

OMIP

Oregon Medical Insurance Pool

Member Handbook



We're here for you!



Oregon

Letter from the Administrator

Thank you for your interest in health benefit coverage through the Oregon Medical Insurance Pool (OMIP). The Oregon Medical Insurance Pool which is an agency in the Oregon Department of Consumer and Business Services, provides program oversight. The OMIP Board contracts with Regence BlueCross BlueShield of Oregon as the Administering Insurer to process applications, make claim payments and provide customer service.

The 1987 Oregon Legislature established OMIP for Oregonians who are unable to obtain health benefit coverage for themselves in the individual insurance market because of their current or past medical conditions or because they do not have access to health insurance portability options.

This handbook gives an overview of the OMIP program. You should read it and the accompanying materials thoroughly for eligibility requirements, premium options and benefits for each plan. It is important that you consider all insurance options and the eligibility requirements available to you prior to applying for OMIP coverage. For example, you may qualify for a portability health insurance policy if you presently or recently had coverage through an employer-provided plan. You will need to consult with your employer's health insurance company or an insurance agent regarding this option.

If you choose to apply for OMIP coverage, please follow the instructions carefully noted in the "How to Apply" section of this handbook as well as the instructions listed on the application. Be sure to attach all of the requested documentation for each section including any denial letters, any previous certificates of creditable coverage and proof of Oregon residency. We will pend incomplete applications, which may delay your effective date for coverage.

Following approval of your application, you will receive an insurance contract for the particular plan in which you enrolled. It provides more detailed information than this handbook does about your coverage.

An insurance agent who assists you with the OMIP application is acting independently and is not a representative of OMIP. An insurance agent cannot determine the effective date of coverage, nor can he or she modify the benefits, terms, conditions or exclusions of the contract.

If you have any questions after reading the enclosed materials, please contact the Administering Insurer Customer Service Department of Regence BlueCross BlueShield of Oregon at (503) 225-6620 or toll free at 1-800-848-7280.

Sincerely,

Rocky King, Administrator
Oregon Medical Insurance Pool

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OMIP
Health Benefit Plan Summary

	Medical Plan 500		Medical & Portability Plan 750		Medical Plan 1000		Medical & Portability Plan 1500	
Lifetime Maximum Benefit	\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000	
Pre-existing Waiting Period, Including Pregnancy	6 months		6 months		6 months		6 months	
	In Network you pay	Out of Network you pay	In Network you pay	Out of Network you pay	In Network you pay	Out of Network you pay	In Network you pay	Out of Network you pay
Annual Prescription Deductible	0		0		0		\$1,000	
Annual Medical Deductible	\$500		\$750		\$1,000		\$1,500	
Maximum Annual Medical Out of Pocket, excluding medical deductible, per individual*	\$1,000	\$2,000	\$3,000	\$6,000	\$4,000	\$8,000	\$6,000	\$12,000
Doctor Visits	20%	40%	20%	40%	20%	40%	30%	50%
Hospital	20%	40%	20%	40%	20%	40%	30%	50%
Outpatient Surgery	20%	40%	20%	40%	20%	40%	30%	50%
Skilled Nursing Care - limited to 60 days	20%		20%		20%		30%	
Home Health Care - limited to 60 visits	20%	40%	20%	40%	20%	40%	30%	50%
Emergency Room**	20% + \$100 copay	20% + \$100 copay	20% + \$100 copay	20% + \$100 copay	20% + \$100 copay	20% + \$100 copay	30% + \$100 copay	30% + \$100 copay
Ambulance	20%		20%		20%		30%	
Maternity	20%	40%	20%	40%	20%	40%	30%	50%
Diagnostic X-Ray/Lab	20%	40%	20%	40%	20%	40%	30%	50%
Transplant**	0%	40%	0%	40%	0%	40%	0%	50%
Hospice	20%	40%	20%	40%	20%	40%	30%	50%
Rehabilitation Inpatient - limited to 60 days	20%	40%	20%	40%	20%	40%	30%	50%
Rehabilitation Outpatient - limited to 60 days	20%	40%	20%	40%	20%	40%	30%	50%
Durable Medical Equipment	20%		20%		20%		30%	
Mental Health	20%	40%	20%	40%	20%	40%	30%	50%
Chemical Dependency	20%	40%	20%	40%	20%	40%	30%	50%
Women's Health Care Services***	20%	Not Covered	20%	Not Covered	20%	Not Covered	30%	Not Covered
Men's Health Care Services***	20%	Not Covered	20%	Not Covered	20%	Not Covered	30%	Not Covered
Immunizations***	20%	Not Covered	20%	Not Covered	20%	Not Covered	30%	Not Covered
Well Baby Care***	20%	Not Covered	20%	Not Covered	20%	Not Covered	30%	Not Covered
Well Child Care***	20%	Not Covered	20%	Not Covered	20%	Not Covered	30%	Not Covered
Prescription Drugs: No out of pocket maximum on prescription drugs**	\$0 Rx deductible		\$0 Rx deductible		\$0 Rx deductible		\$1,000 Rx deductible (annual)	
Generic Co-Insurance	up to \$10 - Cost over \$10 - \$10		up to \$10 - Cost over \$10 - \$10		up to \$10 - Cost over \$10 - \$10		up to \$10 - Cost over \$10 - \$10	
Preferred Brand Co-Insurance	up to \$40 - Cost over \$40 - \$40		up to \$40 - Cost over \$40 - \$40		up to \$40 - Cost over \$40 - \$40		up to \$40 - Cost over \$40 - \$40	
Non-Preferred Brand Co-Insurance	up to \$60 - Cost over \$60 - \$60		up to \$60 - Cost over \$60 - \$60		up to \$60 - Cost over \$60 - \$60		up to \$60 - Cost over \$60 - \$60	

* This is the maximum amount you will pay for covered medical services per individual, per calendar year, excluding the deductibles, before OMIP will begin paying 100% for covered services.

** The Emergency Room copay, out of pocket prescription drug payments, transplants performed at noncontracting facilities, and disallowed charges do not apply to the medical deductible or out of pocket maximum.

***These services do NOT accumulate towards the maximum annual out of pocket expense. Also, you do not have to meet the annual medical deductible before OMIP pays for these services.

This Health Benefit Plan Summary is intended only as a brief summary of our benefit plans. Please refer to the OMIP contract for specific details. Exact terms, conditions, provisions, exclusions and limitations are defined in the OMIP contract.

Eligibility

Who Is Eligible For OMIP?

You and your spouse are eligible to enroll under an Oregon Medical Insurance Pool (OMIP) contract if you meet the eligibility guidelines established by the OMIP Board as outlined in the eligibility requirement section that follows.

Your unmarried children are also eligible if they are under 23 years of age and live with you.

Your children over the age of 23 may be eligible in certain circumstances such as incapacitation.

Your unmarried children, under the age of 23 that do not live with you but are enrolled as a full time student in an accredited institution are eligible to enroll as a dependent on your policy.

Once you enroll, your OMIP health insurance contract will provide additional information regarding eligibility and other information pertinent to your specific contract.

In addition, you may contact our Administering Insurer, Regence BlueCross BlueShield of Oregon's, Customer Service department at 1-800-848-7280 for additional information.

What Are The Requirements To Enroll In OMIP?

Residency Requirement

To apply for OMIP coverage you must be a permanent resident of Oregon.

A resident is defined as a person who resides permanently in Oregon **or** a person who maintains a place of residence in Oregon and resides there at least 180 days per calendar year and files personal income taxes in Oregon.

Eligibility Requirements

To apply for OMIP coverage you must meet either the **medical** eligibility requirements, **portability** (loss of group health benefit coverage) requirements, or be eligible for a **Federal Health Coverage Tax Credit** under the Federal

Trade Adjustment Assistance Program or benefits under the Pension Benefit Guarantee Corporation. The following information will help you decide the category for which you may be eligible.

Medical Eligibility

If any of the following statements fit your situation, you are eligible to apply for OMIP coverage because of medical eligibility.

- You have one or more of the medical conditions listed in Section C of the OMIP application.
- Within the last 6 months, you have been refused individual health insurance coverage due to health reasons.
- Within the last 6 months, you were offered individual health insurance coverage that excluded coverage for a specific medical condition.
- Within the last 6 months, you were offered individual health insurance coverage but were limited by the plans the carrier was willing to offer you due to a specific medical condition.
- You have permanently moved to Oregon and are transferring from another state's high risk pool.

If any of these Medical situations apply to you, please refer to Rate Schedule A, Medical Eligibility, in the OMIP Rate Brochure.

