of whether there are other medical conditions related to, caused by, or exacerbated by obesity or excess weight. However, we do cover screening for obesity and appropriate referrals to a Network dietician, as set forth in Section 4.2.6.

- ***Work-Related Conditions.*** Services and supplies for the treatment of illness or injury arising out of or in the course of employment are not covered to the extent covered under workers' compensation insurance. However, Members who are otherwise exempt from, and not covered by, state or federal workers compensation insurance may be covered. This exclusion applies whether or not the expense for the service or supply is paid under applicable workers compensation laws. Claims for services and supplies covered under the terms of the Policy for the treatment of work-related injury or occupational disease are covered if the claims are: (a) denied or (b) not yet accepted or denied by the workers compensation carrier.

5.2 Preauthorization.

Your Schedule of Benefits lists services and supplies. Some of the listed services and supplies require Preauthorization before you receive the service or supply. Your Provider will request a Preauthorization for you. We will determine if the Policy covers the requested service or supply. A Preauthorization decision may include but not be limited to a consideration of: (a) the benefits available; (b) Medical Necessity; (c) the treatment setting; and (d) the anticipated length of stay.

We will notify you and your Provider when we make our determination. The notification will be in writing or via the telephone with a written follow-up. We will answer Provider requests for Preauthorization of nonemergency services within two business days.

Failure to obtain Preauthorization when required could result in denial of your benefits. Failure to obtain Preauthorization could increase your costs. You could be responsible for the payment for services or supplies not covered by the Policy.

Preauthorization does not apply in emergencies. Services and supplies used in medical emergencies to stabilize and to determine the nature and extent of the emergency are Covered Services. If you are admitted to a hospital or inpatient specialized treatment center on an emergency basis, we need to know. You must send us notification of your admission within one business day or as soon as reasonably possible.

We may use a third party for Preauthorizations.

5.2.1. Preauthorization Expiration.

Preauthorization determinations can expire. The expiration date depends upon the type of benefit sought.

- Relating to your eligibility: 5 business days (unless coverage ends within 5 days).
- Relating to benefit coverage and Medical Necessity: 90 days.

We are not bound by the listed durations if misrepresentations relevant to the request were made.

5.2.2. Preauthorization Appeals.

You have the right to appeal if your request for Preauthorization is denied. You or your Provider can request the appeal. The appeal will be reviewed by appropriate medical reviewer(s). See Section 6.9.4.

5.2.3. Preauthorization Procedures and Services List.

The below list of procedures and services requiring Preauthorization is subject to change. The list of procedures and services are not necessarily Covered Services. The procedures and services on the below list cannot be provided unless you obtain a determination of coverage from us first. See the website for our most current Preauthorization list: www.ohcoop.org.

- Advanced Diagnostic Imaging that occurs in a Provider's office or in an outpatient setting.
- Ambulance transports between medical facilities, by air or ground, except in an emergency.
- Artificial intervertebral disc replacement.
- Back surgeries – instrumented.
- Breast brachytherapy.
- Breast reconstruction, including breast reduction and implants.
- Chelation Therapy.
- Chondrocyte implants.
- Cochlear implants.
- Cosmetic and reconstructive procedures including: (a) skin peels; (b) scar revisions; (c) facial plastic procedures and/or reconstruction; and (d) procedures to remove superficial varicosities or other superficial vascular lesions.
- Durable Medical Equipment expense over $800, including: (a) purchase; (b) rental; (c) repair; (d) lease or rental for longer than three months; or (e) replacement.
- Dynamic elbow, knee, and shoulder flexion devices.
- Elective medical admissions, such as preadmission, or admission to a hospital for diagnostic testing or procedures normally done in an outpatient setting, and transfers to Non-Network Facilities.
- Electron Beam Tomography.
- Enhanced external counterpulsation.
- Excimer laser for psoriasis.
- Experimental or Investigational procedures or surgeries.
- Extensions of previously authorized benefits, such as extension of physical or occupational therapy benefits, Mental Health treatment, or Chemical Dependency treatment.

- Genetic (DNA) testing.
- Habilitation.
- Home health, outpatient and home IV infusion, and enteral nutrition supplies, and Hospice Services.
- Hospitalization for dental procedures when covered under this plan, including pediatric dental procedures.
- Hyperbaric oxygen.
- Ingestible telemetric gastrointestinal capsule imaging system (wireless capsule enteroscopy).
- Laparoscopies of the female reproductive system and hysterosalpingograms, hysteroscopies and chromotubations.
- Mental Health and Chemical Dependency inpatient or residential treatment, including intensive outpatient treatment.
- Mobile cardiac outpatient telemetry.
- Multidisciplinary developmental pediatric evaluations.
- Multidisciplinary pain management and rehabilitation evaluations and programs.
- Neurostimulators – implantable.
- Parenteral nutrition.
- Percutaneous vertebroplasty and balloon-assisted vertebroplasty (kyphoplasty).
- Proton beam treatment delivery.
- Radiofrequency procedures including radiofrequency neurotomy.
- Rehabilitation Services.
- Skilled nursing facility admissions.
- Skin substitutes.
- Sleep studies.
- Surgical procedures.
- Stereotactic radiosurgery.
- Tongue retaining orthodontic appliances for sleep apnea and other sleeping disorders.
- Transmyocardial revascularization (TMR).
- Transplantation of organ, bone marrow, and stem cell, including evaluations, related donor services and/or searches, and HLA tissue typing, except for corneal transplants.
- Varicose vein procedures.

5.3 Claims and Pre-Service Eligibility Determination Procedures.

We will determine whether a claim for benefits is covered under the Policy within the timeframes required by law. Most eligibility determinations are processed within 30 days after we receive a claim submission. We will examine all claims for benefits according to the type of claim, as described below.

- ***Preauthorization.*** You should be aware that certain types of Covered Services require Preauthorization from us before you receive the Covered Service. We will process such Preauthorization requests as quickly as possible. Unless there is an urgent need, a Preauthorization determination will be made within 14 calendar days from when we receive the Preauthorization request.

- ***Retrospective Determinations.*** Preauthorization is generally done before a Covered Service is provided. In some instances Preauthorization may occur on a post-service basis. A claim for benefits for a Covered Service that requires Preauthorization review, but was not submitted for such review before the Covered Service was provided, will be reviewed on a retrospective basis within 30 calendar days from when we receive the request and any other information sufficient for us to make a benefit determination.

- ***Urgent Services Determinations.*** If the time period for making an eligibility determination could put your life, health, or ability to regain maximum function in serious jeopardy (or if instructed by a Physician due to severe pain) we will generally process your request for a pre-service eligibility determination within 24 hours, but in any case no later than 72 hours after we receive the request. If you fail to provide sufficient information for us to determine if the service is covered by the Policy our determination may be delayed. If we require additional information to make an eligibility determination, we will notify you of the additional information we need within 24 hours of receiving the request. We will then notify you of our eligibility determination within 48 hours of receiving the necessary information from you.

- ***Concurrent Services Determinations.*** If you are already receiving services in a hospital or rehabilitation Facility, your Provider may require authorization from us regarding your length of stay or number of treatments. We will make an eligibility determination for all concurrent claim submissions as quickly as possible, generally within one business day after receiving all information necessary to process the claim submission.

- ***Ongoing Services Determinations.*** If we have already authorized an ongoing service, or course of treatment to be provided over a period of time or number of treatments, we will notify you far enough in advance of any reduction or termination of coverage to allow you to appeal and receive an eligibility determination before the coverage is reduced or terminated. If you require an extension of ongoing care to treat an urgent medical condition, you should notify us as quickly as possible and no later than 24 hours before any authorized period of care is reduced or expires. We will notify you of our determination within 24 hours of receiving a request for extended Urgent Care.

- ***Post-Service Determinations.*** After you receive a health care service and a claim is filed in accordance with Section 6.1, we will make an eligibility determination as quickly as possible, but in any case no later than 30 days after we receive the claim submission.

5.4 Least Costly Setting.

The appropriate setting for services must safely provide the needed services at the least cost without adversely affecting your condition or quality of medical care. Payment for services will be limited to the extent of those for the least costly setting.

If you require an outpatient procedure, it can occur: (a) in an ambulatory surgical center; (b) a Provider's office or clinic; or (c) in a hospital outpatient department. If a procedure can be performed safely on an outpatient basis it

should be performed as an outpatient procedure. If it is performed in another setting, the procedure will be covered only to the extent an outpatient procedure would have been covered.

