# Table of Contents

1. Introduction ........................................................................................................... 9

2. Welcome To AllCare PEBB .................................................................................. 11
   2.1 Your AllCare PEBB Plan .................................................................................. 11
   2.2 Member Handbook .......................................................................................... 12
   2.3 Member Service ............................................................................................... 13
   2.4 Your Employer’s Benefit Office ...................................................................... 13
   2.5 Registering For An AllCare PEBB For Me Account ....................................... 13
   2.6 Your AllCare PEBB ID Card ............................................................................ 13
   2.7 AllCare PEBB Nurse Help Line ...................................................................... 14
   2.8 Wellness Benefits .......................................................................................... 14
   2.9 Privacy Of Member Information ...................................................................... 15

3. Eligibility and Enrollment ................................................................................. 17
   3.1 PEBB Member Eligibility and Enrollment ..................................................... 17
   3.1.1 Eligibility, Effective Date, Enrollment ............................................................ 17
   3.2 Dependent Eligibility and Enrollment ........................................................... 17
   3.2.1 Eligible Family Dependents, Eligibility Date ............................................... 17
   3.2.2 Eligible Family Dependent Enrollment ..................................................... 17
   3.2.3 Newborn Eligibility and Enrollment ............................................................ 17
   3.3 Special Enrollment Periods ............................................................................ 18
   3.3.1 Premium Assistance .................................................................................... 18

4. How To Use Your Plan ..................................................................................... 19
   4.1 Indian Health Services Providers .................................................................... 19
   4.2 The Role Of A Preferred Primary Care Provider (PPCP) .................................. 19
   4.2.1 Preferred Primary Care Providers (PPCP) ..................................................... 20
   4.2.2 Established Patients with Preferred Primary Care Provider (PPCP) ....... 20
   4.2.3 Changing Your Preferred Primary Care Provider (PPCP) ....................... 20
   4.2.4 Office Visits ................................................................................................ 20
   4.2.5 Notice of Provider Termination ................................................................. 21
   4.3 Services Provided Without A Preferred Primary Care Provider (PPCP)
      Referral Or By Participating or Out-of-Network Providers ................................ 21
   4.4 Covered Services That Require Prior Authorization ...................................... 23
   4.4.1 Failure to Obtain Prior Authorization ......................................................... 24
   4.5 Medical Cost Management ............................................................................ 25
4.5.1 Coverage of New Technology and New Application of Existing Technology ................................................... 25
4.6 Medically Necessary Services ............................................. 26
4.7 Approved Clinical Trials ................................................ 27
4.8 How Benefits Are Applied ............................................. 27
4.9 Your Costs ..................................................................... 27
4.9.1 Understanding Deductibles ............................................... 28
4.9.2 Understanding Copayments and Coinsurance ....................... 28
4.9.3 Understanding Out-of-Pocket Maximums ................................ 29
4.9.4 Understanding Maximum Cost Shares .................................. 30

5. Covered Services ................................................................ 32
5.1 Provider Services .......................................................... 32
5.1.1 Office Visits, Inpatient and Outpatient Hospital Visits and Home Visits ................................................... 32
5.1.2 E-visits: Electronic Provider Communications ...................... 33
5.1.3 Telemedical Services ..................................................... 34
5.1.4 Administration of Anesthesia, Injectable Medications, and Surgical Procedures 34
5.2 Preventive Services .......................................................... 35
5.2.1 Physical Examinations and Well-Baby Care .......................... 35
5.2.2 Immunizations and Vaccinations ........................................ 36
5.2.3 Gynecological Examinations ............................................ 36
5.2.4 Mammograms .............................................................. 36
5.2.5 Family Planning Services ................................................. 36
5.2.6 Elective Sterilization ....................................................... 37
5.2.7 Prostate Cancer Screening Exams ...................................... 37
5.2.8 Colorectal Cancer Screening Exams .................................... 37
5.2.9 Preventive Services for Members with Diabetes .................... 38
5.2.10 Nutritional Counseling .................................................... 38
5.3 Maternity Services .......................................................... 38
5.3.1 Breastfeeding Counseling and Support ............................... 39
5.4 Hospital and Skilled Nursing Facility Services ......................... 39
5.4.1 Hospital Services .......................................................... 40
5.4.2 Observation Care .......................................................... 41
5.4.3 Skilled Nursing Facility .................................................... 41
5.4.4 Rehabilitative Care (Inpatient) ........................................... 41
5.5 Mental Health and Chemical Dependency Services ................... 41
5.5.1 Mental Health Services .................................................... 41
5.5.2 Chemical Dependency Services ....................................... 42
5.6 Outpatient Hospital Services .............................................. 43
5.11.6 Preferred Mail Order and Preferred Retail Pharmacies ........................................... 58
5.11.7 Prescription Drug Limitations .............................................................................. 59
5.11.8 Prescription Drug Exclusions .............................................................................. 59
5.11.9 Prescription Drug Disclaimer .............................................................................. 60
5.11.10 Prescription Drug Exception Process ............................................................... 61
5.12 Prior Authorization .................................................................................................. 61

6. Limitations For Specified Covered Services ............................................................. 62

- Human Organ/Tissue Transplants ................................................................................ 62
  6.1.1 Covered Services ...................................................................................................... 62
  6.1.2 Benefits for Donor Costs ......................................................................................... 63
  6.1.3 Benefits for Transplant Facility Services Provided to the Organ Recipient ............ 63
  6.1.4 Benefits for Outpatient Medications ....................................................................... 63
  6.1.5 Benefits for Physician/Provider Services Provided to the Organ Recipient .......... 63
  6.1.6 Transplant Prior Authorization ................................................................................ 64
  6.1.7 Transplant Exclusions ............................................................................................. 64

- Restoration Of Head/Facial Structures; Limited Dental Services .................................. 65
  6.2.1 Temporomandibular Joint (TMJ) Services .............................................................. 65
  6.2.2 Outpatient Hospitalization and Anesthesia for Limited Dental Services ............... 66

- Infertility Services ......................................................................................................... 66

- Additional-Cost Tier Services ........................................................................................ 67

- Genetic Testing and Counseling Services ...................................................................... 68

7. Exclusions ..................................................................................................................... 69

8. Claims Administration .................................................................................................. 75

- Submitting Claims ......................................................................................................... 75
  8.1.1 Right of Recovery .................................................................................................... 76

- Third-Party Liability/Subrogation .................................................................................. 76
  8.2.1 Third-Party Liability/Subrogation and How it Affects You ...................................... 77
  8.2.3 Proceeds of Settlement or Recovery .................................................................. 78
  8.2.4 Suspension of Benefits and Reimbursement ...................................................... 78

- Coordination of Benefits (COB) .................................................................................... 79
  8.3.1 Definitions Relating to COB .................................................................................. 79
  8.3.2 Priority between Plans ........................................................................................... 81
  8.3.3 Effect on the Benefits of This Plan ....................................................................... 84
  8.3.4 Right to Receive and Release Necessary Information ....................................... 85
  8.3.5 Facility of Payment ............................................................................................... 85
  8.3.6 COB Right of Recovery .......................................................................................... 85

- Non-Duplication Of Coverage ....................................................................................... 85
  8.4.1 Coordination with Medicare .................................................................................. 85
8.5 RAPAH (Radiologist, Anesthesiologist, Pathologist, Ambulance, and Hospitalists) Provision .......................................................... 86

9. Problem Resolution .................................................................. 87
  9.1 Informal Problem Resolution .................................................. 87
  9.2 Member Grievance and Appeal ................................................. 87
    9.2.1 Your Grievance and Appeal Rights ........................................ 88
    9.2.2 Internal Grievance or Appeal .............................................. 89
    9.2.3 Voluntary Second Level Internal Appeal ....................... 89
    9.2.4 External Review .............................................................. 90
    9.2.5 Information Available Upon Request ............................... 90
    9.2.6 How to Submit Grievances or Appeals ............................... 91
    9.2.7 Assistance from the Department of Consumer and Business Services ................................................................. 91

10. Termination Of Member Coverage ........................................ 92
    10.1 Termination Events ........................................................... 92
    10.2 Termination and Rescission Of Coverage Due To Fraud or Abuse ................................................................. 92
    10.3 Non-Liability After Termination ........................................... 92

11. Continuation Of Medical Benefits (Cobra) ............................ 93
    11.1 Cobra Qualifying Events ..................................................... 93
        11.1.1 Member’s Continuation Coverage ................................. 93
        11.1.2 Spouse’s or Domestic Partner’s Continuation Coverage .... 93
        11.1.3 Dependent’s Continuation Coverage ............................ 93
    11.2 Notice Requirements .......................................................... 94
    11.3 Cobra Administration Services For PEBB ............................ 94
    11.4 Type Of Continuation Coverage .......................................... 94
    11.5 Cobra Election Rights Of PEBB Members ............................ 94
    11.6 Cobra Premiums ............................................................... 94
    11.7 Length Of Continuation Coverage ....................................... 95
        11.7.1 18-Month Continuation Period .................................... 95
        11.7.2 29-Month Continuation Period .................................... 95
        11.7.3 36-Month Continuation Period .................................... 95
        11.7.4 Extension of Continuation Period .................................. 96
        11.7.5 Extension of Coverage for a Spouse or Oregon Registered Certificate Domestic Partner ......................... 96
    11.8 The Trade Act Of 2002 ....................................................... 97
    11.9 When Cobra Continuation Coverage Ends ............................ 97

12. Qualified Medical Child Support Orders (QMCSO) .................... 98
    12.1 Definitions ................................................................. 98
1. Introduction

TO: PEBB Members

FROM: Public Employees' Benefit Board (PEBB)

Thank you for choosing AllCare PEBB. We look forward to meeting your current and future health care needs. Please read the next few paragraphs as we outline several key aspects of AllCare PEBB.

The benefits described on the following pages are effective Jan. 1, 2017, and are designed to provide you and your dependents as PEBB Members with the best possible medical care at reasonable prices and rates. PEBB has designed this Plan in cooperation with AllCare PEBB. The benefits under the Plan are provided by PEBB through AllCare PEBB Health Plan who insures and guarantees benefits, pays claims, provides Member Services and Care Coordination Services to PEBB Members.

This Member Handbook contains important information about your health plan coverage. It is important that you read this Member Handbook carefully as it explains your benefits and Member responsibilities. If you do not understand a term that is used, you may find it in Definitions, section 14. Should you require additional information concerning this medical plan or any topic related to your medical insurance, please contact Member Services at the numbers listed on page 2.

If more than one year has elapsed since the effective date of your previous Member Handbook, benefits may have changed. In all cases, benefits will be administered in accordance with the governing plan documents, insurance contracts or applicable Federal and State regulations.

- Some capitalized terms have special meanings. Please see section 14, Definitions.

- In this handbook, Members participating in the AllCare PEBB plan are referred to as “you” or “your”.

- AllCare PEBB is a Managed Care Organization offering three tier benefit plans. With AllCare PEBB, you will have lower Out-of-Pocket expenses when you obtain Covered Services from a Preferred/Participating Provider and when your care is coordinated by your Preferred Primary Care Provider (PPCP). You may obtain most Covered Services from Out-of-Network providers, but that will result in higher Out-of-Pocket expenses for most Covered Services. Please see section 3 and your Benefit Summary for additional information.

- All AllCare PEBB plan Members must choose a Preferred Primary Care Provider (PPCP) to provide preventive and primary care services and coordinate other care in a convenient and cost-effective manner. Failure to choose a Preferred Primary Care Provider (PPCP) will result in higher Out-of-Pocket expenses for most Covered Services.

- A printable directory of Preferred Primary Care Providers (PPCP) in the AllCare PEBB Service Area is available at AllCareHealth.com/Public-Employees.

- Certain Covered Services require an approved Prior Authorization, as specified in section 4.4.
1. Introduction

- Coverage under the AllCare PEBB plan is available 24 hours a day, seven days a week and during periods of domestic and foreign travel. Worldwide coverage for Urgent and Emergency care.

- All Covered Services are subject to the provisions, limitations and exclusions as are specified in this AllCare PEBB Member Handbook. Please read the provisions, limitations, and exclusions before seeking services because not all health care services are covered by this plan.

Member Services Quick Reference Guide

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and prescription drug claims and benefits</td>
<td>(541) 474-PEBB [7322] or toll free at (888) 460-0185 (800) 735-2900 (TTY)</td>
</tr>
<tr>
<td></td>
<td>AllCareHealth.com/Public-Employees</td>
</tr>
<tr>
<td>Mail order prescription drug services</td>
<td>Postal Prescription Services (503) 797-2100 <a href="http://www.ppsrx.com">http://www.ppsrx.com</a></td>
</tr>
<tr>
<td>Medical Prior Authorization Requests</td>
<td>(541) 474-PEBB [7322] or toll free at (888) 460-0185 (800) 735-2900 (TTY)</td>
</tr>
<tr>
<td></td>
<td>AllCareHealth.com/Public-Employees</td>
</tr>
<tr>
<td>Mental Health and Chemical Dependency Prior Authorization</td>
<td>(541) 474-PEBB [7322] or toll free at (888) 460-0185 (800) 735-2900 (TTY)</td>
</tr>
<tr>
<td></td>
<td>AllCareHealth.com/Public-Employees</td>
</tr>
<tr>
<td>AllCare PEBB Nurse Helpline</td>
<td>Toll free at (866) 234-0637</td>
</tr>
<tr>
<td>AllCare PEBB Resource Line for health education classes</td>
<td>(541) 474-PEBB [7322] or toll free at (888) 460-0185 (800) 735-2900 (TTY)</td>
</tr>
<tr>
<td></td>
<td>AllCareHealth.com/Public-Employees</td>
</tr>
<tr>
<td>AllCare PEBB Help desk</td>
<td>(541) 474-PEBB [7322] or toll free at (888) 460-0185 (800) 735-2900 (TTY)</td>
</tr>
<tr>
<td></td>
<td>AllCareHealth.com/Public-Employees</td>
</tr>
</tbody>
</table>
2. Welcome To AllCare PEBB

Thank you for choosing AllCare PEBB. We look forward to meeting your current and future health care needs. Our goal is to help improve the health and well-being of individuals in the communities we serve. This booklet contains important information about the AllCare PEBB coverage offered to PEBB Subscribers and their Dependents.

2.1 Your AllCare PEBB Plan

Your AllCare PEBB Plan allows you to receive Covered Services from Preferred, Participating, and Out-of-Network Providers. As a Member of our plan, you are required to choose a Preferred Primary Care Provider (PPCP) (see exception below).

Generally, your Out-of-Pocket costs will be less when you receive Covered Services from a Preferred Provider, and when your care is coordinated through your Preferred Primary Care Provider (PPCP).

You also have the option to receive Covered Services from Participating and Out-of-Network Providers without a referral; Prior Authorization rules apply (see section 4.4) and cost shares will be higher.

How to Choose a Preferred Primary Care Provider (PPCP)

Start by selecting a Preferred Primary Care Provider (PPCP). There are more than 270 Preferred Primary Care Providers (PPCP) to choose from. You and your covered Dependents may choose the same or different Preferred Primary Care Provider (PPCP), depending on your preferences and needs. A list of Preferred Primary Care Providers (PPCP) can be found online at AllCareHealth.com/Public-Employees.

We do not require covered dependents living outside of our Service Area (Josephine, Jackson, Curry counties, and Glendale and Azalea in Douglas County) to choose a Preferred Primary Care Provider (PPCP). Participating Network or Out-of-Network cost shares and Prior Authorization rules apply (see section 4.4).

Once you have chosen a Preferred Primary Care Provider (PPCP), please communicate your selection to AllCare PEBB before receiving services:

Phone: Call Member Services at (888) 460-0185, seven days a week, 8 a.m. to 8 p.m., Pacific. Office hours are 8 a.m. to 5 p.m., Pacific, Monday through Friday.

Mail: Download the Preferred Primary Care Provider (PPCP) Selection Form at AllCareHealth.com/Public-Employees. Mail your completed form to:

AllCare PEBB
Attn: PEBB Member Services 1701 NE 7th Street
Grants Pass, OR 97526

Fax: Download the Preferred Primary Care Provider (PPCP) Selection Form online at AllCareHealth.com/Public-Employees. Fax your completed form to (541) 471-3784.

Important note: Please select a Preferred Primary Care Provider (PPCP) of AllCare PEBB before seeking services. You may change your PPCP at any time by notifying Member Services of your PPCP of choice.
Your Preferred Primary Care Provider (PPCP) will work with us to Prior Authorize treatment. If you receive Covered Services from Out-of-Network Providers, it is your responsibility to make sure the Services listed in section 4.4 are Prior Authorized by AllCare PEBB before treatment is received.

It is your responsibility to verify whether or not a provider, Hospital or other facility is a preferred or participating provider with AllCare PEBB even if you have been directed or referred for care by a Preferred/Participating Provider.

If you are unsure about a physician/provider’s, Hospital’s, or other facility’s participation with AllCare PEBB, visit the Online Provider & Pharmacy Directory at AllCareHealth.com/Public-Employees/Lookup-Tools before you make an appointment. If you are searching for a Preferred Primary Care Provider (PPCP), be sure to confirm that the provider you have selected is a Preferred Primary Care Provider (PPCP) who is accepting new patients.

Whenever you visit an AllCare PEBB Provider:

• Bring your AllCare PEBB identification card with you.
• If your office visit is subject to a Copayment, you will need to make that Copayment at the time of your visit.
• If your office visit is subject to a Coinsurance (a percentage of the amount billed for Services), you will most likely not be asked to pay for what you owe at the time of your visit. Your provider’s office will send you a bill for what you owe later. Some providers, however, may ask you to pay for an estimate of what you may owe at the time you receive services and bill or credit you for the balance later.

This Member Handbook contains important information about the health plan coverage offered to PEBB Members. It is important to read this Member Handbook carefully as it explains your AllCare PEBB benefits and Member responsibilities. If you do not understand a term that is used, you may find it in Definitions, section 14. If you need additional help understanding anything in this Member Handbook, please call Member Services at (888) 460-0185. See section 1.3 for additional information on how to reach Member Services.

This Member Handbook is not complete without your:

• AllCare PEBB Benefit Summary. These materials are available at AllCareHealth.com/Public-Employees when you register for an AllCare PEBB For Me account as explained in section 2.5. Benefit Summaries detail your Deductibles, Copayments and Coinsurance for Covered Services.

• Provider & Pharmacy Directory. This document lists Preferred Providers and is available online at AllCareHealth.com/Public-Employees and pebb.members.allcarehealth.com. To look up Participating Providers please go to AllCareHealth.com/Public-Employees. If you do not have Internet access, please call Member Services.

If you need more detailed information for a specific problem or situation, contact Member Services.
2.3 Member Services

We want you to understand how to use your AllCare PEBB benefits and to be satisfied with your health plan coverage. Member Services is available to assist you in understanding your benefits and resolving any problems you may have, including:

- Specific benefit or claim questions.
- Questions or concerns about your health care or service.

**Contacting AllCare PEBB Member Services**

Representatives are available by phone from 8 a.m. to 8 p.m., Pacific Time, seven days a week. Office hours are 8 a.m. to 5 p.m., Pacific Time, Monday through Friday. Please have your Member ID Card available when you call.

2.4 Your Employer’s Benefit Office

For enrollment issues, questions or concerns about adding or dropping a Dependent, or to report name and address changes, please contact your agency benefit office.

2.5 Registering For An AllCare PEBB For Me Account

AllCare PEBB Members can create an AllCare PEBB For Me account online. An account enables you to view your personal health plan information (including your Member Handbook and Benefit Summary), view claims history and benefit payment information, order a replacement AllCare PEBB ID Card, and access other health and wellness information and services.

For technical issues related to your AllCare PEBB For Me account, help desk representatives are available to assist you from 8 a.m. to 5 p.m., Monday through Friday. Members please call 888-460-0185.

2.6 Your AllCare PEBB ID Card

Each Member of AllCare PEBB receives an ID Card. Your AllCare PEBB ID Card lists information about your health plan coverage, including:

- Your plan identification number and group number
- Important phone numbers

The AllCare PEBB ID Card is issued by AllCare PEBB for identification purposes only. It does not confer any right to Services or other benefits under this Member Handbook.

When scheduling an appointment or receiving health services, identify yourself as an AllCare PEBB Member, present your AllCare PEBB ID Card and pay your Copayment or Coinsurance.
2. Welcome to AllCare PEBB

Please keep your AllCare PEBB ID Card with you and use it when you:

- Register for your AllCare PEBB for Me account;
- Visit your health care provider or facility;
- Call for Mental Health/Chemical Dependency;
- Call AllCare PEBB Member Services;
- Call AllCare PEBB Care Management;
- Call AllCare PEBB Nurse Help Line;
- Visit your pharmacy for prescriptions;
- Receive Immediate, Urgent (Immediate) or Emergency Care Services.

2.7 AllCare PEBB Nurse Help Line

AllCare PEBB Nurse Help Line is a free medical advice line for AllCare PEBB Members. Available 24 hours a day, seven days a week, a registered nurse can answer your health-related questions. Please call (866) 234-0637.

Members often call the AllCare PEBB Nurse Help Line when they have sick children, or when they have questions about how to treat flus, colds or backaches.

Please have your AllCare PEBB ID Card available when you call.

2.8 Wellness Benefits

AllCare PEBB Resource Line—Member Services (541) 474-PEBB [7322] or (888) 460-0185

AllCare PEBB Resource Line is your connection to information and services on classes, self-help materials, stop-smoking services, and for referrals to AllCare PEBB Preferred/Participating Providers and to AllCare PEBB programs and services.

Health Education

AllCare PEBB offers a wide variety of classes to help you achieve healthy lifestyle and wellness goals. We can assist you in learning to eat right and manage your weight, prepare for childbirth and much more. If you have diabetes, health education classes also are available (see section 5.10.3, for further information). AllCare PEBB Members receive discounts on health education classes. Your costs, services and the health education classes available may vary by geographic Service Area. For more information on classes available in your area, call the AllCare PEBB Resource Line at (541) 474-PEBB [7322], toll free (888) 460-0185 or visit AllCareHealth.com/Public-Employees.

Tobacco Use Cessation

Your Wellness Benefits include access to tobacco use cessation programs provided through our AllCare PEBB plan. These programs address tobacco dependence through a clinically proven, comprehensive approach to tobacco use cessation that treats all three aspects of tobacco use — physical addiction, psychological dependence and behavioral
patterns. More information about our Tobacco Use Cessation programs can be found online at AllCareHealth.com/Public-Employees.

Wellness information on our Internet site — AllCareHealth.com/Public-Employees

Visit us online at AllCareHealth.com/Public-Employees. For medical information, class information, information on extra values and discounts and a wide array of other information listed with your good health in mind. You also may set up your own AllCare PEBB account to gain access to your specific personal health plan information. See Registering for an AllCare PEBB account, section 2.5, for more details.

Weight Management Program

AllCare PEBB is excited to partner with PEBB to offer Weight Watchers® at no cost to you.

This program is offered to principal subscribers, spouses and domestic partners. With written approval of a Qualified Practitioner, the program is also offered to dependent children age 10 and older. The program is offered in up to four, 13-week sessions per year, provided you participate in at least 10 weeks of every 13-week session. Meetings are available through local community groups, online, or through “At Work” groups.

Members residing in Curry, Josephine and Jackson counties or Glendale and Azalea in Douglas County who wish to enroll in Weight Watchers meetings call Weight Watchers at (800) 651-6000. Members residing in all other counties and Members who wish to participate in Weight Watchers Online call (866) 454-2144. For more information, go to AllCareHealth.com/Public-Employees.

HealthyTEAM Healthy U

Principal subscribers enrolled in a PEBB medical plan, covered spouses or partners, and dependents age 18 and older may participate in an innovative online program called Healthy Team Healthy U. Members work with a team of coworkers in this fun interactive program providing tools to improve diet, be more physically active and enjoy better health. Not only is there no cost to PEBB subscribers, participating in Healthy TEAM Healthy U counts as two health actions in PEBB’s Health Engagement Model (HEM).

To learn more about participating in Healthy Team Healthy U visit https://pebb.healthyteam-secure.com/.

2.9 Privacy Of Member Information

AllCare PEBB respects the privacy of our Members and takes great care to determine when it is appropriate to share your personal health information, in accordance with federal and state privacy laws. We use protected health information and may share it with others as part of your treatment, payment for your treatment, and our business operations.
The following are ways we may use or share information about you, consistent with law:

- We will use the information to administer your benefits and help pay your medical bills that have been submitted to us for payment.

- We may share your information with your doctors or Hospitals to help them provide medical care to you (e.g., if you are in the Hospital, we may give them access to any medical records sent to us by your doctor).