Portability Eligibility

You may be eligible for OMIP portability coverage under certain circumstances when you lose group health benefit coverage as outlined below. If you qualify, you must pay the premium for the portability insurance coverage from the date that your prior group coverage ended regardless of when OMIP notified you of the effective date of your coverage.

- You have exhausted your COBRA benefits or State Continuation coverage.
- No COBRA or State Continuation Coverage or Portability Coverage was available through your previous plan.

- You are eligible for Oregon Portability coverage but moved from the prior insurance carrier's service area.
- You were offered Portability coverage, but your insurance carrier no longer serves the area where you live.
- You are moving to Oregon and have been continuously covered by health insurance for 18 or more months, with no single gap in coverage greater than 63 days and the last coverage was group coverage.

If you are eligible for Portability coverage you must apply for OMIP portability coverage no later than the 63rd day after your prior group health benefit coverage terminates. You must also submit a copy of your "certificate of creditable coverage" from your previous carrier.

If any of these Portability situations apply to you, please refer to the OMIP Rate Schedule B, Portability Eligibility.

Federal Health Coverage Tax Credit Eligibility

If you have been certified by the US Department of Labor as being affected by competition from foreign trade, and are eligible to receive a Federal Health Coverage Tax Credit (HCTC) under Section 35 of the Internal Revenue Code, then you may qualify to enroll in an OMIP plan.

If you qualify for OMIP under this eligibility category, OMIP is assuming you are eligible for a HCTC, which pays 65% of the cost of your monthly OMIP premium. However, the federal government will make the final determination about eligibility for the HCTC. You must apply for OMIP coverage within 63 days of losing your most recent prior health insurance coverage and you must have had the prior coverage in place for a period of not less than 90 days.

If you are eligible due to receiving this Federal Health Coverage Tax Credit, please refer to Rate Schedule A in the OMIP Rate Brochure.

Persons Not Eligible

Note that the following circumstances will make you or your dependent(s) ineligible for OMIP coverage regardless of whether or not you met Residency and Medical, Portability, or Federal Health Coverage Tax Credit Eligibility Requirements:

- You are eligible for or entitled to Medicare.
- You are eligible and enrolled in health care benefits under Medicaid/Oregon Health Plan (OHP) and receive a comprehensive benefit package.
- You are an inmate of a correctional institution or a patient of a public mental institution.
- You have terminated OMIP coverage within the last 12 months for a reason other than becoming eligible for Medicaid/OHP health care benefits. This includes non-payment of OMIP premiums.
- You have received \$2 million in OMIP benefits.
- You are already enrolled in a group plan, or a substantially equivalent health benefit plan when your OMIP coverage becomes effective.
- You have OMIP premiums paid or reimbursed by a public entity or a health care provider for the sole purpose of reducing the payer's financial loss or obligation.
- You are employed by a business with two or more employees and you have applied to OMIP at the direction of an insurance agent, insurance company or an employer to separate yourself from the group health care benefit coverage offered or provided to the rest of the employees at your place of employment.
- You fail to make your initial premium payment.

Pre-existing Conditions

Pre-existing Condition — Six Month Waiting Period

The OMIP contracts have a six-month waiting period for coverage for pre-existing conditions, including pregnancy, unless you are covered under Portability or Federal HCTC eligibility.

We will not pay benefits during the first six months of enrollment for coverage of expenses incurred for a pre-existing condition unless we grant you credit for prior coverage.

There is no waiting period for portability or Federal HCTC enrollees for pre-existing medical conditions.

A pre-existing condition is one for which medical advice, diagnosis, care, or treatment was recommended or received or a treatment plan was followed in the six-months before OMIP coverage began. For purposes of the six month waiting period, the term “pregnancy” shall include, pre and postnatal care, miscarriage, abortion, delivery (vaginal or surgical), and complication of pregnancy, including, but not limited to:

- Intra-abdominal surgical procedures;
- Placenta abruptio and placenta previa;
- Acute exacerbations or heart conditions and/or diabetes;
- Toxemias.

Ectopic pregnancy is not considered a pre-existing medical condition and is not subject to this six-month waiting period for pregnancy.

Credit For Prior Coverage

We will credit each month of prior health benefit coverage, including insurance through another state high risk pool, toward the pre-existing

condition waiting period if you or your enrolled dependents were insured under an individual or group health benefit contract, including Medicaid, prior to becoming insured by OMIP. In these situations, provided there was no lapse of prior coverage of more than 63 days, every month of prior coverage will reduce the six month waiting period under the contract by one month. However, if the OMIP contract includes a benefit that the prior health benefit plan did not cover, the pre-existing condition waiting period will apply to that benefit.

We grant credit toward the six-month waiting period for each month coverage under another health plan which was involuntarily terminated, through no fault or action of your own, provided that the following conditions are met:

- You have applied for OMIP coverage no later than 63 days following the involuntary termination; and
- You request credit toward the pre-existing waiting period on the application; and
- You are not eligible for or currently enrolled in another health benefit plan; and
- You meet all eligibility and enrollment criteria.

Note: Individuals enrolling in OMIP because they receive Federal Trade Adjustment Assistance, need only satisfy three months of prior health insurance coverage to waive the pre-existing waiting period.

Comparing Plans

Plan Differences

OMIP plans differ primarily by the co-insurance amounts, deductible amounts, and maximum medical out-of-pocket expenses you may incur.

When determining what plan will work best for your particular situation, you may want to consider the following aspects:

DEDUCTIBLE

If you rarely utilize health care services, would you prefer a higher deductible, lower premium plan or are you in need of a lower deductible plan that will begin paying for covered services sooner?

PREMIUM

Of the four plans, what premium amount can you most afford to pay?

COINSURANCE

What will your co-insurance amount be for the services you will use most?

MAXIMUM MEDICAL OUT-OF-POCKET

What is the maximum amount (maximum out-of-pocket) you must pay for medical services before the plan begins paying at 100% for those covered services?

OTHER COVERAGE

Do all of your family members need to be covered under an OMIP Plan? Are some members healthy and likely to be able to obtain their own individual coverage in the commercial insurance market?

These are just a few of the questions you may want to consider when deciding on your health benefit coverage. If you have questions regarding health benefit coverage you may want to contact a health insurance agent. If you have specific questions about OMIP plans you can contact the Administering Insurer Customer Service department toll free at 1-800-848-7280.

**Please see the
Health Benefit Plan Summary
at the beginning of this handbook for a more
detailed look at the plan comparisons.**

Professional Providers

A professional provider is any of the following who provides medically necessary services that are within the scope of the provider's state license or registry:

- A Physician (Doctor of Medicine or Osteopathy);

- A Podiatrist;
- A Dentist (Doctor of Medical Dentistry or Doctor of Dental Surgery). Routine dental care is not a benefit of any of the OMIP Plans. You may receive treatment for an accidental injury to natural teeth or a fractured jaw, but services must be provided while enrolled in an OMIP Plan and within 12 months after the injury. The injury must also have occurred while enrolled under an OMIP Plan;
- A Psychologist;
- An Oregon registered clinical social worker;
- A certified nurse practitioner;
- A registered nurse or licensed practical nurse, but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill a patient;
- A registered physical, occupational, speech or audiological therapist. Services of a therapist must be part of a written treatment plan;
- A Physician Assistant.

The term "professional provider" does not include any class of provider not specifically named in the Contracts. We will not pay benefits for their services if they are not named in the Contracts.

Types of Provider Networks Available to You

The OMIP contracts include benefits for In-Network and Out-of-Network providers. The benefits for using In-Network providers are greater than those benefits for using Out-of-Network providers. It is extremely important to use In-Network providers in order to receive the maximum benefit available under your contract.

In-Network Providers will not charge more than your co-insurance amount. Some services may be subject to deductibles that are explained in each plan contract. Out-of-Network providers or hospitals may bill you the full amount of services or a fee in excess of the negotiated fee that has been arranged with

In-Network providers. **See example below.**

Our Administering Insurer, Regence BlueCross BlueShield of Oregon, administers all of the OMIP plans. You may obtain a list of In-Network providers from them at their internet address, www.or.regence.com, or by calling their OMIP Customer Service department at 1-800-848-7280. They can also mail you a provider directory if you prefer.

Example of how we pay benefits when you use an *In-network Provider*

In-Network Provider's charge for a service:	\$50.00
Amount allowed to an In-Network Provider (contracted amount)	\$45.00
The amount OMIP will pay to the In-Network Provider (80% of \$45.00, approved amount)	\$36.00
Your responsibility would be: (20% of \$45.00, approved amount)	\$ 9.00
Total the In-Network Provider Receives	\$45.00

The In-Network provider would write off the \$5.00 difference between the amount billed and the amount allowed for the service.