5.5 Case Management.

If your health care needs become complex, and you are using a high number of health services or multiple Providers, we may assign a case manager to you to help you navigate among multiple services. You or your Provider may also request a case manager.

Case managers are registered nurses or licensed social workers with specialized skills. Your case manager works with your Providers and our medical directors to enhance your quality of care. Case managers may authorize alternative benefits under Section 5.6.

We may utilize the services of a third party to assist with or perform case management.

5.6 Alternative Individual Benefits.

In certain circumstances, we may agree to cover some benefits for you that would not otherwise be covered by the Policy. We make those decisions on a case-by-case basis after examining the totality of the surrounding facts and circumstances.

Alternative individual benefits may be considered if: (a) your Provider, Oregon's Health CO-OP, and you agree in the advisability of alternative benefits in lieu of specified Covered Services; or (b) your condition will require substantial future expenditures for Covered Services, and your health care costs could be significantly reduced with provision of alternate benefits.

A decision by us to cover and pay for alternative benefits is for an individual. It is not a waiver of our right to reject any other request for alternative individual benefits. It is not a waiver of our right to reject any subsequent requests by the same individual.

5.7 Utilization Review.

Utilization review is used to determine coverage of urgent and emergency hospital admissions, as well as continued stay for elective admissions. All hospital admissions are reviewed by our utilization review staff. Our medical director reviews questions regarding: (a) Medical Necessity; (b) possible Experimental or Investigational services; (c) appropriate setting; and (d) appropriate treatment. We reserve the right have a third party assist with or perform the function of utilization management.

We determine Medical Necessity and length of stay for admissions using standards and criteria developed by a nationally-recognized organization.

When you are admitted to the hospital, the Facility will notify us within one business day after the admission. The Concurrent Review Nurse (CCRN) then follows up with the admitting hospital's Utilization Review Department to receive information about your condition to determine if the admission is appropriate. The CCRN may confer with the treating Physician's hospital staff and our Medical Director to determine if the stay is appropriate. Qualified health care personnel will be available for same-day telephone responses to inquiries concerning certification of continued length of stay.

We continue to monitor your care during your hospital stay to determine if you still meet coverage criteria. The CCRN will also work with the hospital staff to arrange a safe discharge to a lower level of care when you are ready. The CCRN may also visit you in the hospital to help coordinate your discharge to home or another care Facility.

If you choose to stay in the hospital longer than we consider Medically Necessary, you will be responsible for those charges.

If you would like information about how we reached a particular utilization review decision, please contact our Customer Service Department. We will provide you with a written summary of the information we consider in utilization review of the particular condition, if we in fact maintain such criteria.

A Physician will be responsible for all final recommendations regarding the necessity or appropriateness of services. The Physician will consult as appropriate with medical and mental health specialists in making such recommendations. The criteria used in the utilization review process and the method of development of the criteria are available for review to Network Providers upon request.

SECTION 6 CLAIMS, COORDINATION OF BENEFITS, AND APPEALS.

This Section 6 describes: (a) how to file claims for benefits under the Policy; (b) how we determine whether claims for benefits are eligible for coverage under the Policy; (c) important timeframes and information with respect to payment of claims; (d) how you may file Grievances; and (e) how you may file Appeals with respect to our determinations regarding your coverage under the Policy.

6.1 How To File a Claim.

Normally your claim will be filed directly by the Provider who treats you. To process your claim, you must present your ID Card to the Provider at the time of service and request that Oregon's Health CO-OP be billed. If you do not have your ID Card with you at the time of service, the Provider may still be able to provide the service. The Provider will bill us directly and we will pay for any Covered Services in accordance with the terms and conditions of the Policy.

If there is any service not covered by the Policy, the Provider may bill you directly. You are responsible to pay for any services not covered by the Policy. If you pay for any service that you believe is a Covered Service, you may request a reimbursement from us.

To request reimbursement for any payments you made directly to a Provider for Covered Services, you must send a written request to us. The written request must include: (a) the itemized bill you received from the Provider; (b) your complete name; (c) your date of birth; (d) your Group name; (e) your Group number; (f) your Policy number; and (g) the time, date and location of service.

All claims must be sent to:

Oregon's Health CO-OP, Claims, P.O. Box 3948, Corpus Christi, TX 78463

6.2 Deadline to File a Claim.

A claim made by your Provider (or any request for reimbursement submitted directly by you) must be made within 90 days of receiving the health care service. A claim submitted after 90 days may still be considered on a case-by-case basis. We will not consider any claim that is filed more than 365 days from the date of service unless you are documented as lacking legal capacity or in the case of a Medicaid claim. All claims submitted by Medicaid must be received by us within three years of the date of service in accordance with ORS 743.847.

6.3 Payment of Claims.

We will make all payments for eligible claims within the timeframes required by law. In most cases, we will make payments for health care services directly to the Provider who treated you. If we received all the information necessary to process your claim, in most cases we will pay that claim within 30 days of receipt. If we cannot process the claim because we need additional information, we will notify you. If we do not receive the additional information within 15 days of our request, we will either deny the claim, or notify you every 45 days while the claim remains unresolved.

If you are billed directly and pay for health care services, you will be reimbursed only if you provide written notice to us as described in Section 6.2. We reserve the exclusive right to pay benefits to you, your Provider, or both. No claim for benefits or payment under the Policy may be assigned to another person or estate.

We also reserve the right to recover from you any amount that may have been paid to your Provider or you in error in excess of any benefits authorized by the Policy due to duplicate coverage or fraud, and regardless of whether we applied any expense against any Deductible under the Policy.

6.4 Questions About Claims.

If you have any questions about the status of a claim for benefits, please contact our Customer Service Department. Please also contact us if you believe we have denied a claim in error.

6.5 Explanation of Benefits.

After we receive your claim for benefits, we will mail you a document called an Explanation of Benefits ("**EOB**"). The EOB is not a bill. The EOB explains how we processed your claim. It outlines how much we intend to pay on your claim and how much you may owe for your Deductible, Copayments, and Coinsurance. If any portion of your claim is denied, the EOB explains the reason why and explains any right you may have to appeal our decision.

6.6 Coordination of Benefits.

If you have health care coverage under more than one health insurance plan, we will coordinate benefits with your health insurance plans to ensure you receive the maximum coverage allowable under Oregon law. This Section 6.6 describes such coordination of benefits ("**COB**") in more detail. Terms used in this Section 6.6 and Section 6.7, specifically relating to COB, are defined in Section 6.6.1 below.

In Oregon, there is a set of rules governing COB. The plan that pays first is called the "primary plan." The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the "secondary plan." The secondary plan may reduce the benefits it pays so that payments from all plan do not exceed 100% of the total allowable expense.

6.6.1. Terms Relating to COB.

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

  - A plan includes: (a) group insurance contracts, health maintenance organization contracts, closed panel plans, or other forms of group or group-type coverage (whether insured or uninsured); (b) medical care components of group long-term care contracts, such as skilled nursing care; and (c) Medicare or any other federal governmental plan, as permitted by law.

  - A plan does not include: (a) hospital indemnity coverage or other fixed indemnity coverage; (b) accident only coverage; (c) specified disease or specified accident coverage; (d) school accident type coverage; (e) limited benefit health coverage, as defined by state law; (f) benefits for non-medical components of group long-term care policies; (g) Medicare supplement policies; (h) Medicaid policies; or (i) coverage under other federal governmental plans, unless permitted by law.

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

- The term "this plan" means, as used in this Section 6.6, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

- The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expense

- The term "allowable expense" means a health care expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any plan covering a person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering a person is not an allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a person is not an allowable expense.

  Below are examples of expenses that are not allowable expenses:

  - The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

  - If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

  - If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

  - If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. If the Provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

  - The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

- The term "closed panel plan" means a plan that provides health care benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

- The term "custodial parent" means the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

6.6.2. Order of Benefit Determination Rules.

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- ***Primary Plan.*** The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other plan.

  - *Oregon COB Provision.* Except as provided in the paragraph below, a plan that does not contain a COB provision that is consistent with Oregon's COB regulations is always primary unless the provisions of both plans state that the complying plan is primary.