- We may use or share your information with others to help manage your health care (e.g., we might talk to your doctor to suggest a disease management or wellness program that could help improve your health).

- We may share your information with individuals who perform business functions for us. We will only share your information if there is a business need to do so and if our business partner agrees to protect the information.

- We may use your information to provide you with information about alternative medical treatments and programs or about health-related products and services that you may be interested in (e.g., we sometimes send out newsletters that let you know about “healthy living” alternatives such as smoking cessation or weight loss programs).

We make every effort to release only the amount of information necessary to meet any release requirement and only release information on a need-to-know basis. Also, wherever feasible, identifiable information is removed from any information shared.

To secure the confidentiality of medical information, we have procedures in place, which you can review at AllCareHealth.com/Public-Employees.

When Member information is used in health studies, identifiable information is not released. All Member-specific information has identifying information removed, and aggregated data are used as early in the measurement process as possible. The privacy of our Members is completely protected.

Our agreements with Preferred Primary Care Providers (PPCP) and Preferred/Participating Providers contain confidentiality provisions that require providers to treat your personal health information with the same care.

You have the right to ask us to restrict how we use or disclose your information for treatment, payment or health care operations. You also have the right to ask us to restrict information we may give to persons involved in your care. While we may honor your request for restrictions, we are not required to agree to these restrictions. You also have the right to register a complaint if you believe your privacy is compromised in any manner.

Members may request to see their medical records. Call your physician’s or provider’s office to ask how to schedule a visit for this purpose.

For more information about uses and disclosures of Member information, including uses and disclosures required by law, please refer to our Notice of Privacy Practices. A copy is available at AllCareHealth.com/Public-Employees or by calling Member Services.
3. Eligibility and Enrollment

This section outlines who is eligible for coverage and the related enrollment procedures that apply to Eligible PEBB Members and Eligible Family Dependents. You have to be properly enrolled in AllCare PEBB to receive benefits.

There will be an Open Enrollment Period each Year. The Effective Date of Coverage for new Members who enroll during the Open Enrollment Period is the beginning of the Plan Year for which they enroll.

3.1 PEBB Member Eligibility and Enrollment

3.1.1 Eligibility, Effective Date, Enrollment

PEBB Members are eligible for coverage as specified in the eligibility or coverage continuation provisions established by PEBB. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

3.2 Dependent Eligibility and Enrollment

3.2.1 Eligible Family Dependents, Eligibility Date

Eligible Family Dependent means an individual who is eligible for coverage by a PEBB Member as specified in the eligibility or coverage continuation provisions established by PEBB. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

3.2.2 Eligible Family Dependent Enrollment

You must enroll Eligible Family Dependents in accordance with the requirements established by PEBB. No Eligible Family Dependent will become a Member until PEBB approves that Eligible Family Dependent for coverage. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

3.2.3 Newborn Eligibility and Enrollment

A newborn or adopted child of a Member who meets the definition of a PEBB Eligible dependent child is eligible for enrollment from the date of birth or placement for the purpose of adoption. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.
3. Eligibility and Enrollment

3.3 Special Enrollment Periods

If you declined enrollment for yourself as a Member or for an Eligible individual during a previous enrollment period (as stated in sections 3.1 and 3.2), you may be eligible to enroll yourself or the Eligible individual during a “special enrollment period.” The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101.

Employees or retirees should refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

3.3.1 Premium Assistance

If you or your Eligible Family Dependent were eligible to enroll under this Plan but did not enroll during a previous enrollment period, and you or your Eligible Family Dependent becomes entitled to group health plan premium assistance under a Medicaid-sponsored or Children’s Health Insurance Program (CHIP)-sponsored arrangement, we will provide a “special enrollment period” for you and your Family Member(s) if you request enrollment within 60 days after the date of entitlement.
4. How To Use Your Plan

Our goal is maintaining your health by promoting wellness and preventive care. We encourage you to work closely with one provider, your Preferred Primary Care Provider (PPCP), who can provide most of your care, refer you to specialists when necessary, and coordinate Hospital care or diagnostic testing.

Coverage under this Plan is provided through AllCare PEBB. With the design of this Plan, you will have lower Out-of-Pocket expenses when you obtain Covered Services from your Preferred Primary Care Provider (PPCP) you selected and recorded with AllCare PEBB, or are referred by your Preferred Primary Care Provider (PPCP) to an AllCare PEBB Preferred Network provider. You may obtain Covered Services from a Participating or Out-of-Network Provider without a referral, but that option will result in higher Out-of-Pocket expenses for most Covered Services: Prior Authorization rules apply (see section 4.4). Please see the Benefit Summary.

You are encouraged to choose a Preferred Primary Care Provider (PPCP) who will provide preventive and primary care Services and coordinate other care in a convenient and cost-effective manner (see section 4.2).

In order to receive Preferred Network Plan benefits for specialty Services (with the exception of routine women’s health specialty services and most preventive services), you must obtain a referral from your Preferred Primary Care Provider (PPCP) before you receive the specialty Services. This plan will not pay for care received from a preferred specialist if you seek this care without a referral from your Preferred PCP.

Certain Covered Services require Prior Authorization, as specified in section 4.4.

Coverage under this Plan is available 24 hours a day, seven days a week and during periods of domestic or foreign travel. Worldwide coverage for Urgent and Emergency care.

4.1 Indian Health Services Providers

Native American Indian and Alaskan Native Members may also access Covered Services from Indian Health Services (IHS) facilities at no greater cost than if the Services were accessed from a Preferred Primary Care Provider (PPCP). For a list of IHS facilities, please visit the IHS website at www.ihs.gov, or contact the regional IHS office at:

Portland Area Indian Health Service
1414 NW Northrup St., Ste. 800, Portland, OR 97209
Telephone: (503) 414-5555

4.2 The Role Of A Preferred Primary Care Provider (PPCP)

To encourage optimum health, we promote wellness and preventive care, such as annual routine physical exams, flu shots, or mammograms. We also believe wellness and overall health is enhanced by working closely with one physician or provider — your Preferred Primary Care Provider (PPCP). Your Preferred Primary Care Provider (PPCP) can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner. If your Preferred PCP doesn’t belong to a Patient
4. How to Use Your Plan

Centered Primary Care Home (PCPCH), AllCare PEBB will provide the wrap-around services a PCPCH normally offers.

4.2.1 Preferred Primary Care Providers (PPCP)

A Preferred Primary Care Provider (PPCP) is a Qualified Practitioner who specializes in family practice, general practice, internal medicine or pediatrics; a nurse practitioner; or a physician assistant, when providing services under the supervision of a physician, who agrees to be responsible for the continuing medical care by serving as case manager. Adult female Members also may choose a physician specializing in obstetrics or gynecology; a nurse practitioner; a certified nurse midwife; or a physician assistant specializing in women's health care as their Preferred Primary Care Provider (PPCP). Child Members may choose a physician specializing in pediatrics as their Preferred Primary Care Provider (PPCP).

A Preferred Primary Care Provider (PPCP) provides preventive care and health screenings, medical management of many chronic conditions, allergy shots, treatment of some breaks and sprains, and care for many major illnesses and nearly all minor illnesses and conditions. Many Preferred Primary Care Providers (PPCP) offer maternity care and minor outpatient surgery as well.

4.2.2 Established Patients with Preferred Primary Care Provider (PPCP)

If you and your family already see a provider, check the provider directory to see if your provider is a Preferred Primary Care Provider (PPCP) for AllCare PEBB. Please inform your Preferred Primary Care Provider (PPCP) that you are an AllCare PEBB Member.

4.2.3 Changing Your Preferred Primary Care Provider (PPCP)

You are encouraged to establish an ongoing relationship with your Preferred Primary Care Provider (PPCP).

If you decide to change your Preferred Primary Care Provider (PPCP), please remember to notify AllCare PEBB, and have your medical records transferred to your new Preferred Primary Care Provider (PPCP).

4.2.4 Office Visits

Preferred Primary Care Provider (PPCP)

We recommend you see your Preferred Primary Care Provider (PPCP) for all routine care and call your Preferred Primary Care Provider (PPCP) first for Urgent (Immediate) or specialty care. If you need medical care when your Preferred Primary Care Provider (PPCP) is not available, the on-call provider available may treat you and/or refer you to another Provider for treatment.
Other Providers (Specialists)

Your Preferred Primary Care Provider (PPCP) will discuss with you the need for diagnostic tests or other specialist services, and may also refer you to see a preferred/participating specialist for your condition. Your Preferred Primary Care Provider (PPCP) will coordinate your care and share important medical information with your specialist. With a Preferred Primary Care Provider (PPCP) referral, you can access specialist Covered Services from Preferred Providers using your Preferred Plan benefits. This plan will not pay for any services (with the exception of routine women’s health specialty services or most preventive services) received from a preferred specialist without a referral from your Preferred PCP.

You may obtain specialty Services from a Participating or Out-of-Network Provider without a referral, but that option will result in higher Out-of-Pocket expenses for most Covered Services. Prior Authorization rules apply (see section 4.4). Whenever you visit a specialist:

- Bring your AllCare PEBB Member ID Card.
- Understand that in most cases when you access your Preferred Network and Participating Network AllCare PEBB benefits you will be charged an office visit copay, which providers usually collect at the time of the visit. However, when you access your Out-of-Network AllCare PEBB benefits, your Out-of-Pocket costs will be a percent of the charges for services. In those cases, your provider’s office will send you a bill for the amount you owe. Some providers, however, may ask you to pay an estimate of what you may owe at the time you receive services, and will bill or credit you the balance later.

4.2.5 Notice of Provider Termination

When a Preferred Primary Care Provider (PPCP)’s contract of participation with us terminates, we will send a notice of instruction to the Members we know are under the care of the terminated provider within 10 business days of the termination date or of our knowledge of the termination date.

Alternative Care Providers

Your AllCare PEBB includes coverage for office visits to Alternative Care Providers, as listed in your Benefit Summary. See section 14 for the definition of Alternative Care Provider. For coverage of spinal manipulation and acupuncture, see sections 5.10.13, 5.10.14 and your Benefit Summary.

4.3 Services Provided Without A Preferred Primary Care Provider (PPCP) Referral Or By Participating or Out-of-Network Providers

You may choose to receive Covered Services from a Participating or Out-of-Network Qualified Practitioner or facility using your Participating or Out-of-Network Plan benefit. See section 4.4 for Prior Authorization requirements.
Even if the provider is listed as a Preferred Provider in our Provider & Pharmacy Directory and the service requires an authorization, and you see this provider without an authorization, the services will not be covered. Benefits for Covered Services received from a Participating and Out-of-Network Provider will be provided as shown in the Benefit Summary (see section 4.4.1).

Generally, when you receive Services from a Participating or Out-of-Network Provider, your Copayments and Coinsurance will be higher.

Important note: While AllCare PEBB will provide reimbursement for Covered Services received using your Participating or Out-of-Network benefits, for benefits to be paid you must receive Medically Necessary Covered Services. All treatments, supplies, and medications excluded by this Plan are not covered no matter what type of approved category of provider you see.

Some Services are available only under your Preferred Plan benefits:

- E-visit (electronic provider communications) Services (see section 5.1.2).
- Bariatric Surgery and related services (see section 5.10.2).
- Any item listed in your Benefit Summary as “Not Covered” in the Participating Network and Out-of-Network.

Prescription Drugs Benefit

Prescription Drugs must be purchased at one of our nationwide Preferred Network Pharmacies (see section 5.11). A list of our Preferred Pharmacies is available online at AllCareHealth.com/Public-Employees. You also may contact Member Services if you need help locating a Preferred Pharmacy near you, or when you are away from your home. See your Benefit Summary for details on your Deductible and Copayments, if applicable, and on how to use this benefit.

Payment for Out-of-Network Physician/Provider Services (Plan Allowable)

After you meet your Deductible, if applicable, and if the Services provided are Medically Necessary Covered Services, we will provide payment to Out-of-Network Providers according to Usual, Customary, and Reasonable charges (Plan Allowable). Plan Allowable charges do not include sales taxes, handling fees and similar surcharges; such taxes, fees and surcharges are not covered expenses. See section 14 for the definition of Plan Allowable.

You will be responsible for costs that are not covered or allowed by your Out-of-Network benefits as shown in the following example (amounts shown are only estimates of what may apply).
## 4.4 Covered Services That Require Prior Authorization

While Prior Authorization is a requirement for coverage of certain Services under this Plan, Prior Authorization is not a treatment directive. The actual course of medical treatment that a Member chooses remains strictly a matter between the Member and the Member’s provider and is separate from the Prior Authorization requirements of this Plan. Prior Authorization is not a guarantee of benefit payment under this Plan and Prior Authorization does not supersede other specific provisions of this Plan regarding coverage, limitations, exclusions and Medical Necessity. Please note AllCare PEBB will not accept retro authorization requests (except as noted in section 5.7.3).

**Services requiring Prior Authorization:**

- Inpatient admissions to a Hospital (not including emergency department care), Skilled Nursing Facility or a rehabilitation facility, all emergency hospitalizations (AllCare PEBB must be notified within 48 hours, or as soon as reasonably possible) and all Hospital and birthing center admissions for maternity/delivery Services;

- Certain outpatient surgical procedures, as provided in section 5.6;

- Outpatient infusion services, as provided in section 5.6;

- Certain in-office surgical procedures, as provided in section 5.1;

- Inpatient, residential and day- or partial-hospitalization treatment Services for Mental Health and Chemical Dependency services, as provided in section 5.5;

- Human Organ/Tissue Transplant Services, as provided in 6.1;

- Restoration of Head/Facial Structures; Limited Dental Services, as provided in section 6.2;

- Temporomandibular Joint (TMJ) Services, as specified in section 6.2.1;
4. How to Use Your Plan

- High Tech Imaging, including PET, MRI, Sleep Study, Virtual Colonoscopy and Capsule Endoscopy, as provided in section 5.10.4;
- Home Health Care Services, as provided in section 5.10.5;
- Home infusion services, as provided in section 5.10.15;
- Hospice Services, as provided in section 5.10.6;
- Medical Supplies, Medical Appliances, Prosthetic and Orthotic devices, and Durable Medical Equipment and repairs in excess of $1,500. However, all oxygen (such as concentrator, portable and liquid gaseous) requires Prior Authorization, as provided in 5.9;
- Outpatient hospitalization and anesthesia for dental services, as provided in section 6.2.2;
- Outpatient cardiac rehabilitation and pulmonary rehabilitation services, as provided in section 5.6.1;
- Physical therapy, occupational therapy, and speech therapy services, as provided in section 5.10.11;
- Bariatric surgery, as provided in section 5.10.2;
- Services for Genetic Testing, as provided in section 6.5;
- Certain Prescription Drugs specified in the AllCare PEBB Formulary, as provided in section 5.11;
- Gender identity disorders, as provided in section 5.10.16;
- Applied Behavior Analysis (ABA) for autism spectrum disorder, as provided in section 5.5.1;
- Electroconvulsive Therapy, as provided in section 5.5
- Transcranial Magnetic Stimulation, as provided in section 5.5.
- Non-Emergent Transportation, as provided in section 5.10.18

AllCare PEBB will provide a Prior Authorization form upon oral or written request; however, your provider will usually communicate directly with us on obtaining Prior Authorization. If you need information on how to obtain Prior Authorization, please call your Member Services at (541) 474-PEBB [7322] or (888) 460-0185.

If an Emergency Medical Condition exists that prevents you from obtaining Prior Authorization, AllCare PEBB must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, to continue coverage of these Services.

4.4.1 Failure to Obtain Prior Authorization

If you do not obtain Prior Authorization as specified in section 4.4 above, claims for those Services will be denied and you will be responsible to pay for those Services.
4.5 Medical Cost Management

Coverage under this Plan is subject to the medical cost management protocols that are established by AllCare PEBB to ensure the quality and cost effectiveness of Covered Services. Such protocols may include Prior Authorization, concurrent review, case management and disease management.

The Plan reserves the right to deny payment for Services that are not Medically Necessary in accordance with the criteria maintained by AllCare PEBB. When more than one medically appropriate Alternative Treatment Option is available, AllCare PEBB will approve the least costly alternative.

Under its medical cost management protocols and the criteria specified in this Member Handbook, AllCare PEBB may approve a substitution for a Covered Service under this Plan. A substituted Service must:

- Be Medically Necessary;
- Have your knowledge and agreement while receiving the Service;
- Be prescribed and approved by your treating Qualified Practitioner; and
- Offer a medically therapeutic value at least equal to the Covered Service that would otherwise be performed or given.

The Plan's coverage of an Alternative Treatment Option for any Member does not obligate AllCare PEBB to:

- Cover an Alternative Treatment Option for any other Member;
- Continue to cover an Alternative Treatment Option beyond the term of the agreement between AllCare PEBB and Member; or
- Cover any Alternative Treatment Option for the Member, other than as specified in the agreement between AllCare PEBB and Member.

Alternative Treatment Option that satisfy the requirements of this Section 4.5 are Covered Services for all purposes under this Plan.

The Plan may disallow a substituted Service at any time by sending a 30-day advance written notice to you and your Qualified Practitioner.

4.5.1 Coverage of New Technology and New Application of Existing Technology

New technologies and new applications of existing technologies are evaluated and approved for coverage when they provide a demonstrable benefit for a particular illness or disease, are scientifically proven to be safe and most effective, and there is no equally effective or less costly alternative.

Emerging and innovative technologies are monitored by AllCare PEBB through review of trend reports from technology assessment bodies, government publications, medical journals, and information provided by providers and professional societies.
4. How to Use Your Plan

A systematic process for evaluating a new technology or new application of an existing technology is proactively initiated when sufficient scientific information is available.

AllCare PEBB has developed standards to guide the evaluation process and to ensure appropriate coverage determinations. New technology must minimally meet the following guidelines to be approved for coverage:

- Technology must improve health outcomes. The beneficial effects must outweigh any harmful effects on health outcomes. It must improve the length of life, ability to function or quality of life.
- Technology must be as beneficial as any established alternative. It should improve the net health outcome as much, or more, than established alternatives.
- Application of technology must be appropriate, in keeping with good medical standards, and useful outside of investigational settings.
- Technology must meet government approval to market by appropriate regulatory agency as applicable.
- Criteria must be supported with information provided by well-conducted investigations published in peer-reviewed journals. The scientific evidence must document conclusions that are based on established medical facts.
- Opinions and evaluations of professional organizations, panels, or technology assessment bodies are evaluated based on the scientific quality of the supporting evidence.

Technology Evaluation Process

Our committee of medical directors and physician specialist advisors evaluate all new technology and determine coverage based on national guidelines, which are based on evidence for safety and efficacy. The committee relies upon a thorough review of pertinent medical literature and utilizes national technology review services that provide independent analysis of a new technology.

Expedited Review

Requests for coverage of new technology may occur before formal policy has been developed. In these cases, an expedited review is implemented and a decision made on a case-by-case basis. This is separate and distinct from the problem resolution procedure set forth in section 9.

4.6 Medically Necessary Services

Members are entitled to comprehensive medical care within the standards of good medical practice. AllCare PEBB’s medical directors and special committees determine which Services are Medically Necessary, as described in section 14, Definitions. Services that do not meet Medically Necessary criteria will not be covered.

Example: Your provider suggests a treatment, medicine, or using a machine that has not been approved for use in the United States. We would not pay for that treatment.
Example: You go to a hospital emergency department to have stitches removed, rather than wait for an appointment in your doctor’s office. The Plan would not pay for that visit.

Example: You stay an extra day in the hospital only because the relative who will help you during recovery cannot pick you up until the next morning. We may not pay for the extra day.

Although a treatment was prescribed or performed by a Qualified Practitioner, it does not necessarily mean that it is Medically Necessary under the Plan guidelines. Obtaining confirmation of coverage from AllCare PEBB beforehand is always recommended.

4.7 Approved Clinical Trials

Benefits may be provided for Covered Services directly related to a Member’s participation in an Approved Clinical Trial. Please contact the plan for more information. If approved:

• AllCare will require you to participate through a Preferred or Participating Provider.

• Services covered may include the routine patient costs for items and services received in connection with the Approved Clinical Trial, to the extent that the items and services are otherwise Covered Services under the Plan.

The following costs are excluded:

• The cost of the investigational item, device or service;

• The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management; and

• The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

The Plan provides benefits for services unrelated to a clinical trial to the extent that the services are otherwise Covered Services under the Plan.

4.8 How Benefits Are Applied

Benefits are subject to the following Plan provisions, if applicable, as specified in the Benefit Summary:

• The Deductible;

• The Copayment or Coinsurance amount; and

• The benefit limits and/or maximums.

4.9 Your Costs

Your plan has Deductibles, Copayments, and coinsurance costs that you pay when you receive care. These costs change depending on your selection of a preferred,
participating, and Out-of-Network provider. Your plan also provides Out-of-Pocket maximums, and maximum cost shares for both individuals and families.

4.9.1 Understanding Deductibles

Your Deductible is the dollar amount shown in the Benefit Summary that you are responsible to pay each Calendar Year. Your provider will bill you for any Deductible amounts you owe and you will pay your provider directly until you have paid the total annual Deductible amount. At that point, the health plan will pay for your covered benefits.

Certain Covered Benefits are covered without a Deductible. Please see your Benefit Summary for information about these Services.

Your Plan has different Deductibles for preferred, participating, and Out-of-Network providers and they accumulate toward your annual Deductible amount in different ways. For example, you may receive services from a preferred or a participating provider and both Deductibles accumulate toward your annual amount. However, any Deductible for Out-of-Network providers accumulates separately.

**Individual Deductible:** An Individual Deductible is the amount shown in the Benefit Summary that must be paid by an individual Member before the Plan pays for Covered Benefits received by that Member. The Individual Deductible applies to each Member when the number of Family Members is two or less.

**Family Deductible:** The Family Deductible applies when there are three or more Members in the family. The Family Deductible is the amount shown in the Benefit Summary that applies to families and is the maximum Deductible that an enrolled family must pay. The Family Deductible accumulates on an individual basis until the maximum family Deductible amount is met. Once the family Deductible is met, no further Deductibles will need to be paid by any enrolled Family Members. No Member will pay more than an Individual Deductible before the Plan begins paying for Covered Services for that Member.

**Out-of-Pocket Costs:** There are certain costs that do not apply toward your Individual or Family Deductible, including:

- Services not covered by the Plan;
- Services in excess of any maximum benefit limit;
- Fees in excess of Usual, Customary and Reasonable (PLAN ALLOWABLE) charges;
- Any costs you must pay if you do not follow the Plan’s Prior Authorization requirements;
- Copayments or coinsurance for any Supplemental Benefits you may have elected to receive such as vision care.

4.9.2 Understanding Copayments and Coinsurance

Certain Covered Services require a Copayment or coinsurance when you receive care. Copayments are specific amounts for certain Covered Services, such as $5 for
ambulatory surgery procedures or $100 for emergency services. Coinsurance is a percentage of the cost of certain Covered Services for which you are responsible.

The Copayment amounts and Coinsurance percentages are different depending upon the type of service received and by Preferred, Participating and Out-of-Network Providers. Please see your Benefit Summary for more information about which services require Copayments or Coinsurance.

You will pay a Copayment directly to your provider at the time of service. In most cases, you will be billed by your provider for any coinsurance you owe.

4.9.3 Understanding Out-of-Pocket Maximums

There is a maximum amount that a Member or a Family is required to pay each Calendar Year. This is the total maximum amount of Copayments and Coinsurance combined.

Your plan has separate maximums for Preferred, Participating, and Out-of-Network providers. The Preferred and Participating Out-of-Pocket costs count toward one another as incurred. Out-of-Network costs paid by you and your family accumulate separately and are not credited toward meeting the Preferred or Participating provider Out-of-Pocket cost limits. Similarly, Out-of-Pocket costs that count toward the maximums for Preferred and Participating providers do not count toward Out-of-Network provider costs. Once any Member meets the Individual Out-of-Pocket Maximum, the Plan will begin to pay 100% for Covered Services that fall under the Out-of-Pocket Maximum (see Benefit Summary).

**Individual Out-of-Pocket Maximum:** Individual Out-of-Pocket Maximum means the total amount of Copayments and Coinsurance that a Member must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for that Member within that Calendar Year.

**Family Out-of-Pocket Maximum:** Family Out-of-Pocket Maximum means the total amount of Copayments and Coinsurance that a family of three or more must pay in a Calendar Year, as shown in the Benefit Summary, before the Plan begins to pay 100% for Covered Services for enrolled Family Members. When the combined Copayment and Coinsurance expenses of three or more enrolled Family Members meet the Family Out-of-Pocket Maximum, all remaining Individual Out-of-Pocket Maximums will be waived for the family for that Calendar Year.

When the number of enrolled Family Members is less than three, the Individual Out-of-Pocket Maximum applies to each enrolled Member.