Example of how we pay benefits when you use an *Out-of-Network Provider*

Out-of-Network Provider's charge for a service:	\$50.00
Amount allowed to an In-Network Provider for the same service (the contracted amount):	\$45.00

How that covered expense would be paid

Contract coinsurance (supposing deductible has been satisfied): (OMIP benefit is 60%, your responsibility is 40%)	40%
Amount OMIP would pay to the Out-of-Network Provider (60% of \$45.00)	\$27.00
Amount you would pay to the Out-of-Network Provider: (40% of \$45.00 + the \$5.00 difference between the amount billed and the amount allowed)	\$23.00
Total the Out-of-Network Provider Receives	\$50.00

These are only examples. They assume that you have met any applicable deductible, but have not met the maximum out-of-pocket limit. The actual benefits of the contract you choose will vary. You will need to read your actual contract to determine how your benefits under the contract will be paid.

Types of Enrollment

The following types of enrollment arrangements are available: Single-party coverage insures one person. This person can be an adult or a child. Two-party coverage insures an adult and one dependent who may be your legal spouse or your child. Family coverage insures an adult and two or more dependents.

Dependents may include your legal spouse and all unmarried, dependent children from birth to their 23rd birthday, including adopted children and children placed for adoption.

Children, including siblings, must be enrolled with a minimum of one parent or on individual policies. Two siblings are not considered two-party coverage.

OMIP bases its premium on the oldest insured person listed on the policy. Therefore, if other members of the family can obtain coverage in the commercial health insurance market, it may be more cost effective to do that and enroll in OMIP only the person who has been declined insurance because of health conditions.

How to Apply

To apply for OMIP coverage, you must complete and sign an OMIP application and attach the required documentation. Examples of documentation include proof of your Oregon residency, a declination letter for individual health insurance because of health reasons dated within six months of your application, a *certificate of creditable coverage* from your prior group health plan. Submit your completed application to:

Oregon Medical Insurance Pool
c/o Regence BCBSO MS E10K
PO Box 1271
Portland, OR 97207-1271

We will pend applications that do not include the required documentation and the resulting delay could effect the date coverage will begin.

You can establish proof of Oregon residency by providing a copy of one of the following:

- A valid Oregon driver's license or identification card issued by the Oregon Department of Motor Vehicles.
- A voter registration card.
- Your prior year's Oregon income tax return that includes your current residence address.
- A dated rental agreement showing your residence address signed by you and the landlord that identifies you as the current tenant.
- A current utility bill listing your name, resident address and dates of service.

You may establish proof of residency by other means if approved by the Administering Insurer.

If you are requesting credit toward the pre-existing condition waiting period or are applying because of Portability eligibility, or because you are eligible for a Health Coverage Tax Credit, you must apply to OMIP **within 63 days** of losing that prior coverage, and you must provide proof of continuous health coverage that was in effect up to 63 days prior to applying for **OMIP coverage. OMIP must receive your application no later than 63 days from the date you lost your prior coverage.**

Proof of continuous health coverage can be obtained from your prior carrier. It is called a "Certificate of Creditable Coverage."

You may apply for OMIP coverage up to 90 days before the date that you want OMIP coverage to begin.

When Coverage Begins

Unless you have a Portability Plan, coverage begins on the first of the month after the Administering Insurer has accepted and approved the application for you and your eligible dependents listed on your application.

Portability coverage begins on the day after your employer-sponsored group health plan ends. The Portability Plan covers you and those eligible family members for whom you have applied and who were active on your prior group coverage at the time that coverage ended. You must have applied for OMIP portability coverage and the application must be received by OMIP within 63 days of losing your employer-sponsored group health plan coverage.

Premium Payments

When to Pay

Do not send money with your application.

After accepting your application, OMIP will notify you in writing and mail you a bill based on the information that you list in your application. A premium endorsement document, which you receive with your insurance contract, will display the premiums that you must pay.

Premium payments are due in advance for all payment methods. As an example we will bill you in January for February's premium. We will allow you a 31 day grace period after the premium due date. **If you do not make your payment within the grace period, your policy will end without notice.**

Methods of Payment

You may pay your premiums with a monthly automatic payment deduction from your checking account or by submitting a payment directly every month or every quarter (three months).

If you select the monthly automatic payment deduction, you must complete and sign authorization in Section I on the application and attach a voided check or deposit slip to the application. Initially, we will mail you a paper bill, and you must directly mail your payment until your authorization for an automatic payment deduction is processed. Just prior to the first automatic deduction, we will mail you a written notice that the deductions are about to begin.

If you want to discontinue the automatic payment process, you must submit a written notice signed by the primary member at least 15 days before the next deduction is to occur. If you have questions about the automatic deductions, you may contact the Administering Insurer's Customer Service department at 1-800-848-7280.

FHIAP Billing

If you are enrolled in the Family Health Insurance Assistance Program (FHIAP) you must enclose a "FHIAP Certificate of Eligibility" with your application. If the certificate is not included with the application, you will receive a bill directly from OMIP for the entire premium. If you enclose your certificate of eligibility FHIAP will bill you directly for your portion of the premium and then forward the entire premium to OMIP.

Federal Health Coverage Tax Credit Billing

If you are enrolling because you receive a Federal Health Coverage Tax Credit you have the option of paying your OMIP premium yourself, either monthly or quarterly.

You would need to send your portion of the premium to the Federal Health Coverage Tax Credit agency and the HCTC agency will then forward the entire premium to OMIP. You will be responsible for late payments irregardless of the fact that the HCTC agency is assisting you with your premium payments.

Premium Rates

OMIP reviews premium rates each year. Premium rate changes normally occur in January of each year. If the premium rates change, you will pay the new rate regardless of how long your OMIP coverage has been in effect.

OMIP bases its premium on the age of the oldest enrolled family member, the selected plan, and the number of family members enrolled. Premium rates will automatically increase on the next premium due date after the oldest person enrolled on the policy reaches the ages of 20, 25, 30, 35, 40, 45, 50, 55, 60, or 65+. OMIP will send a premium notice increase 30 days before the effective date of a new premium rate.

Medical Deductibles

The OMIP Plans each have an annual Medical Deductible you must satisfy before OMIP will begin paying for covered medical services. As an example, if you choose a plan that has a \$500 annual medical deductible, then you will be responsible for paying for the first \$500 in covered medical expenses before OMIP begins paying. If you have a family plan, the maximum family deductible will be three times the individual medical deductible (in this example \$1,500).

The medical deductible accrues on a calendar year basis beginning with January 1st each year. However, the OMIP Plans have a deductible carryover provision. If you incur covered expenses in the last three months of a calendar year and they apply toward, but do not satisfy

the deductible for that year, we will carry them forward and apply them toward the deductible for the following year.

Prescription Medications, Emergency Room Copays, and certain preventive, transplant, and diabetic services do not accrue towards the medical deductible.

If you are utilizing both In-Network and Out-of-Network Providers, you will be responsible for satisfying only one deductible; however, services you receive from In-Network providers have a separate maximum out-of-pocket expense from services you receive from Out-of-Network providers. The Out-of-Network maximum out-of-pocket expense is twice that for the In-Network providers (see section that follows).

There are certain services for which OMIP will pay benefits before you satisfy your deductible. Those services include annual women's exams, outpatient diabetic care, men's preventive services, immunizations, well baby & well child care, and PKU testing.

Prescription Deductible

If you enroll in Plan 1500, you will have an annual Prescription Deductible in the amount of \$1,000 that you must satisfy before OMIP will begin paying for covered prescriptions. The Prescription Deductible accrues on a calendar year basis beginning with January 1st each year.

This means that you will be responsible for paying for the first \$1,000 in prescription expenses before OMIP begins paying.

Maximum Out of Pocket Expense

The maximum out of pocket expense is the most an individual will incur, in a calendar year, beginning January each year, before the plan begins paying at 100% for eligible medical expenses.

If you are using both In-network and Out-of-network providers, we will NOT combine your out-of-pocket expenses for both In-network and Out-of-network services. You will need to satisfy an out of pocket maximum for your **In-Network services** AND a separate out of pocket maximum for your **Out-of-Network services**. The In-network maximum is not the same amount as the Out-of-network maximum. Please read the Health Plan Brochure and the Contract for your specific plan to determine the amount of maximum Out of pocket Expenses for which you will be responsible.