  - *Supplemental Plans.* Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are: (a) major medical coverages that are superimposed over base plan hospital and surgical benefits; and (b) insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

- ***Secondary Plan.*** A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other Plan.

- ***Order of Benefits.*** Each plan determines its order of benefits using the first of the following rules that apply:

  - *Non-Dependent or Dependent.* The plan that covers the person other than as a dependent (for example as an employee, member, policyholder, subscriber or retiree) is the primary plan. The plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (for example as a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policy holder, subscriber or retiree is the secondary plan and the other plan is the primary plan.

  - *Dependent Child Covered Under More Than One Plan.* Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

    (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      (i) the plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or

      (ii) if both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

    (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married, the order of benefits is determined as follows.

      (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is the primary plan. This rule applies to plan years commencing after the plan is given notice of the court decree.

      (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above shall determine the order of benefits.

      (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the

dependent child, the provisions of subparagraph (a) above shall determine the order of benefits.

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows.

- the plan covering the custodial parent;
- the plan covering the spouse of the custodial parent;
- the plan covering the non-custodial parent; and then
- the plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

- *Active Employee or Retired or Laid-off Employee*. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled "Non-Dependent or Dependent" can determine the order of benefits.

- *COBRA or State Continuation Coverage*. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, policy holder, subscriber, or retiree or covering the person as a dependent of an employee, member, policy holder, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled "Non-Dependent or Dependent" can determine the order of benefits.

- *Longer or Shorter Length of Coverage*. The plan that covered the person as an employee, member, policy holder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

- If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

6.6.3. Effect on the Benefits of This Plan.

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

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

6.6.4. Right to Receive and Release Needed Information.

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

6.6.5. Facility of Payment.

A payment made under another plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6.6.6. Right of Recovery.

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

6.7 Coordination With Medicare.

In all cases, coordination of benefits with Medicare will conform with federal statutes and regulations. To the extent permitted by law, the Policy will not pay for any part of a covered expense if the expense is actually paid or would have been paid under Medicare.

If your Group's size is less than 20 employees, Medicare will be assumed to be the primary payer and we will coordinate benefits as the secondary payer even if you have not elected coverage under Medicare. When your Group's size is 20 employees or more, Medicare will be considered the secondary payer.

Please contact our Customer Service Department if you have questions.

6.8 Third Party Liability.

Third party liability means situations where a party other than you or Oregon's Health CO-OP may have an obligation to pay for your claim. For example, third party liability may arise due to a motor vehicle accident, a workplace injury or accident, or a wrongful death. It may involve another party's insurance policy, such as uninsured motorist coverage, underinsured motorist's coverage, workers' compensation insurance, or homeowner's insurance.

If you believe that a third party may be liable for your claim, you must notify us as soon as possible. It is important that you understand our rights and your obligations regarding third party liability. Failure to comply with this Section 6.8 could result in a denial of benefits and/or termination of your coverage under the Policy.

If we believe that a third party may be liable for your claim, we will send you a questionnaire. Please complete and return the questionnaire within 72 hours. If you have any question about third party liability procedures, please contact our Customer Service Department.

We will notify you if we determine that a third party is liable. In that case, we will require your cooperation to help pursue any claim against the third party.

6.8.1. Terms and Conditions.

As a Member, you agree that in all situations where a third party may be liable the following terms and conditions apply.

- The Policy is a secondary plan. We will not pay for any care for which a third party is liable.

- You agree to sign and return to us any document necessary for us to secure your or our rights and obligations against any third party. We will not be required to pay any benefits for any illness or injury unless we receive all signed documents requested from you.

- We are entitled to be reimbursed for any claim payments we have already made for which a third party is liable regardless of whether the third party admits liability or fault and regardless of whether the health care expenses are itemized or expressly included in the recovery.

- We have the right to reimbursement directly from the third party or from any recovery against the third party (whether paid or pending) including as a result of legal action (settlement, judgment, verdict or other monetary recovery) and regardless of fault.

- We have the right to a security interest in and lien upon any recovery for any claim payments we have already made. You agree to hold the right of recovery against the third party in trust for us.

- Before you accept any agreement or settlement of any claim against a third party, you must notify us in writing of the terms offered and you must notify the third party of our interest.

- To the fullest extent permitted by common and statutory law and the Policy, we are subrogated to your rights and remedies against any third party that may be liable for your condition. You must do everything necessary to secure your rights against the liable third party and do nothing to prejudice them.

- We may direct you to take legal action against a third party to recover any expenses. We also have the right to appoint an attorney to pursue legal action in its own name or in your name.

- If we do not receive reimbursement directly from the third party responsible, we are entitled to reimbursement from you, your heirs, beneficiaries or estate.

- You agree that we have the right to first priority over any proceeds you (or your legal representative, estate or heirs, or any trust established to pay future income or for your care) may receive from a third party settlement, award, verdict or other payment in recovery from a third party. Our right to first priority over any amount recovered is not limited in any way by how the recovery is characterized, regardless of actual or admitted liability, and regardless of whether you are made whole.

- Any amount you receive in settlement, regardless of fault, will first be used to reimburse us for any benefits it has already provided. We may deny you benefits until it has been fully reimbursed from any such settlement (less reasonable cost of your attorney's fees, if any, to obtain the settlement). Attorney's fees and court costs are your responsibility and will not be paid by us.

- If you have ongoing medical expenses related to the condition for which you receive a settlement from a third party, we will not cover those ongoing expenses unless the full amount received in settlement has first been used to reimburse us. We may also deny any other unrelated benefits to you in the future until we receive full reimbursement from any settlement.

6.8.2. Motor Vehicle Accidents.

Expenses for any illness or injury resulting from a motor vehicle accident are not Covered Services under the Policy and will not be paid by us if they are covered by an auto insurance policy or other insurance plan.

We may choose whether to advance benefits if you file a claim for expenses related to a motor vehicle accident and the responsible auto insurance policy has not yet paid.

We may choose whether to seek reimbursement under Oregon's Personal Injury Protection statutes including: (a) ORS 742.534; (b) ORS 742.536; (c) ORS 742.538; or (d) other applicable state law. We will normally seek reimbursement under ORS 742.538 if there is no question of liability.

To request that we advance benefits to cover expenses related to a motor vehicle accident, please contact our Customer Service Department.

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

Expenses for any illness or injury resulting from employment or self-employment are not Covered Services under the Policy and will not be paid by us unless you were injured in the course of employment and are an owner, partner, or principal of the employer group covered by us and are otherwise exempt from, and not covered by state or federal workers' compensation insurance.

Subject to this Section 6.8, we may choose whether to advance benefits if you file a claim with us for expenses related to an on-the-job illness or injury and the workers' compensation coverage has denied your claim and you have filed an appeal. Before we will advance any benefits, you must first sign a written agreement to reimburse us out of any money you recover from the workers' compensation coverage.

To request that we advance benefits to cover expenses related to an on-the-job illness or injury, please contact our Customer Service Department.

6.9 Grievances and Appeals.

We take your health and wellbeing seriously. If you have any questions or concerns about the benefits provided by us or about how we reached an eligibility determination, please contact our Customer Service Department. If we are unable to answer your question or address your concern, you have a right under state and federal law to file a formal grievance, and/or appeal a decision by us, as described in this Section 6.9 and in accordance with ORS 743.804(1)(C).

6.9.1. Grievances.

The term "grievance" means:

- a request submitted by you or your Authorized Representative: (a) in writing, for an internal appeal or an external review; or (b) in writing or orally, for an expedited response to a request for an internal appeal that accommodates the clinical urgency of the situation, or an expedited external review; or

- a written complaint submitted by you or your Authorized Representative regarding the: (a) availability, delivery, or quality of a health care service; (b) claims payment, handling or reimbursement for health care services and, unless you have not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination (defined below); or matters pertaining to the contractual relationship between you and Oregon's Health CO-OP.

6.9.2. How to Submit a Grievance.

Unless your grievance involves a claim involving Urgent Care, you must submit your grievance in writing to:

Oregon's Health CO-OP
220 NW Second Avenue, Suite 600
Portland, OR 97209

OR

Fax
503-946-6877 Prior Authorization & Medical Grievances
503-416-8103 All Other Grievances

Email: OHCOOPhelp@valencehealth.com

If your grievance involves Urgent Care, you may submit your grievance in writing or by calling our Customer Service Department.