*Note:* Once any Member meets the Individual Out-of-Pocket Maximum, the Plan will begin to pay 100%* for Covered Services for that Member.

**The following Out-of-Pocket costs do not apply toward your Individual and Family In-Plan or Out-of-Plan:**

- Services not covered by this plan;
- Services in excess of any maximum benefit limit;
4. How to Use Your Plan

- Fees in excess of the Usual, Customary and Reasonable (UCR) charges;
- Individual and Family In-Plan and Out-of-Plan Deductibles;
- Copayments or Coinsurance for a Covered Service if indicated in the Benefit Summary as not applicable to the Out-of-Pocket Maximum;
- Copayments or Coinsurance for hearing exams or hearing aids;
- The additional Copayments that apply to services on the Additional Cost Tier;
- Deductibles, Copayments or Coinsurance payable under your Prescription Drug Benefit;
- Copayments or Coinsurance for infertility Covered Services;
- Copayments or Coinsurance for elective termination of pregnancy Services;
- Copayments or Coinsurance for spinal manipulation and acupuncture services;
- Copayments or Coinsurance for any Supplemental Benefits your Plan may have such as vision; and
- Any penalties you must pay if you do not follow the Plan’s Prior Authorization requirements.

*Important note: Covered Services indicated as not applicable to the Out-of-Pocket Maximum and that do not qualify as Essential Health Benefits are NOT eligible for 100% benefit coverage. The Copayment or Coinsurance for these Services as shown in the Benefit Summary remains in effect throughout the Calendar Year.

4.9.4 Understanding Maximum Cost Shares

**Maximum Cost Share** means the annual limit on cost sharing for Essential Health Benefits as established by the Patient Protection and Affordable Care Act (ACA). Deductibles, Copayments and Coinsurance paid by the Member for Essential Health Benefit Covered Services received apply to the Maximum Cost Share.

Maximum Cost Shares are separate from Out-of-Pocket Maximums and can only be met by Member costs for Preferred/Participating Plan Covered Services that qualify as Essential Health Benefits. Essential Health Benefits encompass 10 broad categories:

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

Not all Services covered under the Plan qualify as Essential Health Benefits. If a Service does not qualify, it will not accumulate to the Maximum Cost Share and will be labeled as such in your Member materials. No costs for Covered Services received Out-of-Network apply to the Maximum Cost Share.

Member costs applied to Maximum Cost Shares will also apply to Preferred Network and Participating Network Out-of-Pocket Maximums. The Maximum Cost Share amounts identified in the Benefit Summary for Preferred Network and Participating Network benefits are one aggregate amount for individuals and families respectively. In other words when an individual meets his or her Maximum Cost Share for the Preferred Network, the Maximum Cost Share for the Participating Network has also been met.

**Individual Maximum Cost Share:** Individual Maximum Cost Share means the total amount of Preferred/Participating Plan Copayments, Coinsurance and Deductible for Preferred/Participating Plan Essential Health Benefit Covered Services that a Member must pay in a Calendar Year, as shown in the Benefit Summary, before we begin to pay 100%* for Preferred/Participating Plan Essential Health Benefit Covered Services for that Member within that Calendar Year.

**Family Maximum Cost Share:** Family Maximum Cost Share means the total amount of Copayments, Coinsurance and Deductible for Preferred/Participating Plan Essential Health Benefit Covered Services that a family of three or more must pay in a Calendar Year, as shown in the Benefit Summary, before we begin to pay 100% for Preferred/Participating Plan Essential Health Benefit Covered Services for enrolled Family Members. When the combined Preferred/Participating Plan Copayment, Coinsurance and Deductible expenses of enrolled Family Members meet the Family Maximum Cost Share, all remaining Individual Maximum Cost Share will be waived for enrolled Family Members for that Calendar Year.

**Your Costs that Do Not Apply to Maximum Cost Share:** The following Out-of-Pocket costs do not apply towards Your Individual and Family Maximum Cost Share:

• Services that do not qualify as Essential Health Benefits;
• Services not covered by this Plan;
• Services in excess of any maximum benefit limit;
• Spinal Manipulation and Acupuncture Services;
• Infertility Services;
• Termination of Pregnancy Services;
• Fees in excess of the Plan Allowable;
• Premiums and penalties; and
• Any costs you must pay if you do not follow AllCare PEBB Prior Authorization requirements.
5. Covered Services

This section describes Services that, when Medically Necessary and not otherwise excluded or limited, are covered under this Plan.

Benefits for the treatment of illness or injury when such treatment is provided by a Qualified Practitioner include the Covered Services that are listed in this section and shown in the Benefit Summary. Covered Services for the diagnosis and treatment of Mental Health or Chemical Dependency are described under Mental Health and Chemical Dependency in section 5.5.

See section 6 (the Limitations section) for the specific coverage provisions that apply to these Covered Services:

- Human Organ/Tissue Transplants;
- Restoration of Head/Facial Structures and Limited Dental Services;
- Temporomandibular Joint (TMJ) Services;
- Surgery and anesthesia for dental Services;
- Infertility Services;
- Bariatric surgery Services; and
- Genetic Testing and Counseling Services.

5.1 Provider Services

5.1.1 Office Visits, Inpatient and Outpatient Hospital Visits and Home Visits

Office visits, inpatient and outpatient Hospital visits and home visits with a Qualified Practitioner are covered as shown in the Benefit Summary. Copayments and Coinsurances as shown in the Benefit Summary apply to all provider visits except those that: (a) are part of a course of maternity care received in the Preferred and Participating Network; (b) are for conditions for which a separate and specific Copayment or Coinsurance amount is specified in this Member Handbook; or (c) are ancillary to the visit and are billed by the Qualified Practitioner. Services provided by your Qualified Practitioner during your visit may have an additional Member financial responsibility. This Plan will not pay for any services received from a preferred specialist without a referral from your Preferred PCP (with the exception of routine women’s health specialty services and most preventive services).

For example: You see your Preferred Primary Care Provider (PPCP) for an office visit and during your visit your provider performs surgery and anesthesia. You would only pay your surgery office visit Copayment or Coinsurance. See your Benefit Summary for details.

Your Benefit Summary also lists different Copayments or Coinsurance that may apply for other specific services, such as allergy shots, maternity care received Out-of-Network and diagnostic services. See your Benefit Summary for details.
If you are unable to keep a scheduled appointment with your provider, please try to notify that office in advance. If not, you may be charged for the missed appointment. Missed appointment charges are not covered expenses under this Plan.

5.1.2 E-visits: Electronic Provider Communications

E-visits are covered as shown in the Benefit Summary. Not all Preferred Providers offer E-visits. Medical doctors (MD), Doctors of Osteopathy (DO), Nurse Practitioners (NP) and Physician Assistants (PA) are the only categories of providers approved for E-visits. Preferred Providers who are authorized to provide E-visits have agreed to use appropriate Internet security technology to protect your information from unauthorized access or release. To be eligible for the E-visit benefit, you must have had at least one prior office visit with your Preferred Primary Care Provider (PPCP) within the last 12 months.

Covered E-visits include, but are not limited to:

- Communications of a new or existing diagnosis or treatment when the equivalent service received through an office visit would have led to a claims submission to be covered by the Plan;
- Communications by your Preferred Primary Care Provider (PPCP) about the management of complex chronic conditions that require extensive education and ongoing monitoring;
- Communications of treatment for relapses of a previous condition that involve extended dialogue and significant physician time and judgment;
- Discussion of lab results that require significant changes in medication or further testing; and
- Extended counseling when person-to-person contact would involve an unwise delay.

Examples of E-mail communications that do not qualify as E-visits include, but are not limited to:

- Renewing prescriptions;
- Scheduling tests;
- Scheduling appointments;
- Reporting normal test results;
- Recommending a referral to another provider;
- A consultative message exchange from a patient who is seen in-person immediately afterward as a result of the consultative message;
- A brief follow-up of an office visit, medical procedure or other treatment to confirm stable condition;
5. Covered Services

• A brief discussion to confirm stability of a chronic problem and continuity of present management of the problem; and

• All communications in connection with mental health or chemical dependency covered services.

5.1.3 Telemedical Services

Telemedical Services are covered at the applicable benefit level for the Service, as shown on the Benefit Summary, had the Service been received in person provided that the Service:

• Is Medically Necessary;

• Does not duplicate or supplant a Service that is available to the patient in person;

• Is provided by a Qualified Practitioner;

• Originates at a qualified site, such as a Hospital, rural health clinic, federally qualified health center, physician’s office, community mental health center, Skilled Nursing Facility, renal dialysis center, or public health services center; and

• Is delivered through a two-way video communication that allows the Qualified Practitioner to interact with the Member receiving the Service who is at an originating site.

For Members utilizing Telemedical Services for the treatment of diabetes where one of the Members is a representative of an academic health center, coverage is provided when Services are delivered through a two-way electronic communication, that includes but is not limited to video, audio, Voice over Internet Protocol, or transmission of telemetry, that allows a health professional to interact with the Member, a parent or guardian of a Member or another health professional on a Member’s behalf, who is at an originating site.

5.1.4 Administration of Anesthesia, Injectable Medications, and Surgical Procedures

Benefits include the administration of anesthesia, injectable medications, and surgical procedures including assistant surgeon and post-operative care.

The following surgical procedures require Prior Authorization:

• Neurostimulator

• Photodynamic/Photochemotherapy

• Spinal cord stimulator

• Pain pump and electronic analysis

• Botox
5.2 Preventive Services

Preventive Services are covered as shown in the Benefit Summary.

In accordance with the Patient Protection and Affordable Care Act of 2010 and related legislation, your Plan covers the following Services in full when received from Preferred/Participating Providers:

- Services rated “A” or “B” by the US Preventive Services Task Force, [https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/](https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as supported by the Health Resources and Services Administration; and
- Preventive care and screenings for women as supported by the Health Resources and Services Administration, [http://www.hrsa.gov/womensguidelines/](http://www.hrsa.gov/womensguidelines/).

*Note:* Additional Plan provisions apply to some Services (e.g.: routine physical examinations and well-baby care must be received from a Preferred/Participating Primary Care Provider (PCP) to be covered in full), see section 5.2.1. If you need assistance understanding coverage for preventive Services under your Plan, please contact Member Services at (888) 460-0185.

5.2.1 Physical Examinations and Well-Baby Care

Periodic health exams and well-baby care Services are covered in full (Deductibles do not apply) only when you receive these Services from a Preferred/Participating Provider. These Services are covered as stated in your Benefit Summary. Your provider will determine which tests are necessary for your physical exam according to your medical history and current health status. More frequent exams will be covered if your provider determines that they are necessary. Vision and hearing screening services are covered when performed during a periodic health examination or well-baby care examination. For a child to be eligible for benefits for routine newborn baby care, the child must be properly enrolled as outlined in section 3. Ancillary Services, such as immunizations, are covered at the specified benefit level when billed by the provider.

**Infants:**

Up to 36 months: Up to 14 well-baby visits.

**Children and Adolescents:**

3 years through 21 years: One exam every year.

**Adults:**

22 years through 34 years: One exam every four years.
35 years through 49 years: One exam every two years.
50 years and older: One exam every year.
5. Covered Services

If, at the time of your routine physical examination or well child care, you need paperwork completed for a third party such as school, camp, team sports, etc., your provider may charge you a fee to complete the paperwork. This additional fee is not covered under this Plan.

Physical Exams for Commercial Driver’s License: Coverage, limited to the PEBB principal subscriber only, is provided for a physical examination required to obtain a commercial driver’s license when that examination is performed by a Qualified Practitioner and is necessary for your continued employment. Your plan covers Physical Exams for Commercial Driver’s License in full.

5.2.2 Immunizations and Vaccinations

Benefits for immunizations and vaccinations are provided in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP) and shown in the Benefit Summary. Immunizations received from a Primary Care Provider (PCP) or Public Health Department are covered in full. Immunizations provided by an Out-of-Network provider will be subject to any Coinsurance shown in the Benefit Summary. Immunizations are covered for the purpose of travel. Some immunizations may be available from a pharmacy, please contact Member Services for additional information.

Covered Services do not include immunizations or vaccinations for insurance, employment, licensing purposes, or solely for the purpose of participating in camps, sports activities, recreation programs or college entrance.

5.2.3 Gynecological Examinations

Benefits for gynecological examinations include breast, pelvic and pap examinations once every Calendar Year. Family planning Services are covered separately (see section 5.2.5). Benefits also include follow-up exams for any medical conditions discovered during an annual gynecological exam that requires additional treatment.

5.2.4 Mammograms

Mammograms are covered once every Calendar Year for women 40 years of age and older, or as recommended by the Qualified Practitioner.

5.2.5 Family Planning Services

Benefits include counseling, exams, elective pregnancy termination, and services for voluntary family planning.

Services and supplies are covered as required by the Patient Protection and Affordable Care Act of 2010 and related legislation; and include, but are not limited to:

- Intrauterine device (IUD) insertion and removal;
- Medical exams and consultation for family planning;
- Depo-Provera to prevent pregnancy;
- Diaphragm devices;
• Insertion and removal of Norplant; and
• Oral contraceptives (birth control pills).

All Covered Services must be received from Qualified Practitioners and Facilities or purchased from Preferred Pharmacies.

• In-Network: Services are covered in full.
• Out-of-Network: Services are covered subject to the provisions of the applicable Out-of-Network benefit, e.g. IUDs and diaphragms are covered under the Medical Supply benefit.

5.2.6 Elective Sterilization

Women’s Services:

Coverage is provided, as stated below, for women’s voluntary sterilization (tubal ligation).

• In-Network: Services are covered in full.
• Out-of-Network: Services are covered subject to the provisions of the applicable Out-of-Network benefit, e.g. your Inpatient or Outpatient Surgery benefit.

Men’s Services:

Coverage is provided, as stated below, for men’s voluntary sterilization (vasectomy).

• Preferred/Participating Plan & Out-of-Network: Services are covered subject to the provisions of the applicable benefit; e.g. your Inpatient or Outpatient Surgery benefit.

5.2.7 Prostate Cancer Screening Exams

Benefits for prostate cancer screening examinations include digital rectal examination and prostate-specific antigen test biennially for men age 50 or older.

5.2.8 Colorectal Cancer Screening Exams

Benefits for colorectal cancer screening examinations are covered in full in the Preferred/Participating Network and include:

• One fecal occult blood test per year plus one sigmoidoscopy every five years; or
• One colonoscopy every 10 years; or
• One double contrast barium enema every five years
• Bowel prep medication is covered in full.

Screening examinations for Members designated high risk are covered as recommended by the Qualified Practitioner.

For diagnostic examinations:

• Preferred/Participating Network: All Services for colorectal cancer exams are
5. Covered Services

covered under the Outpatient Services and Surgery benefit.

• Out-of-Network: All colonoscopy and sigmoidoscopy diagnostic services are covered at a 30% coinsurance level.

• Fecal occult blood test and double contrast barium enemas are covered under the Lab Services benefit.

• Bowel prep medication is covered in full.

5.2.9 Preventive Services for Members with Diabetes

The following Covered Services apply to Members diagnosed with either insulin dependent or non-insulin dependent diabetes mellitus:

• A dilated retinal exam by a qualified Preferred/Participating eye care specialist every Calendar Year;

• A glycosylated hemoglobin (HbA1c) test; urine test to test kidney function; blood test for lipid levels as appropriate; visual exam of mouth and teeth (dental visits are not covered); foot inspection; and influenza vaccine by a Qualified Practitioner every Calendar Year; and

• Pneumococcal vaccines are provided every five years.

5.2.10 Nutritional Counseling

Nutritional counseling services are covered by the Plan and include Medically Necessary nutritional counseling services related to bariatric surgery, prior to and following the surgery. Deductible, Copayments and coinsurance are waived for two visits per Calendar Year.

A maximum of four visits per Calendar Year are covered for all diagnoses, except bariatric surgery and eating disorders which have no annual visit limits.

5.3 Maternity Services

Your benefits include coverage for comprehensive maternity care. Covered Services include:

• Prenatal care by your physician, provider or certified nurse midwife;

• Delivery at an approved facility or birthing center;

• Postnatal care, including complications of pregnancy and delivery;

• Emergency treatment for complications of pregnancy and unexpected pre-term birth;

• Newborn nursery care* and any other Services provided to your newborn are covered only when the newborn child is properly enrolled within time frames outlined in Newborn Eligibility and Enrollment, section 3.2.3.

*Newborn nursery care is a facility Service covered under the enrolled newborn’s Hospital
Services benefit. All other services provided to a newborn, including Physician/Provider Services, are covered under the applicable benefit level shown in the Benefit Summary. For instance, visits made to a hospitalized newborn by a Qualified Practitioner are covered under the Provider Inpatient visits benefit. This Plan does not cover pediatric standby charges for a vaginal delivery. See section 3 regarding newborn eligibility and enrollment.

**Important note:** Maternity Services for a Member who is serving as a surrogate parent are covered, except to the extent that such services are payable under the surrogate parenting contract or agreement.

The services of a lay midwife are not covered. If you are unsure whether or not the services of a particular midwife are covered under this Plan, please contact Member Services.

**Length of maternity hospital stay:** Your services include a hospital stay of a minimum of 48 hours for a normal vaginal delivery and a minimum of 96 hours for a Caesarean delivery. You will not be discharged from the hospital sooner than these guidelines, unless you choose to be. You and your physician/provider will determine the length of your hospital stay and follow-up care based on accepted medical practice.

**Maternity support services:** Members may attend classes to prepare for childbirth. These classes are held at participating hospitals. Call the AllCare PEBB Resource Line at (541) 474-PEBB [7322] or visit AllCareHealth.com/Public-Employees for information on classes, specific dates, locations, registration and prices. Classes vary by geographic area. In addition, Members with high-risk pregnancies may receive support services through care or case management. A care manager may be a social worker or a registered nurse.

**5.3.1 Breastfeeding Counseling and Support**

Coverage for lactation counseling is provided when Medically Necessary as determined by the Qualified Practitioner. Benefits include coverage in full for breast pump equipment and supplies when rented or purchased through our Preferred/Participating Medical Equipment Providers.

Out-of-Network, coverage is subject to your Durable Medical Equipment (DME) benefits.

**5.4 Hospital and Skilled Nursing Facility Services**

A Deductible, Copayment or Coinsurance, whichever is applicable, will be applied once per inpatient stay, even if you are treated in more than one Hospital and/or Skilled Nursing Facility.

Covered Services do NOT include care received that consists primarily of:

- Room and board and supervisory or custodial Services;
- Personal hygiene and other forms of self-care;
- Non-skilled care for senile deterioration, mental deficiency, or developmental disability.
5. Covered Services

In all cases the following are specifically excluded from the Hospital and Skilled Nursing Facility benefit:

- Private duty nursing or a private room unless prescribed as Medically Necessary or otherwise Prior Authorized;
- Take-home supplies and equipment;
- Personal items such as telephone, radio, television and guest meals.

5.4.1 Hospital Services

Benefits are provided as shown in the Benefit Summary.

**In Network Benefit:** You or your Provider are responsible for making sure inpatient hospitalization services are Prior Authorized by AllCare PEBB before receiving this care.

**Out-of-Network Benefit:** You are responsible for making sure inpatient hospitalization services are Prior Authorized by AllCare PEBB before receiving this care from an Out-of-Network hospital.

Only Medically Necessary Hospital services are covered. Covered inpatient services received in a Hospital include:

- Acute (inpatient) care;
- A semiprivate room accommodations (unless a private room is Medically Necessary);
- Coronary care and intensive care;
- Isolation care, when necessary;
- Hospital services and supplies necessary for treatment and furnished by the hospital, such as operating and recovery rooms, anesthesia, dressings, medications, whole blood and blood products, oxygen, x-ray. Co-pay required for advanced imaging, and laboratory services during the period of inpatient hospitalization. Personal items such as guest meals, slippers, etc., are not covered.

AllCare PEBB employs professional clinical staff who may review services you receive in the Hospital. They may review your care to determine Medical Necessity, to make sure that you had quality care and to ensure that you will have proper follow-up care.

Your provider will determine your medically appropriate length of stay. If you choose to stay in the Hospital longer than your physician advises, you will be responsible for the cost of additional days in the Hospital.

If benefits under this Plan change while you or an enrolled dependent is in the Hospital, covered expenses will be based on the benefit in effect when the stay began.

**Members Affected by a Replacement, or Changes to, Group Coverage**

If you or an enrolled dependent is admitted to the Hospital on your effective date of coverage, or if benefits under this Plan change during a period of Hospitalization, covered expenses will be based on the benefit in effect when the stay began. The benefit
5. Covered Services

will continue until discharge from the hospital or until any applicable limits have been reached, whichever is earlier.

5.4.2 Observation Care

Benefits are provided, as shown in the Benefit Summary, for Covered Services provided by the Hospital or the Qualified Practitioner while you are held in the Hospital for observation.

Observation care includes the use of a bed and periodic monitoring that are reasonable and necessary to evaluate your condition as an outpatient or determine the need for possible admission to the hospital as an inpatient. In general, the duration of observation care does not exceed 24-48 hours. Observation care for greater than 48 hours without inpatient admission is generally considered not Medically Necessary and may be subject to medical review.

5.4.3 Skilled Nursing Facility

Benefits are provided as shown in the Benefit Summary for Covered Services from a Skilled Nursing Facility, limited to 180 days per Calendar Year. Services must be Prior Authorized by AllCare PEBB and prescribed by your Qualified Practitioner in order to limit Hospitalization by providing convalescent skilled medical and nursing Services which cannot be adequately provided through a home health program.

5.4.4 Rehabilitative Care (Inpatient)

Benefits are provided for physical, occupational and speech therapy, as shown in the Benefit Summary, for Medically Necessary inpatient rehabilitation to restore or improve lost function following illness or injury. Benefits are limited to Covered Services that can be expected to result in the measurable improvement of a Member’s condition. Inpatient rehabilitation Services are limited to 30 days per Calendar Year. If Services are required following a head or spinal cord injury, or for treatment of a cerebral vascular accident (stroke), the limit may be increased to 60 days per Calendar Year. If a Member is hospitalized when rehabilitative Services begin, rehabilitative benefits will begin on the day treatment becomes primarily rehabilitative. (See section 5.10.11 for coverage of outpatient rehabilitation Services.)

5.5 Mental Health and Chemical Dependency Services

This Plan complies with Oregon and Federal Mental Health Parity.

5.5.1 Mental Health Services

Medically Necessary Mental Health Services are provided at the same level of benefit and coverage as those offered for general health conditions. Policy Deductibles and co-insurance for outpatient mental health treatment have the same requirements as those for the treatment of other health conditions.

Covered Services include diagnostic evaluation; individual and group therapy; inpatient hospitalization; and residential and day or partial hospitalization Services, as well as treatment for autism as described below.
5. Covered Services

All inpatient, residential, day treatment, partial hospitalization, electroconvulsive therapy and transcranial magnetic stimulation Services must be Prior Authorized as specified in section 4.4.

In an emergency situation, go directly to a Hospital emergency department. You do not need Prior Authorization for emergency treatment; however, we must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.

Applied Behavior Analysis (ABA) for autism spectrum disorder

Behavioral therapy programs used to treat autism spectrum disorders are referred to as Applied Behavior Analysis (ABA). Applied behavior analysis includes the use of adaptive behavior treatments. Adaptive behavior treatment may be provided to patients diagnosed with autistic spectrum disorder presenting with deficient adaptive or maladaptive behaviors (e.g., impaired social skills and communication). Medically Necessary ABA services are covered without Prior Authorization (PA) to 40 hours per week and coverage continues through age 18.

Prior Authorization (PA) is required, as specified in section 4.4, of services for patients 19 and over for more than 40 hours of services per week. PA considerations will be made taking into consideration the individual situation and medical necessity utilizing the same process and consideration applied to other physical and mental health requests.

5.5.2 Chemical Dependency Services

Medically Necessary Chemical Dependency Services are provided at the same level of benefit and coverage as those offered for general health conditions. Policy Deductibles and co-insurance for outpatient mental health treatment have the same requirements as those for the treatment of other health conditions.

Covered Services include diagnostic evaluation; detoxification; individual and group therapy; inpatient hospitalization as stated in section 5.5, and residential and day- or partial- hospitalization Services when they are Medically Necessary as determined by AllCare PEBB.

Prior Authorization is required for all inpatient, residential, and day- or partial-hospitalization treatment Services, as specified in section 4.4.

Treatments involving the use of Methadone are a Covered Service only when such treatment is part of a medically supervised treatment program that has been Prior Authorized, as specified in section 4.4.

