PUBLIC EMPLOYEES'

PEBB

BENEFIT BOARD

2003

Benefit Booklet

Effective January 1

through December 31

A Message From PEBB

PEBB's mission is to provide high-quality benefits that are affordable to employees and the state. To meet this mission, PEBB plans benefit programs not just for the coming year but also for the next biennium and even further into the future. In its planning, the Board takes current, past and future circumstances into account.

Currently, the U.S. healthcare marketplace is in turmoil. Regional and national studies continue to post projections of double-digit premium increases for the next several years.

In Oregon, our healthcare system is undergoing additional dramatic changes. We are experiencing a severe, long-term shortage of healthcare providers. Physicians are facing significant increases in liability insurance costs. Hospital fees have joined prescription drugs and new technologies as some of the most frequently cited reasons for increased healthcare costs. In some Oregon communities, entire groups of medical providers will no longer contract with some of the state's largest insurance companies.

Over the last two years, several factors caused PEBB's plans to experience significant financial losses. Among the factors was that the healthcare costs of PEBB members exceeded the amount of premium paid to the medical plans. To maintain affordable coverage, in 2001 PEBB made significant changes to this year's medical plan choices and the benefit program. Nevertheless, the overall, average premium increased by 26 percent.

This year, the Board was able to renew the 2002 plans for 2003 with an 8.75 percent overall increase in medical and dental premium. The renewals required some changes but, in general, PEBB was able to maintain its level of benefits for another year. Assuming no other budget changes, eligible full-time employees will continue to receive fully paid medical and dental benefits for themselves and their families.

The Board remains very concerned about the quality and affordability of benefits in 2003 and beyond. So, PEBB has initiated a series of strategic activities to address immediate and future needs. These activities include creation of a self-funding task force and implementation of a major statewide wellness program. In addition, the Board is initiating partnerships in a variety of market sectors to develop and test strategies that can keep PEBB's mission of high-quality and affordable benefits an achievable goal for the future.

Table of Contents

Dear State of Oregon Employee:

This booklet provides information about the benefits available to you and your family from the state of Oregon. The booklet describes benefit changes that become effective on Jan. 1, 2003.

Section 1 presents the 2003 rates for PEBB medical and dental insurance plans. It also lists your plan options and presents worksheets and checklists to help you choose and enroll in your selections. Section 2 provides more detail about the medical insurance plans available for 2003. Section 3 covers the dental plans. Section 4 presents additional medical and dental options available only to eligible part-time employees. Section 5 explains the life and disability plans. Section 6 addresses the Dependent Care Flexible Spending Account program, and Section 7 Describes the Long-term Care Insurance plan. Section 8 presents the State of Health, PEBB's wellness program.

Along with a directory of resources, Section 9 provides more detailed information about benefits administration. You should familiarize yourself with this material as it touches on your rights as a PEBB member.

If you have any questions about your benefits, call PEBB at (503) 373-1102 (in Salem) or (800) 788-0520 (outside Salem), or e-mail inquiries.pebb@state.or.us.

The Public Employees' Benefit Board contracts for medical, dental, life, disability, and long-term care insurance coverage for eligible employees. The forms used for enrollment are furnished by PEBB. Enrollment forms must be processed through your agency for coverage to be effective.

Eligibility provisions for PEBB members are detailed in the PEBB Eligibility Handbook. An individual who meets the PEBB eligibility requirements is considered an eligible PEBB member.

PEBB members may participate in any of the plans offered in their geographical area, subject to specific eligibility and plan requirements. PEBB members should take the time to review their enrollment materials. They are encouraged to research access to and the quality of care from plan providers in their service area.

How to Enroll in PEBB Benefits

Section 1

Enrolling for Medical and Dental Insurance

All eligible employees may choose from the following PEBB medical plans:

- Regence BlueCross BlueShield of Oregon (BCBSO) Preferred Provider Organization (PPO), which is available statewide
- Kaiser Permanente Health Maintenance Organization (HMO), if you live or work within 30 miles of a Kaiser Permanente facility where you can access care
- Cascade East Health Plans HMO (and Point of Service – POS) if you live or work in Umatilla or Morrow County.

If you are a part-time employee, you have two additional plan options. The rates for these plans are listed on page 8. The plans are described in Section 4.

If you are covered by another group medical plan, you may choose to opt out of PEBB medical coverage. You will receive a taxable cash payment equal to 60 percent of the state contribution for employee-only tier medical insurance coverage.

2003 Medical Plan Monthly Premium Rates

	Employee	Employee & Spouse/Partner	Employee & Child(ren)	Employee & Family
Cascade East HMO	455.66	677.45	532.61	709.14
Kaiser Permanente HMO	419.28	624.74	490.57	654.07
Regence BCBSO PPO	446.18	662.84	520.54	694.26

All eligible employees must enroll in a PEBB dental plan. Even if you are covered by another dental plan, you must be enrolled in a PEBB-sponsored dental plan. Employee participation is mandatory. Employees may also enroll eligible dependents for dental coverage. For 2003, you may choose from the following dental plans:

- Kaiser Permanente if you live or work within 30 miles of a Kaiser Permanente facility where you can access dental care
- ODS Preferred and Traditional Plans, which are available statewide
- Willamette Dental Group (Denkor) if you live or work within the plan's service areas in Oregon, Washington or Idaho.

If you are a part-time employee, you have an additional dental plan option. The rates for this plan are listed on page 8. The plan is described in Section 4.

2003 Dental Plan Monthly Premium Rates

	Employee	Employee & Spouse/Partner	Employee & Child(ren)	Employee & Family
Kaiser Permanente	65.15	97.07	76.22	101.63
ODS Preferred	52.22	77.79	61.10	81.47
ODS Traditional	56.59	84.31	66.21	88.28
Willamette	44.24	65.93	51.78	69.02

Medical and Dental Enrollment Checklist

- ❑ Review the Medical and Dental plan summaries presented in Sections 2 and 3.
- ❑ Choose the plans that best meet your circumstances, including where you live and work.
- ❑ Look in the Eligibility Handbook or call PEBB if you have questions about your or your dependents' eligibility for coverage.
- ❑ Determine the monthly premium cost for the medical and/or dental plans you have selected.
- ❑ Calculate the total cost of your medical and dental choices and your basic life insurance using the Calculation Worksheet.
- ❑ Use the Monthly Rate Calculation Examples on pages 4 through 7 to confirm your calculations.
- ❑ Complete the medical and dental enrollment forms following the instructions on the coversheet of each form. Make a copy of the completed forms for your file. University System employees follow the Enrollment Form instructions below.
- ❑ Turn in your medical and dental enrollment forms to your agency within 60 days of your date of hire.

Oregon University System Employees

Using a number 2 pencil, carefully complete each section of your medical and dental enrollment form. Fill in the Open Enrollment circle at the top of the form. Write your Social Security Number in the boxes and fill in the circles below the number. The agency names and numbers requested on the form are:

OUS Chancellor's Office	58080
Eastern Oregon University	58010
Oregon Institute of Technology	58018
Oregon State University	58030
Portland State University	58090
Southern Oregon University	58040
University of Oregon	58050
Western Oregon University	58020

Calculation Worksheet for Medical, Required Life and Dental Monthly Premium Rates

1. Enter your monthly State contribution amount (from the 2003 State Benefits Contribution Notice or the University System Contribution Memo in your Open Enrollment packet). $_____

2. Enter $1.00 for mandatory basic life insurance. $_____

3. Enter the monthly premium amount for your choice of medical plan (from page 1). If you choose to opt out, please skip to the Opt Out Worksheet below. $_____

4. Enter the monthly premium amount for your choice of dental plan (from page 1). You are required to select at least employee-only dental coverage. You may also choose to cover eligible dependents. $_____

5. Add Lines 2, 3 and 4, and enter the total. $_____

6. Subtract the total from line 1, and enter the balance. If the balance is negative, refer to the State Benefits Contribution Notice or University System Contribution Memo for information about the Premium Subsidy. $_____

Calculation Worksheet for Employees Who Choose to Opt Out of PEBB Medical Coverage

1. **Full-time Employees**: Enter the employee-only monthly state contribution amount from the 2003 State Benefits Contribution Notice or University System Contribution Memo in your Open Enrollment Packet.

   Part-time Employees: Identify the full-time employee-only amount on your 2003 State Contribution Notice or University System Contribution Memo. Multiply that amount by the percentage of hours you work compared with full time. For example, if the employee-only contribution for full-time employees is $387.14 and you work 75% of full time, your contribution amount is $290.36 ($387.14 x 0.75 = $290.36).

   Enter the result. $_____

2. Multiply the number on line 1 by 0.6, and enter the result. $_____

3. Subtract $1.00 for mandatory basic life insurance from the amount on line 2. Enter the result. $_____

4. Enter the monthly premium amount for your choice of dental plan. You are required to be enrolled in employee-only dental coverage. You may also choose to cover eligible dependents. $_____

5. Subtract the amount on line 4 from the amount on line 3, and enter the balance. This is the amount of opt-out cash you will receive as monthly taxable income. $_____

Calculation Examples

The examples on the following pages show how combinations of medical and dental insurance choices affect the premium subsidy employees will receive in 2003.

Cascade East Health Plans Calculation Examples				
	Employee	**Employee & Spouse/partner**	**Employee & Child(ren)**	**Employee & Family**
Cascade East HMO with ODS Preferred Dental				
Contribution	387.14	520.12	443.59	531.97
Medical Rate	455.66	677.45	532.61	709.14
Dental Rate	52.22	77.79	61.10	81.47
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	508.88	756.24	594.71	791.61
Contribution – Total Rate	-121.74	-236.12	-151.12	-259.64
Agency Subsidy	121.74	236.12	151.12	259.64
Employee Balance	0.00	0.00	0.00	0.00
Cascade East HMO with ODS Traditional Dental				
Contribution	387.14	520.12	443.59	531.97
Medical Rate	455.66	677.45	532.61	709.14
Dental Rate	56.59	84.31	66.21	88.28
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	513.25	762.76	599.82	798.42
Contribution – Total Rate	-126.11	-242.64	-156.23	-266.45
Agency Subsidy	126.11	242.64	156.23	266.45
Employee Balance	0.00	0.00	0.00	0.00

Kaiser Permanente Calculation Examples				
	Employee	Employee & Spouse/Partner	Employee & Child(ren)	Employee & Family
Kaiser Permanente HMO with Kaiser Dental				
Contribution	387.14	520.12	443.59	531.97
Medical Rate	419.28	624.74	490.57	654.07
Dental Rate	65.15	97.07	76.22	101.63
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	485.43	722.81	567.79	756.70
Contribution – Total Rate	-98.29	-202.69	-124.20	-224.73
Agency Subsidy	98.29	202.69	124.20	224.73
Employee Balance	0.00	0.00	0.00	0.00
Kaiser Permanente HMO with ODS Preferred Dental				
Contribution	387.14	520.12	443.59	531.97
Medical Rate	419.28	624.74	490.57	654.07
Dental Rate	52.22	77.79	61.10	81.47
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	472.50	703.53	552.67	736.54
Contribution – Total Rate	-85.36	-183.41	-109.08	-204.57
Agency Subsidy	85.36	183.41	109.08	204.57
Employee Balance	0.00	0.00	0.00	0.00
Kaiser Permanente HMO with ODS Traditional Dental				
Contribution	387.14	520.12	443.59	531.97
Medical Rate	419.28	624.74	490.57	654.07
Dental Rate	56.59	84.31	66.21	88.28
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	476.87	710.05	557.78	743.35
Contribution – Total Rate	-89.73	-189.93	-114.19	-211.38
Agency Subsidy	89.73	189.93	114.19	211.38
Employee Balance	0.00	0.00	0.00	0.00
Kaiser Permanente HMO with Willamette Dental				
Contribution	387.14	520.12	443.59	531.97
Medical Rate	419.28	624.74	490.57	654.07
Dental Rate	44.24	65.93	51.78	69.02
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	464.52	691.67	543.35	724.09
Contribution – Total Rate	-77.38	-171.55	-99.76	-192.12
Agency Subsidy	77.38	171.55	99.76	192.12
Employee Balance	0.00	0.00	0.00	0.00

Regence BlueCross BlueShield of Oregon Calculation Examples				
	Employee	Employee & Spouse/Partner	Employee & Child(ren)	Employee & Family
Regence BCBSO PPO with Kaiser Dental				
Contribution	387.14	520.12	443.59	531.97
Medical Rate	446.18	662.84	520.54	694.26
Dental Rate	65.15	97.07	76.22	101.63
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	512.33	760.91	597.76	796.89
Contribution – Total Rate	-125.19	-240.79	-154.17	-264.92
Agency Subsidy	125.19	240.79	154.17	264.92
Employee Balance	0.00	0.00	0.00	0.00
Regence BCBSO PPO with ODS Preferred Dental				
Contribution	387.14	520.12	443.59	531.97
Medical Rate	446.18	662.84	520.54	694.26
Dental Rate	52.22	77.79	61.10	81.47
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	499.40	741.63	582.64	776.73
Contribution – Total Rate	-112.26	-221.51	-139.05	-244.76
Agency Subsidy	112.26	221.51	139.05	244.76
Employee Balance	0.00	0.00	0.00	0.00
Regence BCBSO PPO with ODS Traditional Dental				
Contribution	387.14	520.12	443.59	531.97
Medical Rate	446.18	662.84	520.54	694.26
Dental Rate	56.59	84.31	66.21	88.28
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	503.77	748.15	587.75	783.54
Contribution – Total Rate	-116.63	-228.03	-144.16	-251.57
Agency Subsidy	116.63	228.03	144.16	251.57
Employee Balance	0.00	0.00	0.00	0.00
Regence BCBSO PPO with Willamette Dental				
Contribution	387.14	520.12	443.59	531.97
Medical Rate	446.18	662.84	520.54	694.26
Dental Rate	44.24	65.93	51.78	69.02
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	491.42	729.77	573.32	764.28
Contribution – Total Rate	-104.28	-209.65	-129.73	-232.31
Agency Subsidy	104.28	209.65	129.73	232.31
Employee Balance	0.00	0.00	0.00	0.00

