GROUP VISION PLAN

OEBB

Vision Plan 3

Effective Date: October 1, 2011

www.odscompanies.com/oebb

Member handbooks and more are available at www.odscompanies.com/oebb

Insurance products provided by ODS Health Plan, Inc.

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SECTION 1 WELCOME

ODS is pleased to have been chosen by the participating organization as its vision benefit plan. This handbook is designed to provide members with important information about the Plan's benefits, limitations and procedures.

Members may direct their questions to one of the numbers listed below or access tools and resources on ODS' personalized member website, myODS, at www.odscompanies.com/oebb. myODS is available 24 hours a day, 7 days a week, allowing members to access plan information whenever it's convenient.

ODS
P.O. Box 40384
Portland, Oregon 97240

Medical Customer Service Department

Portland	503-265-2909
Toll-Free	866-923-0409
Relay Service	711 (for the hearing and speech impaired)
En Español	503-265-2961
Llamado Gratis	888-786-7461

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

Note: This handbook may be changed or replaced at any time, by OEBB or ODS, without the consent of any member. The most current handbook is available on myODS, accessed through the ODS website. All plan provisions are governed by OEBB's policy with ODS. This handbook may not contain every plan provision.

SECTION 2 GENERAL PLAN INFORMATION

2.1 **Plan Name:**
OEBB Benefit Plan

2.2 **Plan Sponsor:**
Oregon Educators Benefit Board

2.3 **Type of Plan:** Group Vision Benefit Plan.

2.4 **Plan Year:** October 1st through September 30th.

2.5 **Plan Administrator:** The Plan Sponsor is the administrator of the Plan.

2.6 **Funding Medium and Type of Plan Administration:** The Plan is fully insured. Benefits are provided under a group insurance policy entered into between Oregon Educators Benefit Board and ODS Health Plan, Inc. Claims for benefits are sent to ODS. ODS, not Oregon Educators Benefit Board, is responsible for paying claims.

The Plan is funded by the participating organization and/or subscriber contributions. The amount of total contributions is determined from time to time by the use of sound actuarial and underwriting methods. The portion a subscriber pays toward the total contribution is determined by the participating organization.

2.7 **Provider of Benefits:** Benefits are provided in accordance with a policy of insurance between ODS Health Plan, Inc. and Oregon Educators Benefit Board.

2.8 **Named Fiduciary:** Oregon Educators Benefit Board.

SECTION 3 MEMBER RESOURCES

ODS Website (log in to myODS)
www.odscompanies.com/oebb

Medical Customer Service Department
Portland 503-265-2909; Toll-Free 866-923-0409; En Español 503-265-2961; Llamado gratis 888-786-7461

Telecommunications Relay Service for the hearing impaired
711

3.1 MEMBERSHIP CARD

After enrolling, members will receive identification (ID) cards which will include the group and identification numbers, and the applicable network name. Members will need to present their cards each time they receive services from in-network vision providers.

Members may contact ODS' Medical Customer Service Department or visit myODS for replacement of a lost ID card.

During the first appointment, members should tell their vision provider they have vision benefits through ODS. The member will need to provide their subscriber identification number and ODS Group number. These numbers are located on the I.D. card.

3.2 NETWORKS

Vision benefits can be maximized by using an in-network vision provider. Members may choose an in-network vision provider from the network medical directory, which is available on myODS under "Find Care" or by contacting ODS' Customer Service Department for assistance.

For all members:
ODS Plus Network for residents in Oregon, Idaho, southern Washington and northern California

For subscribers, eligible spouse, domestic partner, or child(ren) if subscribers reside outside the ODS Plus Network service area:
First Choice Health (FCH) for residents in Washington (excluding southwest Washington)
Health InfoNet (HIN) for residents in Montana
Private Healthcare Systems (PHCS) for residents in all other states.

SECTION 4 DEFINITIONS

The following are definitions of some important terms used in this handbook. **Terms used but not otherwise defined in this handbook shall have the same meaning as those terms in the OEBB Member Benefits Guide and the OEBB Administrative Rules.**

Claim Determination period means the plan year or portion thereof commencing October 1 of any calendar year and ending September 30 of the subsequent calendar year.

Coinsurance means the percentages of covered expenses to be paid by a member.

Copay or Copayment means the fixed dollar amounts to be paid by a member to a vision provider when receiving a covered service.

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

Enroll means to become covered for benefits under the Plan (that is, when coverage becomes effective) without regard to when the person may have completed or filed any forms that are required in order to become covered. For this purpose, a person who has vision coverage is enrolled in the Plan regardless of whether the person elects coverage, the person is a spouse, domestic partner or child who becomes covered as a result of an election by a subscriber, or the person becomes covered without an election.

Enrolled Dependent means a subscriber's eligible spouse, domestic partner or child(ren) whose application has been accepted by OEBB and who is enrolled in the Plan.

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

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

In-Network refers to vision providers that are contracted under ODS to provide benefits to members.

Medically Necessary means those services and supplies that are required for diagnosis or treatment of a condition and which are:

a. Appropriate and consistent with the symptoms or diagnosis of the member's condition;
b. Established as the standard treatment by the medical community in the service area in which they are received;
c. Not primarily for the convenience of the member or a vision provider; and;
d. The least costly of the alternative supplies or levels of service that can be safely provided to the member.

Note:
The fact that a provider prescribes, orders, recommends, or approves a service or supply does not, of itself, make the service medically necessary or a covered service. Further information regarding medical necessity can be found in General Exclusions (see section 6).

Member means a subscriber, spouse, domestic partner or child of a subscriber or an individual otherwise eligible for the Plan who has enrolled for coverage under the terms of the Plan.

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

Network means a group of vision providers who contract to provide vision care to members. Such groups are called Preferred Provider Organizations (PPOs), and provide in-network services in their specific service areas. Vision benefits are maximized when an in-network provider is used.

ODS refers to ODS Health Plan, Inc.

Out-of-Network refers to vision providers that have not contracted under ODS to provide benefits to members.

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

The **Plan** is the vision benefit plan sponsored by OEBB and insured under the terms of the policy between OEBB and ODS.

Plan Year means the 12-month period or portion thereof commencing October 1st of any calendar year and ending September 30th of the subsequent calendar year

The **Policy** is the agreement between OEBB and ODS for insuring the vision benefit plan sponsored by OEBB. This handbook is a part of the policy.

Service Area is the geographical area where the in-network providers provide their services.

Subscriber means an eligible employee or former employee who is enrolled in the Plan.