Treatments involving the use of Suboxone or Buprenorphine are a Covered Service only when such treatment is part of a medically supervised treatment program that has been Prior Authorized, as specified in section 4.4. This treatment is also a Covered Service under your Prescription Drug Benefit when prescribed by a Certified Physician that has been Prior Authorized, as specified in sections 4.4 and 5.11.

In an emergency situation, go directly to a Hospital emergency department. You do not need Prior Authorization for emergency treatment; however, AllCare PEBB must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue.
5.6 Outpatient Hospital Services

Benefits are provided as shown in the Other Covered Services section of the Benefit Summary and include outpatient Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See sections 5.1.4 and 5.10.1 regarding injectable or infused medications received in a Provider’s office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, and wound clinic, as ordered by your Qualified Practitioner. We may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, we will not Prior Authorize the Services.

Certain outpatient surgical procedures will require Prior Authorization. For additional information about Prior Authorization, see section 4.4.

Covered Services under these benefits do not include Services for Short-Term Outpatient Rehabilitation. Please refer to those specific Services within section 5.10.11.

5.6.1 Self-Administered Chemotherapy

Self-administered chemotherapy agents, including oral medications and injectable medications, are covered when received from a participating retail or specialty pharmacy as shown on the Benefit Summary.

Self-administered oral chemotherapy is covered under your prescription drug benefit at a lower Out-of-Pocket expense to you.

5.7 Emergency Care Services

Benefits for Emergency Services are provided as described below and shown in the Benefit Summary. Emergency Care Services are provided both in and out of the Service Area anywhere in the world. If an emergency situation should occur, you should take immediate action and seek prompt medical care. You should call 911 or the emergency number listed in the local telephone directory or go to the nearest Hospital emergency department.

5.7.1 Emergency Care

A medical emergency is a sudden unexpected illness or injury that you believe would place your life in danger or cause serious damage to your health if you do not seek immediate medical treatment. Medical emergencies include, but are not limited to:

- Heart attack
- Acute abdominal pain
- Stroke
- Severe chest pain
- Poisoning
5. Covered Services

- Serious burn
- Loss of consciousness
- Bleeding that does not stop
- Unexpected premature birth
- Medically Necessary detoxification

Coverage is provided without Prior Authorization for Emergency Medical Screening Exams and stabilization of an Emergency Medical Condition. This benefit is unlimited and provides worldwide coverage. Hospitalization for an Emergency Medical Condition requires notification to AllCare PEBB within 48 hours, or as soon as reasonably possible following the onset of the treatment in order for coverage to continue.

Covered Services do NOT include Services for the inappropriate (non-emergency) use of an emergency department. This means Services that could be delayed until you can be seen in your Qualified Practitioner’s office. For example: treatment of minor illnesses such as flu or sore throat, checkups, follow-up visits and prescription drug requests.

Definitions

Emergency Medical Condition is a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical attention would:

- Result in serious impairment to bodily functions;
- Result in serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery for which transfer may pose a threat to the health or safety of the woman or the unborn child.

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

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

“Emergency Medical Screening Exams” include medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition. Your plan benefits cover Emergency Services in the emergency department of any Hospital. Emergency department Services are covered when your medical condition meets the guidelines for emergency care as stated.
above. Coverage includes Services to stabilize an emergency Medical Condition and Emergency Medical Screening Exams.

If you or a Family Member believes that immediate assistance is needed for an Emergency Medical Condition, call 911 or go to the nearest emergency department. Tell the emergency personnel the name of your Preferred Primary Care Provider (PPCP) and show them your Member ID Card.

Call your Preferred Primary Care Provider (PPCP) Personal Physician/Provider any time, any day of the week. Your Preferred Primary Care Provider (PPCP) or the provider-on-call will tell you what to do and where to go for the most appropriate care.

You are responsible for the emergency Services Deductible, Copayment and Coinsurance, as shown in the Benefit Summary, whenever you receive Services in an emergency department. Please be prepared to pay your Copayment at the time you receive care. You are responsible for the Copayment for each Hospital emergency department visit. If you are admitted to the Hospital from the emergency department, your emergency Services Copayment/Coinsurance does not apply and all Services are subject to the Inpatient Services benefit shown in your Benefit Summary.

The Plan does not pay for emergency department treatment for medical conditions that are not medical emergencies. Do not go to the emergency department for care that should take place in your provider’s office. Routine sore throats, common colds, follow-up care, and prescription drug requests are not considered to be emergencies.

If you visit an Out-of-Network Emergency department and are subsequently admitted to an Out-of-Network Hospital or facility, Services will be covered under your Out-of-Network Plan benefit, unless your medical condition prohibits transfer to a Participating Hospital or facility.

If you are admitted to an Out-of-Network Hospital, you or a relative should call AllCare PEBB within 48 hours or as soon as reasonably possible.

5.7.2 Emergency Medical Transportation

Benefits include Services for emergency medical transportation by state certified ambulance and certified air ambulance transportation when Medically Necessary. Air ambulance transportation must be Prior Authorized by AllCare PEBB except when used for medical emergencies. Out-of-Area ambulance Services are provided for transportation to the nearest facility capable of providing the necessary care or to a facility specified by AllCare PEBB.

5.7.3 Emergency Eye Care Services

Covered Services include the initial care for Emergency Medical Conditions resulting from an injury to or illness of the eye(s). Members may receive Services directly from an optometrist or ophthalmologist (PPCP referral required and can be submitted up to 5 business days after your visit) or a hospital emergency department (no referral required for emergency department visit).
5.7.4 Emergency Detoxification Services

Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Chemical Dependency treatment program, as stated in section 5.5.2, at the time Services are received. Prior Authorization is not required for emergency treatment; however, we must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to a Preferred/Participating Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized.

5.8 Urgent (Immediate) Care Services

Urgent (Immediate) care is treatment you need right away for an illness or injury that is not life threatening. This includes, but is not limited to, minor sprains, minor cuts and burns, and ear, nose, and throat infections. This benefit is unlimited and provides worldwide coverage. Routine care that can be delayed until you can be seen by a physician or provider in his or her office is not Urgent (Immediate) care.

Whenever you need Urgent (Immediate) care, call your Preferred Primary Care Provider (PPCP) first. Your Preferred Primary Care Provider (PPCP) or the provider-on-call is always available, day or night. He or she may either suggest that you come to the office or go to an emergency department or Urgent (Immediate) care center. If you can be treated in your Preferred Primary Care Provider (PPCP) office or preferred/participating Urgent (Immediate) care center, your Out-of-Pocket expense will usually be lower.

You are responsible for the Urgent (Immediate) care Deductible and Copayment/Coinsurance, as shown in the Benefit Summary, whenever you receive Urgent (Immediate) Care Services. Please be prepared to pay the Copayment/Coinsurance at the time you receive care. You are also responsible for the applicable Deductible and Copayment/Coinsurance shown in the Benefit Summary for any ancillary Services received, such as lab tests that are billed by the Preferred Primary Care Provider (PPCP).

If you are admitted to an Out-of-Network Hospital, you, or a relative, should call AllCare PEBB within 48 hours or as soon as reasonably possible.

Not all Out-of-Network Facilities will file a claim on a Member’s behalf. If you receive Urgent (Immediate) care Services from an Out-of-Network facility, you must submit a claim if the facility or provider does not submit it for you. See section 8.1.1.

5.9 Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, Durable Medical Equipment (DME) and Hearing Aids

Benefits for medical supplies, medical appliances, prosthetic and orthotic devices, Durable Medical Equipment (DME), and hearing aids are provided as shown in the Benefit Summary when required for the standard treatment of illness or injury. AllCare PEBB may authorize the purchase of an item if they determine the cost of purchasing an item would be less than the overall rental of the item. Services must be prescribed by your
Qualified Practitioner. All items with a purchase cost greater than $1,500 require Prior Authorization, as described in section 4.4.

The reasonable cost of repairing an item is covered as long as this cost does not exceed the purchase of a new piece of equipment or device. Items that are replaced due to loss or negligence are not covered. Items that are replaced because a newer or more efficient model is available are not covered unless AllCare PEBB determines otherwise. Repair or replacement is covered if required because of normal growth processes or to a change in your physical condition because of illness or injury. Repairs greater than $1,500 require Prior Authorization, as described in section 4.4.

5.9.1 Medical Supplies (Including Diabetes Supplies)

Benefits are provided as shown in the Benefit Summary for the following medical supplies and diabetes supplies:

- Medically Necessary supplies as ordered by your Qualified Practitioner, including, but not limited to, ostomy supplies, prescribed needles, syringes and chem strips. Non-sterile examination gloves used by you or your caregiver are NOT a covered medical supply.

- Diabetes supplies, such as needles, disposable syringes, lancets and test strips, may be purchased through AllCare PEBB’s medical supply providers or at Participating Pharmacies. Diabetes test strips are limited to 150 per month, unless otherwise prescribed by your Qualified Practitioner. See section 5.9.4 for coverage of diabetic equipment such as glucometers and insulin pump devices.

- Medically Necessary Medical Foods for supplementation or dietary replacement including non-prescription elemental enteral formula for home use, when determined to be Medically Necessary for the treatment of severe intestinal malabsorption and a provider has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition. Medical foods are also covered for the treatment of Inborn Errors of Metabolism, as described in section 5.10.7. Medical foods do not include total parenteral nutrition (TPN), which is covered as described in section 5.10.15.

5.9.2 Medical Appliances

Benefits are shown in the Benefit Summary for the following medical appliances:

- Casts, braces and supportive devices when used in the treatment of medical or surgical conditions in acute or convalescent stages or as immediate post-surgical care.

- Initial and replacement contact lenses, intraocular lenses, prescription lenses or standard frame glasses, when required as a result of injury, illness or surgery, such as, but not limited to, cataract, corneal transplant surgery or for the treatment of keratoconus.

- Rental of an oxygen unit(s) is covered for the initial two months of rental but requires notification to AllCare PEBB upon dispensing by Durable Medical Equipment vendor. Continued use requires Prior Authorization, as specified in section 4.4.
5. Covered Services

- Removable custom orthotic shoe inserts when Medically Necessary. Removable custom orthotic shoe inserts are subject to the benefit maximum of $200 per Calendar Year, and do not apply to your Deductible.
- Medical devices that are surgically implanted into the body to replace or aid function. If you receive a procedure to implant a medical device, you will be responsible for any Copayment or Coinsurance for the medical device in addition to any Copayment or Coinsurance for the procedure.
- Other Medically Necessary appliances as ordered by your Qualified Practitioner.

5.9.3 Prosthetic and Orthotic Devices

Benefits are provided for prosthetic and orthotic devices as shown in the Benefit Summary. Coverage is limited to those prosthetic and orthotic devices that are Medically Necessary and included in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies. Covered Services include rigid or semi-rigid devices used for 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 or an artificial limb device or appliance designed to replace in whole or in part an arm or a leg; breast implants following mastectomy; artificial eyes; and maxillofacial prosthetic devices for the restoration and management of head and facial structures. (For coverage of removable custom shoe orthotics, see section 5.9.2.)

5.9.4 Durable Medical Equipment (DME)

Benefits are provided for DME as shown in the Benefit Summary. Covered Services include Medically Necessary equipment such as a hospital bed, non-motorized wheelchair, ventilator, and similar equipment as approved by AllCare PEBB. Covered Services for DME do not include items that are primarily and customarily used for a non-medical purpose or which are used for environmental control or enhancement (whether or not prescribed by a physician).

5.9.5 Hearing Aids and Hearing Exams

Covered services include hearing aids and supplies. The Coinsurance you pay toward the cost of the hearing aids does not accumulate toward the Calendar Year Out-of-Pocket Maximum.

Hearing exams are covered as an office visit, as shown in the Benefit Summary.

5.10 Other Covered Services

The following are other Covered Services and are provided as shown in the Benefit Summary.

5.10.1 Allergy Shots and Allergy Serums

Allergy shots and allergy serum are covered as shown in the Benefit Summary. The following tests and treatments are covered only when such therapy or testing is approved by The American Academy of Allergy and Immunology, or The Department of Health and
5. Covered Services

Human Services or any of its offices or agencies: therapy and testing for treatment of allergies including, but not limited to, Services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts and neutralization.

Note: See section 5.6 for coverage of infusion at Outpatient Facilities.

5.10.2 Bariatric Surgery

Preferred Plan coverage for bariatric/gastric bypass surgery Services for morbid obesity is provided, as shown in the Benefit Summary for inpatient Services, in accordance with the medical policy and criteria established and maintained by PEBB. Prior Authorization, as specified in section 4.4, is required for coverage of bariatric/gastric bypass surgery Services. Approved surgical procedures may include gastric bypass, gastric stapling, gastoplasty, gastric sleeve, and the Lap-Band adjustable gastric banding system. Services must be received at a plan-approved center of excellence. To locate a plan-approved center of excellence visit our website at AllCareHealth.com/Public-Employees.

Deductible, Copayment and Coinsurance will apply. Amounts paid by the Member for facility Covered Services apply to the annual medical Out-of-Pocket Maximum.

The PEBB criteria require an extensive evaluation prior to surgery and a staged approach:

**Stage 1** — Patient meets clinical criteria necessary to be selected for Stage 2:

- Body mass index (BMI) equal to or greater than 35 with a diagnosis of diabetes; or
- BMI equal to or greater than 40 with any obesity related comorbid condition*; or
- BMI equal to or greater than 50 with or without obesity related comorbid conditions*.

*Obesity related to morbid conditions include obstructive sleep apnea, treated hypertension, treated diabetes, and cardiac disease.

**Stage 2** — Patient completes a six-month work up (in some cases Member may complete requirements in less than six-months) that includes:

- Dietary counseling and education;
- Medical and psychological evaluation; and
- A weight loss of greater than 5 percent during the work-up period.

**Stage 3** — Patient completes the final stage including:

- Compliance with Stage 2 and approval to proceed; and
- Surgery done in a center of excellence based on program criteria.

**Program Selection Guidelines**

Services must be received at facilities that meet Health Evidence Review Commission guidelines for facilities providing bariatric surgery.
5. Covered Services

5.10.3 Diabetes Self-Management Education Program

Benefits are paid in full for initial self-management education programs. You must be enrolled under the Plan throughout the course of the program for benefits to be paid.

5.10.4 Outpatient Diagnostic Pathology, Radiology Tests, High Tech Imaging and Diagnostic Procedures

Benefits are as shown in the Benefit Summary and include inpatient and outpatient diagnostic pathology (lab), high tech imaging (including PET, CT, CTA, MRI, and MRA), radiology (x-ray) tests, sleep studies, virtual colonoscopy, capsule endoscopy, and other Medically Necessary diagnostic procedures. Covered Services include contrast materials (dyes) that may be required for a diagnostic procedure. MRI, PET, sleep studies, virtual colonoscopy and capsule endoscopy services must be Prior Authorized by AllCare PEBB.

5.10.5 Home Health Care Benefit

Benefits for home health care Covered Services are shown in the Benefit Summary, limited to 180 visits (such as skilled nursing visits, physical therapy, speech therapy and occupational therapy) per Calendar Year and are described below. We will provide benefits for home health care as an alternative to hospitalization with consent of the Member. A Home Health Provider must provide Services at your home under a home health care plan. Nothing in this provision will increase benefits to cover home health care Services that are not otherwise covered under this Plan.

Each visit by a person providing Services under a home health care plan or evaluating the need for or developing a plan is considered one home health care visit. Up to four consecutive hours in a 24-hour period of home health care Service is considered one home health care visit. A home health care visit of more than four hours is considered one visit for every four hours or part thereof.

Home health care will not be reimbursed unless your Qualified Practitioner certifies that:

- The home health care Services will be provided or coordinated by a state-licensed or Medicare-certified Home Health Agency or certified rehabilitation agency; and
- AllCare PEBB determines the Services to be Medically Necessary.

If the above criteria are not met, NO benefits will be provided under this Plan for home health care. Rehabilitation Services provided under an authorized home health care plan will be covered as home health care Services.

- Home health care benefits do NOT include:
- Charges for mileage or travel time to and from your home;
- Wage or shift differentials for Home Health Providers;
- Charges for supervision of Home Health Providers; or
- Services that consist principally of Custodial Care including, but not limited to, care for senile deterioration, mental deficiency, mental retardation or mental illness, or care of a chronic or congenital condition on a long-term basis.
5.10.6 Hospice Care Benefit

Benefits are included for hospice care as shown in the Benefit Summary and described below. In addition, the following criteria must be met:

- You obtain Prior Authorization from AllCare PEBB, as specified in section 4.4;
- AllCare PEBB determines the Services to be Medically Necessary;
- Your Qualified Practitioner certifies that you have a terminal illness with a life expectancy not exceeding six months; and
- The Covered Services provided are reasonable and necessary for the condition and symptoms being treated.

When the above criteria are met, the Plan will provide benefits for a full range of Covered Services that are required to be included in a certified hospice care program. Covered Services include the following:

- Nursing care provided by or under the supervision of a registered nurse;
- Medical social services provided by a medical social worker who is working under the direction of a physician, including counseling for the purpose of helping you and your caregivers adjust to the approaching death;
- Services provided by your Qualified Practitioner or a physician associated with the hospice program;
- Durable Medical Equipment, medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness;
- Home health aide Services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care;
- Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills; and
- Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms.

Respite care and other Services not specified above are excluded from coverage.

5.10.7 Inborn Errors of Metabolism

Benefits are provided for Covered Services as shown in the Benefit Summary based upon the type of Services received for diagnosing, monitoring and controlling inborn errors of metabolism, including, but not limited to: phenylketonuria (PKU); homocystinuria; citrullinemia; maple syrup disease; and pyruvate dehydrogenase deficiency; that involve amino acid, carbohydrate and fat metabolism for which medically standard methods exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Covered Services include clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. (For coverage of medical foods, see section 5.9.1.)
5. Covered Services

5.10.8 Podiatry/Foot Services

Benefits include Covered Services of a podiatrist or other Qualified Practitioner and are provided as shown in the Physician/Provider Services section of the Benefit Summary. Covered Services include, but are not limited to, the fitting and follow up exam for removable custom orthotic shoe inserts when Medically Necessary. Removable custom shoe orthotics are covered as stated in section 5.9.2 for Medical Appliances. Covered Services do not include routine foot care such as the removal of corns or calluses, unless you have diabetes.

5.10.9 Reconstructive Surgery

Reconstructive Surgery is covered for conditions resulting from trauma, infection or other diseases and for congenital deformities and anomalies if there is a resultant functional impairment. Benefits are covered as those Services listed in the Benefit Summary based upon the type of Services received. All Covered Services for Reconstructive Surgery must be Prior Authorized. For Reconstructive Surgery of head or facial structures and limited dental Services, see section 6.2.

5.10.10 Reconstructive Surgery of the Breast

Benefits for Reconstructive Surgery of the breast are covered as those Services listed in the Benefit Summary based upon the type of Services received and in accordance with the Women’s Health and Cancer Rights Act of 1998 (WHCRA). Reconstructive Surgery of the breast is covered for:

- Reconstruction of the involved breast following a mastectomy;
- Surgery and construction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

If you have additional questions about your WHCRA benefits, please contact Member Services.

5.10.11 Outpatient Rehabilitation Services

Benefits are included for short-term outpatient physical, occupational and speech therapy (combined limit of 60 visits per Calendar Year). Covered Services provided by a physician or licensed/registered therapist to restore or improve lost function following illness or injury.

Benefits are limited to Covered Services that can be expected to result in measurable improvement of a Member’s condition. Covered services are shown in the Benefits Summary.

Important note: A visit is considered a treatment with one provider. For example, if a physical therapist and a speech therapist are seen on the same day at the same facility, the Services will count as two visits as treatment has been received from two providers.
Covered Services under this benefit do NOT include:

- Adjustments and manipulations of any spinal or bodily area (spinal manipulation is covered under section 5.10.13);
- Exercise programs;
- Rolfing, polarity therapy and similar therapies;
- Growth and cognitive therapies, including sensory integration; and
- Rehabilitation Services provided under an authorized home health care plan as specified in section 5.10.5.

5.10.12 Tobacco Cessation Services

Participation in the tobacco cessation program is covered in full. This in-house program addresses tobacco dependence through a clinically proven, comprehensive approach to tobacco cessation that treats all three aspects of tobacco use — physical addiction, psychological dependence and behavioral patterns. An expert Tobacco Cessation Coordinator will create a quit plan for each program Member that includes:

- One-on-one phone based treatment sessions;
- Unlimited toll-free telephone access to Tobacco Cessation Coordinator;
- A kit of materials designed to help program Members quit tobacco use through active self-management;
- Recommendations on and direct fulfillment of nicotine replacement therapy, if appropriate; and
- Information and decision support for bupropion or Chantix, if appropriate.

5.10.13 Spinal Manipulations

Coverage is provided for spinal manipulation as stated in the Benefit Summary. Rehabilitative therapy billed by a Chiropractor will not be subject to the Prior Authorization requirements and will not count towards the maximum therapy benefit limitation. To be eligible for coverage, all spinal manipulation Services must be Medically Necessary and within the Qualified Practitioner’s scope of license.

5.10.14 Acupuncture

Coverage is provided for acupuncture as stated in the Benefit Summary. To be eligible for coverage, all acupuncture Services must be Medically Necessary and within the Qualified Practitioner’s scope of license.
5. Covered Services

5.10.15 Home Infusion

Coverage is provided for Medically Necessary home infusion services, which includes injectable medications and total parental nutrition (TPN). Services must be Prior Authorized as specified in section 4.4.

5.10.16 Gender Identity Disorder

To be eligible for coverage, all Services must be Medically Necessary and within the Qualified Practitioner’s scope of practice.

- Hormone Replacement Therapy
  - Estrogens (also androgen blockers) and Testosterone
  - “Growth hormones” (puberty blockers)
- Mental Health Services
- Surgical Reconstruction
  - Breast/Chest reconstruction
  - Facial reconstruction
  - Gonadal surgery
  - Genital reconstruction
- Other procedures or services
  - Hair removal (electrolysis)
  - Speech therapy

5.10.17 Osteopathic Manipulative Treatment

Covered services include the manual treatment(s) used to treat somatic dysfunction and related disorders to the body regions of head, cervical, thoracic, lumbar, sacral, pelvic, extremities, rib cage, abdomen, and viscera. To be eligible for coverage, all osteopathic manipulation treatment Services must be Medically Necessary and within the Qualified Practitioner’s scope of license.

5.10.18 Non-Emergent Transportation

On some occasions, you might get services from one of our Centers of Excellence or a Preferred Network Hospital outside of our Service Area. Your AllCare PEBB benefits include a transportation benefit covering your transportation to those kinds of health care appointments.

Transportation services require Prior Authorization by AllCare PEBB, and are provided by ReadyRide. When you call ReadyRide, please have your AllCare PEBB ID card, the name and address of the provider, and the appointment date and time in front of you.

Call ReadyRide between 8 a.m. and 6 p.m. Monday thru Friday at least 2 days before your
appointment. The phone number is (800) 479-7920 or TTY (800) 735-2900.

5.11 Prescription Drug Benefit

The prescription drug benefits that are available under this Plan are described in this section and in the Prescription Drug Benefit Summary. All Covered Services are subject to the specific conditions, duration limitations and all applicable maximums that are specified in this Member Handbook.

Prescription Drug Definition

The following are considered “Prescription Drugs”:

- Any medicinal substance which bears the legend, “Caution: federal law prohibits dispensing without a prescription”;
- Insulin;
- Any medicinal substance of which at least one ingredient is a federal or state legend drug in a therapeutic amount; and
- Any medicinal substance which has been approved by the Oregon Health Resources Commission as effective for the treatment of a particular indication.

5.11.1 Using Your Prescription Drug Benefit

Your prescription drug benefit requires that you fill your prescriptions at a Preferred Network Pharmacy.

You have broad access to over 65,000 Preferred Network Pharmacies and their services at discounted rates. AllCare PEBB Preferred Network Pharmacies are those pharmacies that maintain all applicable certifications and licenses necessary under state and federal law of the United States and have an agreement with AllCare PEBB through their Pharmacy Benefit Manager, MedImpact, to provide Prescription Drugs.

Pharmacies are designated as preferred retail, preferred Choice 90 retail, specialty and mail-order pharmacies. To view a list of our Preferred Pharmacies visit our website at AllCareHealth.com/Public-Employees. You also may contact Member Services at the telephone number listed on your Member ID Card.