Medical Opt-out Calculation Examples				
Opt Out Cash to employee is 60% of the employee-only state contribution (0.6 x $387.14 =$232.28)				
	Employee	**Employee & Spouse/Partner**	**Employee & Child(ren)**	**Employee & Family**
Opt-Out with Kaiser Dental				
Opt Out Contribution	232.28	232.28	232.28	232.28
Dental Rate	65.15	97.07	76.22	101.63
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	66.15	98.07	77.22	102.63
Opt-Out Cash back	166.13	134.21	155.06	129.65
Opt-Out with ODS Preferred Dental				
Opt Out Contribution	232.28	232.28	232.28	232.28
Dental Rate	52.22	77.79	61.10	81.47
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	53.22	78.79	62.10	82.47
Opt-Out Cash Back	179.06	153.49	170.18	149.81
Opt-Out with ODS Traditional Dental				
Opt Out Contribution	232.28	232.28	232.28	232.28
Dental Rate	56.59	84.31	66.21	88.28
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	57.59	85.31	67.21	89.28
Opt-Out Cash Back	174.69	146.97	165.07	143.00
Opt-Out with ODS Willamette Dental				
Opt Out Contribution	232.28	232.28	232.28	232.28
Dental Rate	44.24	65.93	51.78	69.02
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	45.24	66.93	52.78	70.02
Opt-Out Cash Back	187.04	165.35	179.50	162.26

Additional 2003 Medical & Dental Plan Options for Part-time Employees

Eligible part-time employees may enroll in any of the plans described on pages 1-6. For 2003, the Benefit Board is also making the following additional options available to eligible part-time employees.

- Regence BlueCross BlueShield of Oregon (BCBSO) Part-time PPO
- Kaiser Permanente Part-time Employee HMO Plan
- ODS Part-time Employee Traditional Dental Plan

Section 4 summarizes these plans. The rates for these plans reflect an additional one-time subsidy for part-time employees who enroll in the additional part-time plan options. The purpose of the additional subsidy is to make these additional plans more affordable for part-time employees. The rates in the following medical plan tables show the initial monthly premium costs and the costs after the subsidies have been applied. These subsidies apply only to rates for eligible part-time employees who choose one of these additional option medical plans.

2003 Additional Option Part-time Employee Medical Plan Monthly Premium Rates

	Employee	Employee & Spouse/Partner	Employee & Child(ren)	Employee & Family
Kaiser Permanente Part-time HMO				
Original Rate	367.02	546.86	429.42	572.54
PEBB Subsidized Rate	**272.02**	**405.37**	**317.84**	**424.37**
Regence BCBSO Part-time PPO				
Original Rate	365.48	545.16	427.80	570.83
PEBB Subsidized Rate	**270.48**	**403.67**	**316.22**	**422.66**

2003 Additional Option Part-time Employee ODS Dental Plan Monthly Premium Rates

Employee Only $41.42	**Employee & Spouse/Partner** $61.72	**Employee & Child(ren)** $48.47	**Employee & Family** $64.62

Medical and Dental Enrollment Checklist for Part-time Employees with Additional Options

- ❑ Review the Medical and Dental plan summaries presented in Sections 2, 3 and 4.
- ❑ Choose the plans that best meet your circumstances, including where you live and work.
- ❑ Look in the Eligibility Handbook or call PEBB if you have questions about your or your dependent's eligibility for coverage.
- ❑ Determine the monthly premium cost for the medical and/or dental plans you have selected.
- ❑ Calculate the total cost of your medical and dental choices and your basic life insurance using the Calculation Worksheet on page 10.
- ❑ Use the Monthly Rate Calculation Examples on pages 4-7 and 10 to confirm your calculations.
- ❑ Complete the medical and dental enrollment forms following the instructions on the coversheet of each form. Make a copy of the completed forms for your file. University System part-time classified employees follow the Enrollment Form instructions below.
- ❑ Turn in your medical and dental enrollment forms to your agency as soon as possible but no later than 60 days of your date of hire.

Oregon University System Employees

Using a number 2 pencil, carefully complete each section of your medical and dental enrollment form. Fill in the Open Enrollment circle at the top of the form. Write your Social Security Number in the boxes and fill in the circles below the number. The agency names and numbers requested on the form are:

OUS Chancellor's Office	58080
Eastern Oregon University	58010
Oregon Institute of Technology	58018
Oregon State University	58030
Portland State University	58090
Southern Oregon University	58040
University of Oregon	58050
Western Oregon University	58020

Part-time Employee Additional Option Medical Plan Calculation Worksheet

1. From your 2003 State Contribution Notice or University System Contribution Memo, identify the full-time employee contribution amount for your coverage tier. Multiply that amount by the percentage of hours you work compared with full time. For example, if you are covered as employee only and the contribution for full-time employees is $387.14 and you work 75% of full time, your contribution amount is $290.36 ($387.14 x 0.75 = $290.36). Enter the result. $_____
2. Calculate your premium subsidy from your Contribution Notice or Memo; enter the result. $_____
3. Add lines 1 and 2, and enter the total. $_____
4. Enter $1.00 for mandatory basic life insurance. $_____
5. Enter the subsidized monthly premium cost of your choice of Additional Option Medical plans. $_____
6. Enter the monthly premium cost of your choice of dental plan. You are required to have at least employee only dental coverage. You may also cover dependents. $_____
7. Add lines 4, 5 and 6, and enter the total. $_____
8. Subtract line 7 from line 3, and enter the balance. This is the monthly payroll deduction for your medical, dental and basic life coverage. $_____

Calculation Examples

The following examples show how combinations of medical and dental insurance choices affect the premium subsidy part-time employees will receive if they enroll in one of the additional option plans for 2003. The examples show calculations for part-time employees who work 50 percent and 80 percent of full time. If you work a different percentage of time or would like to enroll in a different dental plan, use the Calculation Worksheet on page 3 to determine the monthly costs.

Additional Option Part-time Employee Kaiser HMO With Part-time ODS Dental				
	Employee	Employee & Spouse/Partner	Employee & Child(ren)	Employee & Family
50% Contribution & Subsidy				
Contribution	193.57	260.06	221.80	265.99
Subsidized Medical Rate	272.02	405.37	317.84	424.37
Dental Rate	41.42	61.72	48.47	64.62
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	314.44	468.09	367.31	489.99
Contribution – Total Rate	-120.87	-208.03	-145.51	-224.00
Agency Subsidy	56.00	112.00	69.50	123.50
Employee Balance	-64.87	-96.03	-76.01	-100.50
80% Contribution & Subsidy				
Contribution	309.71	416.10	354.87	425.58
Subsidized Medical Rate	272.02	405.37	317.84	424.37
Dental Rate	41.42	61.72	48.47	64.62
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	314.44	468.09	367.31	489.99
Contribution – Total Rate	-4.73	-51.99	-12.44	-64.41
Agency Subsidy	4.73	51.99	12.44	64.41
Employee Balance	0.00	0.00	0.00	0.00

Additional Option Part-time Employee Regence BCBSO PPO with Part-time ODS Dental				
	Employee	Employee & Spouse/Partner	Employee & Child(ren)	Employee & Family
50% Contribution & Subsidy				
Contribution	193.57	260.06	221.80	265.99
Subsidized Medical Rate	270.48	403.67	316.22	422.66
Dental Rate	41.42	61.72	48.47	64.62
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	312.90	466.39	365.69	488.28
Contribution – Total Rate	-119.33	-206.33	-143.89	-222.29
Agency Subsidy	56.00	112.00	69.50	123.50
Employee Balance	-63.33	-94.33	-74.39	-98.79
80% Contribution & Subsidy				
Contribution	309.71	416.10	354.87	425.58
Subsidized Medical Rate	270.48	403.67	316.22	422.66
Dental Rate	41.42	61.72	48.47	64.62
Basic Life Rate	1.00	1.00	1.00	1.00
Total Rate	312.90	466.39	365.69	488.28
Contribution – Total Rate	-3.19	-50.29	-10.82	-62.70
Agency Subsidy	3.19	50.29	10.82	62.70
Employee Balance	0.00	0.00	0.00	0.00

Life and Disability Plans

Optional Life Insurance

All eligible employees must enroll for Basic Life Insurance. The benefit is $5,000. The monthly premium cost of $1 is deducted from your monthly state contribution.

Employees may also enroll for additional, optional life insurance for themselves and their spouse or domestic partner. The following table presents the current rates.

Monthly Optional Life Insurance Premium Rates											
2003 Employee & Spouse or Domestic Partner Life Insurance Premium Rates											
Age	**To 25**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70& up**
Rate Per $10,000	$0.50	$0.60	$0.80	$0.90	$1.00	$1.50	$2.30	$4.30	$6.60	$12.70	$20.60
AMOUNT											
$20,000	$1.00	$1.20	$1.60	$1.80	$2.00	$3.00	$4.60	$8.60	$13.20	$25.40	$41.20
$40,000	$2.00	$2.40	$3.20	$3.60	$4.00	$6.00	$9.20	$17.20	$26.40	$50.80	$82.40
$60,000	$3.00	$3.60	$4.80	$5.40	$6.00	$9.00	$13.80	$25.80	$39.60	$76.20	$123.60
$80,000	$4.00	$4.80	$6.40	$7.20	$8.00	$12.00	$18.40	$34.40	$52.80	$101.60	$164.80
$100,000	$5.00	$6.00	$8.00	$9.00	$10.00	$15.00	$23.00	$43.00	$66.00	$127.00	$206.00
$120,000	$6.00	$7.20	$9.60	$10.80	$12.00	$18.00	$27.60	$51.60	$79.20	$152.40	$247.20
$140,000	$7.00	$8.40	$11.20	$12.60	$14.00	$21.00	$32.20	$60.20	$92.40	$177.80	$288.40
$160,000	$8.00	$9.60	$12.80	$14.40	$16.00	$24.00	$36.80	$68.80	$105.60	$203.20	$329.60
$180,000	$9.00	$10.80	$14.40	$16.20	$18.00	$27.00	$41.40	$77.40	$118.80	$228.60	$370.80
$200,000	$10.00	$12.00	$16.00	$18.00	$20.00	$30.00	$46.00	$86.00	$132.00	$254.00	$412.00
$220,000	$11.00	$13.20	$17.60	$19.80	$22.00	$33.00	$50.60	$94.60	$145.20	$279.40	$453.20
$240,000	$12.00	$14.40	$19.20	$21.60	$24.00	$36.00	$55.20	$103.20	$158.40	$304.80	$494.40
$260,000	$13.00	$15.60	$20.80	$23.40	$26.00	$39.00	$59.80	$111.80	$171.60	$330.20	$535.60
$280,000	$14.00	$16.80	$22.40	$25.20	$28.00	$42.00	$64.40	$120.40	$184.80	$355.60	$576.80
$300,000	$15.00	$18.00	$24.00	$27.00	$30.00	$45.00	$69.00	$129.00	$198.00	$381.00	$618.00
$320,000	$16.00	$19.20	$25.60	$28.80	$32.00	$48.00	$73.60	$137.60	$211.20	$406.40	$659.20
$340,000	$17.00	$20.40	$27.20	$30.60	$34.00	$51.00	$78.20	$146.20	$224.40	$431.80	$700.40
$360,000	$18.00	$21.60	$28.80	$32.40	$36.00	$54.00	$82.80	$154.80	$237.60	$457.20	$741.60
$380,000	$19.00	$22.80	$30.40	$34.20	$38.00	$57.00	$87.40	$163.40	$250.80	$482.60	$782.80
$400,000	$20.00	$24.00	$32.00	$36.00	$40.00	$60.00	$92.00	$172.00	$264.00	$508.00	$824.00

You may also enroll for Dependent Life Insurance coverage for your spouse, domestic partner and child(ren) for $5,000 each. The monthly premium rate is $1.23.

Required Employee Basic Life Insurance Premium Rate

$1.00 per month

Optional Dependent Life Insurance Premium Rate

$1.23 per month

Accidental Death and Dismemberment Insurance

PEBB also offers Accidental Death and Dismemberment Insurance for employees alone and for employees and their dependents. The rates are shown in the following table.

2003 Accidental Death & Dismemberment Premium Rates		
Amount	**Employee**	**Employee & Dependents**
$50,000	$1.25	$2.10
$100,000	$2.50	$4.20
$150,000	$3.75	$6.30
$200,000	$5.00	$8.40
$250,000	$6.25	$10.50
$300,000	$7.50	$12.60
$350,000	$8.75	$14.70
$400,000	$10.00	$16.80
$450,000	$11.25	$18.90
$500,000	$12.50	$21.00

Short-term and/or Long-term Disability Insurance

Eligible employees may also enroll for Short-term and/or Long-term Disability Insurance. Current disability insurance rates are shown in the following table.