Your grievance must include your name, the number on your ID Card, and a description of your grievance sufficient for us to understand and address it.

Your initial grievance must be received not later than 180 days after the incident. We will acknowledge receipt of your grievance within seven days of receipt. Unless your grievance involves Urgent Care, we will normally complete our investigation and respond to you within 30 days. If we require additional time, we will notify you and respond within an additional 15 days.

6.9.3. Adverse Benefit Determination.

The term "adverse benefit determination" means our denial, reduction, or termination of a health care item or service, or our failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on our: (a) denial of eligibility for or termination of enrollment in the Policy; (b) rescission or cancellation of the Policy or certificate; (c) Source-of-injury exclusion, network exclusion, annual benefit limit, or other limitation on otherwise Covered Services; (d) determination that a health care item or service is Experimental or Investigational or not Medically Necessary, effective, or appropriate; or (f) determination that a course or plan of treatment that you are undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854.

6.9.4. Appeals.

You or your Authorized Representative may appeal an adverse benefit determination by us. Upon request, you may receive, free of charge, reasonable access to documents used in any adverse benefit determination.

We will always provide written decisions about our appeal determination in plain language. We will also provide references to the relevant sections of our Policy and any relevant documentation that relate to our decision. Our personnel involved in the initial denial of benefits or first level of appeal will not be involved in our internal appeal and review process.

6.9.5. How to Submit an Appeal.

Pharmacy appeals must be submitted in writing to:

Oregon's Health CO-OP
Catamaran Prior Authorization and Appeals Department
P.O. Box 5252
Lisle, IL 60532

OR

Fax: 866-511-2202

All other appeals must be submitted in writing to:

Oregon's Health CO-OP
220 NW Second Avenue, Suite 600
Portland, OR 97209

OR

Fax
503-946-6877 Prior Authorization & Medical Appeals
503-416-8103 All Other Grievances Appeals

Email: OHCOOPhelp@valencehealth.com

6.9.6. First Level Appeal.

Unless your appeal involves Urgent Care, it must be submitted to us in writing within 180 days of receiving the adverse benefit determination.

We will acknowledge receipt of your appeal within seven days of receipt and will notify you of our decision within 30 days of receipt, unless additional time is required. For example, we may require additional information or explanation from you regarding your appeal. In such a case, we will notify you or your Authorized Representative before the end of the 30-day period (or within 15 days if your appeal involves a "pre-service" request).Once we complete the review of your appeal, we will notify you in writing and explain the reasons for our decision.

6.9.7. Second Level Appeal.

If you are not satisfied with the outcome of our appeal process, you may file a second appeal.

Your second level appeal must be received by us within 60 days of the date of our determination in response to your first level appeal.

We will notify you of its second level appeal decision within 30 days (or within 15 days if your appeal involves a "pre-service" request).

6.9.8. Additional Rights.

You or your Authorized Representative has the right to submit additional comments, documents, records and other material relating to the adverse benefit determination for consideration.

Upon request, you or your Authorized Representative also has the right to appear before a review panel during either the first or second level appeal.

6.9.9. Ongoing Coverage.

We will continue to provide coverage to you for any approved and ongoing course of treatment pending the conclusion of our internal review of your appeal. If we later determine that the course of treatment was not covered, you may be required to reimburse us for that amount.

6.9.10. Expedited Review.

If your grievance or appeal involves a matter of clinical urgency, please contact (or have your Authorized Representative contact) our Customer Service Department to request expedited review. To qualify for expedited review, you must provide documentation from your Provider that your life, health or ability to regain maximum function is in serious jeopardy or that a delay would subject you to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

6.9.11. External Independent Review.

If you dispute our decision in your case, you have the right to request an outside (external) independent review of our decision if it involves an adverse benefit determination regarding whether a course or plan of treatment is: (a) Medically Necessary; (b) Experimental or Investigational; (c) an active course of treatment for purposes of continuity of care under ORS 743.854; or (d) delivered in an appropriate health care setting and with the appropriate level of care.

External review will be conducted by an independent review organization ("**IRO**") appointed by the Oregon Insurance Division. We pay for the costs of the external review. A request for external review must be submitted to us in writing no later than 180 days after your receipt of our final internal adverse benefit determination. We will notify the Oregon Insurance Division of your request no later than the second business day after receipt of your request.

Normally, you must have exhausted both levels of our internal appeals process described above to become eligible for external review. However, we may waive this requirement and move immediately to external review. Also, you may immediately request external review at any time if we fail to strictly comply: (a) with our appeals process; or (b) with state and federal requirements for internal appeals.

To request external review, you must authorize the release of your medical records. You must also provide complete and accurate information to the IRO. You may submit additional information to the IRO, but you must do so within five business days of your receiving notification that an IRO has been appointed (or within 24 hours in the case of an expedited review).

If your request for external review involves a matter of clinical urgency, please contact (or have your Authorized Representative contact) our Customer Service Department as quickly as possible to request expedited review. In that case, we will expedite the external review.

An IRO must complete its review within: (a) three days for expedited reviews (notification is immediate); or (b) 30 days when not expedited (notification within 5 days).

We are required to follow the decision of the IRO. If we fail to follow the decision of the IRO we may be penalized by the Director of Oregon's Department of Consumer and Business Services. Also, you have a right to sue us if we fail to implement the IRO's decision.

The Director of the Oregon Department of Consumer and Business Services will randomly select an IRO for you. The IROs that provide external review are under contract with us. You may provide information or documentation to the Director if you believe there is a conflict of interest with the IRO assigned to review your case.

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

6.9.12. Additional Assistance.

If you have questions about how to file a grievance or appeal, or if you need assistance in a language other than English, please contact our Customer Service Department by calling toll free 1-844-509-4676.

You also have the right to file a complaint with or seek assistance from the Oregon Insurance Division at any time by contacting any of the following:

Oregon Insurance Division
PO Box 14480
Salem, Oregon 97309-0405
Telephone: (503) 947-7984
Toll-free: (888) 877-4894
E-mail: cp.ins@state.or.us
Website: http://www.insurance.oregon.gov/consumer/tomake.html

6.9.13. Additional Information from Us.

The following information and documentation is available from us at any time free of charge upon request: (a) any documents, records and other information relevant to an adverse benefit determination; (b) copies of the specific internal rule or standard we used in connection with an adverse benefit determination; and (c) copies of any explanation of the scientific or clinical judgment relevant to an adverse benefit determination, if an adverse benefit determination is based on Medical Necessity, Experimental or Investigational treatment, or similar exclusion.

6.9.14. Additional Information from the Oregon Insurance Division.

The following information and documentation is available from the Oregon Insurance Division free of charge upon request: (a) an annual summary of grievances and appeals against us; (b) an annual summary of utilization review policies; (c) an annual summary of quality assessment activities; (d) the results of all publically available accreditation surveys; (e) an annual summary of our health promotion and disease prevention; activities; and (f) an annual summary of scope of network and accessibility of services.

6.10 Rights and Responsibilities.

We strive to provide you with the best health care service available. As a Member, you have a number of important rights and responsibilities, as outlined below. It is our policy to provide a summary of your rights and responsibilities under the Policy to all Providers upon request and to the Group for distribution to all Members.

6.10(a) Your Rights.

You have the following rights under the Policy.

- ***Notice of Privacy Practices.*** We have a Notice of Privacy Practices that you can obtain by calling our Customer Service Department or visiting our website.
- ***Company Information*****.** You have the right receive information about our company, our services, our Providers and your rights and responsibilities under the Policy.
- ***Equal Opportunity*****.** You have the right to be treated with dignity and respect and to receive access to health care and benefits under the Policy regardless of your race, religion, gender, national origin or any disability.
- ***Explanations*****.** You have the right to receive clear explanations about benefits available under the Policy, Covered Services, and decisions related to your health care.
- ***Confidential Information.*** You have the right to have your personal information and medical records protected and kept confidential.
- ***Grievances and Complaints*****.** You have the right to file a Grievance or complaint about us or about any benefits determination you receive, and to appeal any decision you believe is wrong.
- ***Involvement.*** You have the right to communicate, cooperate and participate with your Provider in decisions about your own health care.

- ***Medical Information.*** You have the right to receive information about treatment, procedures and tests including about any risks or possible medical consequences that might be involved.

- ***Refuse Treatment.*** You have the right to refuse treatment and to change your mind about treatment you already agreed to.