- Prescription Drug Services, except preventive and EHB (Essential Health Benefit) drugs, are subject to the Prescription Drug Deductible and Copayment amounts shown in the Prescription Drug Benefit Summary (does not apply to preventive/EHB Drugs).
- Prescription Drug Deductibles and Copayment amounts do not apply to the medical Calendar Year Out-of-Pocket Maximum and are due at the time of purchase.
- Preferred Pharmacies may not charge you more than your Copayment. Please contact Member Services if you are asked to pay more or if you, or the pharmacy, have questions about your Prescription Drug benefits or need assistance processing your prescription.
5. Covered Services

- Some drugs require Prior Authorization for Medical Necessity, length of therapy, step therapy, number of doses or dispensing limits. The AllCare PEBB prescription drug formulary indicates those medications that require Prior Authorization. The formulary is available from Member Services and from the AllCare PEBB website at AllCareHealth.com/Public-Employees.

- You may purchase up to a 90-day supply of most non-Specialty maintenance drugs at one time using our preferred mail service or any Choice 90 retail pharmacy. Preferred Network pharmacy information is available at AllCareHealth.com/Public-Employees.

- Not all Prescription Drugs are available through the mail order pharmacy.

- Diabetes supplies and inhalation extender devices may be obtained at a Preferred Pharmacy. However, some items (including glucometers and insulin pump devices) are considered medical supplies and devices and are covered under the benefit provisions of section 5.9 rather than the prescription drug provisions of this section.

- Injectable medications received in your Provider’s office are covered under sections 5.1.4 and 5.10.1.

- Infusions, including infused medications, received at Outpatient Facilities are covered under section 5.6.

- You must present your ID Card to the Preferred Network pharmacy at the time you request Services. Your use of the ID Card for prescription drugs helps streamline pharmacy costs and eliminates extra work for you, the pharmacist, and AllCare PEBB. If you have misplaced your ID Card or don’t have your ID Card with you when you need to purchase prescription drugs, please ask your pharmacist to call AllCare PEBB at (888) 460-0185.

5.11.2 Use of Out-of-Network Pharmacies

On rare occasions, such as urgent or emergency situations, you may need to use an Out-of-Network pharmacy. If this happens, you will need to pay full price for your prescription at the time of purchase.

To request reimbursement, you will need to contact Member Services. Member Services will help you obtain any necessary forms for reimbursement or you may access these forms on our website AllCareHealth.com/Public-Employees. When you submit the completed forms, include any itemized pharmacy receipts, along with an explanation as to why you used an Out-of-Network pharmacy.

Submission of a claim to AllCare PEBB does not guarantee payment.

If your claim is approved, the Plan will reimburse you the cost of your prescription subject to the terms of this Plan and the Prescription Drug Benefit Summary, less your applicable Copayment. Your reimbursement will be mailed directly to you.
5.11.3 Prescription Drug Formulary

The AllCare PEBB Formulary is a list of Food and Drug Administration (FDA)-approved prescription brand name and generic drugs. It is designed to offer drug treatment choices for covered medical conditions. The Formulary can help you and your Qualified Practitioner choose effective medications that are less costly and minimize your Out-of-Pocket expense. There are effective generic drug choices to treat most medical conditions.

All drugs must be FDA approved, Medically Necessary, and require by law a prescription to dispense. Not all FDA-approved drugs are covered by the Plan. Formulary status is given to drugs that meet evidence-based assessment of therapeutic effectiveness, safety, pharmacoeconomic value and offer an important advantage to existing formulary alternatives.

Newly approved drugs will be reviewed by the MedImpact Pharmacy and Therapeutics Committee for safety and Medical Necessity within 12 months after the drug becomes available on the market. In the case of an urgent situation, AllCare PEBB will authorize the use of a newly approved FDA drug during the review period so a Member does not go without Medically Necessary treatment.

AllCare PEBB’s Formulary is updated regularly throughout the year. You may obtain a copy of the Formulary from the website AllCareHealth.com/Public-Employees or by contacting Member Services.

5.11.4 Generic, Brand Name and Preventive/EHB Prescription Drugs

Both generic and brand names drugs are covered as specified in this section. In general, generic drugs are subject to lower Copayment amounts than brand name drugs. Please refer to the Prescription Drug Benefit Summary for your Copayment information.

Generic medication means a prescription medication that is:
- An equivalent medication to the brand name medication;
- Marketed as a therapeutically equivalent and interchangeable product; and
- Listed in widely accepted references as a generic medication and is specified as a generic medication under the terms of this Plan.

Equivalent medication means the US Food and Drug Administration (FDA) ensures that the generic medication must:
- Have the same active ingredients;
- Meet the same manufacturing and testing standards; and
- Be absorbed into the bloodstream at the same rate and same total amount as the brand name medication.

These requirements ensure that the generic medication has the same effectiveness as the brand name medication. If listings in widely accepted references are conflicting or
5. Covered Services

indefinite about whether a prescription medication is a generic or brand medication, AllCare PEBB will determine whether the prescription medication is a generic or brand name medication.

**Brand name medication** (single source brand) means a prescription medication that has a current patent and is marketed and sold by limited sources or is listed in widely accepted references as a brand name medication based on manufacturer and price.

**Multi-source brand name medication** means a brand name medication for which a generic medication may be substituted under the laws and regulations of the state in which the pharmacy dispensing the prescription is located. Some multi-source brand drugs may be manufactured and distributed as a generic.

**Preventive or EHB drugs** means commonly used medications for treating chronic conditions such as diabetes, high blood pressure, high cholesterol, heart disease, depression, asthma and other breathing disorders and are covered at no expense to you. This list also includes medications and supplements considered Essential Health Benefits as established by the Patient Protection and Affordable Care Act (ACA). These medications are on our formulary, may be generic or brand-name, and are considered first-line treatments for many conditions. Your prescription drug Deductible and Copayment amounts do not apply to Preventive/EHB drugs.

5.11.5 Prescription Drug Quantity

Dispensing limits may apply to certain medications requiring limited use, as determined by AllCare PEBB’s medical policy. Prior Authorization is required for amounts exceeding any applicable medication dispensing limits.

5.11.6 Preferred Mail Order and Preferred Retail Pharmacies

Prescribed maintenance drugs (pharmaceutical products that for the majority of patients are prescribed in a constant, on-going manner) purchased from a preferred mail order pharmacy will be covered subject to the following specific provisions:

- Qualified drugs under this program will be determined by AllCare PEBB. Not all drugs are available through mail order pharmacy.

- Not all maintenance prescription drugs are available in 90 day allotments. Not all Prescription Drugs are available through the mail order pharmacies.

- Copayment(s) will be applied to the quantity stated in the Prescription Drug Benefit Summary.

When using a mail-order pharmacy, payment is required prior to processing your order. If there is a change in AllCare PEBB’s Preferred Network mail service pharmacy, you will be notified of the change at least 30 days in advance.

AllCare PEBB Preferred mail order information is available on the AllCare PEBB website at [AllCareHealth.com/Public-Employees](http://AllCareHealth.com/Public-Employees).
5.11.7 Prescription Drug Limitations

Prescription drug limitations are as follows:

- All drugs must be Food and Drug Administration (FDA) approved, Medically Necessary and require by law a prescription to dispense. Not all FDA approved drugs are covered under this Plan. Newly approved drugs will be reviewed for safety and Medical Necessity within 12 months after the drug becomes available on the market for formulary consideration.

- Certain drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy, number of doses or dispensing limits. Step therapy uses our pharmacy claims history to confirm if certain drugs have been tried first by a Member. If a drug has not been tried first, cannot be tried first, or if the drug history is not available, Prior Authorization is required. For some drugs, AllCare PEBB limits the amount of the drug we will cover. You or your Qualified Practitioner can contact AllCare PEBB directly to request Prior Authorization. If you have questions regarding a specific drug, please call Member Services.

- Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery handling monitoring and administration and are generally high cost. These drugs must be purchased through AllCare PEBB’s designated Specialty Pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply (or minimum package size to approximate a 30-day supply).

- Self-injectable medications are only covered if they are intended for self-administration; labeled by the FDA for self-administration; and are referenced in AllCare PEBB’s Formulary.

- Compound prescription drugs must contain at least one ingredient that is an FDA-approved prescription drug in a therapeutic amount, must meet AllCare PEBB’s medical necessity criteria and be purchased at a Preferred Network pharmacy. Compounded drugs from bulk powders that are not a component of a FDA-approved drug are not covered.

5.11.8 Prescription Drug Exclusions

In addition to the limitations and exclusions set forth in this Member Handbook, Prescription Drug Exclusions are as follows:

- Drugs or medicines delivered, injected, or administered to you by a physician, other provider or another trained person;

- Drugs used in the treatment of the common cold;

- Intrauterine devices (IUDs), except as covered under sections 5.2.5 and 5.9;

- Drugs or medications prescribed that do not relate to the treatment of a covered illness or injury;

- Devices, appliances, supplies and Durable Medical Equipment of any type, even though such devices may require a prescription order. Some of these items may
be covered under your medical benefits. Please refer to the Benefit Summary and section 5.9;

- Experimental or investigational drugs or drugs used by a Member in a research study or in another similar investigational environment;

- Drugs that are not provided in accordance with AllCare PEBB’s formulary management program, unless approved in the exception process (see section 5.11.10);

- Drugs or medications prescribed that are not Medically Necessary or are not provided according to the AllCare PEBB’s medical policy or Prior Authorization requirements;

- Methadone for the treatment of chemical dependency. Methadone to treat chemical dependency is covered under the medical chemical dependency benefit when the treatment is part of an approved medically supervised treatment program and is subject to any applicable benefit limits;

- Over-the-Counter (OTC) drugs, medications or vitamins that may be purchased without a provider’s written prescription and prescription drugs for which there are OTC therapeutically similar forms (OTC medications required to be covered as a preventive Service as established by federal legislation will be covered in full when prescribed by a Qualified Practitioner; see section 5.2.);

- Drugs dispensed from pharmacies outside the United States, except when prescribed for Urgent (Immediate) Care and Emergency Medical Conditions;

- Drugs that, by law, do not require a prescription, except insulin;

- Replacement of lost or stolen medication;

- Drugs dispensed or compounded by a pharmacist that do not have at least one FDA approved medication in therapeutic amount;

- Drugs used for cosmetic purposes;

- Drugs used in the treatment of drug induced fatigue, general fatigue and idiopathic hypersomnia;

- Drugs that are not approved by the Food and Drug Administration (FDA) or that are designated as “less than effective” by the FDA, also known as “DESI” drugs.

5.11.9 Prescription Drug Disclaimer

The AllCare PEBB Plan is not liable for any claim, injury, demand, or judgment based on tort or other grounds (including, but not limited to, warranty or merchantability) arising out of or in any connection with the sale, compounding, dispensing, manufacturing, or use of any prescription drug covered under this plan.

Exclusions that apply to Prescription Drugs, Medicines and Devices:

- Outpatient prescription drugs, medicines and devices except as provided in sections 5.2.5, 5.9, and 5.11, and
• Any drug, medicine, or device that does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Pre-market Approval, or 510K.

5.11.10 Prescription Drug Exception Process

You or an enrolled dependent, your designee or prescribing provider may request access to clinically appropriate drugs not covered by the AllCare PEBB Plan based on exigent circumstances. Requests made under this section will be reviewed and a determination communicated to the requestor within 24 hours of receiving the request. If the request is granted, coverage for the non-covered prescription drug will be covered for the duration of the exigency. An exigent circumstance exists when the enrollee is suffering from a health condition that may seriously jeopardize the enrollee.

5.12 Prior Authorization

Standard Prior Authorization Requests

• **For Services that do not involve urgent medical conditions:** AllCare PEBB will notify your Provider of their decision within 2 business days after the Prior Authorization request is received. However, for reasons beyond our control, AllCare PEBB may extend this timeframe and will complete their review within 14 days after the Prior Authorization is received.

• **For Prescription Drug Services:** AllCare PEBB will notify your Provider and Pharmacy of their decision within 2 business days after the Prior Authorization request is received.

Urgent Prior Authorization Requests

• **For Services that involve urgent medical conditions:** AllCare PEBB will notify your Provider of their decision within 72 hours after the Prior Authorization request is received. If AllCare PEBB needs additional information to complete their review, they will notify the requesting Provider and you in writing within 72 hours after the request is received. AllCare PEBB will then complete their review and notify the requesting Provider of their decision within 14 business days after the Prior Authorization request is received.

• **For Prescription Drug Services:** AllCare PEBB will notify your Provider and Pharmacy of their decision within 24 hours after the Prior Authorization request is received. If AllCare PEBB needs additional information to complete their review, they will notify the requesting Provider and you by phone within 24 hours after the request is received. AllCare PEBB will then complete their review and notify the requesting Provider and Pharmacy of their decision within 72 hours after the Prior Authorization request is received.
6. Limitations For Specified Covered Services

There are limitations on the benefits available under this Plan for the treatment of certain conditions and the use of certain procedures. This section describes these limitations.

6.1 Human Organ/Tissue Transplants

A transplant is defined as a procedure or series of procedures by which an organ or tissue is either:

- Removed from the body of one person (the donor) and implanted in the body of another person (the recipient who is a Member); or
- Removed from and replaced in the same person’s body (a self-donor who is a Member).

The term transplant does not include Services related to the transfusion of blood or blood derivatives (except hematopoietic stem cells) or replacement of a cornea. Corneal replacement is covered under the applicable provider and facility surgical benefits.

6.1.1 Covered Services

(See also the Transplant Exclusion Period in section 6.1.7) Covered Services for transplants are limited to Services that:

- Are Prior Authorized and determined by AllCare PEBB to be Medically Necessary and Medically appropriate according to national standards of care;
- Are provided at a facility approved by AllCare PEBB or under contract with AllCare PEBB (Transplant Services are not covered Out-of-Network);
- Involve one or more of the following organs or tissues:
  - Heart
  - Lung
  - Liver
  - Kidney
  - Pancreas
  - Small bowel
  - Autologous hematopoietic stem cell or bone marrow
  - Allogeneic hematopoietic stem cell or bone marrow; and
- Are directly related to the transplant procedure, including Services that occur before, during and after the transplant procedure.

Covered Services for transplant recipients include medical Services, Hospital Services, medical supplies, medications and prescription drugs while hospitalized, diagnostic modalities, prosthesis, high dosage chemotherapy for stem cell/bone marrow transplants,
and travel expenses. Travel expenses are subject to a $5,000 benefit maximum for transportation, food and lodging. Food and lodging is subject to a $150 per diem. Per Diem expenses apply to the $5,000 travel expenses benefit maximum.

Services for donors are covered when the donor is not eligible for coverage of donation Services under any other Health Benefit Plan or government-funded program. Covered Services for donors include:

- Initial evaluation of the donor and related program administration costs;
- Preserving the organ or tissue;
- Transporting the organ or tissue to the transplant site;
- Acquisition charges for cadaver or live donor;
- Services required to remove the organ or tissue from the donor; and
- Treatment of medical complications directly resulting from the surgery performed to obtain the organ or tissue for a period of time not to exceed 30 consecutive days following that surgery.

6.1.2 Benefits for Donor Costs

Benefits for donor or self-donor costs are payable as long as the recipient is covered by the Plan.

6.1.3 Benefits for Transplant Facility Services Provided to the Organ Recipient

The Deductible, Coinsurance or Copayment provisions of this Plan are waived, except as follows:

- The Member/recipient is responsible for the Coinsurance or Copayment amounts, as shown in the Benefit Summary, for inpatient Hospital Services and for outpatient facility Services that are not billed as a global fee and those amounts will apply to the Member’s Out-of-Pocket Maximum.

6.1.4 Benefits for Outpatient Medications

Outpatient prescription medications for transplant-related Services, including anti-rejection (immunosuppressive) drugs, are covered under the outpatient prescription drug benefits of this Plan, as specified in section 5.11.

6.1.5 Benefits for Physician/Provider Services Provided to the Organ Recipient

Benefits for physician/provider Services are provided as shown in the Benefit Summary. The Member/recipient is responsible for the Coinsurance or Copayment amounts for those Services, as shown in the Benefit Summary, unless those Services are billed as a global fee with the facility Services, and those amounts will apply to the Member’s Out-of-Pocket Maximum.
6. Limitations for Specified Covered Services

6.1.6 Transplant Prior Authorization

(See also section 4.4)

To qualify for coverage under this Plan, all transplant related Services, procedures, treatment protocols and facilities must be Prior Authorized, including:

- Initial consultation;
- Evaluation;
- Transplant facilities;
- Donor evaluation;
- Donor Services;
- High-dose chemotherapy administered prior to the transplant
- HLA typing;
- Travel expenses;
- Pre-transplant care;
- Self-donation Services;
- Transplant Services; and
- Follow-up treatment.

6.1.7 Transplant Exclusions

In addition to the exclusions listed in section 7 of this Plan, the following exclusions apply to human organ/tissue transplants:

- Any transplant procedure that has not been Prior Authorized;
- Any transplant procedure performed at a transplant facility that has not been approved by AllCare PEBB;
- Any transplant that is Experimental/Investigational, as determined by AllCare PEBB;
- Services or supplies for any transplant that are not specified as Covered Services in this section 6.1, such as transplantation of animal organs or artificial organs;
- High-dose chemotherapy administered prior to a transplant, unless those Services have been Prior Authorized;
- Services related to organ/tissue donation by a Member if the recipient is not a Member or the Member/recipient is not eligible for transplant benefits under this Plan; and
- Transplant-related travel expenses for the donor and the donor’s and recipient’s Family Members.
6.2 Restoration Of Head/Facial Structures; Limited Dental Services

Covered Services are limited to those Services that are Medically Necessary for the purpose of controlling or eliminating pain, or restoring facial configuration or functions such as speech, swallowing or chewing. Medically Necessary Covered Services include restoration and management of head and facial structures, including teeth, dental implants and bridges that cannot be replaced with living tissue and that are defective because of trauma, disease or birth or development deformities.

Benefits are covered as listed in the Benefit Summary based upon the type of Services received. Limitations that apply to Covered Services include:

- All treatment, except Emergency Services must be Prior Authorized; and
- Conditions related to trauma must be diagnosed within six months of injury and treatment must begin within twelve months of the injury.

Exclusions that apply to Covered Services include:

- Cosmetic Services;
- Services rendered to improve a condition that falls within the normal range of such conditions;
- Routine Orthodontia;
- Services to treat tooth decay, periodontal conditions and deficiencies in dental hygiene;
- Removal of impacted teeth;
- The making or repairing of dentures;
- Orthognathic surgery to shorten or lengthen the upper or lower jaw, unless related to a traumatic injury or to a neoplastic or degenerative disease; and
- Services to treat temporomandibular joint syndrome except as specified in the following section of this Member Handbook.

6.2.1 Temporomandibular Joint (TMJ) Services

Benefits are provided for TMJ Services from a Preferred/Participating Provider as shown in the Benefit Summary. Covered Services include:

- A diagnostic examination including a history, physical examination and range of motion measurements, as necessary;
- Diagnostic x-rays;
- Physical therapy of necessary frequency and duration, limited to 20 visits per Calendar Year;
- Therapeutic injections; and
6. Limitations for Specified Covered Services

- Therapy utilizing an appliance/splint which does not permanently alter tooth position, jaw position or bite. Benefits for this therapy will be based on the use of a single appliance/splint, regardless of the number of appliances/splints used in treatment. The benefit for the appliance splint therapy will include an allowance for diagnostic Services, office visits and adjustments.

TMJ Services are covered under your Preferred/Participating Plan benefits at the applicable benefit level for the Services received. Out-of-Network benefits do not apply to TMJ Services. Covered Services for TMJ conditions do not include dental or orthodontia Services.

6.2.2 Outpatient Hospitalization and Anesthesia for Limited Dental Services

Benefits for outpatient hospitalization and anesthesia for limited dental Services are covered as those Services listed in the Benefit Summary based upon the type of Services received. Services must be Prior Authorized and will only be provided for Members with complicating medical conditions. Examples of these conditions include, but are not limited to:

- Developmental disabilities;
- Physical disabilities; or
- A combination of medical conditions or disabilities that cannot be managed safely and efficiently in a dental office.
- Dental Services are excluded.

6.3 Infertility Services

Coverage for infertility Services is provided, as shown in the Benefit Summary for other office procedures, when a diagnosis of infertility has been established. Infertility is defined as the inability to become pregnant or the inability to carry a pregnancy to term based on clinical guidelines. Medical Records must be provided by you to support infertility and will be reviewed by AllCare PEBB’s Medical Staff to determine coverage.

Covered Services include the following:

- Diagnostic testing and associated office visits to determine the cause of infertility. This includes the physical examination, related laboratory testing, instruction, and medical/surgical procedures when preformed for the sole purpose of diagnosing and treating an infertile state. Diagnostic Services for the treatment of infertility include, but are not limited to hysterosalpingogram, laparoscopy and pelvic ultrasound.
- Artificial insemination, limited to a lifetime maximum of six cycles and sperm wash;
- Cost of acquiring semen;
- Infertility related drugs or injectables;
- Covered infertility-related supplies.
6. Limitations for Specified Covered Services

Covered Services do NOT include:

- Charges for donor semen from donor banks or other providers;
- Charges for harvesting and storage of semen other than for immediate use;
- Infertility Services not resulting from a medical condition;
- All Services for non-member surrogate mothers;
- Infertility resulting from the aging process as confirmed by elevated FSH; and
- In vitro and in vivo fertilization including Services related to or supporting in vitro fertilization, GIFT, ZIFT, reversals of voluntary sterilization and procedures determined to be experimental or investigational.

Expenses for infertility Services do not accumulate toward the annual Out-of-Pocket maximum.

6.4 Additional-Cost Tier Services

Coverage for certain Additional-Cost Tier Services must be Prior Authorized and is provided as shown in the Benefit Summary. The Deductible and Copayment for these procedures do not apply to your Out-of-Pocket Maximum. See section 4.4 for additional information on Prior Authorization.

The Additional-Cost Tier does not apply to Covered Services related to cancer diagnosis and treatment or to tissue injuries resulting from an external force which require immediate repair.

Additional-Cost Tier Covered Services:

- Upper gastrointestinal endoscopy
- High tech imaging services: MRI, MRA, MRS, CT, CTA, PET (including nuclear imaging)
- Spine procedures
- Spine injections for pain
- Hip replacement
- Hip resurfacing
- Knee arthroscopy
- Knee replacement
- Knee resurfacing
- Knee viscosupplementation
- Shoulder arthroscopy
- Bariatric surgery
6. Limitations for Specified Covered Services

- Sinus surgery
- Morton’s neuroma
- Hammertoe surgery
- Bunionectomy

6.5 Genetic Testing and Counseling Services

Genetic studies require Prior Authorization, as specified in section 4.4., and are covered under the applicable benefit level when there is a medical condition that requires genetic testing to make a certain diagnosis or to aid in planning a treatment course. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature.
7. EXCLUSIONS

In addition to those Services listed as not covered in the Covered Services or Limitations sections, the following are specifically excluded from coverage under this Plan.