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

a. A licensed ophthalmologist;
b. A licensed optician; (this provider does not apply to exam only benefit option)
c. A licensed optometrist;
d. A hardware provider. (this provider does not apply to exam only benefit option)

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

SECTION 5 BENEFIT DESCRIPTION

The Plan pays up to a maximum of $450 every plan year. Routine eye exam and lenses are covered every plan year. Frames are covered every plan year for members under age 17 and every 2 plan years for members 17 years and older. **Late enrollees have a 12-month waiting period for lenses and frames, but are eligible for a routine eye exam (details for Late Enrollment see section 8.5).**

For an in-network provider, covered benefits are reimbursed at 100% of the provider's contracted fee. For an out-of-network provider, covered benefits are reimbursed at 100% of billed charges. Total reimbursements are limited to the plan maximum of $450.

5.1 COVERED PROVIDERS

Covered vision care must be prescribed by a licensed ophthalmologist or licensed optometrist. The Plan allows members to choose any licensed ophthalmologist, optician, optometrist, or hardware provider for services.

5.2 COVERED SERVICES AND SUPPLIES

5.2.1 Routine Eye Examination

One complete eye exam, including the charge for refraction, is covered.

5.2.2 Frames

Frames for corrective lenses are covered.

5.2.3 Lenses

Corrective lenses for either eyeglasses or contact lenses are covered.

Types of covered lenses:

a. Single vision;
b. Bifocal;
c. Trifocal;
d. Standard progressive;
e. Premium progressive;
f. Lenticular lenses;
g. Standard polycarbonate lenses;
h. Corrective contact lenses (disposable or conventional);
i. Oversized lenses (Single Vision, Bifocal, Trifocal, Standard Progressive and Premium Progressive Lenses); and
j. Tint, any color.

SECTION 6 EXCLUSIONS

In addition to the limitations and exclusions described elsewhere in the Plan, the following services, procedures and conditions are not covered, even if otherwise medically necessary, if they relate to a condition that is otherwise covered by the Plan, or if recommended, referred, or provided by a vision provider. In addition, any direct complication or consequence that arises from these exclusions will not be covered.

Benefits Not Stated
Services and supplies not specifically described in this handbook as covered expenses under the Plan are excluded.

Experimental or Investigational Procedures
Services and supplies are excluded that:

a. Are not rendered by a provider within the United States or by one that has not demonstrated medical proficiency in the rendering of the service or supplies;
b. Are not recognized by the medical community in the service area in which they are received;
c. Involve a treatment for which the approval of one or more government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered;
d. Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established; and
e. Are available in the United States only as part of clinical trial or research program for the illness or condition being treated.

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

Inmates
Services and supplies a member receives while in the custody of any state or federal law enforcement authorities or while in jail or prison are not covered.

Missed Appointments

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

Services Otherwise Available
This exclusion includes:

a. services and supplies for which payment could be obtained in whole or in part if a member had applied for payment under any city, county, state, or federal law, except for Medicaid coverage;
b. charges for services and supplies for which a member cannot be held liable because of an agreement between the vision provider rendering the service and another third party payer which has paid or is obligated to pay for such service or supply;
c. services and supplies for which no charge is made, or for which no charge is normally made in the absence of insurance; and
d. services or supplies a member could have received in a hospital or program operated by a government agency or authority. This exclusion does not apply to:

i. covered services rendered at any hospital owned or operated by the state of Oregon; or
ii. veterans of the armed forces, in which case covered services and supplies furnished by the Veterans' Administration of the United States that are not service-related are eligible for payment according to the terms of the Plan.

Services Provided By a Relative
The Plan will not reimburse services provided by members or their relatives. Relatives, for the purpose of this exclusion, would include a spouse or domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner.

Services Provided By Volunteer Workers

Service, War or Insurrection, Riot or Rebellion
The Plan does not cover services or supplies caused by or arising out of service in the armed forces of any country or the active participation in a war or insurrection, or the voluntary participation in a riot or rebellion.

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

Taxes

Third Party Liability Claims
Services and supplies for which a third party is or may be responsible are excluded to the extent of any recovery received from or on behalf of the third party. This includes benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to, or makes benefits available to, a member, whether or not such benefits are requested.(See section 9.3.2).

Treatment after Coverage Terminates
The Plan does not cover services or supplies that a member receives after coverage ends.

Treatment Not Medically Necessary
The Plan does not cover:

a. Services or supplies that are not medically necessary for the treatment of a condition otherwise covered under the Plan;
b. Services or supplies that are either inappropriate or inconsistent with the symptoms or diagnosis of a member's condition;
c. Services or supplies that are not established as the standard treatment by the medical community in the service area in which they are received; and/or
d. Services or supplies that are primarily rendered for the convenience of a member or a vision provider.

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

Treatment Prior to Enrollment
This Plan does not cover services or supplies that a member received before enrollment in this Plan.

Vision Care Related Procedures and Services
The following vision related procedures and services are not covered:

a. Treatment of eyes for special procedures such as orthoptics and vision training;
b. Subnormal vision aids and any associated supplemental testing;
c. Any extra charge for lenses with prisms, prism segs, slab-off and other special-purpose vision aids;
d. Plain nonprescription lenses and nonprescription sunglasses;
e. Medical or surgical treatment of the eyes or supporting structures;
f. Charges for hard and/or scratch resisting coating(s);
g. Charges for ultraviolet (UV) coating;
h. Charges for standard anti-reflective coating;
i. Any expense a member did not have to pay due to discounts received or other promotions;
j. Examination or corrective eyewear required by an employer and safety eyewear unless specifically covered;
k. Lost or broken materials except at normal covered intervals; and
l. Replacement of lenses and frames unless the member is otherwise eligible.

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

SECTION 7 ELIGIBILITY

The Plan's eligibility rules are outlined in the Oregon Administrative Rules under OAR 111-015-0001. Members may also refer to the OEBB Member Benefits Guide for additional information on eligibility. The date a person becomes eligible may be different than the date coverage begins. More specific information can be found under the Enrollment section (see section 8).

7.1 ELIGIBILITY AUDIT

ODS reserves the right to conduct audits to verify a member's eligibility, and may request documentation including but not limited to employee timecards, member birth certificates, adoption paperwork, marriage certificates, domestic partnership registration and any other document necessary to document eligibility on the Plan.

SECTION 8 ENROLLMENT

8.1 NEWLY-HIRED AND NEWLY-ELIGIBLE ACTIVE ELIGIBLE EMPLOYEES

The Plan's enrollment rules for newly-hired and newly-eligible active eligible employees are outlined in the Oregon Administrative Rules under OAR 111-040-0010. Members may also refer to the OEBB Member Benefits Guide for additional information on enrollment.