2003 Short & Long Term Disability Premium Rates		
Duration	Coverage	Rate
Premium = rate X monthly salary		
Short term	60%	$0.0055
Long Term		
Option 1	90-day@60%	$0.0063
Option 2	180-day@60%	$0.0025
Option 3	90-day@$66^{2/3}$%	$0.0099
Option 4	180-day@$66^{2/3}$%	$0.0035

Life and Disability Insurance Checklist

- ❑ Review the descriptions of the life and disability options on pages 63 through 73. Choose any that meet your anticipated needs and circumstances.
- ❑ Determine the monthly premium rates for the coverage you want to select.
- ❑ Calculate the cost of your voluntary life and disability plan choices using the Optional Life and Disability Insurance Calculation Worksheet.
- ❑ Complete the Life and Disability Enrollment Form in your enrollment packet. Follow the instructions on the form coversheet.
- ❑ You must complete a Medical History Statement if you are a new employee enrolling for more than $20,000 of Optional Employee, Spouse or Partner Life coverage within 60 days of your date of hire. Current employees enrolling for any amount of Optional Employee, Spouse or Partner Life coverage must also complete a Medical History Statement. A separate statement must be completed for each person applying for coverage. Submit the top portion of the statement(s) to your agency (with your enrollment form) and send the bottom portion of the statement to:

  The Standard Life Insurance Company
  PO Box 2800
  Portland, OR 97208-2800.

- ❑ Turn in your new enrollment form to your agency no later than 60 days from your date of hire.

Optional Life and Disability Insurance Calculation Worksheet

If you wish to enroll in optional life and disability coverage, list those costs below. Premium costs are deducted from your pay monthly.

1. Enter your Optional Employee Life Insurance premium. $ _____
2. Enter your Optional Spouse or Domestic Partner Life Insurance premium. $ _____
3. Enter your Dependent Life Insurance premium. $ _____
4. Enter your Accidental Death & Dismemberment Insurance premium. $ _____
5. Enter your Short Term Disability Insurance premium. $ _____
6. Enter your Long Term Disability Insurance premium. $ _____
7. Add lines 1 through 6. This is the monthly payroll deduction for your optional life and disability coverage. $ _____

Other Benefits

In addition to medical, dental, life and disability insurance, PEBB also offers Dependent Care Flexible Spending Accounts and Long-term Care Insurance coverage to eligible employees. If you would like to enroll in either of these options, read the information in Sections 6 and 7, and complete the applicable forms. See Section 8 for information about the PEBB statewide wellness program for PEBB members.

PEBB Medical Plans At A Glance

2003 Medical Plans at a Glance

	Cascade East	Kaiser Permanente	Regence BlueCross BlueShield of Oregon	
Type of Plan	HMO/POS [1]	HMO	PPO	
Maximum Out of Pocket			Preferred Providers	Non-preferred Providers
Individual	$1,000	$1,000	$1,000	$2,000
Family	$2,000	$3,000	$3,000	$6,000
Individual Lifetime Max	$1 million	No limit	$2 million	
Type of Providers	Participating providers	Kaiser only	Any licensed provider; you pay less for preferred providers	
Type of Service	**You pay**	**You pay**	**You pay preferred**	**You pay non-preferred**
Office Visit				
Primary Care Provider	$10	$10	15%	30%
Specialist Provider	$10	$10	15%	30%
X-ray and lab	$0	$0	15%	30%
Preventive Care [2]				
Periodic health appraisal [3]	$10	$0	0%	30%
Well-child checkup	$10	$0	0%	30%
Routine immunization	$0	$0	0%	0%
Hearing screenings	$10	$10	0%	30%
Hearing exam and aids	Not covered	$10 [4]	15% [5]	30% [5]
Mammography screening	$0	$0	0%	30%
Hospital				
Ambulance	$50	$75	15%	30%
Inpatient (unlimited days)	$100/day [6]	$50/day [7]	15%	30%
Outpatient	$0	$10	15%	30%
Emergency Room	$50 [8]	$75 [8]	15%	30%
Surgery				
Inpatient	$0	$0	15%	30%
Outpatient	$0	$10	15%	30%
Office-based	$0	$10	15%	30%
Maternity, Gynecology				
Prenatal, postpartum office	$50/pregnancy	$0	15%	30%
Inpatient delivery	$100/day [6]	$50/day [7]	15%	30%
Routine women's exams	$10	$10	$10	30%
Infertility diag., treatment	Not covered	50%	50% [10]	50% [10]
Insulin & Diabetic Sup. [9]	$0	$0	0%	0%
Mental Health [10]				
Inpatient & residential	$100/day [6]	$50/day [7]	15%	30%
Outpatient	$10	$10	15%	30%
Chemical Dependency [10]				
Inpatient & residential	$100/day [6, 15]	$50/day [7]	15%	30%
Outpatient	$10 [11]	$10	15%	30%
Alternative care [12]	$15 [13]	$15 [14]	30%	30%
Durable medical equip.	20%	$0	15%	30%

See footnotes on facing page

[1]Point-of-service option allows you to self-refer to any provider; this benefit pays 70% after you meet $300 deductible.
[2] Based on the plan's schedule.
[3]Includes commercial drivers license exams for employees, except for Cascade East.
[4]Hearing aids covered at 100% to $500 per ear per aid per 36 months.
[5] Hearing aids covered at 100% to $500 per person per 36 months.
[6]You pay $100/day up to $500/stay; then you pay nothing for eligible expenses.
[7]You pay $50/day up to $250/stay; then you pay nothing for eligible expenses.
[8]Waived if patient is admitted.
[9]All plans cover insulin and diabetic supplies in full.
[10]Some diagnoses and treatments may not be covered benefits.
[11]Limited to 52 visits in 24 months.
[12]Includes chiropractic, naturopathic and acupuncture services.
[13]Limited to 20 visits or $1,000, whichever comes first per year.
[14]Limited to $1,000 per year.
[15]Other limitations apply.

2003 Medical Plans Prescription Coverage at a Glance

Cascade East Health Plans			Kaiser Permanente			Regence BCBSO		
Retail	**Supply**	**You Pay**	**Kaiser retail**	**Supply**	**You Pay**	**Retail**	**Supply**	**You pay**
Generic formulary	34-day	$10	Generic formulary	30-day	$10	Generic	34-day	$10
Brand formulary	34-day	$20	Brand formulary	30-day	$15	Preferred	34-day	$15
Non-formulary[1]	34-day	$30	Non-formulary	Not covered		Nonpreferred	34-day	$25
Mail Order			**Mail Order**			**Mail Order**		
Generic formulary	90-day	$30	Maintenance generic	90-day	$10	Generic	90-day	$10
Brand formulary	90-day	$60	Maintenance brand	90-day	$15	Preferred	90-day	$15
Non-formulary[1]	90-day	$90	Non-formulary	Not covered		Nonpreferred	90-day	$25

[1]Prescription drugs not on the Cascade East formulary require prior-authorization.

2003 Routine Vision Coverage

Plan Carrier	**Kaiser Permanente[1]**	**Vision Service Plan (VSP)[2]**	
Services Provided To	Kaiser Permanente members	Regence BlueCross Blue Shield of Oregon, Cascade East Health Plans members	
Type of Service	**You pay**	**You pay VSP doctor**	**You pay out of network**
Routine exam	$10	$10	$10 and additional amount above $42
Complete set of glasses or contacts	Amount above $150 allowance[3]	Amount above $160 allowance[3,4]	Amount above $160 allowance[3]
Laser vision correction	Not covered	Discounts vary by provider	Not covered; no discount

[1]Eyewear allowance provided every 24 months. Routine vision exams provided as needed.
[2]Benefits provided every 12 months for children younger than 17 and every 24 months for adults.
[3]If total allowance is not used at one time, the remainder will be forfeited.
[4] Plan provides 20% discount on complete pairs of prescription glasses and 15% off VSP doctor's professional services when buying contact lenses. Discounts good only for 12 months after date of service of exam and when provided by the same doctor who performed the exam.

Your PEBB Medical Plan Options

Health Maintenance Organization Plans

Health maintenance organization (HMO) plans offer a comprehensive level of services and benefits. PEBB HMO plans are available in specific areas of the state.

To be eligible for benefits from an HMO, you must use the providers (physicians and hospitals) that are part of the plan. You select a primary care physician (PCP) who coordinates your medical care. In most cases, your PCP must approve your treatments, services and referrals to any specialists for these benefits to be paid by the plan. If you do not get a referral or seek care elsewhere, the plan may not pay for the services or may pay a reduced amount.

HMO plans offer advantages in costs and covered services. When you receive care, you usually pay a small, fixed amount called a co-payment. You may also have better coverage for some services such as preventive care. Typically, you will not have to file claim forms.

PEBB sponsors the following HMO plans for 2003:

- Cascade East Health Plan for those who live or work in Umatilla and Morrow Counties
- Kaiser Permanente for those who live or work within 30 miles of a Kaiser Permanente facility in metropolitan Portland, and in Marion, Polk, Linn and portions of Benton county.

Preferred Provider Organization Plans

Preferred provider organization (PPO) plans offer medical services and benefits at two levels of coverage — from preferred providers and from non-preferred providers. When you are in a PPO, you may use any doctors you wish, whether they are preferred providers or not. If you use doctors who are preferred, you pay less when you receive care. If you use providers who are not preferred, you pay more.

- For 2003 PEBB sponsors the Regence BlueCross BlueShield of Oregon PPO plan, which is available statewide. The Regence BCBSO PPO Provider Directory includes lists of both preferred and participating providers. Preferred providers are listed as "PPP." Participating providers are listed as "PAR." If your provider is not listed as either PPP or PAR, they are non-participating and will be considered non-preferred. Only "PPP" designated physicians are considered preferred. "PAR" physicians are considered non-preferred.

Rural Counties PPO Benefit

Some areas of the state have limited preferred providers. In these counties, PEBB has arranged for resident members to receive the preferred provider level of benefit from providers who are either preferred or participating in Regence BCBSO contracts.

This means that if you live in a designated rural county, are enrolled on the Regence BlueCross BlueShield of Oregon plan, and receive care from a preferred or participating provider, you will receive the preferred level of benefits. If you choose to see a non-participating provider, you will receive the preferred benefits, however the provider may bill you for any amounts above Regence BCBSO maximum allowable fees.

The designated rural counties are: Baker, Crook, Curry, Deschutes, Gilliam, Grant, Harney, Jackson, Jefferson, Josephine, Klamath, Lake, Malheur, Morrow, Sherman, Tillamook, Union, Wallowa, and Wheeler.

Opting Out

Employees covered by another group medical plan may opt out of medical insurance within 60 days of their date of hire or during Open Enrollment. Employees requesting to opt out must provide proof of other group insurance coverage. Employees who opt out of coverage for 2003 will receive 60 percent of the state's employee-only contribution for medical benefits in lieu of medical coverage. PEBB determines the Opt-Out availability and formula annually.

For purposes of opting out, group medical plan means any medical plan offered or contributed to by an employer or former employer. Group health plan includes coverage provided by the federal government or other governmental entities as an employer or former employer. Examples are Champus or Tri Care and other group coverage approved by PEBB. Federal or other governmental benefits such as Medicare and Medicaid are not group health plans. Individual plan coverage does not qualify an individual for Opt Out.

Cascade East Health Plans HMO	
Annual Out-of-Pocket Maximum	$1,000/ person; $2,000/family
Type of Provider	Participating providers[1]
TYPE OF SERVICE	**YOU PAY**
Primary care office visit	$10 co-payment per visit
Specialist office visit	$10 co-payment per visit
X-ray & lab	$0
PREVENTIVE CARE	
Periodic health appraisals [2]	$10 co-payment per visit
Well-child checkups (to 19)	$10 co-payment per visit
Hearing screenings	$10 co-payment per visit
Hearing exam & aids	Not covered
Routine immunizations (to 19)	$0
Mammography screening	$0
HOSPITAL	
Ambulance	$50
Inpatient (unlimited days)	$100 co-payment per day up to $500 maximum per stay
Outpatient	$0
Emergency room	$50 co-payment, waived if admitted
SURGERY	
Inpatient	$0
Outpatient	$0
Office-based	$0
MATERNITY & GYNECOLOGY	
Prenatal and postpartum office visits	$50 co-payment per pregnancy
Inpatient Delivery (vaginal or Cesarean)	$100 co-payment per day up to $500 maximum per stay
Routine women's exams	$10 co-payment per visit
Infertility treatment	Not covered
PRESCRIPTION DRUGS	Per 30-day supply retail; per 90-day supply mail order
Generic	$10 co-payment; $30 co-payment
Preferred	$20 co-payment; $60 co-payment
Non-preferred	Not covered
ROUTINE VISION SERVICES (per 12 months children; per 24 months adults) **Benefits provided by VSP**	
Routine vision exam	$10 co-payment per exam
Frames, lenses, contacts	Amount above $160 allowance (additional discounts available from VSP doctors)
MENTAL HEALTH	
Inpatient & Residential	$100 co-payment per day up to $500 per stay
Outpatient	$10 co-payment per visit
CHEMICAL DEPENDENCY	
Inpatient & residential	$100 co-payment per day up to $500 per stay; other limitations apply
Outpatient	$10 co-payment per visit; limited to 52 visits per 24 months
Durable Medical Equipment	20% coinsurance
Alternative Care	$15 co-payment/visit; limited to 20 visits/yr or $1000 in services, whichever comes first

[1] *Under point-of-service option, you pay $300 deductible and 30% coinsurance when using non-participating providers.*

[2] *Based on a schedule. Excludes commercial drivers license exam.*

Cascade East Health Plans

645 West Orchard Avenue
Hermiston, OR 97838
Phone: (541) 567-5555
(866) 577-CEHP (2347)

The Cascade East Health Plan HMO serves employees who live or work in Umatilla or Morrow Counties.