General Exclusions:

We do not cover Services and supplies which:

- Are not provided;
- Are provided without charge or for which you would not be required to pay if you did not have this coverage;
- Are received before the Effective Date of Coverage;
- Are not a Covered Service or relate to complications resulting from a non-covered service;
- Are not furnished by a Qualified Practitioner or Qualified Treatment Facility;
- Are provided by or payable under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U. S. C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are diagnostic tests or health evaluations required, as a matter of course, for all individuals who are in the custody of the local supervisory authority pending the disposition of charges;
- Services provided while incarcerated in any local, state, or federal facility following the conviction of a crime;
- Are self-administered (except as provided in section 5.11), are prescribed by you for your own benefit, or are provided or prescribed by a person who resides in your home or is a member of your family. “Member of your family” for this purpose means any person who could possibly inherit from you under the intestate succession law of any state, plus any in-law, step relative, foster, parent or domestic partner of any such person;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos and books, educational programs to which drivers are referred by the judicial system and volunteer mutual support groups;
- Are provided to yield primarily educational outcomes (except as covered under the wellness benefits). An outcome is “primarily educational” if the outcome’s fundamental, first, or principal character is to provide you with enduring knowledge, skill, or competence through a process of repetitive positive reinforcement over an extended length of time. An outcome is “enduring” if long-lasting or permanent;
- Are performed in association with a Service that is not covered under this Plan;
7. Exclusions

- Are provided for any injury or illness that is sustained by a PEBB Member or a Family Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers’ Compensation Act or similar law is required for the PEBB Member or Family Member. This exclusion also applies to injuries and illnesses that are the subject of a disputed claim settlement or disposition agreement under a Workers’ Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers’ Compensation Act or similar law;

- Are payable under any automobile medical, personal injury protection (PIP), automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services, and whether or not you are refused payment for failure to satisfy any term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This exclusion also applies to charges applied to the Deductibles of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive the Plan’s right to reimbursement or subrogation as specified in section 8.2. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 8.2.3;

- Are provided in an institution that specializes in treatment of developmental disabilities;

- Are provided for treatment or testing required by a third party or court of law which is not Medically Necessary;

- Are Experimental/Investigational;

- Are determined by AllCare PEBB not to be Medically Necessary for diagnosis and treatment of an injury or illness;

- Have not been Prior Authorized as required by this Plan;

- Relate to any condition determined by AllCare PEBB to have been sustained as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member requiring Services, whether or not such Member is charged or convicted of a crime on account of such illegal engagement or act (for purposes of this exclusion, “illegal” means any engagement or act that would constitute a felony or misdemeanor under applicable law if such Member is convicted for the conduct). Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition); and

- Relate to a civil revolution, riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.
The Plan does not cover:

- Charges that are in excess of the Plan Allowable;
- Custodial Care;
- Transplants, except as described in section 6.1;
- Wart removal or treatment, except for plantar and sexually transmitted warts;
- Varicose vein surgery, ablation or stripping;
- Wrist ganglion cyst surgery;
- Breast reduction surgery, except as specified in section 5.10.10;
- Services for Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, Durable Medical Equipment (DME) and Hearing Aids, except as described in section 5.9;
- Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including, but not limited to, air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, tanning beds, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, personal computers and related equipment or other similar items or equipment;
- Physical therapy and rehabilitative Services, except as provided in section 5.4.4 and 5.10.11;
- Telephone visits by a physician or environment intervention or consultation by telephone for which a charge is made to the patient;
- Get acquainted visits without physical assessment or diagnostic or therapeutic intervention provided and treatment sessions by computer Internet service;
- Missed appointments;
- Allergy shots and allergy serums, except as provided in section 5.10.1;
- Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas;
- Transportation or travel time, food, lodging accommodations and communication expenses except as provided in section 6.1 and with AllCare PEBB’s Prior Authorization, as specified in section 4.4;
- Charges for health clubs (except as covered under the wellness benefit) or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Massage therapy (except when service is provided in conjunction with a covered chiropractic treatment. Limited to 15 minute therapeutic procedure);
7. Exclusions

- Thermography;
- Homeopathic procedures;
- Comprehensive digestive stool analysis, cytotoxic food allergy test, dark-field examination for toxicity or parasites, EAV and electronic tests for diagnosis and allergy, fecal transient and retention time, Henshaw test, intestinal permeability, Loomis 24-hour urine nutrient/enzyme analysis, melatonin biorhythm challenge, salivary caffeine clearance, sulfate/creatinine ratio, urinary sodium benzoate, urine/saliva pH, tryptophan load test, and zinc tolerance test;
- Spinal manipulation and acupuncture, except as provided in sections 5.10.13 and 5.10.14;
- Light therapy for seasonal affective disorder, including equipment;
- Any vitamins, dietary supplements, and other non-prescription supplements;
- Services for genetic testing are excluded, except as provided in section 6.5. Genetic testing is not covered for screening, to diagnose carrier states, or for informational purposes in the absence of disease;
- Services to modify the use of tobacco and nicotine, except as provided in section 5.10.12;
- Services for Cosmetic Services including supplies and drugs, except as approved by AllCare PEBB and described in the Covered Services section 5;
- Services related to obtaining insurance, employment, licensure (except as specified in section 5.2.1) or school admission; Services solely for the purpose of participating in camps, sports activities or recreation programs; Services for the purpose of traveling or obtaining a passport for foreign travel;
- Non-sterile examination gloves;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of PLAN ALLOWABLE; and
- Air ambulance transportation for non-emergency situations unless Prior Authorized by AllCare PEBB.

Exclusions that apply to Mental Health and Chemical Dependency Services:

- Conditions that are specified as excluded in Section 14 in the definitions of Mental Health and Chemical Dependency;
- Services provided under a court order or as a condition of parole or probation or instead of incarceration which are not Medically Necessary;
- Personal growth Services such as assertiveness training or consciousness raising;
- Services related to developmental disabilities, developmental delays or learning disabilities including, but not limited to, education Services. A learning disability is a condition where there is meaningful difference between a child’s current academic function and the level expected for a child that age. Educational Services include,
but are not limited to, language and speech training, reading, and psychological and visual integration training as defined by the American Academy of Pediatrics Policy Statement—“Learning Disabilities, Dyslexia and Vision: A Subject Review”;

- School counseling and support Services, home-based behavioral management, household management training, peer support Services, recreation, tutor and mentor Services; independent living Services, therapeutic foster care, wraparound Services; emergency aid for household items and expenses; Services to improve economic stability, and interpretation Services;

- Evaluation or treatment for education, professional training, employment investigations, and fitness for duty evaluations;

- Community Care Facilities that provide twenty-four (24) hour non-medical residential care;

- Speech therapy, physical therapy and occupational therapy Services provided in connection with treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development (except as provided in sections 5.4.4. and 5.10.11);

- Counseling related to family, marriage, sex and career including, but not limited to, counseling for adoption, custody, family planning or pregnancy, in the absence of a DSM-IV-TR diagnosis;

- Except for gender identity disorder, services related to the treatment of sexual disorders, dysfunctions or addiction;

- Vocational, pastoral or spiritual counseling;

- Dance, poetry, music or art therapy, except as part of an approved treatment program;

- Treatments that do not meet the national standards for Mental Health/Chemical Dependency professional practice.

**Exclusions that apply to Provider Services:**

The following Services if they are provided by an Out-of-Network Provider or in some cases, Participating Provider:

- E-visit Services (see section 5.1.2); Bariatric Surgery and related Services (see section 5.10.2);

- Tobacco Use Cessation Services (see section 5.10.12);

- Prescription Drug Services (see section 5.11);

- Human Organ/Tissue Transplants (see section 6.1); and

- Temporomandibular Joint (TMJ) Services (see section 6.2.1);

- Services of homeopaths; faith healers; or lay and Direct Entry midwives; and Services of any unlicensed providers.
7. Exclusions

Exclusions that apply to Reproductive Services:

• Except gender identity disorder, all Services related to sexual disorders or dysfunctions regardless of gender;

• Condoms and other over-the-counter birth control products;

• In vitro and in vivo fertilization including services related to or supporting in vitro fertilization, GIFT, ZIFT, reversals of voluntary sterilization and procedures determined to be experimental or investigational; and

• Home births and all related Services.

Exclusions that apply to Vision Services:

• Surgical procedures which alter the refractive character of the eye, including, but not limited to laser eye surgery, radial keratotomy, myopic keratomelelisis and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism;

• Services for routine eye exams and vision care, refractive disorders, eyeglass frames and lenses, contact lenses, except as provided in section 5.9.2; and

• Orthoptics and vision training.

Exclusions that apply to Dental Services:

• Oral surgery (non-dental or dental) or other dental Services (all procedures involving the teeth; wisdom teeth; areas surrounding the teeth), except as approved by AllCare PEBB and described in the Limitations section;

• Services for temporomandibular joint syndrome (TMJ) and orthognathic surgery, except as approved by AllCare PEBB and described in the Limitations section; and

• Dentures and orthodontia.

Exclusions that apply to Foot Care Services:

• Routine foot care, such as removal of corns and calluses, except for Members with diabetes; and

• Services for insoles, arch supports, heel wedges, lifts and orthopedic shoes. Covered Services for orthotics are described within the Covered Services section under Medical Supplies/Devices.

Exclusions that apply to Prescription Drugs, Medicines and Devices:

• Outpatient prescription drugs, medicines and devices except as provided in sections 5.2.5, 5.9, and 5.11, and

• Any drug, medicine, or device that does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Pre-market Approval, or 510K.
8. Claims Administration

This section explains how AllCare PEBB treats various matters having to do with administering your benefits and claims, including situations that may arise in which your health care expenses are the responsibility of a source other than AllCare PEBB.

8.1 Submitting Claims

All Preferred Primary Care Provider (PPCP) Providers: Preferred Providers, Participating Providers and many Out-of-Network Providers will bill AllCare PEBB for you. You may receive a bill for information purposes only indicating your insurance has been billed. In order to ensure the timely processing of claims, you are encouraged to submit a claim for treatment within 60 days of the date of Service. The Plan will not pay claims received more than 12 months after the date of Service. However, exceptions will be made if we receive documentation of your legal incapacitation. The Plan will pay a covered expense to the provider, the Member, or jointly to both. If the Plan mistakenly makes a payment to which a Member is not entitled, the Plan may recover the payment.

In some instances, the Out-of-Network provider will not bill AllCare PEBB for you. When this occurs, you will be responsible for paying the bill for your services directly to that health care provider. The Plan will reimburse you for Covered Services according to the terms of the Plan.

To request reimbursement, obtain an itemized receipt from the provider’s office. Your itemized receipt must include the following:

- Date of Service
- Member/patient name
- Member/patient date of birth
- Name, address, tax identification number, national provider index (NPI) number, and the address of the provider or facility
- Diagnosis and procedure codes(s)
- Amount charged for each service
- Amount paid for each service and receipt for payment

Submit the itemized receipt to us at the addresses listed below.
You may also submit a claim form available on the AllCare PEBB website at AllCareHealth.com/Public-Employees or by contacting Member Services.

Claims should be submitted to AllCare PEBB at:

AllCare PEBB/AllCare Health Plan, Inc. Attention: Claims Department
1701 NE 7th Street, Grants Pass, Oregon 97526

Mental Health and Chemical Dependency claims should be submitted to:

AllCare PEBB/AllCare Health Plan, Inc.
1701 NE 7th Street, Grants Pass, Oregon 97526
8. Claims Administration

For claim questions, please call:

Toll free: (888) 460-0185,
TTY: (800) 735-2900.

Explanation of Benefits (EOB)

You will receive an EOB from AllCare PEBB after your claim is processed. An EOB is not a bill. An EOB explains how AllCare PEBB has processed your claim, and it will assist you in determining your financial responsibility for the Services shown on the EOB. Deductible, Copayment and Coinsurance amounts, services or amounts not covered and general information about AllCare PEBB’s processing of your claim are explained on the EOB.

Time Frames for Processing Claims

If your claim is denied under the Plan, AllCare PEBB will send an EOB to you with an explanation of the denial within 30 days after your claim is received. If AllCare PEBB needs additional information from you to complete the processing of your claim, the notice of delay will be mailed and describe the information needed and you will have 45 days to submit the additional information. Once AllCare PEBB receives the additional information, they will complete the processing of the claim within 15 days.

Claims Involving Concurrent Care Decisions

If an ongoing course of treatment for you has been approved by AllCare PEBB and they then determine through their medical cost management procedures to reduce or terminate that course of treatment, you will be provided with advance notice of that decision. You may request a reconsideration of that decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. AllCare PEBB will then notify you of their reconsideration decision within 24 hours after your request is received.

8.1.1 Right of Recovery

AllCare PEBB, on behalf of this Plan, has the right, upon demand, to recover from a recipient the value of any benefit or claim payment that exceeded the benefits available under this Plan. This right of recovery applies to any excess benefit, including (but not limited to) benefits obtained through fraud, error, or duplicate coverage relating to any Member. If timely repayment is not made to the Plan, AllCare PEBB is authorized by PEBB to deduct the value of the excess benefit from any future benefit that otherwise would have been available to the affected Member(s) under this Plan. AllCare PEBB, on behalf of the Plan, has the right to recover pharmacy overpayments directly from you or your Family Member.

8.2 Third-Party Liability/Subrogation

The following provisions will apply when you or any enrolled Family Member have received Services for a condition for which one or more third parties may be responsible. “Third party” means any person other than you and PEBB, as the sponsor of this Plan, and includes any insurance carrier providing liability or other coverage potentially available to you. For example, uninsured or underinsured motorist coverage, no-fault
medical payments (auto, homeowners or otherwise), or other insurance (including student plans) whether under your policy or not, is subject to recovery by AllCare PEBB as a third-party recovery. Failure by you to comply with the terms of this section will be a basis for AllCare PEBB to deny any claims for benefits arising from the condition. In addition, you must execute and deliver to AllCare PEBB or other parties any document requested which may be appropriate to secure the rights and obligations of you and the Plan under these provisions.

8.2.1 Third-Party Liability/Subrogation and How it Affects You

Third-party liability refers to claims that are in whole or in part the responsibility of someone besides this Plan or you. Examples of third party liability are motor vehicle accidents, workplace injury or illness, or any other situation involving injury or illness, including wrongful death, in which you or your heirs, beneficiaries or relatives have a basis to bring a lawsuit or to make a claim for compensation against any person or for which you or your heirs, beneficiaries or relatives may receive a settlement (for example, food poisoning or an injury from a defective product are examples of third-party liability). Once it has been established that the third party is responsible to pay and is capable of paying for the expenses for the Services caused by that third party, we will not provide benefits for the Services arising from the condition caused by that third party. Such benefits are specifically excluded from coverage under this Plan.

If AllCare PEBB makes claim payments on your behalf for which a third party is responsible, the Plan is entitled to be repaid promptly for those payments, directly out of any recovery from the third party, including any settlement, award, verdict, payment or other monetary recovery. “Subrogation” means that AllCare PEBB may collect directly from the third party to the extent that the Plan has paid on your behalf for third-party liabilities. Because the Plan has paid for your injuries, the Plan, rather than you, is entitled to recover those expenses. Prior to accepting any settlement of your claims against a third party, you must notify AllCare PEBB in writing of any terms or conditions offered in settlement and must notify the third party of the Plan’s interest in the settlement established by this provision.

To the maximum extent permitted by law, the Plan is subrogated to your rights against any third party who is responsible for the condition, has the right to sue any such third party in your name, and has a security interest in and lien upon any recovery to the extent of the amount of benefits paid by the Plan and for AllCare PEBB expenses in obtaining a recovery. If you should either decline to pursue a claim against a third party that AllCare PEBB believes is warranted or refuse to cooperate with AllCare PEBB in any third party claim that you do pursue, AllCare PEBB has the right, on behalf of the Plan, to pursue such claim directly, including commencing a legal action against such third party or intervening in any action that you have commenced.

AllCare PEBB needs detailed information from you to accomplish this process. A questionnaire will be sent to you for this information. It should be completed and returned to AllCare PEBB as soon as possible to minimize any claim review delay. If you have any questions or concerns regarding the questionnaire, please contact AllCare PEBB. An AllCare PEBB employee who specializes in third-party liability/subrogation can discuss with you what their procedures are and what you need to do.
8.2.3 Proceeds of Settlement or Recovery

If for any reason AllCare PEBB is not paid directly by the third party, AllCare PEBB is entitled to reimbursement from you or your heirs, legal representatives, beneficiaries or relatives, and AllCare PEBB may request refunds from the medical providers who treated you, in which case those providers will bill you for their Services. To the fullest extent permitted by law, the Plan is entitled to the proceeds of any settlement or any judgment that results in a recovery from a third party, whether or not responsibility is accepted or denied by the third-party for the condition, whether or not such monetary recovery is described by any person as something other than a recovery of medical expenses incurred by the Plan and whether or not you are alleged to have any fault, under principles of comparative negligence or otherwise.

With respect to any workers’ compensation recovery, we are entitled to the proceeds whether or not the loss is deemed to be compensable under the worker’s compensation laws. The Plan is entitled up to the full value of the benefits provided by it for the condition, calculated using AllCare PEBB’s Plan Allowable charges for such Services, less the Member’s Out-of-Pocket expenses and attorney fees incurred in making the recovery. The Plan is entitled to such recovery regardless of whether you have been fully compensated or “made whole” for the loss caused by the third party, and regardless of whether you have been partially compensated for such loss.

The Plan is entitled to first priority in repayment, over you and over any other person, for such charges.

By accepting benefits under this Plan, you acknowledge the Plan’s first priority to this repayment and assign to the Plan any benefits you may have from other sources. You must cooperate fully with AllCare PEBB in recovering amounts paid by the Plan. If you seek damages against the third party for the condition and retain an attorney or other agent for representation in the matter, you agree to require your attorney or agent to reimburse the Plan directly from the settlement or recovery in the amount provided by this section.

You must complete AllCare PEBB’s subrogation trust agreement by which you and/or your attorney or agent must confirm the obligation to reimburse the Plan directly from any settlement or recovery. We may withhold benefits for your condition until a signed copy of this agreement is delivered to AllCare PEBB. The agreement must remain in effect and AllCare PEBB may withhold payment of benefits if, at any time, your confirmation of the obligations under this section should be revoked. While this document is not necessary for AllCare PEBB to exercise the Plan’s rights under this section, it serves as a reminder to you and directly obligates your attorney to act in accord with the Plan’s rights.

8.2.4 Suspension of Benefits and Reimbursement

After you have received proceeds of a settlement or recovery from the third party, you are responsible for payment of all medical expenses for the continuing treatment of the illness or injury that the Plan would otherwise be required to pay until all proceeds from the settlement or recovery have been exhausted. If you have failed to reimburse the Plan
as required by this section, the Plan is entitled to offset future benefits otherwise payable under the Plan or under any future Plan sponsored by PEBB, to the extent of the value of the benefits advanced under this section.

If you continue to receive medical treatment for the condition after obtaining a settlement or recovery from one or more third parties, the Plan is not required to provide coverage for continuing treatment until you prove to AllCare PEBB’s satisfaction that the total cost of the treatment is more than the amount received in settlement or recovered from the third party, after deducting the cost of obtaining the settlement or recovery.

The Plan will only cover the amount by which the total cost of benefits that would otherwise be covered under this Plan, calculated using AllCare PEBB’s allowable charges for such services, in the Member’s plan area, exceeds the amount received in settlement or recovery from the third party. The Plan is entitled to suspend such benefits even if the total amount of such settlement or recovery does not fully compensate you for other damages, particularly including lost wages or pain and suffering.

Any settlement arising out of an injury or illness covered by this Plan will be deemed first to compensate you for your medical expenses, regardless of any allocation of proceeds in any settlement document that AllCare PEBB has not approved in advance. In no event shall the amount reimbursed to the Plan be less than the maximum permitted by law.

8.3 Coordination of Benefits (COB)

This Coordination of Benefits (COB) section applies when you or a Family Member has health care coverage under more than one Plan. The term “Plan” is defined below for the purposes of this COB section. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. 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 plans do not exceed 100% of the total Allowable expense.

If you have more than one insurance plan, obtaining Services under this Plan may be affected. Please contact AllCare PEBB Member Services for more information or assistance.

8.3.1 Definitions Relating to COB

Plan

Plan means any of the following that provides benefits or services for medical or dental care 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.

1. **Plan includes**: group and individual health insurance contracts, health maintenance organization (HMO) contracts, Closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other
federal governmental plan, as permitted by law and group and individual insurance contracts and Subscriber contracts that pay or reimburse for the cost of dental care.

2. **Plan does not include**: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage listed under (1) or (2) 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.

**This plan**

As used in this COB section, this Plan means the part of the plan benefits to which this COB section applies and which may be reduced because of benefits provided by other plans. Any other part of this plan providing health care benefits is separate from this Plan. A plan 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 listed in section 8.3.2 determine whether this Plan is a Primary plan or Secondary plan when you or a Family Member has health care coverage under more than one Plan.

When this Plan is primary, AllCare PEBB determines payment for benefits first before those of any other plan without considering any other plan’s benefits. When this Plan is secondary, AllCare PEBB determines benefits after those of another plan and may reduce the benefits paid so that all Plan benefits do not exceed 100% of the total Allowable expense.

**Allowable expense**

Allowable expense means a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any plan covering you or a Family Member. 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 you or a Family Member is not an Allowable expense.

In addition, any expense for which a provider by law or in accordance with a contractual agreement is prohibited from charging is not an Allowable expense.

The following 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 the Member 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 the Family Member 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 the Member is covered by one plan that calculates its benefits or Services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or Services on the basis of negotiated fees, the Primary plan’s payment arrangement shall be the Allowable expense for all plans. However, if the provider has contracted with the Secondary plan to provide the benefit or Service for a specific negotiated fee or payment amount that is different than the Primary plan’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

- The amount of any benefit reduction by the Primary plan the Member have 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.

**Closed panel plan**

A Closed panel plan is a Plan that provides health care benefits to Members 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.

**Custodial parent**

A Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the Dependent child resides more than one half of the Calendar Year excluding any temporary visitation.

**8.3.2 Priority between Plans**

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

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan. If the Primary plan is a closed-panel plan and the secondary plan is not a closed-panel plan, the Secondary plan shall pay or provide benefits as if it were the Primary plan when a covered person uses a non-panel provider, except for Emergency Services or authorized referrals that are paid or provided by the Primary plan.
8. Claims Administration

1. Except as provided in Paragraph (2) below, a Plan that does not contain a 
   COB provision that is consistent with the State of Oregon’s COB regulations 
   is always primary unless the provisions of both plans state that the 
   complying plan is primary.

2. 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 major medical coverages that are superimposed over base plan hospital 
   and surgical benefits, and insurance type coverages that are written in 
   connection with a closed-panel plan to provide Out-of-Network benefits.

B. 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.

C. Each Plan determines its order of benefits using the first of the following rules that 
   apply:

1. **Non-Dependent or Dependent**. The Plan that covers a Family Member 
   other than as a Dependent, for example as a PEBB Member is, the Primary 
   plan, and the Plan that covers the Family Member as a Dependent is the 
   Secondary plan. However, if the Family Member is a Medicare beneficiary 
   and, as a result of federal law, Medicare is secondary to the plan covering 
   the Family Member as a Dependent; and primary to the plan covering the 
   Family Member as other than a Dependent (e.g. a retired employee); then 
   the order of benefits between the two plans is reversed so that the Plan 
   covering the Family Member as an employee, subscriber or retiree is the 
   Secondary plan and the other Plan is the Primary plan.

2. **Dependent Child Covered Under More Than One Plan**. Unless there is a 
   court decree stating otherwise, when a Family Member is a Dependent 
   child 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 
         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:

      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
ii. Has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

iii. 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;

iv. 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; or

v. 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 Dependent child are as follows:

1. The Plan covering the Custodial parent, first;
2. The Plan covering the spouse of the Custodial parent, second;
3. The Plan covering the non-custodial parent, third;
4. The Plan covering the Dependent spouse of the non-custodial parent, last.

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

d) For a Dependent child:

i. Who has coverage under either or both parents’ plans and also has coverage as a Dependent under a spouse’s plan, the rule in paragraph (5) applies.

ii. In the event the Dependent child’s coverage under the spouse’s plan began on the same date as the Dependent child’s coverage under either or both parents’ plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the Dependent child’s parent(s) and the Dependent’s spouse.
3. **PEBB Member or Retired or Laid-off Employee.** The Plan that covers a PEBB Member as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same PEBB Member as a retired or laid-off employee is the Secondary plan. The same would hold true if a PEBB Member 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 D (1) can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a PEBB Member or Family Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the Plan providing coverage as an employee, subscriber or retiree or as a Dependent of an employee, 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 D(1) can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the Member for the longer period of time is the Primary plan and the Plan that covered the Member for the shorter period of time is the Secondary plan.

6. 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 would have paid had it been the Primary plan.

### 8.3.3 Effect on the Benefits of This Plan

When this Plan is secondary, benefits may be reduced 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 any amounts it would have credited to its Deductible in the absence of other health care coverage.

If a Member is enrolled in two or more Closed Panel plans and if, for any reason, including the provision of services 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.
8.3.4 Right to Receive and Release Necessary Information

Certain facts about health care coverage and Services are needed to apply this COB section and to determine benefits payable under this Plan and other Plans. AllCare PEBB may get the facts needed from, or give them to, other organizations or persons for the purpose of applying this section and determining benefits payable under this Plan and other Plans covering you or a Family Member claiming benefits. AllCare PEBB need not tell, or get the consent of, any person to do this. Each individual claiming benefits under this Plan must give AllCare PEBB any facts needed to apply this section and determine benefits payable.

8.3.5 Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, the Plan 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. The Plan 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.

8.3.6 COB Right of Recovery

If the amount of the payments made by Plan is more than should have paid under this COB section, the Plan may recover the excess from one or more of the persons paid or for whom benefits were paid; or any other person or organization that may be responsible for the benefits or Services provided for you or a Family Member. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of Services.

8.4 Non-Duplication Of Coverage

8.4.1 Coordination with Medicare

In all cases, coordination of benefits with Medicare will conform to federal statutes and regulations. Medicare means Title XVIII of the Social Security Act, as enacted or amended. Medicare eligibility and how AllCare PEBB determines benefit limits under this Plan are affected by disability and employment status. Please contact AllCare PEBB Member Services if you have questions.
8.5 RAPAH (Radiologist, Anesthesiologist, Pathologist, Ambulance, and Hospitalists) Provision

AllCare PEBB has implemented a special policy for applying benefits to claims received from Radiologists, Anesthesiologists, Pathologists, Ambulance Companies, and Hospitalists that provided services to AllCare PEBB Members, who are not directly contracted with AllCare PEBB (Preferred Network) nor contracted within the AllCare PEBB Participating Network. This provision does not apply to services received outside of the Preferred/Participating network tiers, with exception of Pathology:

- Professional services provided by a Radiologist, Anesthesiologist (excluding outpatient chronic pain management), Ambulance Company, or Hospitalists in the AllCare PEBB plan Service Area will fall under the Preferred Network benefit.