8.2 QUALIFIED STATUS CHANGES

The Plan's enrollment rules for qualified status changes are outlined in the Oregon Administrative Rules under OAR 111-040-0040. Members may also refer to the OEBB Member Benefits Guide for additional information on qualified status changes.

Eligible employees and their spouse, domestic partner, and children may also have additional enrollment rights under the Children's Health Insurance Program Reauthorization Act of 2009. If prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage was terminated due to loss of eligibility. Special enrollment must be requested within 60 days of the termination.

Additionally, if an eligible employee, spouse, domestic partner or child covered under Medicaid or CHIP becomes eligible for a premium assistance subsidy, and special enrollment is requested within 60 days of the determination of eligibility, they may enroll in the Plan outside of the open enrollment period.

The special enrollment rights as described above apply:

a. To an eligible employee who loses other coverage or becomes eligible for a premium assistance subsidy;
b. To a spouse, domestic partner, or child who loses coverage under the other plan or becomes eligible for a premium assistance subsidy; or
c. To both if neither is enrolled in the Plan, and either loses coverage under the other plan or becomes eligible for a premium assistance subsidy.

To enroll, an eligible employee will need to submit a complete and signed application within the required timeframe, along with a certificate of creditable coverage from the previous plan.

Note: A new dependent may cause a premium increase. Premiums will be adjusted accordingly. Such adjustments will apply during the first 31 days of coverage for newborn or adopted children. If payment is required but not received, the child will not be covered. Proof of legal guardianship will be required for coverage of a grandchild beyond the first 31 days from birth.

8.3 EFFECTIVE DATES

The Plan's effective dates for enrollment are outlined in the Oregon Administrative Rules under OAR 111-040-0001. Members may also refer to the OEBB Member Benefits Guide for additional information on the effective date of coverage.

8.4 OPEN ENROLLMENT

The Plan's open enrollment rules are outlined in the Oregon Administrative Rules under OAR 111-040-0020. Members may also refer to the OEBB Member Benefits Guide for additional information on open enrollment.

8.5 LATE ENROLLMENT

The Plan's late enrollment rules are outlined in the Oregon Administrative Rules under OAR 111-040-0030. Members may also refer to the OEBB Member Benefits Guide for additional information on late enrollment.

8.6 RETURNING TO ACTIVE ELIGIBLE EMPLOYEE STATUS

The Plan's enrollment rules for those individuals returning to active eligible employee status are outlined in the Oregon Administrative Rules under OAR 111-040-0035. Members may also refer to the OEBB Member Benefits Guide for additional information on returning to active eligible employee status.

All plan provisions will resume at re-enrollment whether or not there was a lapse in coverage. Any exclusion period that was not completed at the time the subscriber was laid off or had a reduction in hours must be satisfied. However, the period of layoff or reduction in hours will be counted toward the exclusion period. Upon re-enrollment in the Plan, any waiting period required by the Plan will not have to be re-served.

8.7 REMOVING AN INELIGIBLE INDIVIDUAL FROM BENEFIT PLANS

The Plan's rules for removing an ineligible individual from the Plan are outlined in the Oregon Administrative Rules under OAR 111-040-0015. Members may also refer to the OEBB Member Benefits Guide for additional information on removing an ineligible individual from the Plan.

8.8 WHEN COVERAGE ENDS

Termination dates for loss of eligibility, death of the active eligible employee, and retirement of the active eligible employee are outlined in the Oregon Administrative Rules under OAR 111-040-0005. In addition, there are a variety of other circumstances in which a member's coverage will end. These are described in the following paragraphs.

8.8.1 Group Plan Termination

If the Plan is terminated for any reason, coverage ends for the participating organization, and members on the date the Plan ends.

8.8.2 Termination by a Subscriber

A subscriber may terminate his or her coverage, or coverage for any enrolled dependent, by giving ODS written notice through OEBB, in accordance with OEBB's Administration Rules. Coverage will end on the last day of the month through which premiums are paid. If a subscriber terminates his or her own coverage, coverage for any dependents also ends at the same time.

8.8.3 Rescission By Insurer

The Plan's enrollment rules for rescission by insurer are outlined in OEBB's Administrative Rules. Members may also refer to the OEBB Member Benefits Guide for additional information on rescinding.

8.8.4 Certificates of Credible Coverage

Certificates of creditable coverage will be issued when coverage ends, when COBRA coverage ends, and when a member requests a certificate while covered under the Plan or within 2 years of losing coverage.

8.8.5 Other

Additional information is in Continuation of Health Coverage (see section 13).

8.9 DECLINATION OF COVERAGE

The Plan's rules for declining coverage are outlined in the Oregon Administrative Rules under OAR 111-040-0050. Members may also refer to the OEBB Member Benefits Guide for additional information on declining coverage.

SECTION 9 CLAIMS ADMINISTRATION & PAYMENT

The following sections explain how claims are administered.

9.1 SUBMISSION AND PAYMENT OF CLAIMS

In no event, except absence of legal capacity or in the case of a Medicaid claim, is a claim valid if submitted later than 12 months from the date the expense was incurred. Claims submitted by Medicaid must be sent to ODS within 3 years after the date the expense was incurred.

A vision provider may bill charges directly to ODS. If not, the member should forward the bills to ODS at the address listed below. The vision provider should use his or her billing form and include the following:

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

ODS
Attn: Medical Claims Department
P.O. Box 40384
Portland, Oregon 97240

If the treatment is for an accidental injury, a statement explaining the date, time, place, and circumstances of the accident must be included with the bill.

9.1.1 Explanation of Benefits (EOB)

Soon after receiving a claim, ODS will report on its action on the claim by providing the member a document called an Explanation of Benefits (EOB). Members are encouraged to access their EOBs electronically by signing up through myODS. ODS may pay claims or deny them. If all or part of a claim is denied, the reason will be stated in the EOB.

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that ODS has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period noted explained in section 9.1.

9.1.2 Claim Inquiries

ODS' Medical Customer Service Department can answer questions about how to file a claim, the status of a pending claim, or any action taken on a claim. ODS will respond to an inquiry within 30 days of receipt.

9.2 DISPUTE RESOLUTIONS

9.2.1 Definitions

For the purposes of section 9.2 the following definitions apply:

Adverse Benefit Determination means a written notice from ODS, in the form of a letter or an Explanation of Benefits (EOB), of any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including one based on a determination of a member's eligibility to participate in the Plan and one resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not necessary and customary by the standards of generally accepted practice for the prevention or treatment of disease or accidental injury.

Appeal is a written request by a member or his or her representative for ODS to review an adverse benefit determination.