How the Medical Plan Works

With Cascade East you must select a primary care provider (PCP) to coordinate all your care. You may change PCPs up to four times per year, and every member of your family may choose a different PCP. When you select and use a primary care provider, you will not have to pay a deductible before benefits start – only a small co-payment at the time of service. We encourage you to use preventive care and early detection benefits.

You may select a physician or an advanced registered nurse practitioner as your PCP. You may also receive services from a physician's assistant who is supervised by a PCP. Your PCP will take care of most of your health care needs, will send you to a specialist if you need one, and will arrange to admit you to a hospital if necessary.

The PCP is extremely important. This provider normally will be the first person called when you need medical care during normal office hours. The PCP assumes the primary responsibility for medical care, makes referrals when needed for more specialized services and maintains medical records. If your PCP is unavailable, he or she will arrange for another participating provider to assume responsibility for your care.

When you and your enrolled dependents have selected your PCPs, we will notify the PCPs. You should then contact the PCP's office to introduce yourselves as new CEHP members and arrange for medical records to be transferred, if needed.

To change your PCP, you may either notify us in writing or call our Customer Service Department before obtaining treatment from a new PCP. PCP changes will become effective on the first of the month following notification. You may change your PCP a maximum of four times in 12 months.

Besides the managed care benefit when you coordinate care through your primary care practitioner, we have a Point of Service (POS) option. The POS option allows you to self refer at any time to any provider. This benefit, however, is paid at 70% after you meet a $300 deductible. The POS option goes into effect only when you do not get a referral from your PCP. If your PCP refers you, (and, if required, the referral is prior authorized by CEHP), your managed care co-payment is all that applies.

The care needed by most Cascade East members can be provided by local practitioners or Good Shepherd Medical Center. When appropriate, members may be referred to the Tri-Cities, Walla Walla, Spokane, The Dalles or Portland, where Cascade East has contracts with hospitals and physicians.

Prior Authorization

Your PCP will request prior authorization by CEHP of all hospital admissions (except those for childbirth), any referral outside of the service area, and some other infrequently used services. Prior authorization assures you and the referral provider that those services will be covered. Emergency care requires no prior authorization.

Emergency Care

In a medical emergency only, we will cover emergency care provided at the nearest appropriate facility even though it may not be your primary hospital or a participating facility.

Prescription Drug Plan

The Cascade East Prescription Drug program is administered by Express Scripts. For a listing of participating pharmacies, refer to the CEHP Provider Directory, or call CEHP Customer Service. You will receive mail-order information and order forms in the new member packet you receive with your ID card. Cascade East will assist you with benefit information, location of the nearest participating pharmacy, eligibility status, prior authorizations, and billing information and assistance.

Contact Cascade East Customer Service at (541) 567-5555 or toll free (866) 577-CEHP (2347).

You pay a flat dollar amount – called a co-payment – at participating pharmacies at the time you purchase a 34-day supply of your prescription. Your co-payment amount depends on your choice of drugs. You pay $10 for a preferred generic drug on the CEHP formulary, and $20 for preferred brands on the CEHP formulary.

Drugs not on the CEHP formulary must have prior authorization to be covered by the plan.

You also have a mail-order benefit that allows you to purchase your medications through Express Scripts. You may purchase a 90 day-supply of your prescription by mail order. You pay $30 for a preferred generic drug on the CEHP formulary and $60 for preferred brands on the CEHP formulary.

Our Formulary

The following list of drugs is a condensed version of the Cascade East Health Plans formulary of preferred generic and brand drugs. This list is subject to change.

TOPICAL ANESTHETICS

ethyl chloride -generic
lidocaine – generic, LIDODERM
lidocaine/prilocaine - EMLA
tetracaine hcl – generic
tetracaine/benzocaine/butamben - CETACAINE

ANTIINFECTIVES

CEPHALOSPORINS
cefaclor - generic
cefadroxil – generic, DURICEF
cefprozil - CEFZIL
cefuroxime axetil - CEFTIN
cephalexin - generic
cephradine - generic

CLINDAMYCINS
clindamycin hcl - generic

MACROLIDES
azithromycin - ZITHROMAX
clarithromycin - BIAXIN
erythromycin base – generic, ERY-TAB, PCE
erythromycin estolate – generic
erythromycin ethylsuccinate – generic
erythromycin stearate - generic

PENICILLINS
amoxicillin – generic, AMOXIL
amoxicillin/ clavulanate - AUGMENTIN
ampicillin trihydrate - generic
cloxacillin sodium - generic
dicloxacillin – generic, DYNAPEN
oxacillin – generic, BACTOCILL
penicillin g potassium - generic
penicillin v potassium - generic

SULFONAMIDES & COMBINATIONS
erythromycin/sulfisoxazole – generic
sulfadiazine - generic
sulfamethoxazole/trimethoprim – generic
sulfisoxazole – generic
sulfisoxazole acetyl – GANTRISIN PEDIATRIC
sulfisoxazole/phenazopyridine - AZO-GULFASIN

TETRACYCLINES
doxycycline hyclate – generic
minocycline – generic, DYNACIN
tetracycline - generic

URINARY ANTIINFECTIVES
cinoxacin - generic
fosfomycin tromethamine - MONUROL
methenamine mandelate - generic
nitrofurantoin - FURADANTIN
nitrofurantoin macrocrystal - generic
nitrofurantoin/nitrofuran mac - MACROBID
trimethoprim – generic, PRIMSOL

QUINOLONES
ciprofloxacin - CIPRO
levofloxacin - LEVAQUIN
ofloxacin – FLOXIN
moxifloxacin - AVELOX

TOPICAL ANTIBACTERIAL DRUGS
bacitracin - generic
gentamicin - generic
mupirocin - BACTROBAN
silver sulfadiazine – generic

ORAL ANTIFUNGAL DRUGS
clotrimazole - MYCELEX TROCHE
fluconazole - DIFLUCAN
flucytosine - ANCOBON
griseofulvin microsize – generic, GRIFULVIN V SUSP
griseofulvin ultramicrosize – generic
ketoconazole - generic
nystatin - generic
terbinafine - LAMISIL
traconazole - SPORANOX

TOPICAL ANTIFUNGALS & COMBINATIONS
ciclopirox - LOPROX
clotrimazole – generic
clotrimazole/betamethasone - LOTRISONE
econazole - SPECTAZOLE
ketoconazole - generic, NIZORAL

miconazole nitrate - FUNGOID
neo/gramicid/nystatin/triamcin - generic
nystatin - generic
nystatin/triamcinolone - generic

ORAL ANTIVIRAL DRUGS

abacavir sulfate - ZIAGEN
acyclovir - ACYCLOVIR
amantadine - AMANTADINE
amprenavir - AGENERASE
delavirdine mesylate - RESCRIPTOR
didanosine - VIDEX
efavirenz - SUSTIVA
famciclovir - FAMVIR
ganciclovir - CYTOVENE
indinavir - CRIXIVAN
lamivudine –EPIVIR/HBV
lamivudine/zidovudine - COMBIVIR
lopinavir – ritonavir - KALETRA
nelfinavir mesylate - VIRACEPT
nevirapine - VIRAMUNE
rimantadine - FLUMADINE
ritonavir - NORVIR
saquinavir - FORTOVASE
saquinavir mesylate - INVIRASE
stavudine - ZERIT
valacyclovir - VALTREX
zalcitabine - HIVID
zidovudine - RETROVIR

TOPICAL ANTIVIRAL DRUGS

acyclovir - ZOVIRAX OINTMENT

ANTIINFECTIVES SPECIALIZED INDICATIONS

atovaquone - MEPRON
bacitracin - generic
chloroquine phosphate - generic
dapsone - DAPSONE
ethambutol - generic, MYAMBUTOL
hydroxychloroquine - generic
isoniazid - generic
linezolid - ZYVOX
mebendazole - generic
metronidazole - generic
neomycin - generic
paromomycin - PAROMOMYCIN
pentamidine - NEBUPENT
piperazine citrate - generic
polymyxin b - POLYMYXIN B SULFATE
pyrazinamide - generic
pyrimethamine - DARAPRIM
quinine sulfate - generic
rifabutin - MYCOBUTIN
rifampin - RIFAMPIN, RIMACTANE
thiabendazole - MINTEZOL
vancomycin - VANCOCIN

ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS

altretamine - HEXALEN
anagrelide - AGRYLIN
anastrozole - ARIMIDEX
azathioprine - generic,IMURAN
bexarotene - TARGRETIN
bicalutamide - CASODEX
busulfan - MYLERAN
capecitabine - XELODA
chlorambucil - LEUKERAN
cyclophosphamide - generic, CYTOXAN
cyclosporine – generic, NEORAL, SANDIMMUNE
estramustine phosphate sodium - EMCYT
etanercept - ENBREL
etoposide - VEPESID
flutamide - EULEXIN
hydroxyurea - generic
leflunomide - ARAVA
letrozole - FEMARA
leucovorin - LEUCOVORIN CALCIUM
levamisole - ERGAMISOL
lomustine - CEENU
megestrol – generic, MEGACE
melphalan - ALKERAN
mercaptopurine - PURINETHOL
methotrexate - generic
mitotane - LYSODREN
mycophenolate mofetil - CELLCEPT
nilutamide - NILANDRON
octreotide - SANDOSTATIN
procarbazine - MATULANE
sirolimus - RAPAMUNE
tacrolimus - PROGRAF
tamoxifen - NOLVADEX
temozolomide - TEMODAR
testolactone - TESLAC
thioguanine - THIOGUANINE
tretinoin - VESANOID
uracil mustard - URACIL MUSTARD

CARDIOVASCULAR MEDICATIONS

CARDIAC GLYCOSIDES

digoxin - generic, LANOXICAPS, LANOXIN

CALCIUM ANTAGONISTS

amlodipine - NORVASC
diltiazem – generic, DILACOR XR, TIAZAC
felodipine - PLENDIL
nicardipine - generic
nifedipine – generic, ADALAT CC, PROCARDIA XL, NIMOTOP
nisoldipine - SULAR
verapamil – generic, CALAN SR

DIURETICS

amiloride hydrochloride - generic
bumetanide - generic
chlorthalidone – generic
furosemide - generic
hctz/amiloride - generic
hctz/triamterene - generic
hydrochlorothiazide - generic
hydroflumethiazide - DIUCARDIN
indapamide - generic
methyclothiazide - generic
metolazone - MYKROX,ZAROXOLYN

spironolactone - generic
spironolactone/hctz - generic
torsemide - DEMADEX
trichlormethiazide - generic

BETA-ADRENERGIC ANTAGONIST DRUGS

acebutolol - generic
atenolol - generic
betaxolol - generic
carvedilol - COREG
labetalol – generic
metoprolol succinate - TOPROL XL
metoprolol tartrate - generic
nadolol - NADOLOL
penbutolol - LEVATOL
pindolol - generic
propranolol - generic
timolol - generic

ANTIHYPERTENSIVE AND COMBINATION DRUGS

benazepril/amlodipine besylate - LOTREL
benazepril/hctz - LOTENSIN HCT
captopril/hctz - generic
chlorthalidone/atenolol - generic
clonidine – generic, CATAPRES-TTS
clonidine hcl/chlorthalidone -generic
doxazosin - CARDURA
enalapril maleate/felodipine - LEXXEL
guanabenz - generic
guanethidine - ISMELIN
guanfacine - generic
hctz/bisoprolol fumarate – generic, ZIAC
hctz/propranolol - generic
hctz/valsartan - DIOVAN HCT
hydralaz/reserpine/hctz - generic
hydralazine - generic
hydralazine/hctz - generic
lisinopril/hctz - ZESTORETIC
methyldopa - generic
methyldopa/hctz - generic
minoxidil - generic
prazosin - generic
rauwolfia serpentina/bfmtz - generic
reserpine - generic
reserpine/hctz - HYDROSINE
terazosin – geneirc, HYTRIN
trandolapril/verapamil - TARKA

ACE INHIBITORS

benazepril - LOTENSIN
captopril - generic
lisinopril - ZESTRIL
quinapril - ACCUPRIL
ramipril - ALTACE

ANGIOTENSIN II RECEPTOR ANTAGONISTS

candesartan cilexetil - ATACAND
irbesartan - AVAPRO
losartan - COZAAR
telmisartan - MICARDIS
valsartan - DIOVAN

VASODILATING DRUGS

ethaverine - ETHAVERINE
isosorbide dinitrate – generic, DILATRATE-SR
isosorbide mononitrate – generic, IMDUR
nitroglycerin – generic, NITRO-DUR, NITROSTAT
papaverine - generic

ANTIDYSRHYTHMIC DRUGS

CLASS 1 - MEMBRANE STABILIZING

moricizine - ETHMOZINE

CLASS 1A

procainamide – generic, PROCANBID
quinidine sulfate - generic
quinidine gluconate - generic
disopyramide – generic,NORPACE CR
quinidine sulfate - generic

CLASS 1B

mexiletine - generic
tocainide - TONOCARD

CLASS 1C

flecainide - TAMBOCOR
propafenone - RYTHMOL

OTHER ANTIARRHYTHMICS

amiodarone - generic, CORDARONE
dofetilide - TIKOSYN
sotalol – generic, BETAPACE/-AF

ANTILIPIDEMIC DRUGS

atorvastatin calcium - LIPITOR
cerivastatin - BAYCOL
cholestyramine/aspartame - generic
cholestyramine/sucrose - generic
clofibrate - CLOFIBRATE
colestipol - COLESTID
gemfibrozil - generic
niacin –NIASPAN
pravastatin - PRAVACHOL