- Professional services provided by a Pathologist will fall under the Preferred Network Benefit.
9. Problem Resolution

9.1 Informal Problem Resolution

All people who work with AllCare PEBB share responsibility for assuring Member satisfaction. If you have a problem or concern about your coverage, including benefits or services by Preferred/Participating Providers or payment for services by Out-of-Network Providers, please ask for AllCare PEBB's help. Member Services is available to provide information and assistance.

You may call AllCare PEBB or meet with a representative at the phone number and address listed on your Membership ID Card. If you have special needs, such as a hearing impairment, AllCare PEBB will make efforts to accommodate your requirements. Please contact AllCare PEBB for assistance with whatever special needs you may have.

9.2 Member Grievance and Appeal

Definitions:

Adverse Benefit Determination

An Adverse Benefit Determination means a:

- Denial of eligibility for or termination of enrollment in this Plan;
- Imposition of a pre-rescission or cancellation of coverage under this Plan;
- Imposition of a pre-existing condition exclusion, source of injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise Covered Services;
- Determination that a health care item or service is Experimental/Investigational or not Medically Necessary; or
- Determination that a course of plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care.

Appeal

A type of Grievance that is a written request from a Member or an Authorized Representative of the Member requesting further consideration of an Adverse Benefit Determination.

Authorized Representative

An individual who by law or by the consent of a Member may act on behalf of the Member.

Concurrent Care

An approved ongoing course of treatment to be provided over a period of time or for a specified number of treatments.
9. Problem Resolution

Grievance

A communication from a Member or an Authorized Representative of a Member expressing dissatisfaction with an Adverse Benefit Determination, without specifically declining any right to Appeal or review, that is:

- In writing, for an internal Appeal or an external review; or in writing or orally, for an expedited response or an expedited external review; or

- A written complaint submitted by a Member or an authorized Representative of a Member regarding the:
  - Availability, delivery or quality of a health care service;
  - Claims payment, handling or reimbursement for health care services and, unless the Member has not submitted a request for an internal Appeal, the complaint is not disputing an Adverse Benefit Determination; or
  - Matters pertaining to the contractual relationship between a Member and AllCare PEBB.

9.2.1 Your Grievance and Appeal Rights

If you disagree with AllCare PEBB's decision about your medical bills or health care services you have the right to an internal review. You may request a review if you have an Adverse Benefit Determination. You may also file a quality of care or general complaint with AllCare PEBB. You may appoint an Authorized Representative to act on your behalf during your Grievance or Appeal. Please include as much information as possible including the date of the incident, name of individuals involved, and the specific circumstances. In filing a Grievance or Appeal:

- You can submit written comments, documents, records and other information relating to your Grievance or Appeal and we will consider that information in AllCare PEBB's review process.

- You can, upon request and free of charge, have reasonable access to and copies of the documents and records held by the Plan that relate to your Grievance or Appeal.

Filing a Grievance or Appeal does not affect your right to receive benefits for covered services as otherwise provided under this Plan.

If you receive the services that were denied in the Adverse Benefit Determination, and if the Adverse Benefit Determination is upheld by internal or external review, you will be financially responsible for any benefits paid by the Plan for such services pursuant to Oregon state law.

To the extent possible, complaints filed by telephone will be resolved at the point of service by Member Services. All Grievances and Appeals (except those involving Prior Authorizations, as discussed below) will be acknowledged within seven days of receipt by AllCare PEBB and resolved within 30 calendar days or sooner depending on the clinical urgency. If circumstances beyond our control prevent us from resolving your Grievance or Appeal within 30 days, AllCare PEBB may request additional time to resolve the issue if
AllCare PEBB provides you with a notice of delay, including a reason for the delay, before the 30 day period has elapsed.

Urgent Medical Conditions: If you believe your health would be seriously harmed by waiting for AllCare PEBB’s decision on your Grievance or Appeal of a denied Prior Authorization request or Concurrent Care request, you may request an expedited review by calling a Member Services representative at 888-460-0185. If your Appeal is urgent, and qualifies for external review, you may request to have both your internal and external Appeal expedited at the same time. AllCare PEBB will let you know by phone and letter if your case qualifies for an expedited review. If it does, AllCare PEBB will notify you of the decision within 72 hours of receiving your request.

Grievances and Appeals Involving Prior Authorizations (Non-Urgent): If your Grievance or Appeal involves a Prior Authorization request for a non-urgent medical condition, AllCare PEBB will notify you of the decision within 30 days of receiving your request for an internal Grievance or Appeal.

Grievances and Appeals Involving Concurrent Care Decisions: If AllCare PEBB has approved an ongoing course of treatment for you and determines through AllCare PEBB’s medical management procedures to reduce or terminate that course of treatment, AllCare PEBB will provide advance notice to you of that decision. You may request reconsiderations of the decision by submitting an oral or written request at least 24 hours before the course of treatment is scheduled to end. AllCare PEBB will then notify you of the reconsideration decision within 24 hours of receiving your request.

9.2.2 Internal Grievance or Appeal

You must file your internal Grievance or Appeal within 180 days of the date on AllCare PEBB’s notice of initial Adverse Benefit Determination, or that initial determination will become final. Please advise AllCare PEBB of any additional information that you want considered in the review process. If you are seeing an Out-of-Network Provider, you should contact the provider’s office and arrange for the necessary records to be forwarded to AllCare PEBB for the review process. Your Grievance or Appeal will be reviewed by AllCare PEBB staff not involved in the initial determination. You may present your case in writing. Once a final determination is made, you will be sent a written explanation of that decision.

9.2.3 Voluntary Second Level Internal Appeal

If you are not satisfied with AllCare PEBB’s decision of the internal Grievance or Appeal and your Appeal is of an Adverse Benefit Determination that involves (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care, you may request a voluntary second level internal Appeal. If your case is eligible, it will be reviewed by AllCare PEBB’s Quality Improvement Committee. The Quality Improvement Committee is made up of individuals not involved in the initial internal Grievance or Appeal. You must submit your written request for the voluntary second level internal Appeal within 60 days from the date on the internal Grievance or Appeal decision notice, or that initial decision will become final. You or your Authorized Representative may present your case to the Quality Improvement Committee. The Quality Improvement Committee will then review your case and provide a written explanation of their decision.
9. Problem Resolution

Committee will review the documentation presented by you and send a written explanation of its decision within 30 days of receiving your request for the voluntary second level internal Appeal.

9.2.4 External Review

If you are not satisfied with the internal Grievance or Appeal decision or the decision of the voluntary second level internal Appeal and your Appeal involves (a) Medically Necessary treatment, (b) Experimental/Investigational treatment, (c) an active course of treatment for purposes of continuity of care, or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care; you may request an external review by an Independent Review Organization (IRO). Your request must be made within 180 days of the receipt of the internal Grievance or Appeal decision or voluntary second level internal Appeal decision, or that internal decision will become final. If you agree, AllCare PEBB may waive the requirement that you exhaust the internal review process before beginning the External Review process. When the External Review process is begun, an IRO will be assigned to the case, and we will forward complete documentation regarding the case to the IRO.

If you request an External Review, you must agree to authorize release of medical records needed by the IRO and submit any additional information to the IRO no later than five days after the appointment of the IRO, or 24 hours in cases of expedited review. The IRO is entirely independent of AllCare PEBB. There is no cost to you to obtain an External Review decision within three days from the expedited review and within 30 days when not expedited. The IRO will notify you and AllCare PEBB of its decision. The Plan and AllCare PEBB agree to comply with the IRO decision when the decision involves (a) Medically Necessary treatment; (b) Experimental/Investigational treatment; (c) an active course of treatment for purposes of continuity of care; or (d) whether a course of treatment is delivered in an appropriate setting at an appropriate level of care.

All costs for the handling of External Review cases are paid by the Plan, and AllCare PEBB administers these provisions in accordance with the insurance laws and regulations of the State of Oregon. By electing to submit your Appeal to an IRO, you are also agreeing to be bound by and to comply with the IRO decision regarding your Appeal in lieu of Appealing to a state of federal court. If the Plan and AllCare PEBB do not comply with the IRO decision, you have the right to sue under applicable Oregon law.

9.2.5 Information Available Upon Request

AllCare PEBB will provide, upon request, Annual summaries of Grievances and Appeals, utilization review policies, quality assessment activities, our health promotion and disease prevention activities, our scope of network and accessibility of services, and the results of all publicly available accreditation surveys.
9.2.6 How to Submit Grievances or Appeals

You may contact Member Services at (888) 460-0185. If you are hearing impaired and use a Teletype (TTY) Device, please call AllCare PEBB TTY (800) 735-2900. Written Grievances or Appeals should be sent to:

AllCare PEBB
Appeals and Grievance
1701 NE 7th Street
Grants Pass, Oregon 97526

You may fax your Grievance or Appeal to (541) 471-3789 or you may hand deliver to the following addresses.

AllCare PEBB
Appeals and Grievance
1701 NE 7th Street
Grants Pass, Oregon 97526

AllCare PEBB
Appeals and Grievance
3629 Aviation Way
Medford, Oregon 97504

Please note that your enrolled dependents also have the right to Grievance and Appeal as described here.

9.2.7 Assistance from the Department of Consumer and Business Services

You also have the right to file a complaint and seek assistance from the director of the DCBS at:

Oregon Insurance Division
Consumer Advocacy Unit
P.O. Box 14480
Salem, OR 97309-0405

503-947-7984
888-877-4894 (toll-free)
503-378-4351 (fax)
cp.ins@state.or.us (email)

http://www.insurance.oregon.gov/ins/consumer/consumer.html (website)
10. Termination Of Member Coverage

10.1 Termination Events

Termination of Member coverage under the Plan will occur on the last day of the month in which a Member becomes ineligible for coverage as specified in the eligibility provisions established by PEBB. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and termination of coverage.

10.2 Termination and Rescission Of Coverage Due To Fraud or Abuse

Coverage under this Plan, either for you or for your covered dependent(s), may be rescinded (meaning your coverage is retroactively canceled) or terminated in case of a fraud or intentional misrepresentation of material fact by you or by your covered dependent in obtaining, or attempting to obtain, benefits under this Plan.

If coverage is rescinded, the Plan will retain any money you paid for coverage as liquidated damages and will have the right to recover from you or from your covered dependents the benefits paid as a result of such wrongful activity. We will provide all affected Plan Members with 30 days’ notice before rescinding your coverage.

10.3 Non-Liability After Termination

Upon termination of this Plan, PEBB shall have no further liability for Services received beyond the effective date of the termination.
11. Continuation of Medical Benefits (Cobra)

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal law that applies to employers with 20 or more employees, including PEBB, continuation of Plan coverage may be available in certain instances, as described in this section. The term “qualified beneficiary” is used in this section to refer to a Member who is qualified for enrollment in COBRA continuation coverage.

11.1 Cobra Qualifying Events

11.1.1 Member’s Continuation Coverage

A Member who is covered by the Plan may elect continuation coverage under COBRA if coverage is lost due to termination of employment (other than for gross misconduct) or a reduction in work hours.

11.1.2 Spouse’s or Domestic Partner’s Continuation Coverage

A spouse or domestic partner who is covered by the Plan has the right to elect continuation coverage under COBRA if coverage is lost for any of the following qualifying events:

- The death of the Member;
- The termination of the Member’s employment (for reasons other than gross misconduct) or reduction in hours;
- The divorce of the Member and the spouse;
- Termination of the domestic partnership; or
- The Member becomes covered under Medicare.

11.1.3 Dependent’s Continuation Coverage

A dependent child who is covered under the Plan has the right to continuation under COBRA if coverage is lost for any of the following qualifying events:

- The death of the Member;
- The termination of the Member’s employment (other than for gross misconduct) or reduction in a Member’s hours;
- The Member’s divorce;
- Termination of the domestic partnership;
- The Member becomes covered under Medicare; or
- The child ceases to qualify as an Eligible Family Member under the Plan.
11. Continuation Of Medical Benefits

A newborn child or a child placed for adoption who is properly enrolled under the terms of the Plan during the COBRA continuation period will be a qualified beneficiary.

11.2 Notice Requirements

A Family Member’s coverage ends on the last day of the month in which a divorce or termination of domestic partnership occurs or a child loses dependent status under the Plan. Under COBRA, you or your Family Member has the responsibility to notify your employer if one of these events occurs. Written notice must be given no later than 60 days after the loss of coverage has occurred, or the qualifying event, whichever is later. Oral notice is not binding until confirmed in writing. If notice is not timely given, continuation coverage will not be available.

When your employer receives notification of one of the above “qualifying” events, you will be notified that you or your Family Member, as applicable, have 60 days from the date coverage is lost or the date you receive the notice, whichever is later, to elect continuation coverage. If this election is not made within this 60-day period, your right to elect continuation coverage under the Plan will be lost.

11.3 Cobra Administration Services For PEBB

PEBB has delegated the COBRA administration services to Benefit Help Solutions (BHS). You may contact BHS regarding COBRA administration matters at (503) 765-3581 or (800) 556-3137.

11.4 Type Of Continuation Coverage

A qualified beneficiary will be provided the same coverage that was in effect immediately prior to the qualifying event.

11.5 Cobra Election Rights Of PEBB Members

A Member or his or her spouse or domestic partner may elect continuation coverage for all covered Family Members. In addition, each Family Member has an independent right to elect COBRA. Thus, a Family Member may elect continuation coverage even if the PEBB Member does not.

11.6 Cobra Premiums

If you are eligible for COBRA continuation coverage, you do not have to show that you are insurable (that you do not have any serious health conditions). However, you must pay the full premium for your continuation coverage, including the portion of the premium that your employer was previously paying. After you elect COBRA, you will have 45 days from the date of election to pay the first premium. You must pay premium back to the point you would otherwise have lost coverage under the Plan. After that, you must pay the premium for each month as of the first of the month, and in all events within 30 days. If you fail to pay your monthly premium, you will be notified that your coverage is being terminated.
11.7  Length Of Continuation Coverage

11.7.1  18-Month Continuation Period

When coverage ends due to a Member’s termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period for the Member and all covered Family Members will be 18 months from the date of the qualifying event, or the date coverage is lost, whichever is later.

11.7.2  29-Month Continuation Period

If a Member is disabled, continuation coverage for that qualified beneficiary and his or her covered Family Members may continue for up to 29 months from the date of the original qualifying event, or loss of coverage, whichever is later. The 29-month period applies only if the following conditions are met:

- The Social Security Administration (SSA) determines that the qualified beneficiary is disabled at any time prior to the qualifying event or during the first 60 days of COBRA continuation coverage; and
- The qualified beneficiary provides his or her employer with a copy of the SSA determination within the initial 18-month continuation period and not later than 60 days after the SSA determination was issued.

The premium for COBRA continuation coverage may increase after the 18th month to 150% of the otherwise applicable amount.

If the SSA makes a final determination of non-disability, the qualified beneficiary must notify the COBRA Administrator within 30 days. Written notification of non-disability should be provided to:

Benefit Help Solutions
PO Box 67230
Portland, OR 97268-1230
Fax: 888-393-2943

11.7.3  36-Month Continuation Period

If a spouse, domestic partner or dependent child loses coverage because of any of the following reasons, COBRA provides for up to 36 months of continuation of coverage:

- The Member’s death;
- The Member’s eligibility for Medicare;
- Divorce;
- Termination of the domestic partnership; or
- A child becomes ineligible for dependent coverage.
11.7.4 Extension of Continuation Period

If second qualifying event occurs during the initial 18- or 29-month continuation period (for example, the death of the employee, divorce, or child loses status as an Eligible Family Member under the Plan), coverage for a qualified beneficiary may be extended up to 36 months.

However, in no case will the continuation coverage exceed 36 months from the date of the original qualifying event.

If a spouse or dependent child has continuation coverage due to the employee’s termination or reduction in hours and if the qualifying event occurred within 18 months after the employee became entitled to Medicare, the coverage period is extended to 36 months from the employee’s Medicare entitlement date.

11.7.5 Extension of Coverage for a Spouse or Oregon Registered Certificate Domestic Partner

If a surviving, divorced, or Oregon Registered Certificate Domestic Partner of a Member is at least 55 years old at the time of death or the dissolution of the marriage, or partnership she or he may be eligible to continue coverage under this Plan. This State of Oregon provision for continuation of coverage will terminate upon the earliest of any of the following:

- The failure to pay premiums when due, including any grace period;
- The date that this Plan is terminated;
- The date on which the surviving, divorced or legally separated spouse becomes covered under any other group health plan, including spousal coverage because of remarriage; or
- The date on which the surviving, divorced or legally separated spouse becomes eligible for federal Medicare coverage.

The covered dependent children of the spouse or domestic partner also remain eligible for coverage under the Plan with the spouse or domestic partner as long as they remain otherwise eligible under the terms of the Plan.
11.8 The Trade Act Of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (TAA). TAA allows workers displaced by the impact of foreign trade, and individuals age 55 or older who are receiving pension benefits paid by the PBGC, to elect COBRA coverage during the 60-day period that begins on the first day of the month in which the individual first becomes eligible for TAA benefits. Eligible individuals can either take a tax credit or get advance payment of 65 percent of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Member Contact Center toll-free at 866-628-4282. TTD/TTY caller may call toll-free at 266-686-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact/2002act_index.asp](http://www.doleta.gov/tradeact/2002act_index.asp).

11.9 When Cobra Continuation Coverage Ends

Continuation coverage will end automatically for a qualified beneficiary when any of the following events occurs:

- PEBB no longer provides health coverage to any Members;
- The premium for the continuation coverage is not paid on time;
- The qualified beneficiary later becomes covered under another health plan that has no exclusions or limitations with respect to any pre-existing conditions. If the other plan has applicable exclusions or limitations, the COBRA continuation coverage will terminate after the exclusion or limitation no longer applies;
- The qualified beneficiary later becomes entitled to Medicare;
- The earliest date that the qualified beneficiary no longer qualifies for such coverage in accordance with federal COBRA regulations; or
- The applicable maximum period of continuation coverage occurs.
12. Qualified Medical Child Support Orders (QMCSO)

A child of a PEBB Member will be enrolled in the Plan as required by a qualified medical child support order. The procedures and rules regarding this enrollment are described in this section.

12.1 Definitions

For purposes of this section, the following definitions shall apply:

A “Member” means any current or former Member who is covered, or who is eligible for coverage, under the Plan to which an Order is directed.

“Alternate Recipient” means any child of a Member who is recognized under an Order as having a right to enrollment under the Plan with respect to such Member.

An “Order” means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction (or through an administrative process established under a state law which has the effect of a court order) which:

- Provides for child support with respect to a child of a Member under the Plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under the Plan; or

- Enforces a state law relating to medical child support with respect to the Plan. A “Qualified Medical Child Support Order” or “QMCSO” means an Order:
  - Which creates or recognizes the existence of an Alternate Recipient’s right to receive,
  - or assigns to an Alternate Recipient the right to receive, benefits for which a Member or beneficiary is eligible under the Plan; and
  - With respect to which PEBB has determined satisfies the QMCSO standards set forth below.

Procedures” means the Qualified Medical Child Support Order procedures as prescribed in this section. “Designated Representative” means a representative designated by an Alternate Recipient to receive copies of notices that are sent to the Alternate Recipient with respect to an Order.

12.2 Notice Upon Receipt Of Order

Upon the receipt of any Order, PEBB will promptly notify the Member and each Alternate Recipient identified in such Order of the receipt of such Order, and will further furnish them each with a copy of these Procedures. If the Order or any accompanying correspondence identifies a Designated Representative, then copies of the acknowledgment of receipt notice and these Procedures will also then be provided to such Designated Representative.
12.3 Notice Of Determination

Within a reasonable period after its receipt of the Order, PEBB will determine whether the Order satisfies the QMCSO standards prescribed below so as to constitute a QMCSO, and shall thereupon notify the Member, each Alternate Recipient, and any Designated Representative of such determination.

An Order will not be deemed to be a QMCSO unless the Order: Clearly specifies:

• The name and last known mailing address (if any) of the Member and of each Alternate

• Recipient covered by the Order (or the name and mailing address of a State or agency official acting on behalf of the Alternate Recipient);

• Either a reasonable description of the type of coverage to be provided under the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and

• The period to which the Order applies.

Does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent that the Order pertains to the enforcement of a state law relating to a medical child support.

If an Order contains inconsistencies or ambiguities that might pose a risk of future controversy or liability to the Plan, the Order will not be considered to be a QMCSO.

12.4 Enrollment Of Alternate Recipient

An Alternate Recipient with respect to an Order determined to be a QMCSO who properly submits the applicable enrollment forms to PEBB will become covered under the Plan to which such Order applies as soon as practicable after the applicable enrollment forms are received. An Alternate Recipient will be eligible to become covered under the Plan as of a particular date without regard to any open enrollment period restrictions otherwise applicable under the Plan.

12.5 Cost Of Coverage

An Alternate Recipient will be treated as having been voluntary enrolled in the Plan by the Member as a dependent of such Member, including in regard to the payment by the Member for dependent coverage under the Plan. The amount of any required contributions to be made by the Member for coverage under the Plan will be determined on the basis of the Alternate Recipient being treated as the Member’s covered dependent. Any additional required contribution attributable to the coverage of the Alternate Recipient will not be separately charged. Rather, the full amount of the required contribution shall be paid by the Member in accordance with the payroll deduction or other procedures of the Plan as pertaining to the Member.
12. Qualified Medical Child Support Orders (QMCSO)

12.6 Reimbursement Of Plan Expenses

Unless the terms of the Order provide otherwise, any payments to be from the Plan as reimbursement for group health expenses paid either by the Alternate Recipient, or by the custodial parent or legal guardian of the Alternate Recipient, will not be paid to the Member. Rather, such reimbursement will be paid either to the Alternate Recipient, or to the custodial parent or legal guardian of such Alternate Recipient. However, if the name and address of a State or agency official has been substituted in the Order for that of the Alternate Recipient, then the reimbursement will be paid to such named official.

12.7 Status Of Alternate Recipient

An Alternate Recipient under a QMCSO generally will be considered a beneficiary of the Member under the Plan to which the Order pertains.

12.8 Treatment Of National Medical Support Notice

If PEBB receives an appropriately completed National Medical Support Notice (NMSN) issued pursuant to the Child Support Performance and Incentive Act of 1998 in regard to a Member who is a non-custodial parent of a child, and if the NMSN is determined by PEBB to satisfy the QMCSO standards prescribed above, then the NMSN shall be deemed to be a QMCSO respect to such child.

PEBB, upon determining that the NMSN is a QMCSO, shall within 40 business days after the date of the NMSN notify the State agency issuing the NMSN of the following:

- Whether coverage of the child at issue is available under the terms of the Plan, and if so, as to whether such child is covered under the Plan; and

- Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the State or agency official acting on behalf of the child) to effectuate the coverage under the Plan.

PEBB shall within such time period also provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

Nothing in this section shall be construed as requiring the Plan, upon receipt of a NMSN, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as in effect immediately before receipt of such NMSN.

13.1 Duplicating Provisions

If any charge is described as covered under two or more benefit provisions, the Plan will pay only under the provision allowing the greater benefit. This may require a recalculation based upon both the amounts already paid and the amounts due to be paid. The Plan has NO liability for benefits other than those this Plan provides.

13.2 Failure To Provide Information

You warrant that all information contained in applications, questionnaires, forms, or statements submitted to PEBB and to AllCare PEBB to be true, correct, and complete. If you willfully fail to provide information required to be provided under this Plan or knowingly provide incorrect or incomplete information, then your rights and those of your Family Members may be terminated as described in the Termination of Member Coverage (Section 10).

13.3 Member Responsibility

It is your responsibility to read and to understand the terms of this Plan. Neither PEBB nor AllCare PEBB will have any liability whatsoever for your misunderstanding, misinterpretation or ignorance of the terms, provisions and benefits of this Plan. If you have any questions or are unclear about any provision concerning this Plan, please contact AllCare PEBB. They will assist you in understanding and complying with the terms of the Plan.

13.4 Membership ID Card

Each Member of the Plan receives a Member ID Card. Your Member ID Card lists information about your health plan coverage, including:

- Your Member identification number and group number;
- Your particular health plan;
- Important phone numbers.

The Membership ID Card is issued by AllCare PEBB for Member identification purposes only. It does not confer any right to Services or other benefits under this Plan.