Complaint means an expression of dissatisfaction about a specific problem a member has encountered or about a decision by ODS or an agent acting on behalf of ODS, and which includes a request for action to resolve the problem or change the decision. A complaint does not include a request for information or clarification about any subject related to the Plan.

Utilization Review means a system of reviewing the necessity, appropriateness, or quality of services and supplies using specified guidelines, including the application of practice guidelines, prior authorization of procedures, and retrospective review. An adverse benefit determination that the item or service is not necessary or appropriate, is investigational or experimental, or in which the decision as to whether a benefit is covered involved a professional judgment is a utilization review decision.

9.2.2 Time Limit for Submitting Appeals

A member has **180 days** from the date of an adverse benefit determination to submit an initial written appeal. If an appeal is not submitted within the timeframes outlined in this section, the rights to the appeals process will be lost.

9.2.3 The Review Process

The Plan has a 2-level internal review process consisting of a first level appeal and a second level appeal.

Note:
The timelines addressed in the sections below do not apply when the member does not reasonably cooperate; or circumstances beyond the control of either party prevents that party from complying with the standards set (but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise).

9.2.4 First Level Appeals

It may be possible to resolve an appeal with a phone call to ODS' Medical Customer Service Department. Otherwise, an appeal must be submitted in writing to ODS. If necessary, ODS' Medical Customer Service Department can provide assistance filing an appeal. The member may review the claim file and present evidence as part of the appeal process, and may appoint a representative to act on his or her behalf. ODS will acknowledge receipt of the written appeal within 7 days and conduct an investigation by persons who were not involved in the original determination.

When an investigation has been completed, ODS will notify the member in writing of the decision, the basis for the decision, and if applicable, information on the right to a second level appeal.

9.2.5 Second Level Appeals

A member who disagrees with the decision regarding the first level appeal may request a review of the decision. The second level appeal must be submitted in writing within 60 days of the date of ODS' action on the first level appeal.

Investigations and responses to a second level appeal will be by persons who were not involved in the initial determinations, and will follow the same timelines as those for the first appeal. The member may review the claim file and present evidence as part of the appeal process, and may appoint a representative to act on his or her behalf. ODS will notify the member in writing of the decision, and the basis for the decision.

9.2.6 External Review

If the claim meets the criteria below, a member may request that the claim be reviewed by an Independent Review Organization, appointed by the Oregon Insurance Division.

a. The dispute must relate to an adverse determination based on a utilization review decsion: or whether a course or plan of treatment that a member is undergoing is an active course of treatment;
b. The request for external review must be in writing no more than 180 days after receipt of the final internal adverse benefit determination;
c. The member must sign a waiver granting the Independent Review Organization access to his or her medical records;
d. The member must have exhausted the appeal process described in section 9.2.4 and 9.2.5. However, ODS may waive this requirement of a dispute referred directly to the external review with the member's consent; and
e. The member shall provide complete and accurate information to the Independent Review Organization in a timely manner;
f. The decision of the independent review organization is binding except to the extent other remedies are available to the member under state or federal law.

A final internal adverse benefit determination based on specific exclusions or limitations on the amount, duration or scope of coverage that does not involve medical judgment or a decision on whether a person is a member under the Plan does not qualify for external review. A complaint decision does not qualify for external review.

9.2.7 Additional Member Rights

The member has the right to file a complaint or seek other assistance from the Oregon Insurance Division. Assistance is available:

By phone:	503-947-7984 or toll-free 1-888-877-4894
By mail:	Consumer Advocacy Department of Consumer and Business Services 350 Winter Street NE, Room 440-2 Salem, Oregon 97301
By internet	http://www.cbs.state.or.us/external/ins/

This information is subject to change upon notice from the Director of the Oregon Insurance Division.

9.3 BENEFITS AVAILABLE FROM OTHER SOURCES

Situations may arise in which vision care expenses may be the responsibility of someone other than ODS. Here are descriptions of the situations that may arise.

9.3.1 Coordination of Benefits (COB)

This provision applies to the Plan when a member has vision coverage under more than one plan. A complete explanation of COB is in section10.

9.3.2 Third-Party Liability

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

Because recovery from a third party may be difficult and take a long time, and payment of benefits where a third party may be legally liable is excluded under the terms of the Plan, as a service to the member, ODS will pay a member's expenses based on the understanding and agreement that the member is required to honor ODS' rights of subrogation as discussed below, and, if requested, to reimburse ODS in full from any recovery the member may receive, no matter how the recovery is characterized.

Upon claiming or accepting benefits, or the provision of benefits, under the terms of the Plan, the member agrees that ODS shall have the remedies and rights as stated in this section. ODS may elect to seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, ODS' right of reimbursement or subrogation as discussed in this section. ODS has the sole discretion to interpret and construe these reimbursement and subrogation provisions.

9.3.2.1 Definitions:

For purposes of section 9.3.2, the following definitions apply:

Benefits means any amount paid by ODS, or submitted to ODS for payment to or on behalf of a member. Bills, statements or invoices submitted to ODS by a provider of services, supplies or facilities to or on behalf of a member are considered requests for payment of benefits by the member.

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a third party (or any right to assert the foregoing) by or on behalf of a member, regardless of the characterization of the claims or damages of the member, and regardless of the characterization of the recovery funds. (For example, a member who has received payment of vision expenses from ODS may file a third party claim against the party responsible for the member's injuries, but only seek the recovery of non-economic damages. In that case, ODS is still entitled to recover benefits as described in section 9.2.4.)

Third Party means any person or entity responsible for the injury or illness, or the aggravation of an injury or illness, of a member. Third party includes any insurer of such person or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the member including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, PIP coverage, and workers' compensation insurance.

Recovery Funds means any amount recovered from a third party.

9.3.2.2 Subrogation

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

Under this section, ODS may pursue the third party in its own name, or in the name of the member. ODS is entitled to all subrogation rights and remedies under the common and statutory law, as well as under the Plan.