- ***Informed Consent.*** You have the right to fully understand any consent form you are asked to sign, to make changes to any consent form, and to refuse to sign any consent form you do not understand or agree to.

- ***Make Recommendations.*** You have the right to make recommendations regarding our member rights and responsibilities policy.

- ***Vote on Certain Matters of Oregon's Health CO-OP.*** If you are over 18 years of age and are currently covered under the Policy, you may be qualified to be a voting member of Oregon's Health CO-OP according to the governance documents.

6.10(b) Your Responsibilities.

You have the following responsibilities under the Policy.

- ***Review Policy.*** You have a responsibility to review and understand the Policy and any other written communication you receive from us.

- ***Understand Rights and Responsibilities.*** You have a responsibility to contact us if you have any questions about the Policy or your rights or responsibilities under it.

- ***Cooperation.*** You have a responsibility to work with us and to provide information when requested so that we can provide benefits to you under the Policy.

- ***Provide Complete Information.*** You have a responsibility to work with and provide complete and truthful information to your Provider so that you can receive the best health care possible.

- ***Understand Benefits.*** You have a responsibility to contact us if you have questions about benefits under the Policy or about your health care.

- ***Follow Instructions.*** You have a responsibility to work with your Provider and follow any treatment plans or instructions you agree to.

- ***Preauthorization.*** You have a responsibility to obtain Preauthorization for certain health care services from us when necessary before you are treated.

- ***Policy Information.*** You have a responsibility to inform your Provider that you are covered by the Policy and to present your Member information and ID Card when requested.

- ***Medical Appointments.*** You have a responsibility to show up for your medical appointments on time and to contact your Provider far enough in advance if you need to cancel or reschedule your appointment. You are also responsible for paying any late fees your Provider may charge if you fail to notify them of a cancellation in time.

- ***Understand Health Issues and Develop Treatment Goals.*** You have a responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

SECTION 7 CONTINUATION OF COVERAGE.

Continuation coverage may be available to you when you would otherwise lose your coverage under the Policy. This Section 7 explains your right to continuation coverage. For more information about your continuation coverage rights and obligations, you should contact the Group's plan administrator.

7.1 Oregon Continuation Coverage.

The Oregon continuation coverage rules are discussed in this Section 7.1. These Oregon rules apply if the Group normally employed fewer than 20 employees during the preceding year. Otherwise, the federal COBRA continuation coverage rules will apply. Your Group will be able to tell you whether the Oregon rules or the federal COBRA rules apply to the Policy. If you elect Oregon continuation coverage, you must pay for the full cost of the coverage on a self-pay basis. Under both Oregon continuation coverage rules and the federal COBRA rules, same-sex couples validly married in other states qualify as spouses.

7.1.3. Eligibility.

If the Oregon rules apply, you are eligible for Oregon continuation coverage if you incur a qualifying event and you were enrolled in the Policy during the three-month period ending on the date of the qualifying event.

If the Oregon rules apply, a "qualifying event" means your loss of eligibility for coverage under the Policy caused by: (a) your voluntary or involuntary termination of the employment; (b) your reduction in hours worked; (c) your becoming eligible for Medicare; or (d) the termination of your enrollment in the Policy.

If you become eligible for Oregon continuation coverage, then continuation coverage is also available to: (a) your spouse or dependent child who, on the day before the qualifying event, was enrolled in the Policy; and (b) a child born to or adopted by you during the period of the continuation of coverage who would have been enrolled in the Policy if the child had been born or adopted on the day before the qualifying event.

The Oregon continuation of coverage is not available to you or any individual who is eligible for Medicare, or who after the date of the qualifying event becomes eligible for coverage under any other program providing hospital or medical expense coverage.

7.1.4. Election.

If the Oregon rules apply, an eligible individual who wishes to continue coverage must provide us with a written request for continuation no later than 10 days after the later of: (a) the date of a qualifying event; or (b) the date the individual is provided with the notice of the continuation coverage election rights.

7.1.5. Payment.

If you elect Oregon continuation of coverage, you must pay the premium for the coverage on a monthly basis. The payment for a month must be made prior to the beginning of the month. It must be paid directly to us. The required premium payment will not exceed the group premium rate charged by us to the Group for the coverage being continued.

7.1.6. Duration.

If the Oregon rules apply, continuation of coverage for any individual ends on the earliest of the following dates: (a) nine months after the date of the qualifying event; (b) the last day of the month for which the last timely premium payment for the coverage is received by us; (c) the last day of the month coinciding with or next following the date the individual becomes eligible for Medicare or another program providing hospital and medical expense coverage; or (d) the date that the insurance policy for the Policy is terminated; however, if the employer replaces the terminated policy with another group health insurance policy, then the continuation coverage will be made available under the replacement policy.

7.2 COBRA Continuation Coverage.

The federal continuation coverage rules are discussed in this Section 7.2. The Consolidated Omnibus Budget Reconciliation Act ("**COBRA**") is a federal law that will apply to the Policy for a year if the Group normally employed 20 or more employees during the preceding year. Otherwise the Oregon continuation coverage rules will apply.

COBRA continuation coverage is a continuation of coverage under the Policy when coverage would otherwise end because of a life event known as a qualifying event (discussed in this Section 7.2). If COBRA applies to the Policy, after the occurrence of a qualifying event COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Policy is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for the coverage on a self-pay basis. If you or any qualified beneficiary elects COBRA continuation coverage, you must pay for the full cost of the coverage on a self-pay basis.

7.2.1. Employee Eligibility.

If COBRA applies, and you are an employee, you are eligible for continuation coverage if you lose your coverage under the Policy because: (a) your hours of employment are reduced; or (b) your employment ends for any reason other than for gross misconduct.

7.2.2. Spouse Eligibility.

If COBRA applies, your spouse will become eligible for continuation coverage if your spouse loses coverage under the Policy because: (a) your hours of employment are reduced; (b) your employment ends for any reason other than for gross misconduct; (c) you become entitled to Medicare benefits; (d) you and your spouse become divorced or legally separated; or (e) you die.

7.2.3. Dependent Child Eligibility.

If COBRA applies, your dependent children will become eligible for continuation coverage if they lose coverage under the Policy because: (a) your hours of employment are reduced; (b) your employment ends for any reason other than for gross misconduct; (c) you becomes entitled to Medicare benefits; (d) you and your spouse become divorced or legally separated; (e) your child stops being eligible for coverage under the Policy as a dependent child; or (f) you die.

7.2.4. Notice of Qualifying Event.

The Policy will offer COBRA continuation coverage to qualified beneficiaries only after it has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Group will notify the Group's plan administrator of the qualifying event within 30 days after the date coverage ends.

In the case of your divorce or legal separation, or your dependent child's losing eligibility for coverage as a dependent child, you must notify the Group within 60 days after the qualifying event occurs. Your notice must include the nature and date of the qualifying event, the name of the person losing coverage, and a mailing address for that person.

Once the Group's plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary may separately elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

7.2.5. Duration.

COBRA continuation coverage is a temporary continuation of coverage. The coverage will continue to be made available for a length of time that is based on the particular qualifying event that causes the loss of eligibility for coverage under the Policy.

- ***18-month Coverage Period.*** Coverage for you, your spouse, and your dependent children may continue for up to 18 months, if the loss of coverage is due to your termination of employment or reduction in hours

- ***36-month Coverage Period.*** Coverage for your spouse and dependent children may continue for up to 36 months if the loss of coverage is due to: (a) your divorce or legal separation; (b) your eligibility for Medicare benefits if it causes a loss of coverage; (c) your death; or (d) your child no longer qualifies as a dependent child.

- ***Extension if You Are Already Entitled to Medicare.*** If you became entitled to Medicare benefits less than 18 months before your termination of employment or reduction of the hours of employment (an 18-month continuation coverage period), COBRA continuation coverage for your spouse and children (but not for you) may last until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare eight months before the date on which your employment terminates, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months, minus 8 months).

7.2.6. Disability Extension.

If you or anyone in your family covered under the Policy is determined by the Social Security Administration ("**SSA**") to be disabled and you notify the Group's plan administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage, and must last at least until the end of the 18-month period of continuation coverage.