Please keep your Member ID Card with you and use it when you:

- Visit your health care provider or facility;
- Call for Mental Health/Chemical Dependency Member Services;
- Call or correspond with Member Services;
- Call AllCare PEBB Nurse Help Line;
- Visit your pharmacy for prescriptions;
- Receive Urgent (Immediate) or Emergency Care Services.
13.5 Non-Transferability Of Benefits

No person other than a Member and his or her dependents are entitled to receive benefits under this Plan. Such right to benefits is nontransferable.

13.6 Nonwaiver

No delay or failure when exercising or enforcing any right under this Plan shall constitute a waiver or relinquishment of that right and no waiver or any default under this Plan shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of this Plan shall be deemed to have been made unless and until such waiver has been reduced to writing and signed by the party waiving the provision.

13.7 No Recourse For Acts Of Providers

The Hospitals, Skilled Nursing Facilities, physicians and other persons or organizations providing Services to you do so as independent contractors. Neither PEBB nor AllCare PEBB is liable for any claim or demand due to damages arising out of or in any manner connected with any injuries suffered by you while receiving such Services.

13.8 Notice

Any notice required of PEBB or AllCare PEBB under this Plan shall be deemed to be sufficient if mailed to the Member at the address appearing on the records of AllCare PEBB. Any notice required of you shall be deemed sufficient if mailed to the office of AllCare PEBB at 1701 NE 7th Street, Grants Pass, Oregon 97526.

13.9 Notice Required For Reimbursement and Payment Of Claim

Plan payments for most Services are made directly to the providers of Services. Except as otherwise specifically provided in this Plan, if you are billed directly and pay for benefits which are covered by this Plan, reimbursement from the Plan will be made only upon your written notice to AllCare PEBB of the payment. Payment will be made to the Member, subject to written notice of claim, or, if deceased, to the Member’s estate, unless payment to other parties is authorized in writing by you. See section 8.1 regarding timely submission of claims.

13.10 Physical Examination and Autopsy

When reasonably required for purposes of claim determination, PEBB shall have the right to make arrangements for the following examinations, at Plan expense, and to suspend the related claim determination until AllCare PEBB has received and evaluated the results of the examination:

- A physical examination of a Member; or
- An autopsy of a deceased Member, if not forbidden by law.
13.11 Professional Review and Right To Examine Records

All Members, by acceptance of the benefits of this Plan, shall be deemed to have consented to the examination of medical records for purposes of utilization review, quality assurance and peer review by AllCare PEBB or their designee.

All Members, for purposes other than utilization review, quality assurance and peer review, may be required to authorize any provider to give and discuss with AllCare PEBB any information relating to any condition for which benefits are claimed under this Plan. AllCare PEBB may transfer this information between providers or other organizations who are treating you or performing a Service on behalf of AllCare PEBB. If you do not consent to the release of records or to discussions with providers, AllCare PEBB will be unable to determine the proper payment of any benefits and will deny the claims accordingly. Consent to the release of records and discussion with providers is a condition of payment of any benefits. Neither the consent to, nor the actual examination of the records or discussion with providers will constitute a guarantee of payment.

13.12 Severability

Invalidation of any term or provision herein by judgment or court order shall not affect any other provisions, which shall remain in full force and effect.

13.13 Suggestions

You are encouraged to make suggestions to AllCare PEBB. Suggestions may be oral or written and should be directed to the Member Services team at AllCare PEBB.

13.14 Right Of Recovery

AllCare PEBB, on behalf of the Plan, has the right, upon demand, to recover payments in excess of the maximum benefits specified in this Plan or payments obtained through fraud, error, or duplicate coverage. If reimbursement is not made to the Plan, AllCare PEBB is authorized by PEBB to deduct the overpayment from future benefit payments under this Plan.

13.15 Workers’ Compensation Insurance

This Plan is not in lieu of, and does not affect, any requirement for coverage by Workers’ Compensation or similar laws.

13.16 No Guarantee Of Employment

Neither the maintenance of the Plan nor any part thereof shall be construed as giving any Member covered hereunder, or other Members, any right to remain in the employ of the State of Oregon or any other employer authorized by law to participate in this program. No employee or official of PEBB in any way guarantees to any Member or beneficiary the payment of any benefit or amount which may become due in accordance with the terms of the Plan.

13.17 Required Information To Be Furnished

Each Member must furnish AllCare PEBB such information as is considered necessary or desirable for purposes of administering the Plan, and the provisions of the Plan respecting any payments hereunder are conditional upon the prompt submission by the Members of such true, full and complete information as AllCare PEBB may request.

13.18 Payment Of Benefits To Persons Under Legal Disability

Whenever any person entitled to payments under the Plan is determined to be a minor or under other legal disability or otherwise incapacitated in any way so as to be unable to manage such person's financial affairs, or otherwise incapable of giving a valid receipt and discharge for any payment, the following provision shall apply. AllCare PEBB, in its discretion, may direct that all or any portion of such payments be made (i) to such person, (ii) to such person's legal guardian or conservator, or (iii) to such person's spouse or to any other person, in any manner which AllCare PEBB considers advisable, to be expended for the person's benefit. AllCare PEBB's decision will, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred shall operate as a complete discharge of the obligations under the Plan in respect thereof by PEBB and AllCare PEBB.

13.19 State Medicaid Benefits Rights

Notwithstanding any provision of the Plan to the contrary:

- Payment for benefits with respect to a Member under the Plan shall be made in accordance with any assignment of rights made by or on behalf of such Member, or a Family Member, as required by a State Medicaid Plan;

- The fact that an individual is eligible for or is provided medical assistance under a State Medicaid Plan shall not be taken into account in regard to the individual’s enrollment as a Member or beneficiary in the Plan, or in determining or making any payments for benefits of the individual as a Member or Family Member in the Plan; and

- Payment for benefits under the Plan shall be made to a state in accordance with any state law which provides that the state has acquired the rights with respect to a Member for items or Services constituting medical assistance under a State Medicaid Plan.

For purposes of the above, a “State Medicaid Plan” means a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act.
13.20 **Veteran’s Rights**

The Plan will provide benefits to Members entering into or returning from service in the armed forces as may be required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). In general, USERRA provides that:

A Member who takes unpaid military leave, or who separates from employment to perform services in the armed forces or another uniformed service, can elect continued coverage under the Plan (including coverage for the Eligible Family Dependents). The applicable Contribution for such coverage, and the Contribution payment procedures, shall be as generally prescribed for COBRA continuation coverage in section 11. Effective for elections made on or after December 10, 2004, the period for such continuation coverage shall extend until the earlier of:

a) The end of the 24-month period beginning on the date on which the Member’s absence for the purpose of performing military service begins; or

b) The date the Member fails to timely return to employment or reapply for a position covered by PEBB or any other employer authorized by law to participate in this program upon the completion of such military service.

13.21 **Controlling State Law**

The laws of the State of Oregon shall apply and shall be the controlling state law in all matters relating to the Plan.

13.22 **Limitations On Provisions**

The provisions of the Plan and any benefits provided by the Plan shall be limited as described herein. Any benefit payable under any other employee benefits plan maintained by PEBB shall be paid solely in accordance with the terms and provisions of such Plan, and nothing in this Plan shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other plan.

13.23 **Gender and Number**

Masculine gender shall include the feminine and neuter, the singular shall include the plural, and the plural shall include the singular, unless the context clearly indicates otherwise.

13.24 **Headings**

All article and section headings in the Plan are intended merely for convenience and shall in no way be deemed to modify or supplement the actual terms and provisions set forth thereunder.

In the event that one or more provisions of this document conflict with one or more provisions of any other plan document, the provisions of this document, as from time to time amended, shall control.

13.26 Legal Action
No civil action may be brought under state or federal law to recover Plan benefits until receipt of a final decision under the Member Grievance and Appeal process specified in section 9 of this Member Handbook.

13.27 Protected Health Information
Disclosure: In accordance with the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), AllCare PEBB may disclose de-identified summary health information to PEBB for purposes of modifying, amending or terminating this Plan. In addition, AllCare PEBB may disclose protected health information (PHI) to PEBB in accordance with the following provisions of this Plan as established by PEBB:

- PEBB may use and disclose the PHI it receives only for the following purposes:
  - Administration of the Plan; and
  - Any use or disclosure as required by law.
- PEBB shall ensure that any agent or subcontractor to whom it discloses such PHI shall agree to the same restrictions and conditions that apply to PEBB with respect to such information.
- PEBB shall not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of PEBB.
- PEBB shall report to AllCare PEBB any use or disclosure of PHI that is inconsistent with the provisions of this section of which the Employer becomes aware.
- PEBB shall make PHI available to Members in accordance with the privacy regulations of HIPAA.
- PEBB shall allow Members to amend their PHI in accordance with the privacy regulations of HIPAA.
- PEBB shall provide Members with an accounting of its disclosure of their PHI in accordance with the privacy regulations of HIPAA.
- PEBB shall make its internal practices, books and records relating to the use and disclosure of PHI received from AllCare PEBB available to the Secretary of the Department of Health and Human Services in accordance with the privacy regulations of HIPAA.
- PEBB shall, if feasible, return or destroy all PHI received from AllCare PEBB and retain no copies of such information when no longer needed for the purpose for which such information was received except that, if such return or destruction is not
feasible, PEBB shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

• PEBB shall provide for adequate separation between PEBB and AllCare PEBB with regard to the use and disclosure of PHI. For that purpose, access to PHI shall be limited to the following employees or classes of employees of PEBB or designated individuals:
  • Plan Design Manager;
  • Director of Operations;
  • PEBB’s Designated Consultants; and
  • Internal Auditors, including representatives of the Oregon Secretary of State or Department of Justice, when performing Health Plan Audits.

Further, PEBB shall restrict the access to and use of PHI by the employees designated above to the administrative functions that those employees perform for PEBB with regard to this Plan. In addition, PEBB shall establish an effective mechanism for resolving any issues of non-compliance by the employees designated above with regard to their use of PHI.

Security: In accordance with the security standards of HIPAA, PEBB shall:

• Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

• Ensure that the separation of access to PHI that is specified in paragraph (j) above is supported by appropriate security measures;

• Ensure that any agent or subcontractor to whom PEBB provides PHI agrees to implement appropriate security measures to protect such information; and

• Report to the Plan any security incident regarding PHI of which PEBB becomes aware.
14. Definitions

The following are definitions of important terms used in this Plan:

Adverse Benefit Determination
See section 9.

Alternative Treatment Option
Alternative Treatment Option means payment for services or supplies that are not otherwise benefits of the Plan, but that AllCare PEBB determines to be Medically Necessary and cost effective subject to the requirements in Section 4.5.

Alternative Care Provider
Alternative Care Provider means a naturopath, chiropractor, acupuncturist or massage therapist who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.

Ambulatory Surgery Center
Ambulatory Surgery Center means an independent medical facility that specializes in elective same-day or outpatient surgical procedures.

Annual
Annual means once per Calendar Year.

Appeal
See section 9.

Approved Clinical Trial
Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment or cancer or other life-threatening disease or condition and is one of the following:

• A federally funded or approved trial;
• A clinical trial conducted under an FDA investigational new drug application; or
• A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Authorized Representative
See section 9.

Benefit Summary
Benefit Summary means any documents with that title that are part of your AllCare PEBB and summarize the benefit provisions under your AllCare PEBB.
Calendar Year

Calendar year means a 12-month time period beginning January 1 and ending December 31.

Center of Excellence

A Center of Excellence is a hospital or medical center recognized by its peers in the medical community as providing high quality health care in one or more specialties.

Chemical Dependency

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

Coinsurance

Coinsurance means the dollar amount that you are responsible to pay to a health care provider for a Covered Service after your claim has been processed by AllCare PEBB. Your Coinsurance for a Covered Service is shown in the Benefit Summary and is a percentage of the charges for the Covered Service.

Contribution

Contribution means the dollar amount that a Member may be required to pay as a condition to coverage under the Plan toward the monthly premium cost of the Plan established by PEBB.

Copayment

Copayment means the dollar amount that you are responsible for paying to a health care provider when you receive certain Covered Services, as shown in the Benefit Summary.

Cosmetic Services

Cosmetic Services means Services or surgery performed to reshape normal structures of the body in order to improve your appearance or self-esteem.

Covered Service

Covered Service means a Service that is:

- Listed as a benefit in the Benefit Summary and in the Covered Services section of this Member Handbook;
- Medically Necessary;
- Not listed as an Exclusion or Limitation in the Benefit Summary or in the relevant sections of this Member Handbook; and
14. Definitions

- Provided to you while you are a Member and eligible for the Service under this Plan.

Custodial Care

Custodial Care means Services that:

- Do not require the technical skills of a licensed nurse at all times;
- Include, but are not limited to, assistance with dressing, bathing, eating, ambulation, taking medication and incontinence care; and
- Are not likely to improve your medical condition.

Such Services will still be considered Custodial Care even if:

- You are under the care of a physician;
- The Services are prescribed by a Preferred/Participating Provider;
- The Services function to support or maintain your condition; or
- The Services are being provided by a registered nurse or licensed practical nurse.

Deductible

See section 4.9.1.

Durable Medical Equipment (DME)

Durable Medical Equipment means equipment that must:

- Be able to withstand repeated use;
- Be primarily and customarily used to serve a medical purpose; and
- Not be generally useful to a person except for the treatment of an injury or illness.

Effective Date of Coverage

Effective Date of Coverage means the date upon which coverage under this Plan commences for a PEBB Member, which shall be:

- The first day of the month after which a PEBB Member is properly enrolled.

Emergency Medical Condition

See section 5.7.

Emergency Medical Screening Exams

See section 5.7.
Emergency Services
See section 5.7.

Essential Health Benefits
Essential Health Benefits means the general categories of services established under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations:

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

E-visit
E-visit (electronic provider communications) means a consultation through email with a Preferred Provider that is, in the judgment of the Preferred Provider, Medically Necessary and appropriate and involves a significant amount of the Preferred Provider’s time. An E-visit must relate to the treatment of a covered illness or injury.

Exclusion Period
Exclusion Period means a period of time during which specified treatments or Services are excluded from coverage under this Plan, unless such exclusion is modified or eliminated by the application of Creditable Coverage.

Experimental/Investigational
Experimental/Investigational means those Services that are determined by AllCare PEBB not to be Medically Necessary or accepted medical practice in the Service Area, including Services performed for research purposes. In determining whether Services are Experimental/Investigational, AllCare PEBB, as the Plan’s claims administrator, will consider whether the Services are in general use in the medical community in the U.S.; whether the Services are under continued scientific testing and research; whether the Services show a demonstrable benefit for a particular illness or disease; whether they are
proven to be safe and efficacious; and whether they are approved for use by appropriate governmental agencies.

AllCare PEBB determines on a case-by-case basis whether the requested Services will result in greater benefits than other generally available Services, and will not approve such a request if the Service poses a significant risk to the health and safety of the Member. AllCare PEBB will retain documentation of the criteria used to define a Service deemed to be Experimental/Investigational and will make this available for review upon request.

Grievance
See section 9.

Health Benefit Plan

Health Benefit Plan means any hospital or medical expense policy or certificate issued by a health care service contractor or health maintenance organization and any plan provided by a multiple-employer welfare arrangement or other benefit arrangement defined in ERISA.

HIPAA

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Home Health Provider

A Home Health Provider is a public or private agency that specializes in providing skilled nursing Services and other therapeutic Services in the home and which has been licensed by the proper authority as a Home Health Agency, or is Medicare approved as a Home Health Agency.

Hospital

Hospital means an institution which:

- Maintains permanent full-time facilities for bed care of resident patients;
- Has a physician or surgeon in regular attendance;
- Provides continuous 24-hour-a-day nursing Services;
- Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
- Is legally operated in the jurisdiction where located; and
- Has surgical facilities on its premises or has a contractual agreement for surgical Services with an institution having a valid license to provide such surgical Services.

Hospital does NOT include an institution that is principally a rest home, nursing home, convalescent home or home for the aged. Hospital does NOT include a place principally for the treatment of alcohol or Chemical Dependency or Mental Health disorders.
In Plan
The level of benefits specified in the Benefit Summary or covered Services provided by a preferred/participating provider in the AllCare PEBB network.

Maximum Cost Share
See section 4.9.3.

Medically Necessary
Medically Necessary means Services that are in the reasonable opinion of AllCare PEBB, consistent with the written criteria regarding medically indicated Services that are maintained by the AllCare PEBB. The criteria are based on the following principles:

- The Service is medically indicated according to the following factors:
  - The Service is necessary to diagnose or to meet the reasonable health needs of the Member;
  - The expected health benefits from the Service are clinically significant and exceed the expected health risks by a significant margin;
  - The Service is of demonstrable value and that value is superior to other Services and to the provision of no Services; and
  - Expected health benefits can include:
    - Increased life expectancy;
    - Improved functional capacity;
    - Prevention of complications; or
    - Relief of pain.
  - The Qualified Practitioner recommends the Service.
  - The Service is rendered in the most cost-efficient manner and type of setting consistent with nationally recognized standards of care, with consideration for potential benefits and harms to the patient.
  - The Service is consistent in type, frequency and duration with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Plan.

In the case of a life-threatening illness, a Service that would not meet the criteria above may be considered Medically Necessary for purposes of reimbursement, if:

- It is considered to be safe within promising efficacy, as demonstrated by accepted clinical evidence reported by generally-recognized medical professionals or publications; and
- The treatment is provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National
14. Definitions

Institutes of Health for a life-threatening condition.

For the purpose of this exception, the term “life-threatening” means more likely than not to cause death within one year of the date of the request for diagnosis or treatment.

Member

Member means principal subscriber or an eligible spouse, domestic partner, or dependent child who is properly enrolled in this Plan, and entitled to Services under this Plan.

Member Handbook

Member Handbook means this document which summarizes the provisions of this Plan.

Mental Health

Mental Health means Services related to all disorders listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders except for:

- Diagnostic codes relating to Mental Retardation;
- Diagnostic codes relating to Learning Disorders;
- Diagnostic codes relating to Paraphilias; and
- Diagnostic “V” codes.

Network — AllCare PEBB Network

AllCare PEBB Network means the network of Preferred/Participating Providers that contract either directly or indirectly with AllCare PEBB/AllCare Health Plan, Inc. and has agreed to serve our Members of this Plan.

Open Enrollment Period

Open Enrollment Period means the period determined by PEBB during which Members may enroll themselves, an eligible spouse, domestic partner, and dependent children in this Plan for the upcoming Plan Year, subject to the terms and provisions as found in the Oregon Administrative Rule Chapter 101 and PEBB Summary Plan Description.

Out-of-Network

The level of benefit specified in the Benefit Summary for covered services provided by an Out-of-Network provider.

Out-of-Network Provider

Out-of-Network Provider means any provider that does not have a written agreement with AllCare PEBB to participate as a health care provider for this Plan. Services provided by an Out-of-Network provider carry greater cost shares than when you receive services from preferred or participating providers.
Out-of-Pocket Maximum
See section 4.9.2.

Outpatient Surgical Facility
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. It does NOT provide Services or accommodations for patients to stay overnight.

Participating Provider
Participating Provider means any provider that contracts indirectly with AllCare PEBB/AllCare Health Plan, Inc. through the First Choice and First Health Networks.

PEBB
PEBB means the Oregon Public Employees’ Benefit Board, the sponsor of this Plan.

PEBB Member
PEBB Member means an active Oregon public employee, former employee, or legislatively approved individual who is eligible for enrollment in this Plan in accordance with the provisions specified in the PEBB Summary Plan Description and the Oregon Administrative Rules, Chapter 101.

Plan
Plan means the group health plan sponsored by PEBB, as summarized in this Member Handbook.

Plan Allowable/Usual, Customary, and Reasonable (UCR)
When a Service is provided by a Preferred/Participating Provider, Plan Allowable means the fees that AllCare PEBB has negotiated with Preferred/Participating Providers for that Service. Plan Allowable charges will never be less than our negotiated fees.

When a Service is provided by an Out-of-Network Provider, Plan Allowable charges will based on the lesser of:

- The fee a professional provider usually charges for a given Service;
- A fee which falls within the range of usual charges for a given Service billed by most professional providers in the same locality who have similar training and experience;
- A fee which is prevalent or which would not be considered excessive in a particular case because of unusual circumstances; or
- The fee determined by comparing charges for similar Services to a national database adjusted to the geographical area where the Service was performed.
Plan Allowable charges do not include sales taxes, handling fees and similar surcharges and such taxes, fees and surcharges are not covered expenses.

Plan Year

Plan Year means the 12-month period ending on December 31.

Preferred Network Pharmacy

Preferred Pharmacy means a pharmacy that has a signed contract with AllCare PEBB’s Pharmacy Benefit Manager, MedImpact, and has agreed to provide medications and other Services at special rates. There are four types of Preferred Pharmacies:

1. Retail: a Preferred Pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.

2. Choice 90 Retail: a Pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.

3. Specialty: a Preferred Pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.

4. Mail Order: a Preferred Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

Preferred Primary Care Provider (PPCP)

Your Preferred Primary Care Provider (PPCP) is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. You must see your primary care provider before you see any other health care provider.

(Note: Not all Qualified Practitioners are Preferred Primary Care Providers (PPCP). To obtain a listing of Preferred Primary Care Providers (PPCP), please see the Provider & Pharmacy Directory online or call Member Services.)

Preferred Primary Care Provider (PPCP) Referral

Preferred Primary Care Provider (PPCP) Referral means a referral by a Preferred Primary Care Provider (PPCP) for a Member to receive services from a Specialist. To be eligible for coverage, any services received as a result of the referral must qualify as Medically Necessary Covered Services under this Plan. Prior Authorization applies, as specified in section 4.4. This plan will not pay for any services received from a preferred specialist without a referral from your Preferred Primary Care Provider (PPCP) (with the exception of routine women’s health specialty services).

Preferred Provider

Preferred Provider means any provider that contracts directly with AllCare PEBB/AllCare Health Plan, Inc. For Native American Members, Covered Services obtained through the Indian Health Services are considered to be Covered Services obtained from a Preferred Provider.
Prior Authorization

Prior Authorization or Prior Authorized means a request to AllCare PEBB by you or by a Qualified Practitioner regarding a proposed Service, for which prior approval is required by AllCare PEBB. Prior Authorization review will determine if the proposed Service is eligible as a Covered Service or if an individual is a Member at the time of the proposed Service. To facilitate our review of the Prior Authorization request, we may require additional information about the Member’s condition and/or the Services requested. We may also require that a Member receive further evaluation from a Qualified Practitioner of our choosing. Prior Authorization is subject to the terms and provisions of this Member Handbook. Prior Authorization is not a guarantee of benefit payment (e.g., if the Member’s coverage terminates before the Prior Authorized procedure is performed). See section 4.4.

Qualified Practitioner

Qualified Practitioner means a physician, Women’s Health Care Provider, nurse practitioner, nurse practitioner midwife, clinical social worker, physician assistant, psychologist, dentist, or other practitioner who is professionally licensed by the appropriate governmental agency to diagnose or treat an injury or illness and who provides Covered Services within the scope of that license.

Qualified Treatment Facility

Qualified Treatment Facility means a facility, institution or clinic duly licensed by the appropriate governmental agency, which is primarily established and operating within the lawful scope of its license.

Reconstructive Surgery

Reconstructive Surgery means surgery that restores features damaged as a result of injury or illness or to correct a congenital deformity or anomaly that results in a functional impairment.

Service

Service means a health care related procedure, surgery, consultation, advice, diagnosis, referrals, treatment, supply, medication, prescription drug, device or technology that is provided to a Member by a Qualified Practitioner.

Service Area

Service Area means Josephine, Jackson, Curry Counties and Glendale and Azalea in Douglas County.

Skilled Nursing Facility

Skilled Nursing Facility means a convalescent or chronic disease facility which is accredited by the Joint Commission on Accreditation of Hospitals (JCAHO) or certified as a “Skilled Nursing Facility” by the Secretary of Health and Human Services pursuant to Title XVIII of the Social Security Act as amended.
Telemedical Visit
See section 5.1.3.

Usual, Customary, and Reasonable (UCR)
Describes predefined charges established by your plan for services that you receive from an Out-of-Network provider. When the cost of Out-of-Network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your Out-of-Pocket maximums or maximum cost share.

Urgent (Immediate) Care
See section 5.8.

Women’s Health Care Provider
A Women’s Health Care Provider means an obstetrician or gynecologist, or physician assistant specializing in women’s health, advanced registered nurse practitioner specialist in women’s health or certified nurse midwife, practicing within the applicable lawful scope of practice.

Administered by
AllCare Health Plan, Inc.
1701 NE 7th Street
Grants Pass, OR 97526
Telephone: (888) 460-0185
TTY: (800) 735-2900