9.3.2.3 Right of Recovery

In addition to its subrogation rights, ODS may, at its sole discretion and option, ask that a member, and his or her attorney, if any, protect its reimbursement rights. If ODS elects to proceed under this section, the following rules apply:

a. The member holds any rights of recovery against the third party in trust for ODS, but only for the amount of benefits ODS paid for that illness or injury.

b. ODS is entitled to receive the amount of benefits it has paid for that illness or injury out of any settlement or judgment which results from exercising the right of recovery against the third party. This is so regardless of whether the third party admits liability or asserts that the member is also at fault. In addition, ODS is entitled to receive the amount of benefits it has paid whether the vision expenses are itemized or expressly excluded in the third party recovery.

c. If, and only if, ODS asks the member, and his or her attorney, to protect its reimbursement rights under this section, then the member may subtract from the money to be paid back to ODS, as an expense for collecting from the other party, a proportionate share of reasonable attorney fees.

d. ODS may ask the member to sign an agreement to abide by the terms of this section. If ODS elects to proceed under this section it will not be required to pay benefits for the illness or injury until the agreement is properly signed and returned.

e. This right of recovery includes the full amount of the benefits paid, or pending payment by ODS, out of any recovery made by the member from the third party, including, without limitation, any and all amounts from the first dollars paid or payable to the member (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or vision expenses of the member), regardless of the characterization of the recovery, whether or not the member is made whole, or whether or not any amounts are paid or payable directly by the third party, an insurer or another source. ODS' recovery rights will not be reduced due to the member's own negligence.

f. If it is reasonable to expect that the member will incur future expenses for which benefits might be paid by ODS, the member shall seek recovery of such future expenses in any third party claim.

9.3.2.4 Motor Vehicle Accidents

Any expense for injury or illness that results from a motor vehicle accident and is payable under a motor vehicle insurance policy is not a covered benefit under the Plan and will not be paid by ODS.

If a claim for vision expenses arising out of a motor vehicle accident is filed with ODS, and if motor vehicle insurance has not yet paid, then ODS may advance benefits, subject to the rights and remedies outlined in the Subrogation and Right of Recovery sections stated above, and subject to the next paragraph.

In addition to the rights and remedies outlined in the Subrogation and Right of Recovery sections stated above, in third party claims involving the use or operation of a motor vehicle, ODS, at its sole discretion and option, is entitled to seek reimbursement under the Personal Injury Protection statutes of the state of Oregon, including ORS 742.534, ORS 742.536, or ORS 742.538.

9.3.2.5 Additional Third Party Liability Provisions

In connection with ODS' rights to obtain reimbursement, or to exercise its right of subrogation, or direct recovery in motor vehicle accidents, as discussed in the above sections, members shall do one or more of the following, and agree that ODS may do one or more of the following, at its discretion:

a. If the member seeks payment by ODS of any benefits for which there may be a third party claim, the member shall notify ODS of the potential third party claim. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to ODS by the member's provider.

b. Upon request from ODS, the member shall provide all information available to the member, or any representative, or attorney representing the member, relating to the potential third party claim. The member and his or her representatives shall have the obligation to notify ODS in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the member is seeking recovery of benefits paid by ODS from the third party.

c. In order to receive an advance payment of benefits pursuant to section 9.3.2, ODS requires that any member seeking payment of benefits by ODS, and if the member is a minor or legally incapable of contracting, then the member's parent or guardian, must fill out, sign and return to ODS a Third-Party Questionnaire and Agreement that includes a questionnaire about the accident and the potential third-party claim. If the member has retained an attorney to represent himself or herself with respect to a third-party claim, then the attorney must sign the Third-Party Recovery Agreement, acknowledging the obligations described in that agreement.

d. The member shall cooperate with ODS to protect its recovery rights in section 9.3.2, and in addition, but not by way of limitation, shall:

    i. Sign and deliver such documents as ODS reasonably requires to protect its rights;
    ii. Provide any information to ODS relevant to the application of the provisions of section 9.3.2, including medical information (including doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments; and

iii. Take such actions as ODS may reasonably request to assist ODS in enforcing its rights to be reimbursed from third party recoveries.

e. By accepting the payment of benefits by ODS, the member agrees that ODS has the right to intervene in any lawsuit or arbitration filed by or on behalf of a member seeking damages from a third party.

f. The member agrees that ODS may notify any third party, or third party's representatives or insurers of its recovery rights set forth in section 9.3.2.

g. Even without the member's written authorization, ODS may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 9.3.2.

h. This section applies to any member for whom advance payment of benefits is made by ODS whether or not the event giving rise to the member's injuries occurred before the member became covered by ODS.

i. If the member continues to receive vision treatment for an illness or injury after obtaining a settlement or recovery from a third party, ODS will provide benefits for the continuing treatment of that illness or injury only to the extent that the member can establish that any sums that may have been recovered from the third party for the continuing vision treatment have been exhausted for that purpose.

j. If the member or the member's representatives fail to do any of the foregoing acts at ODS' request, then ODS has the right to not advance payment of benefits or to suspend payment of any benefits for or on behalf of the member related to any sickness, illness, injury or medical condition arising out of the event giving rise to, or the allegations in, the third arty claim. In exercising this right, ODS may notify medical providers seeking authorization or prior authorization of payment of benefits that all payments have been suspended, and may not be paid.

k. Coordination of benefits (where the member has vision coverage under more than one plan or health insurance policy) is not considered a third party claim.

l. If any term, provision, agreement or condition of section 9.3.2 is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

SECTION 10 COORDINATION OF BENEFITS

Coordination of Benefits (COB) occurs when a member has vision coverage under more than one plan.

10.1 DEFINITIONS

For purposes of section 10, the following definitions apply:

Plan means any of the following that provides benefits or services for vision care or treatment. If separate contracts are used to provide coordinated coverage for covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes:

a. Group insurance contracts and group-type contracts;
b. HMO (Health Maintenance Organization) coverage;
c. Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;
d. Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law; or
e. Other arrangements of insured or self-insured group or group-type coverage.

Plan does not include:

a. Fixed indemnity coverage;
b. Accident-only coverage;
c. Specified disease or specified accident coverage;
d. School accident coverage;
e. Benefits for non-medical components of group long-term care policies;
f. Medicare supplement policies;
g. Medicaid policies; or
h. Coverage under other federal governmental plans, unless permitted by law.

Each contract or other arrangement for coverage described above is a separate plan. If a plan has 2 parts and COB rules apply to only one of the 2, each of the parts is treated as a separate plan.

Complying Plan is a plan that complies with these COB rules.

Non-complying Plan is a plan that does not comply with these COB rules.

Claim means a request that benefits of a plan be provided or paid.

An **Allowable Expense** means a vision expense, including deductibles and copayments/ or coinsurance, that is covered at least in part by any plan covering the member. When a plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the member is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a member is not an allowable expense.

The following are examples of expenses that are **not** allowable expenses:

a. The amount of the reduction by the primary plan because a member has failed to comply with the plan provisions concerning prior authorization of services or because the member has a lower benefit because that member did not use an in-network provider;
b. Any amount in excess of the highest reimbursement amount for a specific benefit, if a member is covered by 2 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;
c. Any amount in excess of the highest of the negotiated fees, if a member is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees;
d. If a 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 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.