Prescription Medications do not accumulate toward the maximum out of pocket expense.

Other services which do not accumulate toward the maximum out of pocket expense include:

- Prescription Medications
- Annual Women's Exams
- Immunizations/PKU testing
- Non-Contracted Facility Transplants
- Preventive Services
- Well Baby/Well Child Care

Please read your contract carefully for any additional services which may not accumulate towards the maximum out of pocket expense.

When Coverage Ends

Termination

If your policy is terminated (either by you or by us), you will not be eligible to re-enroll in OMIP for twelve months following the termination date.

The policy will terminate automatically without notice if any of the following circumstances apply:

- You cease to be an Oregon resident. Your policy will terminate at the end of the month in which you are no longer an Oregon resident;
- You become eligible or entitled to Medicare. Your policy will terminate on the date in which you begin receiving Medicare benefits.
- You become eligible and enrolled in health care benefits under ORS chapter 414 (Medical Assistance or Medicaid/OHP) and are receiving a comprehensive benefit package. Your policy will terminate on the date you began receiving Medicaid/OHP benefits;
- A public entity or a health care provider is paying your OMIP premiums or reimbursing you for them for the sole purpose of reducing the financial loss or obligation of the payor. Your policy will terminate as of the date the public entity or health care provider began paying your OMIP premiums or began reimbursing you for them;
- You are employed by a business with two or more employees and applied for OMIP coverage at the direction of an insurance agent or insurance company for the purpose of separating yourself so that employer's group health insurance benefits offered or provided to the rest of the employees would not cover you. Your policy will terminate as of the effective date of OMIP coverage, as if you never had OMIP coverage;

- You have had substantially equivalent health benefits as of the effective date of OMIP coverage. Your policy will terminate as of the effective date of OMIP coverage as if you never had OMIP coverage;
- You have received \$2 million in OMIP benefits. Your policy will terminate on the date in which you reach your \$2 million lifetime benefit allowance;
- You become an inmate at a correctional institution or a patient at a public mental institution as defined under ORS 179.321. Your policy will terminate on the date in which you become an inpatient or inmate;
- You fail to make your premium payment within the 31 day grace period. Your policy will terminate at the end of the month for which you have paid premium;
- If you make a material misrepresentation or omission on your application, we have the right to rescind OMIP coverage back to the first day it went into effect. We have this right for the first two years of coverage. However, after the first two years, we may rescind coverage from the beginning, refuse to renew coverage or deny or reduce a claim payment because of a material misstatement or misrepresentation, but only if the misrepresentation was fraudulent;
- We will terminate your coverage if you misuse the provider network by being disruptive, unruly or abusive, threaten the physical health or well-being of health care staff, or seriously impair the ability of the Administering Insurer or its providers to provide service to you;
- In addition, we may refuse to renew your coverage if we refuse to renew all other policies of the same form, and Oregon law or administrative rule allows or requires us to do so.

Medicare & OMIP

If you become eligible for Medicare, you cannot continue your OMIP policy. It is your responsibility to let us know if you become eligible for Medicare. Your OMIP policy will end on the date that Medicare starts. If we discover that Medicare became effective at a date in the past, we will retroactively terminate your OMIP coverage to that date. Note: If you receive Medicare due to disability, it is possible to “Suspend” your OMIP coverage during this time. Please see section below.

Suspending Coverage

Generally, if you terminate your OMIP coverage, you cannot come back to OMIP for a period of 12 months. However, if you become enrolled in **Medicaid/OHP** or **Medicare** for reasons due to disability you may choose to place your OMIP coverage in suspense while you are receiving Medicaid or Medicare due to disability.

To request suspension you must notify the Administering Insurer in writing within 30 days of receiving notice of eligibility for Medicaid or Medicare due to disability. We will suspend OMIP coverage effective the **date in which you became enrolled** in Medicaid or Medicare due to disability.

We will suspend OMIP coverage for a maximum of 12 months. OMIP will not collect premiums from you while the OMIP contract is suspended. If your coverage is reinstated within the same calendar year, your out-of-pocket medical expenses and deductibles will carry over from the time your coverage was suspended.

If you lose eligibility for Medicaid or Medicare during the twelve month suspension period, you may request, in writing, that coverage under the OMIP contract be resumed. You must submit the request to the Administering Insurer within 30 days of notice of losing eligibility for Medicaid or Medicare due to disability.

If you are still eligible for Medicaid/OHP or Medicare due to disability after the twelve month suspension period, or you fail to request resumption of OMIP coverage, we will terminate the OMIP contract retroactively effective at the end of the month in which you became eligible for Medicaid/OHP or Medicare due to disability.

If OMIP no longer offers this contract at the time coverage is resumed, we will offer coverage available through the most similar current OMIP Plan.

If your coverage was suspended and then resumed you will receive credit toward the six-month waiting period for pre-existing conditions based on the number of months you were previously covered by the OMIP contract and the number of months you were eligible for health care benefits through Medicaid or Medicare due to disability.

Adding/Removing Dependents

You must notify the Administering Insurer, Regence BlueCross BlueShield of Oregon, in writing, if you wish to add or remove family members from coverage. This includes newborns.

Note that the addition of family members may result in a premium increase if single or two-party coverage existed before the change in coverage.

In order to enroll a newborn, you must complete a status change form and pay the additional premium within 60 days after the birth.

If you fail to apply for the newborn coverage within 60 days after the birth and/or fail to pay the additional premium, OMIP will not add the child for coverage. In such a case, OMIP will not pay for any services that the child received since birth, including any maternity related hospital or physician charges.

We will cover adopted children as enrolled family members for 60 days after the date the child is placed with you for the purpose of adoption, so long as you complete a status change form and pay the additional premium within 60 days of placement. Placement means that you have

assumed and retained a legal obligation for full or partial support of the child in anticipation of the adoption. In order to continue coverage beyond 60 days, you must submit a request in writing with proof of legal placement.

Switching Plans/Open Enrollment Periods

Only at Open Enrollment may OMIP members switch their coverage to a different plan. Open Enrollment occurs in December for a January 1 effective date.

Benefit Limitations and Exclusions

OMIP contracts place some exclusions and limitations on the benefits available for the treatment of certain conditions and the use of certain procedures. These exclusions and limitations are explained in the OMIP contract under Benefit Exclusions and Benefit Limitations. Please be sure to read your entire contract carefully for a complete description of coverage, exclusions and limitations.

Under no circumstances will OMIP pay more than \$2 million in benefits for any enrollee. This amount applies to all contracts and is reduced by benefits paid under any prior OMIP contract.

Following is a BRIEF list of contract exclusions.

- Acupuncture
- Appliances or equipment primarily for comfort or convenience
- Charges in excess of usual and customary or reasonable amounts for services and supplies
- Chiropractic Care
- Cosmetic or reconstructive surgery
- Custodial care
- Dental examinations and treatment
- Experimental or Investigational procedures

Medical Management Services

- Family planning services and supplies
- Hearing aids, eyeglasses and contacts
- Massage or Massage Therapy
- Orthognathic surgery
- Orthopedic Shoes
- Treatment for obesity or weight control

Prescription Exclusions

There are some medications that OMIP does NOT cover. The BENEFIT EXCLUSIONS and BENEFIT LIMITATIONS section of your OMIP contract includes a list of medications that we do NOT cover. Please review this section of your contract carefully. For a complete listing of medications that OMIP contracts cover, please request a Preferred Medication List from our Administering Insurer, Regence BlueCross BlueShield of Oregon, at 1-800-848-7280.

The following is a BRIEF list of the Prescription Medication Plan Exclusions. It's important to carefully read the contract for a complete description of coverage and exclusions and/or limitations.

- Contraceptives
- Fertility Medications
- Prescription Medications that the Federal Drug Administration (FDA) newly approves
- Non Prescription Medications
- Prescription Medications for Cosmetic Purposes
- Prescription Medications for Smoking Cessation
- Prescription Medications for Weight Loss, Treatment of Obesity and Morbid Obesity
- Prescription Medications With No Proven Therapeutic Indications.

Preauthorization

OMIP requires Preauthorization for certain services such as in-patient Hospital and Skilled Nursing Facility stays, Hospice Programs, Skilled Nursing Facility Care and Home Health Care. There are other medical services and supplies which must be preauthorized before OMIP will consider them for payment under the Contract.

Preauthorization and Prior Authorization means a determination by OMIP prior to the provision of services, for which we will provide reimbursement subject to contract language, limitations, exclusions, and eligibility. It also means we have determined that the proposed service or supply is Medically Necessary or a covered benefit based upon the information provided to us.