In order to be eligible for this extended continuation coverage period, the disabled individual (or someone on the individual's behalf) must notify the Group's plan administrator of the SSA disability determination within 60 days of the issuance of the determination by the SSA (or, if later, within 60 days of the end of the month in which you terminate employment or have your hours reduced) and before the end of the otherwise applicable 18-month continuation period, whichever period ends first. The notice must include a copy of the SSA determination. If the notice of the SSA determination is not provided to the Group's plan administrator within this time period, then the 11-month extension of coverage will not be available.

If the SSA later makes a final determination that the individual is no longer disabled, you must notify the Group's plan administrator within 30 days of the final determination by the SSA.

7.2.7. Second Qualifying Event Extension.

If your spouse or dependent child experiences another qualifying event while receiving 18 months of COBRA continuation coverage (i.e., if you die, get divorced or legally separated, or if your dependent child stops being eligible for coverage as a dependent child), your spouse or dependent child can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months.

To receive this extended period of coverage, notice of the second qualifying event must be properly given to the Group's plan administrator. The notice must be provided to the Group's plan administrator within 60 days of the second qualifying event. Your notice must include the nature and date of the second qualifying event, the name of the person losing coverage, and a mailing address for that person.

7.2.8. Deadline for Election.

When the Group's plan administrator is notified that one of the above events has occurred, it will notify you or your covered dependents of the right to elect COBRA continuation coverage. The COBRA-eligible person must then elect continuation coverage within 60 days of the later of: (a) the date coverage would otherwise be lost; or (b) the date of notification from the Group's plan administrator.

Failure to elect continuation coverage within that period will cause coverage to end as it normally would under the terms of the Policy.

7.2.9. Cost.

You are responsible for the full cost of COBRA continuation coverage and any administrative fee assessed. Payment for COBRA continuation coverage for any month is due on the first day of the month. In all events, it must be made within 30 days of the due date. The only exception is the initial premium payment for the continuation coverage during the period preceding the election. In this case, the payment must be made within 45 days of the date of election. Premium rates may change annually.

7.2.10. When Continuation Coverage Ends.

COBRA continuation coverage will end if one of the following events occurs.

- ***Failure to Pay*.** COBRA will end if you fail to timely pay the full required continuation coverage premium.
- ***Group Termination*.** COBRA will end if your Group no longer offers group health coverage to any of its employees.
- ***Later Coverage*.** COBRA will end if you later become covered under any other group health plan. However, coverage under another plan will not cause COBRA to end if the other plan excludes or limits coverage for a pre-existing condition.
- ***Medicare*.** COBRA will end if you become entitled to Medicare benefits.
- ***End of Disability*.** COBRA will end if you qualified for an extra 11 months of COBRA continuation coverage based on a disability (along with persons receiving COBRA continuation coverage by reference to your disability) on the date of a final determination by the SSA that you are no longer disabled.
- ***Maximum Period Ends*.** COBRA will end when the applicable maximum period of continuation coverage ends.
- ***Fraud*.** COBRA may be terminated for cause. For example, it may be terminated if you submit a fraudulent claim.

COBRA continuation coverage may also be terminated for any reason the Policy would normally terminate coverage of an employee or dependent not receiving continuation coverage. Once COBRA continuation coverage ends, it cannot be reinstated.

7.2.11. Termination of Employment.

If you are terminated from employment for gross misconduct you are not entitled to COBRA continuation coverage. In such a case, your spouse and dependents are also not entitled to COBRA continuation coverage under the Policy.

7.2.12. Domestic Partner.

An employee's Domestic Partner, even if covered under a group health plan, has no independent COBRA election rights. Though a Domestic Partner does not have an independent COBRA election right, if an employee and Domestic Partner are both covered by the Policy, and they together lose coverage upon the employee's termination of employment or reduction in hours, the employee may elect COBRA continuation coverage that includes the Domestic Partner and the Domestic Partner's children, if any.

7.3 Spouses over 55 Years of Age.

If you die, become divorced or legally separated, and your covered spouse is 55 years of age or over, your spouse and any covered dependents may continue coverage under the Policy on a self-pay basis until the earliest to occur of the following.

- ***Failure to Pay*.** Coverage will end for failure to pay premiums when due.
- ***Group Terminates Health Care Coverage*.** Coverage will end if the Group terminates the Policy, unless another group health plan is made available by the Group to its employees.
- ***Later Coverage*.** Coverage will end if your legally separated, divorced or surviving spouse becomes covered under another group health plan, or becomes eligible for Medicare.

In order to be eligible for COBRA continuation coverage, your spouse or dependent must give written notice of the termination of marriage or legal separation, or death of the employee, to the Group's plan administrator within: (a) 30 days of the date of the employee's death; (b) 60 days of the date of legal separation; or (c) 60 days of the date of entry of the divorce decree.

7.4 USERRA Continuation Coverage.

7.4.1. Coverage During Military Service.

If you leave employment to perform services in the Armed Forces or another uniformed service, and if you would then otherwise cease to be eligible for coverage under the Policy, you will then have the choice between two forms of continuation coverage. First, you can elect Oregon or COBRA continuation coverage as applicable and discussed above. Alternatively, you can elect continuation coverage that is made available pursuant to the Uniformed Services Employment and Reemployment Rights Act ("**USERRA**"). The terms and conditions of the USERRA continuation coverage are discussed below.

7.4.2. Right to Coverage.

If you leave employment to enter into military service, you may elect USERRA continuation coverage. If you elect USERRA continuation coverage, you can also elect USERRA continuation coverage for any eligible dependents. Your dependents do not have separate USERRA coverage rights. Therefore, dependents cannot elect separate continuation coverage under USERRA if you choose not to do so.

7.4.3. Scope of Coverage.

The USERRA continuation coverage rules do not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the Veterans Administration.

During the period that you remain in such military service, you and covered dependents are eligible for coverage under the Policy even if they are then also covered under another group health program, such as the Civilian Health and Medical Program of the Uniformed Services.

7.4.4. Duration.

If you elect USERRA continuation coverage, the period for that coverage will extend for up to 24 months after the date you leave employment for the purpose of performing military service.

USERRA coverage will end automatically for you and dependents before the end of the 24-month coverage period if any of the following events occurs:

- ***Failure to Pay*.** Coverage will end if the premium for the USERRA continuation coverage is not paid on time.

- ***Group Terminates Health Care Coverage*.** Coverage will end if Group no longer provides health coverage to any employees.

- ***Employment Following Service*.** Coverage will end if you fail to timely return to employment or reapply for a position with the Group upon the completion of such military service.

7.4.5. Election.

If you intend to leave employment to perform service in the military, it is generally required by USERRA to provide us with notice of your intent. When feasible, the notice is to be provided to us at least 30 days prior to your departure.

If you do not provide the advance notice, then you will not have the right to elect USERRA coverage. You, however, may still be eligible to elect Oregon or COBRA continuation coverage, as applicable.

When we receive a notice of intended departure, you will be provided with an USERRA coverage election form. To elect USERRA continuation coverage, you must complete the election form, and mail or deliver it to the Group's plan administrator. The completed election form must be postmarked or delivered within 60 days after the last day of the month in which you left employment to perform military service (or, if later, within 60 days after the USERRA election form was provided to you). If you do not submit a completed USERRA election form by the due date, you will lose the right to elect USERRA coverage.

If you were unable to give advance notice of a departure for military service because it was impossible or unreasonable to do so under the circumstances, or because you were precluded from doing so by military necessity, the 60-day election deadline will be waived. In this situation, you should submit the USERRA election form when first able to do so.

In all cases, the right to USERRA coverage is conditioned upon you first remitting payment for the period extending through the date the election is made, as discussed more fully below.

7.4.6. Payment.

Generally, if you elect USERRA continuation coverage you are required to pay the entire cost of the continuation coverage. If the period of your absence is less than 30 days, the contribution rate will be the same as for active employees. If the absence is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

The USERRA continuation coverage payment rules are substantially the same as applicable under the COBRA rules discussed earlier. Thus, if you elect continuation coverage you are not required to send payment for continuation coverage with the USERRA election form. However, you must make the first payment for USERRA coverage in full within 45 days after the date of the initial election. If you do not make the first payment for continuation coverage within that 45-day period, you (and your covered dependents) will lose all USERRA coverage rights under the Policy.

After you have made the initial payment, future payments for USERRA coverage will be due as of the first day of each month. However, you have a grace period of 30 days to make each monthly payment. If you fail to make a monthly payment before the end of a grace period, the USERRA continuation coverage will be terminated effective as of the last day of the period for which the USERRA continuation coverage premium was received.