This Plan is the part of this policy that provides benefits for vision expenses to which the COB provision applies and which may be reduced because of the benefits of other plans. A policy may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

A **Closed Panel Plan** is a plan that provides vision benefits to covered persons primarily in the form of services through a network 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.

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 child resides more than one half of the calendar year excluding any temporary visitation.

10.2 HOW COB WORKS

If the member is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then the other plan(s) pay(s). The order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

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

The **Secondary Plan** (the plan(s) that pay(s) benefits after the primary plan) will reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall provide benefits as if it were the primary plan when a member uses an out-of-network provider, except for emergency services that are paid or provided by the primary plan.

This Plan will coordinate with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in OAR 836-020-0770 to 836-020-0805 (non-complying plan) on the following basis:

a. If this Plan is primary, it will provide its benefits first.
b. If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan's benefits. This Plan will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan.
c. If the non-complying plan reduces its benefits so that the member receives less in benefits than he or she would have received had this Plan provided its benefits as the secondary plan and the non-complying plan provided its benefits as the primary plan, then this Plan shall advance additional benefits equal to the difference between the amount that was actually paid and the amount that should have been paid if the non-complying plan had not improperly reduced its benefits. Additional payment will be limited so that ODS will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the member against the non-complying plan.

10.3 ORDER OF BENEFIT DETERMINATION (WHICH PLAN PAYS FIRST?)

The first of the following rules that applies will govern:

a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent, for example, an employee, member of an organization, subscriber, or retiree, then that plan will determine its benefits before a plan that covers the member as a dependent.
b. **Dependent Child/Parents Married, Registered under the Oregon Family Fairness Act, or Living Together.** If the member is a dependent child whose parents are married, registered under the Oregon Family Fairness Act, or are living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the 'Birthday Rule'.) This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, then the following rules apply:

    i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent 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.
    ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses of the child, the 'birthday rule' described above applies.
    iii. If there is not a court decree allocating responsibility for the dependent child's healthcare expenses, the order of benefits is as follows:
        A. The plan covering the custodial parent;

B. The plan covering the spouse or registered domestic partner of the custodial parent;
C. The plan covering the non-custodial parent; and then
D. The plan covering the spouse or registered domestic partner of the non-custodial parent.

This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

d. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (b. or c.) above shall determine the order of benefits as if those persons were the parents of the child. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

e. **Active/Retired or Laid Off Employee.** The plan that covers a member as an active employee, that is, one who is neither laid off nor retired (or as that employee's dependent) determines its benefits before those of a plan that covers the member as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

f. **COBRA or State Continuation Coverage.** If a 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 covering the member as an employee, member of an organization, subscriber, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

g. **Longer/Shorter Length of Coverage.** The plan that covered a member as an employee, member of an organization, subscriber, or retiree (non-dependent) longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

h. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

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

10.4 EFFECT ON THE BENEFITS OF THIS PLAN

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other vision 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 vision coverage.

If a member is enrolled in 2 or more closed panel plans and if, for any reason, including the provision of service by an out-of-network provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

10.5 ODS' Right To Collect And Release Needed Information

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

10.6 Facility Of Payment

If another plan makes payments this Plan should have made under this coordination provision, this Plan can reimburse the other plan directly. Any such reimbursement payments will count as benefits paid under this Plan and this Plan will be released from liability regarding them. The term 'payments' includes providing benefits in the form of services, in which case 'payments' means the reasonable cash value of the benefits provided in the form of services.

10.7 Right Of Recovery

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

SECTION 11 MISCELLANEOUS PROVISIONS

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

11.1 REQUEST FOR INFORMATION

When necessary to process claims, ODS may require that a member submit information concerning benefits to which the member is entitled. ODS may also require a member to authorize any vision provider to give ODS information about a condition for which a member claims benefits.

11.2 CONFIDENTIALITY OF MEMBER INFORMATION

The confidentiality of a member's protected health information is of extreme importance to ODS. Protected health information includes, but is not limited to enrollment, claims, and medical information. ODS uses such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. ODS does not sell this information. The Notice of Privacy Practices provides more complete detail about how ODS uses members' information. A copy of the notice is available on the ODS website by following the HIPAA link, or by calling ODS at 503-243-4492.

11.3 TRANSFER OF BENEFITS

Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on ODS.

11.4 RECOVERY OF BENEFITS PAID BY MISTAKE

If ODS mistakenly makes a payment for a member to which he or she is not entitled, or pays a person who is not eligible for payments at all, ODS has the right to recover the payment from the person paid or anyone else who benefited from it, including a vision provider. ODS' right to recovery includes the right to deduct the amount paid by mistake from future benefits it would provide for a member even if the mistaken payment was not made on that member's behalf.

11.5 CONTRACT PROVISIONS

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

11.6 RESPONSIBILITY FOR QUALITY OF VISION CARE

In all cases, members have the exclusive right to choose their vision provider. ODS is not responsible for the quality of vision care a member receives, since all those who provide care do so as independent contractors. ODS cannot be held liable for any claim or damages connected with injuries a member suffers while receiving vision services or supplies.

11.7 WARRANTIES

All statements made by OEBB, or a member, unless fraudulent, will be considered as representations and not warranties. No statement made for the purpose of effecting coverage will void the coverage or reduce benefits unless contained in a written form and signed by OEBB or the member, a copy of which has been given to OEBB or to the member or member's beneficiary.

11.8 NO WAIVER

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

11.9 GROUP IS THE AGENT

OEBB is the member's agent for all purposes under the Plan. OEBB is not the agent of ODS.

11.10 GOVERNING LAW

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

11.11 WHERE ANY LEGAL ACTION MUST BE FILED

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

11.12 TIME LIMITS FOR FILING A LAWSUIT

Any legal action arising out of, or related to, the Plan and filed against ODS by a member or any third party, must be filed in court within 3 years of the time the claim arose. For example, a claim that benefits were not authorized or provided, and any and all damages relating thereto, would arise when the last level of administrative appeal under the Plan has ended.

11.13 EVALUATION OF NEW TECHNOLOGY

ODS develops medical necessity criteria for new technologies and new use of current technologies. The technological committee reviews information consisting of medical studies, national, regional or local clinical practice guidelines, and local and national carrier benefits to develop the criteria. The reviews are performed once a year or more often if needed.

SECTION 12 CONTINUATION OF VISION COVERAGE

The Plan's continuation of coverage rules are outlined in the Oregon Administrative Rules under OAR 111-050-0001 through OAR 111-050-0080. Additional guidance on how to obtain continuation of coverage is outlined in the following sections.