Services and supplies that require Preauthorization are described in the BENEFITS and CLAIMS ADMINISTRATION sections of the Contract.

Professional Providers and facilities with whom we have contracted will normally request Preauthorization for you or your Enrolled dependent(s). However, you are responsible for obtaining Preauthorization if the service or supply is to come from a non-contracting Professional Provider or Facility.

OMIP Preauthorizes reviews of nonemergency services within two business days. The authorization is binding if obtained within 30 days of the date services are rendered, provided your contract is still in force. It is a good idea to have your physician re-confirm the Preauthorization is still in effect within five days before the service. If you have not paid your OMIP premium as of the date of the service, we will not confirm the Preauthorization of the service.

We will not pay for any benefits for services if the premium has not been paid.

We will cover the preauthorized service or supply if you received it prior to termination of enrollment, under the following circumstances:

- 1) If you or your Enrolled dependent's coverage terminates within five business days of the preauthorized service or supply; and
- 2) if the service or supply is actually incurred within those five business days regardless of the termination date, unless we are aware the coverage is about to terminate; and
- 3) We disclose this information in our written Preauthorization.

If coverage for you or your enrolled dependents terminates later than five business days after the Preauthorization date, but before the end of 30 calendar days, we will not cover services you received after termination even if we have preauthorized them.

If coverage remains in effect for at least 30 calendar days after the Preauthorization, we will cover the preauthorized service or supply if you receive it within the 30 calendar days.

When counting the days described above, day one will begin on the day after we preauthorize the service or supply.

Services That Require Preauthorization

Below is a partial list of services that require Preauthorization. For a complete list, please see your specific Contract.

- All Inpatient Hospital Care
- All Transplants
- Any Skilled Nursing Care
- Certain Prescriptions (See Prescription Preauthorization in your Contract)
- Diagnostic or Surgical Procedures for Temporomandibular Joint (TMJ) Syndrome
- Growth Hormones
- Home Health Care
- Home Infusion Therapy
- Hospice Care

- Inpatient Mental Health and Chemical Dependency Benefits (Call 1-800-824-8563)
- Purchase of Durable Medical Equipment in excess of \$5,000.00
- Rental of Durable Medical Equipment in excess of \$500.00
- Skilled Nursing Facility Care
- Special Facility Care — Ambulatory Surgery Center or Birthing Center
- Treatment of children under age 19 for Gender Identity disorders

Utilization Review

Utilization review is a set of formal procedures the Administering Insurer uses to reduce medical costs and monitor medical care. Utilization review procedures are used across a wide range of services, from hospital stays to medical treatment for specific medical conditions.

A licensed medical doctor (M.D.) or a doctor of osteopathic medicine (D.O.) determines whether services are medically necessary or appropriate. You have the right to a timely review with a peer review committee or medical consultant for denials of coverage based on medical necessity or appropriateness.

If you have any questions about the Administering Insurer's utilization review policies, call the Customer Service department at 1-800-848-7280. A representative will explain utilization review policies for specific diseases or conditions. Information that is considered proprietary or confidential in nature might not be disclosed to you.

Case Management

Case management is a program to provide early detection and intervention in cases of serious illness or injury that have the potential for major continuing claims expense. The Administering Insurer will identify appropriate cases, evaluate recommended treatment plans and propose appropriate alternative benefits.

A physician will make all final recommendations regarding the necessity of care, appropriateness of services or the site at which the services are provided. The recommendations will include appropriate consultations with medical and/or mental health specialists.

Alternative Services

Alternative benefits are services or supplies that are not otherwise benefits of the contract, but which we determine are medically necessary and cost effective for particular cases. We will not pay for alternative benefits until we have received specific written approval by you or your legal representative. The fact that we agree to pay alternative benefits for a member shall not obligate us to pay such benefits for other members, nor shall it obligate us to pay continued or additional alternative benefits for the same member.

Claims Processing

Medical Claims

Present your health insurance identification card to the provider's office staff at the time you receive services. In most cases, the hospital or other medical provider will bill OMIP directly through the Administering Insurer. The provider will bill you for charges that your contract does not cover or for the charges that are your responsibility under the plan.

If the provider cannot bill OMIP directly, you will need to make arrangements to pay the charges yourself.

It is your responsibility to request reimbursement from the Administering Insurer for these expenses. To do this, you should follow the following procedure:

- Ask the provider for an itemized statement of services that includes the charges, diagnosis and procedure codes as well as the name of the provider and the patient and the date the services were rendered.
- Write your identification and group numbers clearly on the statement. You can find those numbers on your health insurance identification card.
- Make a copy of all the paperwork for your records.
- Send the original statement or billing to:

Oregon Medical Insurance Pool
c/o Regence BCBSO MS 5K
PO Box 1271
Portland, OR 97207-1271

The Administering Insurer will send you a Claims Processing Report after you have submitted your claim information. The report will detail the amount that was billed, the amount that was paid, the amount that was reduced because of using a preferred provider or facility and any amount still owed the provider. Payments may be made directly to the provider, to the provider and you jointly, or to you alone.

Prescription Claims

The Administering Insurer contracts with a prescription drug vendor to administer the prescription medication program. You must present your identification card to a participating pharmacy listed in the pharmacy directory so that the pharmacy can submit your prescription claim electronically. You must submit paper claims for prescriptions filled at nonparticipating pharmacies. Contact the Administering Insurer Customer Service department at 1-800-848-7280 for questions, a pharmacy directory, preferred medication list, or a prescription claim form.

Prescription medication must be medically necessary for diagnosis and/or treatment of an illness or injury, and must be the result of a prescription order. Any balances that exceed maximum amount payable under the prescription benefit are not eligible for payment under any other provisions of the contract.

The amount you pay depends on whether your medication is considered a generic medication, preferred name brand medication, or a nonpreferred name brand medication. You will pay the least amount if you utilize generic medications. You will pay the highest amount if you utilize non-preferred brand name medications.

For a complete listing of medications and how they are paid, you may access a Preferred Medication List from our Administering Insurer, Regence BlueCross BlueShield of Oregon at 1-800-848-7280.

The pharmacy benefit limits you to a 34-day supply at a time and allows refills once you have used 75 percent of the prescription. The pharmacy program also includes a medication dispensing limit, a utilization review program and a pre-authorization requirement for certain high cost prescription medications. You may contact the Administering Insurer's Customer Service department at 1-800-848-7280 for additional information or to arrange for an additional supply for special circumstances such as a vacation supply.

OMIP offers a mail order prescription service, that is also limited to a 34-day supply at a time.

You must submit all claims within one year from the time you incurred the expense.

Grievance, Appeal, External Review

The Administering Insurer has a procedure to keep lines of communication open and to provide an opportunity for mutual understanding among our members, providers, and us. Grievance and appeals are promptly directed to appropriate individuals so that we can take action quickly, and on an informal basis if possible.

If you believe that a policy, action, or decision is incorrect, you have the right to contact the Administering Insurer's Customer Service department. If they cannot resolve your concern to your satisfaction, you may file a formal written grievance. The Customer Service department will provide you with the appropriate form to submit.

You will have 180 days from the date of a claim denial or adverse action to file an initial grievance. You may also file a grievance by telephone or get assistance filing a grievance by calling the Customer Service department.

If you are unhappy with the grievance decision, you have the right to an appeal. You must file Appeals within 180 days of the date of the notice of a grievance determination. You have the right to appear, designate a representative, or participate in the review by telephone call at the initial appeal.

The Grievance and Appeal process offers three levels of review, and in some cases four levels of review. A different committee of people, who were not involved in the original decision, will review each appeal. A licensed physician will make determinations of medical necessity and appropriateness of service.

Grievances & Appeals should be sent to:

Regence BlueCross BlueShield of Oregon
Oregon Medical Insurance Pool
Customer Service Department
Grievance and Appeals Coordinator
Mail Station C-7A
P.O. Box 1271
Portland, OR 97207-1271

The Administering Insurer will acknowledge its receipt of grievances and appeals within five business days. A decision will be made within 30 calendar days of receipt of the grievance or appeal. However, you will receive a notice if additional time or information is needed to review your initial grievance or appeal. In such cases, a decision will be made within 45 days. These time frames do not apply when a member does not reasonably cooperate, or if circumstances beyond our control, or the member's control, prevent complying with the standards.