7.5 Replacement of Insurance Policy.

If the Policy is replaced by a policy of another insurer, we will remain liable with respect to an individual who is hospitalized on the policy replacement date. The coverage will be provided under the Policy while the individual remains hospitalized.

If we are the insurer for the replacement policy, we will remain liable for covered expenses under the terms of the Policy.

7.6 Strike or Lockout.

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

In the event of cessation of work by employees due to a strike or lockout, your coverage under the Policy will continue in effect if: (a) you were covered by the Policy on the date of the cessation of work; (b) you continue to pay your individual contribution; and (c) your union or other representative timely pays the contribution that would have been paid by the Group.

Coverage will not be continued beyond the earliest of the following dates: (a) the date as of which fewer than 75% of the employees normally enrolled have continued their coverage under the Policy; (b) the date as of which you take full-time employment with another employer; or (c) the date as of which you otherwise lose eligibility under the Policy.

If you are no longer eligible for continued coverage under this strike or lockout provision, you may still be eligible for continued coverage under the general continuation of coverage provisions of the Policy. Continuation of coverage under this provision will be concurrent with any eligibility period under Oregon or COBRA continuation, as applicable.

7.7 Workers' Compensation.

If you have an illness or injury covered by workers' compensation, you may continue your coverage under the Policy by self-paying the full amount of the Policy premium. The coverage will continue until the earlier of: (a) the date that you take full-time employment with another employer; or (b) six months from the date you first pay your health insurance premium under this Section 7.7.

Continuation under this Section 7.7 will be concurrent with Oregon or COBRA continuation coverage, as applicable.

SECTION 8 GENERAL.

8.1 No Transfer.

Only Members are entitled to the health care coverage offered under the Policy. The benefits under the Policy are not transferable to any other person. Any attempted transfer will be void and we will have no obligation to provide coverage to any person other than a Member.

8.2 Change of Beneficiary.

Unless a Member makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Member and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of the Policy or to any change of beneficiary or beneficiaries or to any other changes in the Policy.

8.3 Entire Contract; Changes.

The Policy including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by an executive officer of Oregon's Health CO-OP and unless

such approval be indorsed hereon or attached hereto. No insurance producer has authority to change the Policy or to waive any of its provisions. There are no promises, terms, obligations, representations or warranties other than those contained in the Policy. The Policy supersedes all other communications, representations or verbal or written agreements between the parties. The Policy will be binding upon the parties.

8.4 No Waiver.

No waiver of any provision of the Policy will be binding on a party unless it is in writing and signed by the party making the waiver. A party's waiver of a breach of a provision of the Policy will not be a waiver of any other provision or a waiver of a subsequent breach of the same provision.

8.5 Exhaustion of Appeals.

No claim may be filed in court until all internal levels of appeal provided by the Policy in Section 6 have first been fully exhausted. No civil action may be brought later than three years after the final decision is rendered upon the conclusion of the internal appeals process in Section 6.

8.6 Governing Law.

If the Policy is governed by state law, it will be governed under the laws of the State of Oregon.

8.7 Venue.

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

8.8 Legal Actions.

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

8.9 Physical Examinations and Autopsy.

We will, at our own expense, have the right and opportunity to examine a Member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

8.10 Time Limit On Certain Defenses.

After two years from the date of issue of the Policy no misstatements, except fraudulent misstatements, made by the applicant in the Group Application will be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of that period.

8.11 Statements Deemed Representations.

Statements made by applicant, policyholder, or insured person are deemed representations and not warranties.

SECTION 9 DEFINITIONS.

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

"**Advanced Diagnostic Imaging**" means CT scans, MRIs, PET scans, and nuclear cardiology.

"**Allowed Amount**" has the following meaning, depending on whether the term is applied to a Network or a non-Network Provider. For a Network Provider, the "Allowed Amount" for a Covered Service is the discounted maximum fee that the Network Provider has agreed to accept for the Covered Service.

For a Non-Network Provider, the "Allowed Amount" for a Covered Service means a percentage of the amount for the Covered Service that Providers in the relevant geographical area usually charge for the same or similar service or supply. For Non-Network Providers, we determine the Allowed Amount.

"**Authorized Representative**" means an individual who by law or by the consent of a person may act on behalf of the person.

"**Balance Billing**" means the amount by which the Non-Network Provider's charge for the Covered Service exceeds the Allowed Amount for the Covered Service. You are responsible for paying all charges from Balance Billing.

"**Basic Health Program**" means a health plan established under Section 1331 of the Patient Protection and Affordable Care Act of 2010 (PPACA) designed for individuals with a household income between 133% and 200% of the federal poverty level.

"**Brand Name Drug**" means a Prescription Drug that a pharmaceutical company has exclusive rights to produce and sell.

"**Calendar Year**" is the period beginning January 1 of any year through December 31 of the same year.

"**Contract Year**" is the period of time from the effective date of the contract or policy to the expiration date of the contract or policy.

"**CDC**" means Centers for Disease Control and Prevention.

"**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.

"**CHIP**" means the Children's Health Insurance Program administered by the United States Department of Health and Human Services.

"**COB**" means "coordination of benefits" and refers to the method for determining which insurer is primarily responsible for payment and in which amounts when a Member is covered by more than one insurer.

"**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act.

"**Coinsurance**" is an amount that you must pay for a specific Covered Service, expressed as a percentage of the Allowed Amount. The Schedule of Benefits states the Coinsurance (if applicable) for each Covered Service.

"**Complications of Pregnancy**" means conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency Caesarean section are not complications of pregnancy.

"**CO-OP**" means a Consumer Operated and Oriented Plan.

"**Copayment**" means a fixed amount that you must pay for a specific Covered Service. The Schedule of Benefits states the Copayment (if applicable) for each Covered Service.

"**Covered Service**" means a health care service or supply that is covered as a benefit under the Policy in accordance with the terms and conditions of the Policy.

"**Creditable Coverage**" means an individual's prior health coverage under any of the following: (i) a group health plan; (ii) individual health insurance; (iii) Medicare; (iv) Medicaid; TRICARE; Indian Health Service or tribal organization; a state high risk pool; Federal Employees Health Benefit Plan; Children's Health Insurance Program; a public health plan; or a health benefit plan under the Peace Corps Act.

"**Customer Service Department**" means our customer service department. You can contact our Customer Service

Department by calling toll-free 1-844-509-4676 or by writing to us at Oregon's Health CO-OP, P.O. Box 3948, Corpus Christi, TX 78463.

"**Deductible**" means the amount you must pay before you receive any benefits for specified Covered Services in a Calendar Year. You pay your Deductible directly to your Provider. The Schedule of Benefits states your Deductible and indicates which specific Covered Services are subject to your Deductible.

"**Domestic Partner**" means an individual who has entered into a Domestic Partnership, which is a civil contract entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon.

"**Durable Medical Equipment**" is defined in Section 4.9.5, and means equipment that: (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose rather than convenience or comfort; (c) is generally not useful to a person in the absence of an illness or injury; and (d) is appropriate for use in the home.

"**Eligible Employee**" means an employee who meets the qualifications set forth in Section 2.1.

"**Eligible Family Member**" means a person who meets the qualifications set forth in Section 2.2.

"**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: (a) place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy; (b) result in serious impairment to bodily functions; or (c) result in serious dysfunction of any bodily organ or part. In the case of a pregnant woman who is having contractions, an Emergency Medical Condition exists when there is inadequate time to affect a safe transfer to another hospital before delivery, or when a transfer may pose a threat to the health or safety of the woman or the unborn child.

"**Emergency Medical Transportation**" means ambulance services for an Emergency Medical Condition.

"**Emergency Services**" means evaluation of an Emergency Medical Condition and treatment to keep the condition from getting worse.

"**EOB**" means Explanation of Benefits ("EOB"), which is a document that is not a bill but which explains how we processed your claim.

"**Essential Health Benefits**" means the benefit categories set forth in Section 4.