12.1 FAMILY AND MEDICAL LEAVE

If the participating organization grants a leave of absence under the Family and Medical Leave Act of 1993, as amended (FMLA), the following rules will apply:

a. Affected member(s) will remain eligible for coverage during FMLA leave.
b. If members elect not to remain enrolled during a FMLA leave, they will be eligible to re-enroll in the Plan on the date the subscriber returns from leave. To re-enroll, a complete and signed application must be submitted within 60 days of the return to work. All of the terms and conditions of the Plan will resume at the time of re-enrollment as if there had been no lapse in coverage. Any exclusion period served prior to the FMLA leave will be credited and any group eligibility-waiting period under the Plan will not have to be re-served.
c. A subscriber's rights under FMLA will be governed by that statute and its regulations.

12.2 LEAVE OF ABSENCE

If granted a non-FMLA leave of absence by the participating organization, a subscriber may continue coverage for up to 3 months. Premiums must be paid through OEBB in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by the participating organization at a subscriber's request during which he or she is still considered to be employed and is carried on the employment records of the participating organization. A leave can be granted for any reason acceptable to the participating organization, including disability and maternity.

12.3 STRIKE OR LOCKOUT

If employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, a subscriber may continue coverage for up to 6 months. The subscriber must pay the full premiums, including any part usually paid by the participating organization, directly to the union or trust, and the union or trust must continue to pay ODS the premiums when due.

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

a. Fewer than 75% of those normally enrolled choose to continue their coverage;
b. A subscriber accepts full-time employment with another employer; or
c. A subscriber otherwise loses eligibility under the Plan.

12.4 RETIREES

The Plan's continuation rules for retirees are outlined in the Oregon Administrative Rules under OAR 111-050-0010 through 111-050-0050. Members may also refer to the OEBB Member Benefits Guide for additional information on retiree continuation.

12.5 OREGON CONTINUATION COVERAGE FOR SPOUSES AND DOMESTIC PARTNERS AGE 55 AND OVER

12.5.1 Introduction

ORS 743.600 to 743.602 are state regulations requiring certain group health insurance policies to offer enrolled spouses and domestic partners the opportunity to request a temporary extension of health insurance coverage for themselves and their dependents if coverage is lost due to a specific event identified in the statutes ("55+ Oregon Continuation").

55+ Oregon Continuation only applies to employers with 20 or more employees. ODS will provide 55+ Oregon Continuation coverage to those members who elect coverage under ORS 743.600 to 743.602, subject to the following conditions:

a. Other than the inclusion of domestic partners, ODS will offer no greater rights than ORS 743.600 to 743.602 requires;
b. ODS will not provide 55+ Oregon Continuation coverage for members who do not comply with the notice, election, or other requirements outlined in section 12.5.3; and
c. As the Plan Administrator, OEBB or its designated third party administrator is responsible for providing the required notices within the statutory time periods, including the notice of death and the election notice. If OEBB or its designated third party administrator fails to notify the eligible spouse or domestic partner, premiums shall be waived from the date the notice was required until the date notice is received by the spouse or domestic partner. OEBB shall be responsible for such premiums.

12.5.2 Eligibility Requirements for 55+ Oregon Continuation Coverage

The spouse or domestic partner of the subscriber may elect 55+ Oregon Continuation coverage for himself or herself and any enrolled children if the following requirements are met:

a. Coverage is lost because of the death of the subscriber, dissolution of marriage or domestic partnership with the subscriber, or legal separation from the subscriber;
b. The spouse or domestic partner is 55 years of age or older at the time of such event; and
c. The spouse or domestic partner is not eligible for Medicare.

12.5.3 Notice and Election Requirements for 55+ Oregon Continuation Coverage

Notice of Divorce, Dissolution, or Legal Separation. Within 60 days of legal separation or the entry of a judgment of dissolution of marriage or domestic partnership, a legally separated or divorced spouse, or a legally separated or former domestic partner, eligible for 55+ Oregon Continuation who seeks such coverage shall give OEBB or its designated third party administrator written notice of the legal separation or dissolution. The notice shall include the mailing address of the legally separated or divorced spouse, or the legally separated or former domestic partner, seeking coverage.

Notice of Death. Within 30 days of the death of the subscriber whose surviving spouse or domestic partner is eligible for 55+ Oregon Continuation, the participating organization shall give the designated third party administrator, if any, written notice of the death and the mailing address of the surviving spouse or domestic partner.

Election Notice. Within 14 days of receipt of the above notice (or within 44 days of the death of the subscriber if there is no third party administrator), OEBB or its designated third party administrator shall provide notice to the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, that coverage can be continued, along with an election form. If OEBB or its designated third party administrator fails to notify the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, within the required 14 days (or 44 days if there is not party administrator), premiums shall be waived until the date notice is received.

Election. The surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, must return the election form within 60 days after the form is mailed. Failure to exercise this election within 60 days of the notification shall terminate the right to continued benefits under this section.

12.5.4 Premiums for 55+ Oregon Continuation Coverage

The monthly premiums for 55+ Oregon Continuation is limited to 102% of the premiums paid by a current subscriber. The first premium shall be paid by the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, to the Participating Organization or the designated third party administrator within 45 days of the date of election. All remaining monthly premiums must be paid within 30 days of the premium due date.

12.5.5 When 55+ Oregon Continuation Coverage Ends

55+ Oregon Continuation will end on the earliest of any of the following:

a. The failure to pay premiums when due, including any grace period allowed by the Plan;
b. The date that the Plan terminates, unless a different group policy is made available to Group members;
c. The date on which the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, becomes insured under any other group health plan;
d. The date on which the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, remarries or registers another domestic partnership under the Oregon Family Fairness Act and becomes covered under another group health plan; or
e. The date on which the surviving, legally separated or divorced spouse, or the surviving, legally separated or former domestic partner, becomes eligible for Medicare.

12.6 COBRA CONTINUATION COVERAGE

12.6.1 Introduction

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is a federal law requiring certain employer-sponsored group health plans to offer qualified beneficiaries the opportunity to elect a temporary extension of health insurance coverage if coverage is lost due to a qualifying event. For purposes of this section, a qualified beneficiary is someone who is covered under the Plan the day before a qualifying event, and can include the subscriber and the subscriber's spouse and dependent children. The Plan Administrator means either OEBB or a third party administrator delegated by OEBB to handle COBRA administration. Specific qualifying events are listed below.