If you are not satisfied with the first and second level appeal determination and the dispute involves medical necessity, experimental or investigational procedures or need for continuity of care, you may request to have an external review. You must send OMIP a written request for an external review within 180 days after the date of the notice of an appeal determination. An independent external review organization assigned by the State of Oregon's Insurance Division will review your appeal and report its decision within 30 days (3 days for expedited reviews). **OMIP will be bound by the decision of the External Review Organization only in those decisions relating to medical necessity, experimental or investigational procedures, or need for continuity of care.**

If you have concerns regarding a decision, action, or statement by your provider, we encourage you to discuss these concerns with your provider. If you remain dissatisfied after your provider discussion, you may also file a formal written grievance with the Customer Service department.

Filing a Complaint with the Oregon Insurance Division

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

by calling:
(503) 947-7984

or by **writing** to:
Oregon Insurance Division
Consumer Assistance Unit
350 Winter Street NE, Room 440-2
Salem, OR 97310

or through the **internet** at:
<http://www.oregoninsurance.org>

The information stated above is subject to change upon notice from the Director.

Subscriber Information and Practices

The 1989 Oregon Legislature passed a law giving everyone certain rights regarding information collected about them in connection with insurance. The information below summarizes OMIP's Administering Insurer's practices and describes how you can exercise your rights.

Collection and disclosure of information

The Administering Insurer must obtain information about any other coverage you may have or had. The Administering Insurer must also know your medical history as well as that of your dependents to determine your eligibility for the program and to process claims. This information is collected from the application form, other carriers, medical providers and health care facilities.

The Administering Insurer treats this information confidentially and uses it only in connection with the application process, claims and any appeal decisions. The Administering Insurer will only disclose information to authorized persons in accordance to all applicable laws and as necessary to perform the functions of the Oregon Medical Insurance Pool.

Consent to Examination of Medical Records

All subscribers or enrollees, by signing the Authorization for Use and Disclosure of Protected Health Information that comes with the application, are deemed to have consented to the examination of medical records for purposes of utilization review, quality assurance and peer review by the insurer or its designee.

Coverage decisions

The Administering Insurer will provide you with a reason for denying eligibility if it finds that it is unable to provide you with the requested coverage.

Access to information

You may review available personal information by sending a signed, written request to:

Oregon Medical Insurance Pool
c/o Regence BCBSO MS E10K
PO Box 1271
Portland, OR 97207-1271

Your right to review personal information does not extend to data that relates to a claim or a civil or criminal proceeding against you.

Requesting changes

You may request that the Administering Insurer correct, amend or delete personal information that you believe to be incorrect or irrelevant by sending a signed written request.

The Administering Insurer will notify you of its decision concerning your change request. If the Administering Insurer decides not to honor the request, you may submit a brief statement of the desired change. This statement becomes a part of the record and is shown to anyone reviewing the record.

Questions about the Administering Insurer's information practices or rights under this provision may be directed to:

Oregon Medical Insurance Pool
c/o Regence BCBSO MS 5K
PO Box 1271
Portland, OR 97207-1271

Glossary

Administering Insurer means the insurance company selected in keeping with ORS 735.620 to operate OMIP on behalf of the OMIP Board. Regence BlueCross BlueShield of Oregon is the Administering Insurer selected by the OMIP Board through a competitive bidding process.

Alternative Benefits means services or supplies which are not otherwise benefits of this Contract, but which we believe to be Medically Necessary and cost effective.

Amount Payable means the amount that this Contract covers and any Co-insurance or other amount that you or your Enrolled Dependent must pay.

Appeal means a request to have an adverse Grievance decision reviewed.

Approved Hospice means a private or public Hospice agency or organization approved by Medicare or accredited by the Joint Commission on Accreditation of Hospitals.

Benefit Plan or Medical Benefit Plan means any of the health coverage plans that OMIP offers to enrollees.

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

Claim means a request for payment under the terms of an insurance Contract.

Claims Processing Report means a form used by OMIP to report its actions after you have sent a payment Claim on your insurance. This is also referred to as an Explanation of Benefits.

Co-insurance means the amount of payment for sharing of the medical services that you owe after you have met the deductible payment amount.

Compound Drug means two or more medications that a pharmacist mixes together. In order to be covered, compound medications must contain, in therapeutic amount, either one

federal legend medication or one state restricted medication. Coinsurance amounts are assessed on each covered prescription medication Claim.

Contract means the benefit plan contract, all attached schedules, signature sheets, exhibits, supplements, addenda, attachments, amendments, endorsements, applications, riders, and any information submitted as part of an application for the OMIP Contract or for membership in OMIP.

Contract Holder means the person in whose name we issue the contract.

Contracting Agency means any of the following with whom the Administering Insurer has contracted to provide services and supplies under this Contract: Home Health Care Agency; Home Infusion Therapy Agency; Hospice Care Program.

Contracting Durable Medical Equipment Supplier means a supplier of Durable Medical Equipment that has contracted to provide services and supplies to the Member under this Contract.

Copayment means a fixed amount that you pay for a medical service such as an office or emergency room visit.

Cosmetic means services and supplies that are applied to normal structures of the body primarily for the purposes of improving or changing appearance or enhancing self-esteem.

Covered Expenses means the amounts that this Contract pays for Covered Services.

Covered Outpatient Prescription Medication Expense For Participating pharmacies this means the amount that they have agreed to accept contractually. For Nonparticipating pharmacies, Covered Prescription Drug Expense means the pharmacy's retail price for a prescription medication or the amount the Pharmacy Benefit Manager would have paid a Participating pharmacy for the same prescription medication, whichever is less.

Creditable Coverage means prior health care coverage as defined in 42 U.S.C. 300gg as amended and in effect on July 1, 1997.

Dependent means the Contract Holder's spouse, child, step-child, or adopted child that is enrolled in OMIP.

Deductible means an annual amount that an enrollee must pay out-of-pocket each calendar year before the Plan begins to pay for benefits for that Enrollee.

Durable Medical Equipment means an item that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful to a person in the absence of Illness and/or Injury and is appropriate for use in the member's home. Examples include oxygen equipment and wheelchairs. Covered durable medical equipment must be medically necessary and may not serve solely as a comfort or convenience item.

Eligibility means the Medical or Portability requirements that individuals must meet to qualify for the OMIP program. See When Coverage Begins; Residency Requirements; Eligibility for Enrollment; and If We Refuse to Renew sections.

Emergency Medical Condition or **Medical Emergency** means a medical condition with symptoms of sufficient severity for which a prudent layperson who possesses an average knowledge of health and medicine, would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

Emergency Medical Screening Exam means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

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

Enrolled Dependent means a Dependent of the Contract Holder whose application is accepted by OMIP and who is Enrolled under an OMIP Contract.

Enrollee or **Member** means an individual who is enrolled in one of the OMIP medical benefit plans.

Exclusions means specified conditions or circumstances, listed in a Contract, for which OMIP pays no benefits. Exclusions may apply to services that are Medically Necessary.

External Review is a review performed by a state contracted independent review organization when an Enrollee has exhausted all internal Grievance procedures and wants the opinion of a medical professional who is separate from the patient's health insurance company. External Review applies only to disputes about medical necessity, experimental or investigational treatment, or need for continuity of care.

Generic Medication means prescription medication that is an equivalent medication to the brand name medication, is marketed and sold by more than one source, and is listed in widely accepted references as a generic medication based on manufacturer and price. Equivalent medication means the Food and Drug Administration (FDA) ensures that the generic medication must have the same active ingredient, meet the same manufacturing and testing standards, and be absorbed into the blood stream at the same rate and same total amount as the brand name medication. These requirements ensure that the generic has the same effectiveness as the brand name medication.

Grievance means a written complaint submitted to OMIP's Administering Insurer by or on behalf of a Member regarding the:

- (a) availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
- (b) claims payment, handling or reimbursement for health care services; or
- (c) matters pertaining to the contractual relationship between a Member and OMIP.

Homebound means that the condition of the patient is such that there exists a normal inability to leave home. If the patient does leave home, the absences must be infrequent, or short duration and mainly for receiving medical treatment.

Home Health Aide means an employee of an Approved Hospice who provides intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist or speech therapist.

Home Health Care means services and supplies that a home health agency provides to a home bound patient.

Hospice means a program designed to provide comfort and supportive services to Terminally Ill patients and their families.

Hospice Treatment Plan means a written plan of care established and periodically reviewed by the patient's attending physician. The physician must certify in the plan that the patient is Terminally Ill. The plan must describe the services and supplies for Medically Necessary or Palliative Care to be provided by the Approved Hospice.