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

"**Experimental or Investigational**" means services or supplies that we determine are not Medically Necessary or do not conform to generally accepted practice standards for the community because they are experimental or investigational for the diagnosis and treatment of illness or injury. Experimental and investigational includes services and supplies that: (a) any government agency considers to be experimental or investigational; (b) are not approved for reimbursement by the Centers for Medicare and Medicaid Services; (c) are provided for research purposes; (d) have not received approval by the FDA or other governmental agencies; or (e) are provided under investigational protocol. We may make decisions about whether services or supplies are investigational by relying upon external reviews by external review organizations or agencies. We may also rely on medical literature and expert opinions of specialists.

"**Facility**" means a licensed health care facility, including but not limited to a hospital, an ambulatory surgery center, a skilled nursing facility, and a freestanding birthing center.

"**FDA**" means the U.S. Food and Drug Administration.

"**Formulary**" means a list of drugs selected by us in consultation with a team of health care providers. The list represents prescription therapies that provide a quality and safe treatment program. The Formulary includes Brand Name Drugs and Generic Drugs. The Formulary designates which drugs and medications are Specialty Drugs or

Maintenance Drugs.

"**Generic Drug**" means a Prescription Drug with the same active ingredient and as safe and effective as a Brand Name Drug.

"**Group**" means the employer or association group that entered into the Group Contract with us. The name of the Group is set forth on the cover page of this Member Benefit Handbook.

"**Group Application**" means the group application that the Group completed and submitted to us to apply for the issuance of the Policy.

"**Group Contract**" means the contract between the Group and us under which we agree to issue the Policy.

"**Group Contract Schedule of Terms**" means the document with that title that is attached to the Group Contract.

"**Group Contract Year**" means the 12-month period that begins on the effective date of the Group Contract.

"**Habilitation Services**" means health care services that help a person keep, learn or improve skills and functioning for daily living. An example includes therapy for a child who is not walking or talking at the expected age. These services may include: (a) physical and occupational therapy; (b) speech-language pathology; and (c) other services for people with disabilities in a variety of inpatient or outpatient settings.

"**Hospice Services**" means services to provide comfort and support for persons in the last stages of a terminal illness, and includes medical services that alleviate symptoms or afford temporary relief but do not cure.

"**Hospitalization**" means care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

"**ID Card**" means the identification card issued by us to the Members that evidences coverage under the Policy.

"**IRO**" means independent review organization and is defined in Section 6.9.11.

"**Mail Order Pharmacy**" means a pharmacy that specializes in direct delivery of your prescriptions to your home. Most covered drugs and medications are available through a mail order service. Network mail order pharmacies are designated in the Network pharmacy list. Forms and instructions for using a mail order service are available on our website, www.ohcoop.org, or call our Customer Service Department.

"**Maintenance Drug**" means a Prescription Drug typically used for long term treatment of chronic conditions, such as high blood pressure, high cholesterol, and diabetes.

"**Medical Supplies**" is defined in Section 4.9.5 and 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.

"**Medically Necessary**" or "**Medical Necessity**" means health care services or supplies that we believe are reasonably needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, and that we believe meet all of the criteria set forth in Section 4.

"**Member**" means an Eligible Employee or Eligible Family Member who is enrolled to receive coverage under the Policy. A Member is an "enrollee" for the purpose of ORS 743.730.

"**Member Benefit Handbook**" means the document you are reading.

"**Mental Health**" or "**Nervous Conditions Health**" means all disorders listed in the current edition of the "Diagnostic and Statistical Manual of Mental Disorders, DSM-V," except for: (a) Mental Retardation; (b) Learning Disorders; (c) Paraphilias; and (e) "V" codes V15.81 through V71.09, except for treatment to children five years of age or younger for diagnostic codes V61.20, V61.21, and V62.82.

"**Mental Health Provider**" means a Provider that has met our credentialing requirements, is eligible for reimbursement under Section 4.5, and is: (a) a Facility; (b) a residential program; (c) a day or partial Hospitalization program; (d) an outpatient service; or (e) an individual behavioral health or medical professional authorized for reimbursement under Oregon law.

"**Network**" means the Providers and suppliers who have a contract with us to provide Covered Services to our Members.

"**Network Provider**" means a Provider who is in the Network.

"**Non-Network**" means the Providers and suppliers who do not have a contract with us to provide Covered Services to our Members.

"**Non-Network Provider**" means a Provider who is not in the Network. .

"Out-Of-Pocket" means amounts you must pay directly to Providers out of your own personal funds for Covered Services. "Out-Of-Pocket" spending includes amounts you spend to satisfy your Deductible, Copayment, and Coinsurance obligations under the Policy. "Out-Of-Pocket" spending does not include amounts you may spend on the premium, charges from Balance Billing, or health care services or supplies that are not covered by the Policy.

"**Out-of-Pocket Maximum**" is defined in Section 3.7 and means is the maximum amount of aggregate Out-of-Pocket expenses you must pay in a Calendar Year for your Deductible, all Copayments, and all Coinsurance.

"**Oregon's Health CO-OP**" means Community Care of Oregon, Inc., an Oregon nonprofit corporation.

"**Orthotic Devices**" means defined in Section 4.9.5 and means rigid or semi-rigid 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.

"**Physician**" means a licensed Doctor of Medicine or Doctor of Osteopathy.

"**Policy**" means the legal agreement that requires us to cover some or all of your health care costs, in return for the payment premiums. The Policy includes: (a) this Member Benefit Handbook; (b) the Schedule of Benefits; (c) the Group Application; (d) the Group Contract; and (e) the Group Contract Schedule of Terms.

"**Policy Year**" means the 12-month period that begins on the effective date of the Policy. If the Policy is renewed, it means the 12-month period that begins on the first day of the new 12-month term.

"**Preauthorization**" means an advanced decision by us to determine whether a health care service, treatment plan, prescription drug or Durable Medical Equipment is Medically Necessary. The Policy may require Preauthorization for certain services before you receive them, except in an emergency. Preauthorization is not a promise your health insurance or plan will cover the cost.

"**Preexisting Condition Exclusion**" means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial), including: (a) a condition identified as a result of a pre-enrollment questionnaire or physical exam; or (b) a review of medical records relating to the pre-enrollment period.

"**Prescription Drug**" means a drug or medication that must be prescribed by a licensed Physician or medical provider.

"**Primary Care Provider**" means a Network Provider designated as a "Primary Care Provider" in our Provider Directory. The following professionals can be Primary Care Providers: (a) Physicians who specialize in family medicine, general practice, internal medicine, osteopathic medicine, or pediatrics; (b) nurse practitioners who

specialize in adult practice, family practice, pediatrics, or women's health care; (c) physician assistants; and (d) naturopathic doctors

"**Prosthetic Devices**" is defined in Section 4.9.5 and 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.

"**Provider**" means a Physician, naturopathic doctor, nurse practitioner, or health care professional acting within their scope of license, or Facility licensed, certified or accredited as required by state law that provides health care services or supplies.

"**Provider Directory**" means the directory we maintain that lists the Network Providers. The Provider Directory is on our website at www.ohcoop.org.

"**Rehabilitation Services**" means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. The services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and outpatient settings.

"**Retail Pharmacy**" means a pharmacy that provides most Prescription Drugs and medications to the general public.

"**Schedule of Benefits**" means the document that has that title and is an attachment to this Member Benefit Handbook. The Schedule of Benefits displays your Deductible, Out-of-Pocket-Maximums, Copayments, and Coinsurance.

"**Specialist**" means a Provider that is not a Primary Care Provider and who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

"**Specialty Drug**" means a Prescription Drug that requires specialized delivery, handling, or administration. Specialty Drugs are injectable, infused, oral or inhaled therapies. Generally, Specialty Drugs are expensive. Due to the nature of these drugs, Specialty Drugs are not considered Maintenance Drugs and are limited to a 30-day supply. Specialty Drugs are available from Specialty Pharmacies.

"**Specialty Pharmacy**" means a pharmacy that can provide Specialty Drugs. A Specialty Pharmacy may also be a Retail Pharmacy. Specialty Pharmacies are designated in the Network pharmacy list.

"**SSA**" means Social Security Administration.

"**TMJ**" means temporomandibular joint.

"**Urgent Care**" means care for an illness, injury or condition serious enough that a reasonable person would promptly seek care. Urgent Care is not: (a) care necessary for an Emergency Medical Condition; or (b) routine care that can be delayed until you can be seen by a Provider in the Provider's office.

"**USERRA**" means the Uniformed Services Employment and Reemployment Rights Act.

"**USPSTF**" means the U.S. Preventive Services Task Force.