OTHER CARDIOVASCULAR DRUGS

midodrine - PROAMATINE
pentoxifylline - generic

AUTONOMIC AND CNS MEDICATIONS

ANALGESICS

acetaminophen/phenyltolox - NOVAGESIC
butorphanol - STADOL NS
codeine phosphate/apap - generic
codeine phosphate/aspirin - generic
codeine sulfate - generic
dihydrocodeine/apap/caffeine - DHC PLUS
hydrocodone bitartrate/apap - generic,LORTAB ELIXIR
hydrocodone bitartrate/apap – generic, LORCET/PLUS/HD, NORCO
hydrocodone bitartrate/aspirin - generic
levorphanol - generic
meperidine - generic
meperidine/promethazine – generic

methadone – generic, DOLOPHINE
morphine - generic, MSIR, MS CONTIN
opium/belladonna alkaloids - generic, B & O
oxycodone - generic, OXYFAST, OXYCONTIN, OXYIR
oxycodone/acetaminophen – generic
oxycodone/aspirin - generic
pentazocine/naloxone – generic
propoxyphene hcl - generic
propoxyphene hcl/acetaminophen - generic
propoxyphene hcl/asa/caffeine - generic
propoxyphene napsylate/apap - generic
salicylate/phenyltolox - generic

DRUGS TO PREVENT AND TREAT HEADACHES

acetaminophen/butalbital - generic, AXOCET,PHRENILIN, PHRENILIN FORTE
acetaminophen /butalbital/codeine/ caffeine – FIORICET/CODE3, FIORINAL/CODE3
acetaminophen/caffeine/butalb - generic,ESGIC/-PLUS
apap/isometheptene/dichlphen – generic, MIDRIN
aspirin/caffeine/butalbital - generic
aspirin/meprobamate - EQUAGESIC
codeine/asa/caffeine/butalb – generic
dihydroergotamine - D.H.E. 45, MIGRANAL
ergotamine tartrate/caffeine - ERCAF
ergotamine/belladonna/pb – BELLERGAL-S
naratriptan - AMERGE
sumatriptan - IMITREX
zatriptan benzoate – MAXALT/-MLT
zolmitriptan - ZOMIG

ANTIANXIETY AND SEDATIVE-HYPNOTIC DRUGS

ANXIOLYTICS

alprazolam - generic
buspirone - BUSPAR
chlordiazepoxide hcl - generic
clorazepate - generic
diazepam - generic
lorazepam - generic
meprobamate - generic
oxazepam - generic

SEDATIVE/HYPNOTIC DRUGS

chloral hydrate - generic
estazolam - generic
flurazepam - generic
glutethimide - generic
paraldehyde - generic
temazepam - generic
triazolam - generic
zaleplon - SONATA
zolpidem - AMBIEN

ANTIMANIA DRUGS

lithium carbonate – generic, ESKALITH CR, LITHOBID
lithium citrate - generic

ANTICONVULSANT DRUGS

carbamazepine – generic, TEGRETOL/-XR
clonazepam - generic,KLONOPIN
diazepam - DIASTAT
divalproex – DEPAKOTE/-ER
ethosuximide – generic, ZARONTIN
ethotoin - PEGANONE
felbamate - FELBATOL
gabapentin - NEURONTIN
lamotrigine - LAMICTAL
levetiracetam - KEPPRA
mephobarbital - generic
methsuximide - CELONTIN
oxcarbazepine - TRILEPTAL
paramethadione - PARADIONE
phenacemide - PHENURONE
phenobarbital - generic
phenytoin sodium - generic, DILANTIN
primidone – generic, MYSOLINE
tiagabine - GABITRIL
topiramate - TOPAMAX
valproic acid – generic, DEPAKENE
zonisamide - ZONEGRAN

ANTIDEPRESSANT DRUGS

amitriptyline - generic
amitriptyline hcl/perphenazine - generic
amitriptyline/chlordiazepoxide - generic
amoxapine - generic
bupropion – generic, WELLBUTRIN/-SR
citalopram - CELEXA
clomipramine - generic
desipramine - generic
doxepin - generic
fluoxetine - PROZAC
imipramine hcl - generic
maprotiline - generic
nefazodone - SERZONE
nortriptyline - generic
paroxetine - PAXIL
protriptyline - generic
sertraline - ZOLOFT
trazodone - generic
venlafaxine – EFFEXOR/-XR

MAO INHIBITORS

phenelzine - NARDIL
ranylcypromine - PARNATE

ANTIVERTIGO AND ANTIEMETIC DRUGS

dolasetron mesylate - ANZEMET
granisetron - KYTRIL
meclizine hcl - generic
ondansetron - ZOFRAN
prochlorperazine maleate – generic, COMPAZINE
promethazine – generic, PHENERGAN SUPP.
trimethobenzamide - generic,TIGAN

ANTIPARKINSON DRUGS

benztropine - generic, COTOLATE
bromocriptine mesylate - generic, PARLODEL
carbidopa/levodopa - generic, SINEMET CR
entacapone - COMTAN
levodopa - LARODOPA

pergolide mesylate - PERMAX
pramipexole - MIRAPEX
ropinirole - REQUIP
selegiline - generic
trihexyphenidyl - generic

ANTIPSYCHOTIC DRUGS

chlorpromazine - generic
clozapine - generic, CLOZARIL
fluphenazine hcl - generic,PERMITIL
haloperidol - generic
loxapine succinate - generic
mesoridazine - SERENTIL
molindone - MOBAN
olanzapine - ZYPREXA
perphenazine - generic
quetiapine fumarate - SEROQUEL
risperidone - RISPERDAL
thioridazine - generic, MELLARIL-S
thiothixene - generic
trifluoperazine - generic

CNS STIMULANT / OTHER CNS-AUTONOMIC DRUGS

CNS STIMULANT DRUGS

amphetamine/dextroamphetamine - ADDERALL
d-amphetamine – generic, DEXTROSTAT, DEXEDRINE
methylphenidate - generic
pemoline – generic, CYLERT

OTHER CNS/AUTONOMIC DRUGS

bupropion - ZYBAN
disulfiram - generic
donepezil - ARICEPT
glatiramer acetate - COPAXONE
naltrexone - generic, REVIA
neostigmine bromide - PROSTIGMIN
nicotine - NICOTINE PATCH
pyridostigmine - MESTINON
tacrine - COGNEX

DERMATOLOGICAL MEDICATIONS

adapalene - DIFFERIN
alclometasone - ACLOVATE
anthralin - DRITHO-SCALP, DRITHOCREME
becaplermin - REGRANEX
benzoyl peroxide - generic,TRIAZ
benzoyl peroxide/sulfur – generic
betameth/propylene glycol – generic, DIPROLENE/AF
betamethasone dipropionate -generic, MAXIVATE
betamethasone valerate -generic
calcipotriene - DOVONEX
clindamycin phosphate - generic
clioquinol/hydrocortisone - generic
clioquinol/pramoxine/hc - generic
clobetasol propionate – genric, CORMAX, TEMOVATE
crotamiton - EURAX
desonide – generic, DESOWEN
desoximetasone - generic
diflorasone - generic, PSORCON
erythromycin base - generic, AKNE-MYCIN, EMGEL
erythromycin base/benz per - BENZAMYCIN
fluocinolone acetonide – genric, FS SHAMPOO
fluocinonide - generic
fluorouracil - EFUDEX, FLUOROPLEX
fluticasone propionate - CUTIVATE
formaldehyde - FORMA-RAY, FORMADON
halcinonide - HALOG, HALOG-E
halobetasol propionate - ULTRAVATE
hydrocortisone – generic, DERMACORT,LACTICARE-HC, NUTRACORT
hydrocortisone valerate - generic
hydroquinone - generic, LUSTRA, MELQUIN
hydroquinone/sunscreens - LUSTRA-AF
iodoquinol/hydrocortisone - generic
isotretinoin - ACCUTANE
lactate, ammonium – generic, LAC-HYDRIN
lindane- generic
metronidazole - METROCREAM, METROGEL, METROLOTION, NORITATE
mometasone - ELOCON
monochloroacetic acid - VERZONE
paba/oxyben/dioxyb/hydroquinon - generic, NUQUIN HP
permethrin – generic
podofilox - CONDYLOX
pramoxine/hc acetate - EPIFOAM
pramoxine/hydrocortisone - PRAMOSONE
selenium sulfide - generic
sulfacetamide/sulfur,sublimed - generic, NOVACET, SULFACET-R, VANOCIN
tazorac - TAZORAC
tretinoin – generic, RETIN-A/ MICRO, AVITA
triamcinolone acetonide - generic
trichloroacetic acid - generic

ORAL DERMATOLOGICAL DRUGS

trioxsalen - TRISORALEN

EAR-NOSE-THROAT MEDICATIONS

DRUGS AFFECTING THE EAR

acetic acid - generic
acetic acid/aluminum acetate - BOROFAIR OTIC
acetic acid/hydrocortisone – generic
antipyrine/benzocaine - generic
benzocaine - AMERICAINE DROPS,OTOGESIC
ciprofloxacin/hc - CIPRO HC
neomycin sulfate/polymyxin/hc - genric
ofloxacin - FLOXIN
phenylephrine/antipy/b-caine -

TYMPAGESIC
pramoxine/hc/chloroxylenol - CORTANE-B
trolamine polypeptide oleate - CERUMENEX

DRUGS AFFECTING THE NOSE
azelastine hcl - ASTELIN
beclomethasone – BECONASE/-AQ, VANCENASE/-AQ/DS
budesonide –RHINOCORT/-AQ
fluticasone propionate - FLONASE
ipratropium - ATROVENT
mometasone - NASONEX

DRUGS AFFECTING THE THROAT AND MOUTH
chlorhexidine – generic, PERIOGARD
triamcinolone acetonide - generic
pilocarpine hcl - SALAGEN

ENDOCRINE MEDICATIONS

ANTIDIABETIC
acarbose - PRECOSE
acetohexamide - generic
chlorpropamide - generic
glimepiride - AMARYL
glipizide - generic, GLUCOTROL XL
glucagon, human recombinant - GLUCAGON
glyburide - generic, GLYCRON
glyburide – metformin - GLUCOVANCE
insulin – HUMULIN
insulin - NOVOLIN
insulin - VELOSULIN BR
insulin lispro - HUMALOG
metformin - GLUCOPHAGE
miglitol - GLYSET
pioglitazone hcl - ACTOS
repaglinide - PRANDIN
rosiglitazone maleate - AVANDIA
tolazamide - generic
tolbutamide - generic

ADRENAL CORTICOSTEROID DRUGS
cortisone - CORTISONE
dexamethasone – generic, HEXADROL
fludrocortisone - FLORINEF
hydrocortisone - generic
methylprednisolone - generic
prednisolone - generic, PRELONE
prednisone – generic, DELTASONE, ORASONE
triamcinolone - TRIAMCINOLONE

THYROID AND ANTITHYROID DRUGS
levothyroxine - generic, SYNTHROID
liothyronine - CYTOMEL
liotrix - THYROLAR
potassium iodine/iodine - IODINE STRONG
propylthiouracil - generic
thyroid - generic, WESTHROID

OTHER ENDOCRINE DRUGS
alendronate - FOSAMAX
aminoglutethimide - CYTADREN
cabergoline - DOSTINEX
calcitonin - MIACALCIN
desmopressin acetate – generic, DDAVP
etidronate - DIDRONEL
risedronate - ACTONEL

GASTROINTESTINAL MEDICATIONS

ANTISPASMODICS/DRUGS AFFECT GI MOTILITY
belladonna alkaloids - generic
belladonna alkaloids/phenobarb – generic
clidinium/chlordiazepoxide - generic
dicyclomine - generic
diphenoxylate/atropine sulfate -generic
hyoscyamine – generic, ANASPAZ, LEVSIN, LEVBID
loperamide – generic, IMODIUM
metoclopramide - generic
paregoric - PAREGORIC
propantheline - generic

ANTIULCER DRUGS
cimetidine - generic
lansoprazole - PREVACID
lansoprazole/amox tr/clarith - PREVPAC
misoprostol - CYTOTEC
omeprazole - PRILOSEC
ranitidine – RANITIDINE
sucralfate – generic, CARAFATE SUSP

OTHER GI DRUGS
alosetron - LOTRONEX
amylase/lipase/protease – COTAZYM, PANCRELIPASE, LIPRAM, PANCREASE MT, ZYMASE
cell/amy/lip/prot/p-tlox/hyos - GASTRINEX
electrolyte solution/peg's - COLYTE
enzymes, digestive - ENZYMAX
hydrocortisone – CORTENEMA, PROCTO-HC
hydrocortisone acetate - CORTIFOAM, PROCTOCORT
mesalamine - ASACOL, FIV-ASA, PENTASA, ROWASA
pramoxine/hc acetate - PROCTOFOAM-HC
pramoxine/hydrocortisone - PROCTOCREAM-HC
sacrosidase - SUCRAID
sulfasalazine - generic
ursodiol - URSO

IMMUNOLOGICALS AND VACCINES
epoetin alfa - PROCRIT
filgrastim - NEUPOGEN
interferon a-2b/ribavirin - REBETRON
interferon alfa-2a,recomb. - ROFERON-A
interferon alfa-2b , recomb. - INTRON A

interferon beta-1a - AVONEX
interferon beta-1b - BETASERON
interferon gamma-1b,recomb. - ACTIMMUNE
oprelvekin - NEUMEGA
sargramostim - LEUKINE
somatrem - PROTROPIN
somatropin - GENOTROPIN, NUTROPIN/AQ, NORDITROPIN

MUSCULOSKELETAL MEDICATIONS

SALICYLATES AND RELATED DRUGS

aspirin sa– generic
chol sal/magnesium salicylate – generic, TRILISATE
diflunisal - generic
salsalate - generic