COBRA only applies to employers with 20 or more employees on 50% of the typical business days in the prior calendar year. ODS will provide COBRA continuation coverage to those qualified beneficiaries who elect coverage under COBRA, subject to the following conditions:

a. Other than the exception on domestic partner coverage, ODS will offer no greater COBRA rights than the COBRA statute requires;
b. ODS will not provide COBRA coverage for those qualified beneficiaries who do not comply with the notice, election or other requirements outlined below;
c. ODS will not provide COBRA coverage if the participating organization or Plan Administrator fails to provide the required COBRA notices within the statutory time periods, including the initial notice, the election notice, and notice of a qualifying event, or if the participating organization or Plan Administrator otherwise fails to comply with any of the requirements outlined below; and
d. ODS will not provide a disability extension if the participating organization or Plan Administrator fails to notify ODS within 60 days of its receipt of a disability extension notice from a qualified beneficiary.

12.6.2 Qualifying Events

Subscriber. A subscriber may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct , which may include, but is not limited to, misrepresenting immigration status to obtain employment), a reduction in hours.

Spouse. The spouse of a subscriber has the right to continuation coverage if coverage is lost for **any** of the following qualifying events:

a. The death of the subscriber;
b. The termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the participating organization;
c. Divorce or legal separation from the subscriber; or
d. The subscriber becomes entitled to Medicare.

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

Children. A dependent child of a subscriber has the right to continuation coverage if coverage is lost for **any** of the following qualifying events:

a. The death of the subscriber;
b. The termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in a subscriber's hours of employment with the participating organization;
c. Parents' divorce or legal separation;
d. The subscriber becomes entitled to Medicare; or
e. The dependent ceases to be a "dependent child" under the Plan.

Domestic Partners. A domestic partner, who at the time of the qualifying event was covered under the Plan, can elect COBRA continuation coverage. Under the Plan, the domestic partner would have the same rights to COBRA continuation coverage as a spouse does, unless otherwise stated. Where this COBRA section refers to divorce or legal separation, termination of domestic partnership would apply for domestic partners.

12.6.3 Other Coverage

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

12.6.4 Notice and Election Requirements

Qualifying Event Notice. The Plan provides that a dependent member's coverage terminates as of the last day of the month in which a divorce or legal separation occurs (spouse's coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the subscriber or a family member has the responsibility to notify the Plan Administrator if one of these events occurs by mailing or hand-delivering a written notice to the Plan Administrator. The notice must include the following: 1) the name of the Group; 2) the name and social security number of the member(s); 3) the affected beneficiary(ies); 4) the event (e.g. divorce): and 5) the date the event occurred. Notice must be given no later than 60 days after the loss of coverage under the Plan. If notice of the event is not timely given, continuation coverage will not be available.

Election Notice. When the Plan Administrator receives a timely qualifying event notice, members will be notified of their right to continuation coverage within 14 days after the Plan Administrator receives the notice.

Otherwise, members will be notified by the Plan Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the subscriber's termination of employment (other than for gross misconduct), reduction in hours, death of the subscriber, the subscriber's becoming entitled to Medicare.

Election. A member must elect continuation coverage within 60 days after plan coverage ends, or, if later, 60 days after the Plan Administrator sends notice of the right to elect continuation coverage to the members. If continuation coverage is not elected, group vision coverage for all members will end.

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

12.6.5 COBRA Premiums

Those eligible for continuation coverage do not have to show that they are insurable. However, under the law, they are responsible for all premiums for continuation coverage except for members who qualify for premium reduction under any applicable federal law. The first payment for continuation coverage is due within 45 days after a qualified beneficiary provides notice of electing coverage (this is the date the election notice is postmarked, if mailed, or the date the election notice is received by the Plan Administrator, if hand-delivered). This payment must include the amount necessary to cover all months that have elapsed between the date regular coverage ended and the payment date. Subsequent payments are due on the first day of the month; however, there will be a grace period of 30 days to pay the premiums. ODS will not send a bill for any payments due. The qualified beneficiaries are responsible for paying the applicable premiums, in good funds, when due; otherwise continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

12.6.6 Length of Continuation Coverage

If COBRA is elected, the participating organization will provide the same coverage as is available to similarly situated members under the Plan.

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

36-Month Continuation Period. In the case of losses of coverage due to a subscriber's death, divorce or legal separation, or a child ceasing to be a dependent under the terms of the Plan, coverage under the Plan may be continued for up to a total of 36 months.

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

12.6.7 Extending the Length of COBRA Coverage

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

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

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

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

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

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

Second Qualifying Event: An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the subscriber's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Such second qualifying events may include the death of a subscriber, divorce or legal

separation from the subscriber, or a child ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a subscriber becomes entitled to Medicare after his or her termination of employment or reduction of hours.).

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

Note: Longer continuation coverage may be available under Oregon Law for a subscriber's spouse or domestic partner who has entered into a "Declaration of Domestic Partnership" that is recognized under Oregon law age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership (see section 12.5) .

12.6.8 Newborn or Adopted Child

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

12.6.9 Special Enrollment and Open Enrollment

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

12.6.10 When Continuation Coverage Ends

COBRA coverage will automatically terminate before the end of the maximum period if:

a. any required premiums are not paid in full on time;
b. a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
c. a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA.;
d. the participating organization ceases to provide any group vision plan for its employees; or
e. during a disability extension period (see section 12.6.7), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate).

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

Questions about COBRA should be directed to the Plan Administrator. The Plan Administrator should be informed of any address changes.

12.6.11 The American Recovery and Reinvestment Act of 2009, as amended

This Act provides for premium reductions for continuation coverage under COBRA. Eligible members pay 35% of their COBRA premiums. The premium reduction applies to periods of vision coverage beginning on or after February 17, 2009 and continues up to 15 months for those eligible for COBRA due to an involuntary termination of employment that occurred during the period beginning September 1, 2008 and ending May 31, 2010. Questions about this Act and related notice requirements should be directed to the Plan Administrator.

12.7 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Coverage will terminate if a subscriber is called to active duty by any of the armed forces of the United States of America. However, if a subscriber requests to continue coverage under USERRA, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, provided the subscriber pays any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for active eligible members. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

If a subscriber does not elect continuation coverage under USERRA or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day he or she returns to active employment with the participating organization if released under honorable conditions, but only if he or she returns to active employment:

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

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

When coverage under the Plan is reinstated, all plan provisions and limitations will apply to the extent that they would have applied if the subscriber had not taken military leave and coverage had been continuous under the Plan. There will be no additional eligibility-waiting period as if the subscriber had been continuously covered under the Plan from the original effective date. (This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by military service, as determined by the VA. Complete information regarding rights under the USERRA is available from the participating organization).

SECTION 13 RESERVED FOR FUTURE USE

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