Hospital means a facility that provides diagnostic and treatment services for inpatient surgical and medical care of persons who are injured or ill. It must be licensed under applicable laws as a general Hospital. Its services must be under the supervision of a staff of physicians and must include 24-hour-a-day nursing service by registered nurses. Facilities that are primarily for rest, the aged or convalescent are not considered hospitals, and neither are institutions and facilities operated by agencies of the state or federal government.

Illness means a physical Illness or mental Illness which results in a Covered Expense. Physical Illness is a disease or bodily disorder. Mental Illness is an Axis I diagnosis listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, except those specifically excluded in the BENEFIT EXCLUSIONS section of the Contract.

In-Network or Preferred Professional Provider means a Professional Provider who has a Preferred Provider Plan in effect with Regence BlueCross BlueShield of Oregon.

Use of an **In-Network Provider** is required to receive the maximum benefit level of this Plan. If you seek care from a Non-Preferred Provider (someone who is not part of the network of Providers), benefits payable under the Plan will be less than they would be for an In-Network Provider after the annual Deductible.

Injury means a personal bodily Injury to you or your Enrolled Dependent caused directly by external, violent, and accidental means, and independent of all other causes.

Maximum Out-of-pocket means the maximum amount an individual will incur in a calendar year before the plan begins paying at 100% for eligible medical expenses. The OMIP Benefit Plans have a separate and higher maximum out-of-pocket expense for out-of-network providers compared to in-network providers.

Medical Emergency means a sudden and unexpected Illness or Injury which requires immediate attention.

Medically Necessary means those services and supplies that are required for diagnosis or treatment of Illness or Injury and which, in the reasonable judgment of OMIP, are: appropriate by treatment setting and level of care, in amount, duration and frequency of care; consistent with the symptoms or diagnosis and treatment of you or your Enrolled Dependent's condition; appropriate with regard to widely accepted standards of good medical practice; not primarily for the convenience of you or your Dependents or a Provider of services or supplies; and the least costly of the treatment settings, alternative supplies or levels of service which can be safely provided to the patient. This means, for example, that care rendered in a Hospital inpatient setting or by a nurse in the patient's home is not Medically Necessary if it could have been provided in a less expensive setting, such as a Skilled Nursing Facility, without harm to the patient.

The fact that a Professional Provider furnished, prescribed, ordered, recommended, or approved a service or supply does not, of itself, make the service or supply Medically Necessary. OMIP will consult with medical professional consultants, peer review committees, or other appropriate sources for recommendations regarding the necessity of the services received by members.

Medically Necessary care excludes care that is primarily custodial care. Custodial care helps a person conduct activities of daily living and can be provided by people without medical or paramedical skills, for example, help in bathing, eating, dressing or getting in or out of bed. Custodial care also includes care that is primarily for the purpose of separating a patient from others or preventing a patient from harming himself or herself. While a condition must be Medically Necessary for benefits to be paid, a Medically Necessary condition can be excluded from benefits provided by this Contract.

Member or enrollee means an individual who is enrolled in one of the OMIP medical benefit plans.

Morbid Obesity means a condition in which a person has a body mass index of 40.0 kg/m² or more.

Obesity means a condition in which a person has a body mass index of at least 30.0 kg/m² but less than 40.0 kg/m².

OMIP means the Oregon Medical Insurance Pool.

Out-of-Network or Nonpreferred or Nonparticipating Facility or Professional Provider is a Hospital, Skilled Nursing Facility or Special Facility or Professional Provider that does **not** have a Preferred Provider Plan in effect with the Administering Insurer. If you receive care from such a Facility or Professional Provider, you may be liable for charges in addition to the Deductible and Co-insurance required by your Plan.

Palliative Care means care primarily for the relief or control of distressing symptoms, not cure.

Participating Facility means a Hospital, Skilled Nursing Facility or Special Facility that has a Participating Provider in effect with the Administering Insurer.

Participating Pharmacy means a pharmacy that has signed a Participating pharmacy agreement with the Administering Insurer and that submits claims electronically on-line at the time of dispensing.

Participating Professional Provider means a Professional Provider who has a Provider Contract in effect with the Administering Insurer.

Participating Provider Contract means a contract between the Administering Insurer and Professional Providers or Hospitals, Skilled Nursing Facilities or Special Facility to participate in one or more provider panels at payment rates specified in the contract.

Pharmacist means an individual licensed to dispense prescription medication and counsel a patient about how the medication works and its possible adverse effects.

Pharmacy means any duly licensed outlet in which prescription medications are regularly compounded and dispensed.

Portability Coverage or Portability Plan means that ongoing health insurance is available to you if you were Enrolled in an employer-sponsored group health Plan for at least six months immediately prior to that insurance coverage ending. Normally, you receive the ongoing insurance coverage from the insurer that provides coverage to your previous employer. The particular health Plan you receive is called Portability Coverage or Portability Plan. If your former employer's insurer cannot provide you Portability Coverage in Oregon, you can purchase it from OMIP.

Preauthorization/Prior Authorization means a determination by OMIP prior to provision of services that we will provide reimbursement for the services. Preauthorization does not include referral approval for evaluation and management services between Providers.

Pre-existing Condition means a condition for which medical advice, diagnosis, care, or treatment was recommended or received in the six-months before coverage began. For purposes of the six month waiting period, the term pregnancy shall include, pre and postnatal care, miscarriage, abortion, delivery (vaginal or surgical), and complication of pregnancy, including, but not limited to: intra-abdominal surgical procedures; placenta abruptio and placenta previa; acute exacerbations or heart conditions and or diabetes; toxemias.

Preferred Facility means a Hospital, Skilled Nursing Facility or Special Facility that has an effective Preferred Provider Plan Contract with Regence BlueCross BlueShield of Oregon.

Prescription Medication means medications and biologicals that relate directly to the treatment of an Illness or Injury and that can legally be dispensed only with a prescription order. By law, they must bear the legend: "Caution – federal law prohibits dispensing without prescription." They also include medications that the Administering Insurer has designated as Prescription medications. For purposes of the OMIP outpatient prescription medication benefit, prescription medications also include covered insulin and diabetic supplies, self-injectable medications, and compound medications. OMIP requires a prescription order for insulin and diabetic supplies.

Prescription Order means a written prescription or oral request for prescription medications issued by a Professional Provider who is licensed to prescribe medications.

Professional Provider or **Provider** means any of the following, for Medically Necessary services which are within the scope of the provider's state license or registry:

- A **physician** (doctor of medicine or osteopathy);
- A **podiatrist**;
- A **pharmacist**;

A **dentist** (doctor of medical dentistry or doctor of dental surgery), but only for treatment of surgery that does not involve repair, removal or replacement of teeth, gums or supporting tissue;

A **psychologist**;

An Oregon-registered **clinical social worker**;

A **certified nurse practitioner**;

A **registered nurse** or **licensed practical nurse**, but only for services rendered upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill a patient;

A **physician assistant**;

A **registered physical, occupational, speech or audiological therapist**.

The term "**Professional Provider**" does not include any other class of Provider not named previously, and no benefit of the Contract will be paid for their services.

Reconstructive means services, procedures, and surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

Residential Care Facility means an institution that furnishes food and shelter to adult persons unrelated to the proprietor and that provides care or services beyond food.

Self-Injectable Drugs means outpatient injectable prescription medications intended for self-administration and approved by the Administering Insurer for self-injection.

Skilled Nursing Facility means a Facility licensed under applicable laws to provide inpatient care under the supervision of a medical staff or a medical director. It must provide continuous 24-hour-a-day nursing service supervised by registered nurses.

Special Facility means either an ambulatory surgical Facility or a birthing center.

Spell of Illness means a period of consecutive days beginning with the first day not part of a previous Spell of Illness on which you are admitted to a Hospital, and ending at the close of the first 60-day period thereafter during which you have neither been a Hospital inpatient nor been confined in any other type of Facility.

Terminally Ill means that the patient's condition has reached a point where recovery can no longer be expected and he or she is facing imminent death.

Transplant means a procedure or a series of procedures by which an organ or tissue is either: removed from the body of one person (called a donor) and implanted in the body of another person (called a recipient); or removed from and replaced in the same person's body (called a self-donor). In treatment of cancer, the term transplant includes any chemotherapy and related course of treatment which the transplant supports.

Usual and Customary or Reasonable Charge means:

- **Usual** — not more than the provider's, dispenser's or vendor's Usual charge for a given service or supply; and
- **Customary** — an amount which falls within the range of Usual charges for the service or supply billed by most Professional Providers, dispensers or vendors of the same or similar service or supply in our service area; or
- **Reasonable** — an amount which is Usual and Customary or which, because of unusual circumstances, inadequacy of data or other reasons, is established by the Administering Insurer on an individual basis.