NON-STEROIDAL ANTIINFLAMMATORY AGENTS

celecoxib - CELEBREX
diclofenac potassium - generic
diclofenac sodium - generic
diclofenac sodium/misoprostol - ARTHROTEC
etodolac - generic
fenoprofen - generic
flurbiprofen - generic
ibuprofen - generic
indomethacin - generic
ketoprofen - generic
ketorolac - generic
meclofenamate - generic
nabumetone - RELAFEN
naproxen sodium - generic
oxaprozin - DAYPRO
piroxicam - generic
rofecoxib - VIOXX
sulindac - generic
tolmetin - generic

OTHER DRUGS FOR ARTHRITIS

auranofin - RIDAURA
leflunomide - ARAVA
penicillamine - CUPRIMINE

DRUGS TO PREVENT AND TREAT GOUT

allopurinol - generic
colchicine - generic
colchicine/probenecid - generic
sulfinpyrazone - generic
probenecid - generic

SKELETAL MUSCLE RELAXANTS

baclofen - generic
carisoprodol - generic
carisoprodol/aspirin – generic
chlorzoxazone - generic
codeine/carisoprodol/aspirin - generic
cyclobenzaprine - generic
dantrolene - DANTRIUM
metaxalone - SKELAXIN
methocarbamol - generic
methocarbamol/aspirin - generic
orphenadrine - generic
orphenadrine/aspirin/caffeine - generic
salicylamide/apap/ptx - DOLOREX

NUTRITION,BLOOD MODIFIERS,ELECTROLYTES

VITAMINS & MINERALS & RELATED PRODUCTS

calcitriol - ROCALTROL
calcium acetate - PHOSLO
doxercalciferol - HECTOROL
ergocalciferol - generic
fe polysacc/cyanocobalamin/fa - NIFEREX-150 FORTE
fe polysacc/cyanocobalamin/fa - FERREX 150 FORTE
ferrous fum/c/b12/stomach conc - ANEMAGEN, CHROMA-TINIC, FERRAGEN
ferrous fum/c/b12/stomach conc - CHROMAGEN
ferrous fum/vit c/b12/fa - CHROMAGEN FA, CHROMAGEN FORTE
folic acid - FOLIC ACID
multivitamins w/minerals – generic, ELDERCAPS
potassium aminobenzoate - AMINOBENZOATE POTASSIUM
triple vitamins w/fluoride - generic

FLUORIDE PRODUCTS

sodium fluoride – generic, KARIDIUM, LURIDE
stannous fluoride - generic,GEL-KAM

POTASSIUM SUPPLEMENTS

pot bicarb/pot chloride/ca - generic
potassium chloride – generic, K-DUR
potassium gluconate - gemeroc
phosphorus - K PHOS TAB NEUTRAL
potassium bicarb/ca - FFERVESCENT POTASSIUM
sodium citrate/citric acid – genric

POTASSIUM REMOVING RESINS

sodium polystyrene sulfonate - generic

DRUGS AND VITAMINS AFFECTING COAGULATION

aspirin/dipyridamole - AGGRENOX
clopidogrel - PLAVIX
dalteparin (porcine) - FRAGMIN
dipyridamole - generic
enoxaparin - LOVENOX
phytonadione - MEPHYTON
ticlopidine – generic, TICLID
warfarin sodium - generic, COUMADIN

HEMOSTATICS

aminocaproic acid - AMINOCAPROIC ACID, AMICAR
thrombin - THROMBOGEN

BLOOD DETOXICANTS

lactulose -generic

NUTRITIONAL/SUPPLEMENT PRODUCTS

mannitol - RESECTISOL

zinc sulfate - generic, ZINCATE

OBSTETRICAL & GYNECOLOGICAL MEDICATIONS

PRENATAL VITAMINS

prenatal vitamins - generic

prenatal vitamins - ENFAMIL NATALINS, PRENATE ULTRA

SPECIALIZED OB/GYN DRUGS

gonadotropin,chorionic -NOVAREL, PREGNYL, PROFASI HP

isoxsuprine - genmeric

leuprolide - LUPRON

nafarelin - SYNAREL

OB/GYN TOPICAL ANTIINFECTIVES

clindamycin phosphate - CLEOCIN

metronidazole - METROGEL-VAGINAL

propionate/amino acids/urea - generic

sulfathiaz/sulfacet/sulfabenz - generic

OVULATORY STIMULANTS

clomiphene - generic

follitropin alpha, recomb - GONAL-F

follitropin beta, recomb - FOLLISTIM

menotropins - REPRONEX

ANDROGEN DRUGS

danazol - generic

fluoxymesterone - generic

methyltestosterone - VIRILON

oxandrolone - OXANDRIN

oxymetholone - ANADROL

stanozolol - WINSTROL

testosterone - ANDRODERM

ESTROGEN DRUGS

estradiol – generic, CLIMARA, VIVELLE/-DOT, ALORA, ESTRING, ESTRADERM

estrogens, conjugated -PREMARIN

estrogens, esterified -ESTRATAB

estropipate - generic

ethinyl estradiol - ESTINYL

methyltestosterone/estrogen,ester – ESTRATEST/-HS

ESTROGEN/PROGESTIN COMBINATIONS

conj.estrogen/medroxyprogesterone - PREMPHASE, PREMPRO

estradiol/norethindrone - COMBIPATCH

SELECTIVE ESTROGEN RECEPTOR MODULATOR

raloxifene - EVISTA

PROGESTIN DRUGS

medroxyprogesterone – generic, DEPO-PROVERA, norethindrone - MICRONOR

norethindrone acetate - AYGESTIN

progesterone - PROMETRIUM

ORAL CONTRACEPTIVES

desogestrel-ethinyl estradiol - ORTHO-CEPT

levonorgestrel - PLAN B

norethindrone-ethin estradiol – generic, MODICON, ORTHO NOVUM

norethindrone-mestranol – generic, ORTHO NOVUM 1/50

norgestimate-ethinyl estradiol – ORTHO TRI-CYCLEN, ORTHO-CYCLEN

levonorgestrel-ethin estradiol - ALESSE, TRIPHASIL

noreth a-et estra/fe fumarate - ESTROSTEP FE, LOESTRIN FE

norethindronea-ethinyl estradiol - LOESTRIN

desogestrel-ethinyl estradiol - APRI

ethynodiol diace-eth estradiol - ZOVIA

norgestrel-ethinyl estradiol - LO/OVRAL,OGESTREL, OVRAL

OXYTOCICS

methylergonovine - METHERGINE

OPHTHALMIC MEDICATIONS

acetazolamide – generic, DIAMOX SEQUEL

apraclonidine - IOPIDINE

atropine sulfate – generic

bacitracin - BACITRACIN

bacitracin/polymyxin b sulfate - generic

betaxolol - BETOPTIC S

brimonidine tartrate - ALPHAGAN

brinzolamide - AZOPT

carbachol – generic, ISOPTO CARBACHOL

carteolol - generic

chloramphenicol - generic

ciprofloxacin - CILOXAN

cromolyn - generic

cyclopentolate - generic

dexamethasone sod phosphate - generic

diclofenac sodium - generic

dipivefrin - generic

dorzolamide - TRUSOPT

dorzolamide/timolol - COSOPT

echothiophate iodide - PHOSPHOLINE IODIDE

emedastine difumarate - EMADINE

epinephrine hcl – EPIFRIN, GLAUCON

epinephryl borate - EPINAL

erythromycin base - generic

fluorometholone – generic,EFLONE,FLUOR-OP, FML/FORTE

flurbiprofen - generic

gentamicin - generic

gentamicin/prednisolone - PRED-G

homatropine hbr - generic

ketorolac – ACULAR/PF

ketotifen fumarate - ZADITOR

latanoprost - XALATAN

levobunolol - generic

levocabastine - LIVOSTIN

lodoxamide - ALOMIDE

loteprednol etabonate - LOTEMAX

medrysone - HMS
methazolamide - generic,MZM
metipranolol - OPTIPRANOLOL
naphazoline - generic
naphazoline hcl/pheniramine - ALLERSOL-A
natamycin - NATACYN
nedocromil - ALOCRIL
neomycin sulf/dexamet sod phos - generic
neomycin/bacitracin/poly/hc - OCUTRICIN HC OP
neomycin/bacitracin/polymyxin - OCUTRICIN
neomycin/gramicidin/polymyxin – generic
neomycin/polymyxin/dexameth – generic, DEXACIDIN, MAXITROL
neomycin/polymyxin/prednisol - POLY-PRED
ofloxacin - OCUFLOX
olopatadine hcl - PATANOL
oxytetracycline hcl/polymyxin - TERAK
phenylephrine hcl - generic
physostigmine sulfate - PHYSOSTIGMINE SULFATE
pilocarpine hcl – generic, OCUSERT PILO, PILOPINE H.S., PILOPTIC
pilocarpine hcl/epinephrine – E-PILO, P1E1,P2E1,P4E1,P6E1
polymyxin b sulfate/tmp - generic
prednisolone acetate – generic, PRED FORTE,PRED MILD,
prednisolone sod phosphate - generic
proparacaine - generic
rimexolone - VEXOL
sodium/calcium/mag/potassium - BSS
sodium/calcium/mag/potassium - CYTOSOL
sulfacetamide sodium – generic, OCUSULF, SULF-10
sulfacetamide/fluorometholone - FML-S
sulfacetamide/phenylephrine - VASOSULF
sulfacetamide/prednis sp - generic
sulfacetamide/prednisolone ac - generic,VASOCINE
timolol - generic,TIMOPTIC,-XE
timolol hemihydrate - BETIMOL
tobramycin - generic
tobramycin sulfate/dexameth - TOBRADEX
trifluridine – generic, VIROPTIC
tropicamide – generic, MYDRIAFAIR
vidarabine - VIRA-A

RESPIRATORY MEDICATIONS

BRONCHODILATORS AND RELATED DRUGS

acetylcysteine - generic, MUCOSOL
albuterol – generic, PROVENTIL HFA, PROVENTIL SA, VOLMAX
albuterol sulfate/ipratropium - COMBIVENT
aminophylline - generic
atropine sulfate - generic
beclomethasone – BECLOVENT, VANCERIL/-DS
budesonide - PULMICORT
chlorpheniramine maleate/epi - ANA-KIT
cromolyn – generic, INTAL
dyphylline - DILOR
ephedrine sulfate - generic
epinephrine hcl - ANA-GUARD, EPIPEN, -JR
flunisolide - AEROBID
fluticasone propionate – FLOVENT/-ROTADISK
guaifenesin/dyphylline - BRONKOPHYLLINE GG,DIFIL-G
guaifenesin/theophylline - THEOLATE
ipratropium – generic, ATROVENT
isoetharine hcl - generic
metaproterenol - generic, ALUPENT MDI COMP,
montelukast sodium - SINGULAIR
nedocromil - TILADE
pirbuterol - MAXAIR AUTOHALER
salmeterol – SEREVENT/-DISKUS
terbutaline sulfate - BRETHINE
theophyll/ephedrine/phenobarb - THEOTAL
theophylline - generic, SLO-BID, T-PHYL, THEO- DUR, UNI-DUR, UNIPHYL
triamcinolone acetonide - AZMACORT
zafirlukast - ACCOLATE

ANTIHISTAMINE AND DECONGESTANT DRUGS

azatadine / pse - TRINALIN
benzonatate – BENZONATATE
cetirizine - ZYRTEC
cod/bdph - generic
cod/pro - generic
cyproheptadine - generic
dexchlorpheniramine maleate - generic
dm/pro - generic
fexofenadine - ALLEGRA
gua/hyd -generic
gua/ppm – generic,ENTEX LA, EXGEST LA
gua/ppm/cod - NOVAGEST
gua/pse - genric, ENTEX PSE, GUAIFEDPD
guafenesin/codeine - generic
guaifenesin – generic, AMIBID LA,LIQUIBID
hydp/cpmp - TUSSIONEX
loratadine - CLARITIN
pe/ppm/bpm – generic, BROMOPHEN TD
pe/pro - generic
pe/pyr/cpm - generic,
ppm/cpm/pnd - NOLAMINE
promethazine - generic
pse/acrivas - SEMPREX-D
pse/aza - TRINALIN
pse/bpm – generic, BROMFED/-PD
pse/fexofenadine - ALLEGRA-D
pse/lor - CLARITIN-D

OTHER RESPIRATORY DRUGS

deoxyribonuclease - PULMOZYME

UROLOGICAL MEDICATIONS

ANTICHOLINERGIC ANTISPASMODICS

oxybutynin – generic, DITROPAN XL

tolterodine tartrate - DETROL

CHOLINERGIC STIMULANTS

bethanechol - generic

URINARY ANESTHETICS

phenazopyridine - generic

OTHER GENITOURINARY PRODUCTS

alprostadil - EDEX, MUSE

citric acid/k-na citrates - CYTRA-3

citric acid/potassium citrate - CYTRA-K

finasteride - PROSCAR

meth/me blue/ba/salol/atp/hyos - generic

pentosan polysulfate sodium - ELMIRON

sildenafil citrate - VIAGRA

yohimbine hcl – generic

DIAGNOSTIC & MISCELLANEOUS MEDICATIONS

MISCELLANEOUS DRUGS

ergoloid mesylates – generic

sodium succinate - generic

WEIGHT LOSS PRODUCTS

phentermine hcl - generic

diethylpropion - generic

phendimetrazine - generic

phentermine hcl - generic

sibutramine hcl m-hydrate - MERIDIA

orlistat - XENICAL

MEDICAL (MISCELLANEOUS) SUPPLIES

DIABETIC SUPPLIES

glucose monitors –

ACCU-CHEK ADVANTAGE

ACCU-CHEK COMPLETE CARE KIT

ACCU-CHEK EASY

ACCU-CHEK III

FAST TAKE SYSTEM

GLUCOMETER DEX

GLUCOMETER ELITE

GLUCOMETER ENCORE

ONE TOUCH BASIC SYSTEM

ONE TOUCH PROFILE SYSTEM

SURE STEP SYSTEM

glucose testing (blood) –

ACCU-CHEK ADVANTAGE

ACCU-CHEK COMFORT CURVE

ACCU-CHEK EASY

ACCU-CHEK INSTANT

CHEMSTRIP BG

GLUCOMETER DEX

GLUCOMETER ELITE,ENCORE

GLUCOMETER ENCORE

ONE TOUCH TEST STRIP

TRACER BG

Preventive Health Care

Cascade East Health Plan covers periodic preventive medical exams according to the following schedule:

Well-Baby Care

Newborn	All nursery care
To age 1 year	As recommended by the PCP

Children:

Age 1-2 years	One exam every three months
Age 3-11 years	One exam every year
Age 12-17 years	One exam every three years

Adults:

Age 18-39 years	One exam every five years
Age 40+	As recommended by the PCP

Women's Annual Exam

Female plan members may see any CEHP obstetrician, gynecologist or other women's health care provider for their annual women's exam or pregnancy without a referral from their PCP. CEHP will also cover, without a referral, any medically necessary follow-up visits resulting from an annual women's exam. Routine breast and pelvic exams, including pap smears, are covered once every calendar year unless a woman is designated high risk. Women designated as high risk will receive exams as recommended by their PCP. Routine mammography breast screening is covered according to the following schedule:

Designated high risk	As recommended by your PCP
Age 35-39 years	One exam while in this age range
Age 40 and over	One exam every year

Immunizations

Immunizations are covered for all ages as recommended by the member's PCP. Immunizations for purposes of employment, licenses, travel or passport are not covered by the plan.