Well-Baby Care means regular check-ups for your Enrolled child up to age two. These well visits help keep your baby healthy.

Well-Child Care means routine (once every two years) check-ups for your Enrolled child age two to eighteen.

Notice Of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

The Oregon Medical Insurance Pool (OMIP) is administered by Regence BlueCross BlueShield of Oregon. We, at OMIP and at Regence BlueCross BlueShield of Oregon, know you value your privacy. That is why OMIP is committed to the confidentiality and security of your personal information. OMIP maintains physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of your personal information.

We collect personal information, such as your name, contact information, and health information, from you, your health care providers, and other insurers that provide you coverage. OMIP is required by law to maintain the privacy of this information and to explain our legal duties and privacy practices. OMIP provides the protections and apply the practices described in this notice to all personal information that OMIP maintains, including to personal information of former members who are no longer covered by us. OMIP hopes this notice will clarify our responsibilities to you and give you an understanding of your rights. OMIP abides by the notice that is currently in effect. This notice is in effect as of April 1, 2006.

Your Rights

Inspection and Copies. You have the right to request an inspection or copies of protected health information that OMIP maintains about you in a “designated record set” except psychotherapy notes and information that OMIP compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding. A “designated record set” is a group of records that is used to administer your health benefits, including enrollment information and claims. OMIP may limit the information that you can inspect or copy if OMIP has reason to believe that is necessary to protect you or another person from harm. If OMIP limits your right to inspect or copy, you can ask for a review of that decision.

Amendment. If you believe that protected health information OMIP maintains about you in a designated record set is inaccurate or incomplete, you have the right to request an amendment to correct or complete the information. You must submit your request in writing and explain the reason for the amendment. If the amendment is made, OMIP will make reasonable efforts to inform others, including people you identify, that the information has been amended and OMIP will use our best efforts to include the amendment with any future disclosure. OMIP may decline to amend information under certain circumstances. This is likely to occur if OMIP did not create the original record. If OMIP declines to amend the information, you have the right to submit a statement of disagreement. You should know that OMIP is allowed to attach a rebuttal statement in response to your statement of disagreement.

Notice. You have the right to receive a paper copy of this notice upon request.

Accounting. You have the right to request a list of certain disclosures of protected health information. The list will not include disclosures made for treatment, payment, or health care operations. It also will not include disclosures made pursuant to an authorization, made prior to six years before the date of the request, incidental disclosures, disclosures made for national security or intelligence, disclosures made to a correctional facility or disclosures made prior to April 14, 2003. The list will include the date of any accountable disclosure, to whom that disclosure was made, a brief description of the information disclosed, and the purpose for that disclosure (provided this information is known to us). OMIP will supply this list free of charge once a year at your request. If you request an accounting more than once in a 12-month period, OMIP may charge a reasonable fee.

Special Handling. You have the right to request restrictions on our use or disclosure of protected health information in addition to the restrictions imposed by law. OMIP is not required to agree to your request and OMIP may be unable to do so. If OMIP does agree, we will comply with your request except in the case of emergency. You also have the right to request that OMIP communicates with you in confidence. OMIP will make every effort to accommodate your request if it is reasonable and you provide an alternate means to communicate. You should know that redirecting communication may not prevent others on your policy from discovering that you sought medical care. Accumulated deductibles and co-payment information may reveal that you obtained services. In addition, historic claims reports may include services which were obtained during the time communications were redirected.

Complaints. You have the right to submit a complaint if you believe OMIP has violated your privacy rights. To submit a complaint, write to: The Regence Group, Privacy Office, P.O. Box 1071, Mailstop E12B, Portland, OR 97207 or call our Customer Service Department at the phone number provided at the end of this notice. You also have the right to submit a complaint to the Secretary of the U.S. Department of Public Health & Human Services. Be assured that OMIP will not retaliate against you for submitting a complaint.

Permitted Uses and Disclosures

To administer health benefits, OMIP collects, use and discloses protected health information for a variety of purposes:

Treatment. OMIP may disclose protected health information to a health care provider in order for the provider to treat you. OMIP may also use or disclose protected health information in an effort to provide preventive health, early detection, and case management programs.

Payment. OMIP may use or disclose protected health information for payment purposes, including to adjudicate claims, issue Explanation of Benefits, or coordinate benefits with other entities responsible for paying your claims.

Health Care Operations. OMIP may use or disclose protected health information to facilitate operations, including underwriting, customer service, and detection or prevention of fraud or abuse.

Business Associates. Occasionally, OMIP contracts with business associates to perform insurance-related functions on our behalf. OMIP may disclose protected health information to these business associates in order to allow them to perform these functions. They also may collect, use or disclose protected health information on our behalf. OMIP contractually obligates our business associates to provide the same privacy protections that OMIP provides.

Plan Sponsors and Group Health Plans. If you are enrolled in a group health plan, OMIP may disclose protected health information to the group health plan or plan sponsor to facilitate administration of the plan. For example, OMIP supply enrollment lists so that premiums can be paid appropriately.

As Permitted or Required by Law. OMIP uses or discloses protected health information as permitted or required by law. For example, some laws require that OMIP discloses protected health information to your personal representatives or to certain government agencies.

Public Health Activities. OMIP may disclose protected health information for public health activities. These activities include prevention and control of disease, activities performed by coroners, activities performed by organ or tissue donation and transplantation services, activities performed by the Food and Drug Administration, medical research, research intended to improve the health care system, activities necessary to avert a serious threat to the health or safety of a person, and activities relating to workers' compensation benefits.

Health Oversight. OMIP may disclose protected health information to health oversight agencies. These agencies are authorized by law to conduct audits; perform inspections and investigations; license health care providers, insurers and facilities; and to enforce regulatory requirements. These agencies include: State Commissioner of Insurance, State Board of Medicine, and the U.S. Department of Labor.

Health Related Services. OMIP may use protected health information to provide information about treatment alternatives or other health related benefits or services that may be of interest to you. This may include enhancements to your health plan and health related products or services available only to health plan members that add value to, but are not a part of, your benefit plan.

Legal Proceedings. OMIP may disclose protected health information in the course of a judicial or administrative proceeding, and in response to a court order, subpoena, discovery request, or other lawful process.

Law Enforcement. OMIP may disclose protected health information to law enforcement officials in response to an administrative subpoena, a warrant, or an administrative request intended to identify or locate a suspect, victim, or witness. OMIP also may disclose protected health information for the purpose of reporting a crime on our premises.

Military and National Security. OMIP may disclose protected health information to armed forces personnel for military activities and to authorized federal officials for national security and intelligence activities.

Correctional Institution. If you are an inmate, OMIP may disclose protected health information to your correctional institution for treatment purposes or to ensure the safety of yourself and others.

Marketing. OMIP does not use or disclose protected health information for marketing purposes without your authorization. However, OMIP may communicate with you face-to-face about products or services that may interest you or OMIP may send you a promotional gift of nominal value.

Others Involved in Your Health Care. OMIP may disclose protected health information to personal representatives such as appointed guardians, executors, conservators, and in many cases parents of minor children, in addition to attorneys in fact when a valid power of attorney exists. Also, if you give us verbal permission or if your permission can be implied (for example, while you are unconscious during an emergency), OMIP may disclose protected health information to family members or others who call on your behalf. This permission is valid only for a limited time. If you want to authorize ongoing disclosures to family members or friends, you must submit written authorization.

Authorizations. You may give us written authorization to use protected health information or disclose protected health information about yourself to anyone for any purpose. An authorization remains valid for two years unless the authorization states otherwise or you revoke it. You may revoke an authorization at any time by submitting a written revocation, but a revocation will not affect any use or disclosure permitted by the authorization while it was in effect. An authorization is required for us to use or disclose your protected health information for purposes other than those described in this notice.

Future Changes

We reserve the right to change our privacy practices and this notice at any time without advance notice. If OMIP makes a material change to our privacy practices, OMIP will send a new, updated notice. The new notice will apply to all protected health information in our possession, including any information created or received before the revised notice became effective.

Contacting Us

You may reach us during regular business hours by calling our Customer Service department at (503) 225-6620 or toll-free at (800) 848-7280. For more information about this notice or to file a written privacy-related complaint, you may write to: The Regence Group, Privacy Official, P.O. Box 1071, MS E12B, Portland, OR 97207.

Notes

Notes

OMIP
We're here for you!

Oregon Medical Insurance Pool
250 Church Street SE, Suite 200
Salem, Oregon 97301-3921
1-800-848-7280