Routine Vision Benefits Through VSP

Vision Service Plan (VSP) provides routine vision benefits in this plan, which include eye exams, discounts on eyeware and allowances to help pay for eyeware.

- Frequency of services for adults: every 24 months for exam, lenses and frames.
- Frequency of services for children: every 12 months for exam, lenses and frames.

When obtaining services from a VSP doctor, you make a $10 co-payment. Members receive a 20 percent discount off the VSP doctor's usual and customary fees for prescription glasses in addition to a $160 allowance toward the cost of materials. **Note: If you do not use the entire allowance at one time, the balance will be forfeited.** A 15 percent discount applies to the doctor's professional services for prescription contact lenses. Discounts are only good for 12 months after date of service of the exam and when provided by the same doctor who performed the exam.

Obtaining services from a VSP doctor

When you want to obtain vision care services, call a VSP doctor to make an appointment. Make sure you identify yourself as a VSP member and be prepared to provide the covered member's Social Security Number. The VSP doctor will contact VSP to verify your eligibility and plan coverage and will also obtain authorization for services and eyewear. To obtain a list of doctors, call VSP at (800) 877-7195 or visit the web site at www.vsp.com.

Obtaining services from an out-of-network provider

If you receive an eye exam and/or materials from an out-of-network provider, you pay the full cost of the exam and materials; the plan will reimburse you up to a maximum of $42 of the exam cost and up to $160 for materials, minus your $10 copayment. To obtain reimbursement after you use an out-of-network provider, you pay the entire bill when you receive services, then send your itemized receipt and full patient and member information to VSP. Claims must be submitted to VSP within six months from your date of service. Submit your itemized receipt with the employee's name, Social Security Number, mailing address, patient name, date of birth and relationship to employee to VSP, PO Box 997105, Sacramento, CA 95899. Please contact VSP at (800) 877-7195 with questions about the vision benefit.

Limitations and Exclusions

CEHP does not cover the following services, even if such services are provided by a Participating Provider:

- Behavior modification
- Benefits not stated
- Charges over usual and customary or reasonable
- Cosmetic or reconstructive services and supplies
- Counseling or treatment in the absence of illness
- Custodial care
- Dental examinations and treatments, except repair of injury
- Developmental delay
- Experimental or investigational services
- Family planning
- Gender identity disorders
- Growth hormones
- Hearing aids
- Home births
- Intoxicants & controlled substances
- Mental illness treatment for which there is no effective cure
- Care for mental retardation and/or learning disabilities
- Oral impotence drugs
- Orthognathic surgery
- Orthopedic shoes, arch supports, or orthotic devices for the foot
- Paraphilia
- Care for personality disorders
- Physical exercise programs
- Routine services and supplies that do not involve treatment of a disease or injury
- Self-inflicted hazard
- Services or supplies received as a consequence of illegal action on your part, or while in the custody of any state or federal law enforcement authorities or while in jail or prison
- Services otherwise obtainable
- Service-related conditions
- Standby charges when the provider renders no actual treatment to the patient
- Surgery to alter refractive character of the eye
- Treatment after insurance ends
- Treatment for admissions prior to coverage
- Treatment for obesity or weight control
- Treatment not medically necessary
- Treatment prior to enrollment
- Work-related conditions

Kaiser Permanente HMO	
Annual Out-of-Pocket Maximum	$1,000 per person; $3,000 per family
Type of Providers	Kaiser Permanent facilities and providers only
Individual Policy Maximum	None
TYPE OF SERVICE	**YOU PAY**
Primary care office visit	$10 co-payment per visit
Specialist office visit	$10 co-payment per visit
X-ray & lab	$0
PREVENTIVE CARE [1]	
Periodic health appraisals	$0 per visit
Well-child checkups (to age 19)	$0 per visit
Hearing screenings	$10 co-payment per screening
Hearing exam & aids [2]	$10 co-payment for exam [2]
Routine immunizations	$0
Mammography screening	$0
HOSPITAL	
Ambulance	$75 co-payment
Inpatient	$50 co-payment per day up to $250 maximum per stay
Outpatient	$10 co-payment
Emergency room	$75 co-payment; waived if admitted
SURGERY	
Inpatient	$0
Outpatient	$10 co-payment
Office-based	$10 co-payment
MATERNITY & GYNECOLOGY	
Prenatal and postpartum office visits	$0
Delivery (vaginal or Cesarean)	$50 co-payment per day up to $250 maximum per stay
Routine gynecological exams	$10 co-payment per visit
Infertility treatment	50% coinsurance
PRESCRIPTION DRUGS (per 30-day supply retail; per 90-day supply of Kaiser-defined maintenance drugs by mail order)	
Generic formulary	$10 co-payment
Brand formulary	$15 co-payment
Non-formulary	Not-covered
ROUTINE VISION SERVICES (per 12 months children; per 24 months adults)	
Routine vision exam	$10 co-payment
Frames, lenses, contacts	Amount above $150 allowance
MENTAL HEALTH AND CHEMICAL DEPENDENCY	
Inpatient & residential	$50 co-payment per day up to $250 per stay
Outpatient	$10 co-payment per visit
Durable Medical Equipment	$0
Alternative Care	$15 co-payment per visit; limited to $1,000 in services per year [3]

[1] *Based on a schedule. Includes commercial driver's exam.*

[2] *Hearing aids covered at 100% to $500 per ear per aid every 36 months.*

[3] *Kaiser participating alternative care providers only.*

Kaiser Permanente HMO

KAISER PERMANENTE®
500 NE Multnomah, Suite 100
Portland, OR 97232-2099
Phone: (800) 813-2000

To be eligible to enroll with Kaiser Permanente, you must live or work within the zip codes listed here. As a member, you will be covered for care only when you use Kaiser Permanente facilities, except for qualifying emergency and urgent care services. If you live outside the service area, please consider the location of Kaiser Permanente facilities when making your enrollment decision.

Oregon: The service area consists of the following zip codes:

Benton County: 97330, 97331, 97333, 97339, 97370

Clackamas County: 97004, 97009, 97011, 97013, 97015, 97017, 97022, 97023, 97027, 97034, 97035, 97036, 97038, 97042, 97045, 97049, 97055, 97067, 97068, 97070, 97222, 97267, 97268

Columbia County: All zip codes

Hood River County: 97014

Linn County: 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97389

Marion County: 97002, 97020, 97026, 97032, 97071, 97137, 97301, 97302, 97303, 97305, 97306, 97307, 97308, 97309, 97310, 97311, 97312, 97313, 97314, 97325, 97342, 97346, 97352, 97359, 97362, 97373, 97375, 97381, 97383, 97384, 97385, 97392

Multnomah County: All zip codes

Polk County: All zip codes

Washington County: All zip codes

Yamhill County: All zip codes

Washington: The service area consists of the following zip codes:

Clark County: All zip codes

Cowlitz County: All zip codes

Lewis County: 98591, 98593, 98596

Skamania County: 98639, 98648

Wahkiakum County: 98612, 98647

How the medical plan works

Kaiser members must receive care from Kaiser Permanente providers in Kaiser facilities for coverage to apply. Soon after you enroll as a new member, you'll receive a directory of all providers with locations, hours, and telephone numbers for making appointments, seeking advice, and asking about your medical plan benefits. You will receive your Kaiser Permanente identification card soon after your effective enrollment date.

You choose your primary care provider

We encourage members to select a primary care provider — a physician, nurse practitioner, or physician assistant practicing in the family practice, internal medicine and pediatrics specialties. Membership Services can help you make your selection, or you can look for provider credentials in the "Our Medical Staff" section of our Web site.

We are very selective about the quality of providers we choose. We carefully review the education and training of the doctors and other health care professionals we select. Continuing medical education is mandatory, and we require them to complete the training and exams to be board certified. Nine of every 10 of our doctors are board certified, while the national average is six of 10.

Kaiser Permanente and PEBB on the Web

Our Web site, www.kp.org/nw has been called one of the best health plan sites on the Web by *Time* magazine and others. From our Members Only section, you can:

- Order prescription refills for at-home mail delivery at no extra charge.
- Request routine medical and dental appointments.
- Research health and drug information.
- Join discussion groups moderated by health professionals.
- Send messages to Kaiser Permanente advice nurses and pharmacists, who can consult your medical records or your personal care provider, if they need to.

For Oregon PEBB employees, we've prepared a special Web page to tell you more about your medical plan. To reach this site, set your Internet browser to www.kaiserpermanente.org/ehealth/nw/pebb/.

Preventive services

Well-baby and child care (0-12 years)

Your children are covered for scheduled visits to Pediatric or Family Practice physicians for routine examinations, developmental assessments and guidance. Visits may include height and weight, phenylketonuria (PKU) exam, eye exam, hearing screen, immunizations, scoliosis check, parental counseling, or sports and camp physicals.

Well-teen care (13-17 years)

Scheduled visits are covered to Pediatric or Family Practice physicians for routine examination, breast exam and Pap test for females, other routine testing (such as cholesterol) as necessary, or sports and camp physicals.

Adult physical exams (18 years and older)

Scheduled visits to Internal Medicine, Family Practice, or Obstetrical or Gynecological physicians or nurse practitioners are covered for routine screening or early detection. These exams may include height and weight, blood pressure check, cholesterol check, hearing and vision screening, counseling and immunizations. They may also include a breast exam, mammogram and Pap test for females.

Emergency care

You are covered for emergency care. Your *Medical Directory* will provide you with information about accessing emergency care both inside and outside the network of Kaiser Permanente plan hospitals.

When you use our plan hospitals for emergency care information about your condition and care is transferred quickly to our electronic medical information system and is available to your health care team right away.

Eye care

Optical centers are available in 12 of our locations, with full service from a professional staff and a wide range of competitive prices. Eight locations also offer contact lenses. Your member handbook lists each of the optical service locations.

You are covered for routine eye exams and for treatment of eye disease and injury. You pay a $10 co-payment for a routine eye exam, and you don't need a referral to make an appointment. In addition, your optical plan can be used when you purchase prescription sunglasses and contact lenses from Kaiser Permanente.

You may use your optical plan benefit once every two years. Replacement eyeglasses/cosmetic contact lenses are covered if a member's prescription changes 0.50 or more within 12 months of the initial exam.

A $150 maximum allowance paid by the plan applies to the lenses and frames; you pay a $10 co-payment for the exam. Be prepared to pay a deposit toward the balance due when you place your order.

If you are covered at the same time under two Kaiser Permanente medical plans that each have a supplemental optical benefit, you are entitled to apply the value of both toward the purchase of a single pair of eyeglasses or contacts. Check with Membership Services or at an Optical Center to find out about dual coverage.

Medical treatment for eye injuries and disease is a part of your base medical coverage and is covered the same as any other condition.

Your prescription drug benefit

Fill your prescription in the same location they're written. There is no additional charge for our home-delivery service. You can order refills by mail, telephone, or over the Internet. You can also use the telephone and Internet to order prescriptions for pickup at Kaiser Permanente pharmacies. Be sure to have your Kaiser Permanente ID card and prescription information ready when you call.

When you pick up your prescription at one of our pharmacies, you may receive up to a 30-day supply for each co-payment. When you use the home-delivery service, you may receive up to a 90-day supply for medications considered "maintenance." We consider a drug a maintenance drug if it is appropriate for chronic use as prescribed, and there is evidence that the drug is safe and effective when used for a chronic condition.

To get a prescription at your usual co-payment, the drug must be prescribed within the Kaiser Permanente formulary process or meet the exception criteria. To be provided in accordance with the formulary process, a drug must be included on our formulary or meet our exception criteria, as determined by your Kaiser Permanente doctor. Drugs reviewed and approved by doctors and pharmacists of the Kaiser Permanente Formulary and Therapeutics Committee are included on the formulary. To find out if a particular drug is included on the formulary, call or stop by any Kaiser Permanente pharmacy.

Our formulary does not impede your doctor from prescribing the most appropriate medication for your condition. When a Kaiser Permanente doctor feels that a non-formulary drug is the most appropriate therapy to meet a patient's individual medical needs, the doctor may make an exception based on one of the following:

- The patient is intolerant of formulary alternatives.
- The patient has experienced treatment failure with the formulary alternatives.
- The patient is allergic to formulary alternatives.
- The patient is a new member currently using a non-formulary drug. (A transition period is available while new members switch to the formulary alternative.)
- The non-formulary drug is for a dosage form or strength used in titrating a dose.

Dental prescriptions are limited to the FDA-approved prescription drugs listed on the formulary. No exceptions are allowed. A doctor or dentist may request additions. Requests are reviewed every other month.

Limitations and Exclusions

Limitations

Kaiser Permanente is not responsible for delay or failure to render service because of unusual circumstances, such as wars, riots, labor disputes not involving Kaiser Permanente, or major disasters or epidemics affecting our facilities or personnel. Non-emergency care may be postponed in the event of labor disputes involving Kaiser Permanente organizations.

In the event of a strike, lock-out or labor dispute affecting your group, you may continue your group coverage for the term of the disruption or six months, whichever is less. You are responsible for payment of premiums during this period. Contact your group or Membership Services to determine the amount of your premiums and whether your payment should be made through your group or directly to Kaiser Permanente.

Exclusions

Services from non-Plan providers that are not emergencies or not referred; custodial or care in an intermediate care facility; cosmetic services; dental care and dental X-rays; physical exams for insurance, employment, or licensing; routine footcare services that are not medically necessary; experimental and investigational procedures and services; procedures not generally and customarily available in the service area; all cost associated with designated blood donations for the immediate use at the time of collection for a designated donor; reversal of voluntary, surgically induced infertility; cognitive or long-term rehabilitation programs; transplants other than prescribed heart, heart-lung, lung, kidney, liver, bone-marrow, simultaneous kidney-pancreas, and cornea transplants; educational or clinical programs for weight control and food supplements used in conjunction with such programs; living expenses and transportation for any person in connection with a covered organ transplant, except for medically necessary ambulance transportation; services to induce pregnancy, such as in vitro fertilization and ovum transplants, except artificial insemination is covered; Gamete Intrafallopian Transfer (GIFT); Zygote Intrafallopian Transfer (ZIFT); cost of donor semen, donor eggs, and related services; injections drugs for infertility treatment; sexual reassignment surgery; methadone maintenance not medically necessary and prescribed; care for conditions covered by workers' compensation; conditions for which care is required by law to be provided by a government agency; military service-connected conditions; psychological testing that is court-ordered or not ordered by a Plan physician; mental health services on court order or as a condition of parole or probation not ordered by a Plan physician; vision therapy (orthotics and eye exercises); low vision aids; radial keratotomy, photorefractive keratectomy, and refractive surgery; drugs to treat sexual dysfunction; outpatient medical supplies (non-reusable), except those applied directly to a wound or lesion by a Plan physician; non-human and artificial organs and their implantation; prescribed drugs that are necessary for or related to services excluded under your service agreement; home births; hypnotherapy and related services; drugs that are not FDA approved except as required by state law; genetic testing.

This is a summary of benefits only. Please consult your group service agreement or contract and your member handbook - A Guide to Your Kaiser Permanente Medical Benefits - for more information.

Regence BlueCross BlueShield of Oregon PPO		
Annual Out-of-Pocket Maximum	$1,000 per person; $3,000 per family	$2,000 per person; $6,000 per family
Type of Providers	Any licensed provider; you pay less when you use the plan's preferred providers	
TYPE OF SERVICE	**YOU PAY PREFERRED**	**YOU PAY NON-PREFERRED**
Primary care office visit	15% co-insurance	30% co-insurance
Specialist office visit	15% co-insurance	30% co-insurance
X-ray & lab	15% co-insurance	30% co-insurance
PREVENTIVE CARE		
Periodic health appraisals [1]	0%	30% co-insurance
Well-child checkups (to age 19)	0%	30% co-insurance
Hearing screenings	0%	30% co-insurance
Hearing exam & aids [2]	15% co-insurance	30% co-insurance
Routine immunizations	0%	0%
Mammography screening	0%	30% co-insurance
HOSPITAL		
Ambulance	15% co-insurance	30% co-insurance
Inpatient	15% co-insurance	30% co-insurance
Outpatient	15% co-insurance	30% co-insurance
Emergency room	15% co-insurance	30% co-insurance
SURGERY		
Inpatient	15% co-insurance	30% co-insurance
Outpatient	15% co-insurance	30% co-insurance
Office-based	15% co-insurance	30% co-insurance
MATERNITY & GYNECOLOGY		
Prenatal and postpartum office visits	15% co-insurance	30% co-insurance
Inpatient delivery (vaginal and Cesarean)	15% co-insurance	30% co-insurance
Routine women's exams	$10 co-payment	30% co-insurance
Infertility treatment (Limitations apply)	50% co-insurance	50% co-insurance
PRESCRIPTION DRUGS (per 34-day supply at local pharmacy; per 90-day supply at mail-order pharmacy)		
Generic	$10 co-payment	
Preferred	$15 co-payment	
Non-preferred	$25 co-payment	
VISION SERVICES (per 12 months children; per 24 months adults) **Benefits provided by VSP**		
Routine vision exam	$10 co-payment	$10 co-payment & amount above $42
Frames, lenses, contacts	Amount above $160 allowance (additional discounts available from VSP doctors)	
MENTAL HEALTH AND CHEMICAL DEPENDENCY		
Inpatient & Residential	15% co-insurance	30% co-insurance
Outpatient	15% co-insurance	30% co-insurance
Durable Medical Equipment	15% co-insurance	30% co-insurance
Alternative Care	30% co-insurance	30% co-insurance

[1] *Based on a schedule. Includes commercial driver's license exams.*

[2] *Hearing aids covered at 100% to $500 per person per 36 months.*

Regence BlueCross BlueShield

Regence
BlueCross BlueShield of Oregon
PO Box 1271
Portland, OR 97207-1271
Phone: (800) 826-9813 (outside Portland)
(503) 220-3849 (Portland)

Regence BCBSO PPO Plan

The Regence BlueCross BlueShield of Oregon PPO offers worldwide coverage. Outside of Oregon and in Southwest Washington, benefits are available through the Blue Card (see Worldwide Coverage, page 18).

This plan offers two levels of coverage based on the type of provider you use. You receive a better benefit if you use preferred providers.

PEBB has identified 19 Oregon counties with what PEBB considers to be an insufficient number of preferred providers within the PPO network to serve employees in these counties. The counties are:

- Baker
- Crook
- Curry
- Deschutes
- Gilliam
- Grant
- Harney
- Jackson
- Jefferson
- Josephine
- Klamath
- Lake
- Malheur
- Morrow
- Sherman
- Tillamook
- Union
- Wallowa
- Wheeler

Employees who live in these counties and who enroll in the PPO plan will receive the same level of benefit when they use non-preferred providers as they would using preferred providers.

Explanation of Provider Terms and Claims Payment

The Regence BlueCross BlueShield of Oregon PPO (Regence BCBSO) plan provides statewide and worldwide coverage for eligible expenses with any licensed provider. However, you receive a better benefit and pay less if you use preferred providers.

A preferred provider has an agreement with Regence BCBSO to accept discounted fees as payment in full for covered services. Participating providers file fees with Regence BCBSO and discount the fees, but to a lesser degree than preferred providers. A participating provider accepts the terms and conditions of Regence BCBSO and agrees not to balance bill the participating members for charges above the filed fees. Participating providers are considered non-preferred providers. Non-participating providers have no contract or agreement with Regence BCBSO. Non-participating providers generally bill participating members for all balances up to the billed charge that are not paid by the plan. Non-participating providers are also considered non-preferred providers. You can determine whether providers are preferred or participating by looking in the Regence BCBSO provider directory or Web site.

The following are examples of claims payment based on whether you use a preferred, participating or non-participating provider:

Example

Physician's Billed Charge = $100

Preferred provider contracted fee for this service = $80

Participating provider contracted fee for this service = $90

Preferred Provider

Using these charges, if you use a preferred provider and you are enrolled on the PPO Plan, Regence BCBSO pays 85% of $80 or $68 and you pay 15% of $80 or $12. The physician accepts $80 as paid in full.

Participating Provider

Using these charges, if you use a participating provider (non-preferred) and you are enrolled on the PPO Plan, Regence BCBSO pays 70% of $90 or $63 and you pay 30% of $90 or $27. The physician accepts $90 as paid in full.

Non-participating Provider

Using these charges, if you use a provider that is neither preferred nor participating (non-preferred) and you are enrolled on the PPO Plan, Regence BCBSO pays 70% of $90 or $63. You pay 30% of $90 or $27 plus the difference between the billed charge and the participating provider contracted fee which is an additional $10. In this instance, you pay the $27 plus the $10 for a total amount of $37.

Claims Payment in Designated Rural Areas

Some areas of the state have limited preferred providers. In these counties, PEBB has arranged for resident members to receive the preferred provider level of benefit from providers who are either preferred or participating in Regence BCBSO contracts.

This means that if you live in a designated rural county, are enrolled on the Regence PPO plan and receive care from a preferred or participating provider, you will receive the preferred level of benefits. If you choose to see a non-participating provider, you will receive the preferred benefits, however the provider may bill you for any amounts above Regence BCBSO maximum allowable fees.

The designated rural counties are: Baker, Crook, Curry, Deschutes, Gilliam, Grant, Harney, Jackson, Jefferson, Josephine, Klamath, Lake, Malheur, Morrow, Sherman, Tillamook, Union, Wallowa, and Wheeler.

The following are examples of claims payment for Regence BCBSO PPO Plan enrollees living in the designated rural counties based on whether you use a preferred, participating or non-participating provider:

Example

Physician's Billed Charge = $100

Preferred provider contracted fee for this service = $80

Participating provider contracted fee for this service = $90

Rural Counties - Preferred or Participating

Using these charges, if you use a preferred or participating provider and you are enrolled on the PPO Plan, Regence BCBSO pays 85% of $90 or $76.50 and you pay 15% of $90 or $13.50. The physician accepts $90 as paid in full.

Rural Counties - Non-Participating

Using these charges, if you use a non-participating provider and you are enrolled on the PPO Plan, Regence BCBSO pays 85% of $90 or $76.50 and you pay 15% of $90 or $13.50 plus the difference between the billed charge and the participating provider contracted fee which is an additional $10. In this instance, you pay $13.50 plus $10 for a total amount of $23.50.

Worldwide Coverage

Regence BCBSO provides worldwide coverage. In addition, Regence BCBSO participates in a national Blue Cross Blue Shield program known as PPO Blue Card. This program allows you to receive the discounts other Blue Cross Blue Shield plans have negotiated with local facilities, physicians and other providers. This program also allows you to receive the higher PPO benefit for services when you use another state's PPO providers.

Hold Harmless

Regence BCBSO holds contracts with both preferred and participating facilities, physicians and providers, which ensures that you are not billed for charges that exceed contracted maximum allowable fees. You are not responsible for charges billed over these amounts. Providers may collect coinsurance or co-payment amounts.

Prescription Drug Plan

You pay a flat dollar amount - called a co-payment - for covered prescriptions at participating pharmacies at the time you purchase your prescription. You pay $10 for a generic drug, $15 for preferred brands on the Regence BCBSO formulary, and $25 for all other brands.

You also have a mail-order benefit that allows you to purchase your medications through Postal Prescription Services (PPS) or Walgreens Healthcare Plus. You may purchase up to a 90-day supply of maintenance medicine by making a single co-payment when you place your order. Refills can be conveniently ordered by using the refill slip you receive with your original order. Request a mail-order pharmacy brochure from PEBB using the Information Request Form on page 101 or contact Regence BCBSO.

At non-participating pharmacies you pay the total cost at the time of purchase and will be reimbursed by Regence BCBSO for the total cost less the applicable co-payment.

Regence BCBSO has created a preferred medication benefit to help manage the high cost of prescription drugs. Regence BCBSO developed the Preferred Medication List to provide high-quality, effective, affordable prescription benefits.

This program has multiple co-payment levels. The amount you pay will depend upon where your medication falls within the following categories:

- Generic medications
- Preferred brand name medications
- Non-preferred brand name medications (brand name medications not on the list).

Your co-payment responsibility is lowest for generic medications and highest for non-preferred brand name medications. Please refer to your member handbook for specific co-payment information.

Preferred products are limited to the dosage form and strength listed; if no strength is listed, all strengths for the listed dosage form are preferred. Sustained action/release (SA/SR), extended release (ER/XR), long-acting (LA), and enteric coated (EC) are only preferred if listed.

Some medications listed may be contract exclusions and, therefore, are not covered. Please refer to your contract or member handbook for more detailed information. Please note – this list is subject to change.

Routine Vision Benefits Through VSP

VSP provides routine vision benefits in this plan, which include eye exams, discounts on eyeware and allowances to help pay for eyeware.

- Frequency of services for adults: every 24 months for exam, lenses and frames.
- Frequency of services for child(ren): Every 12 months for exam, lenses and frames.

When obtaining services from a VSP doctor, you pay a $10 co-payment. Members receive a 20 percent discount off the VSP doctor's usual and customary fees for prescription glasses in addition to a $160 allowance toward the cost of materials. **Note: If you do not use the entire allowance at one time, the balance will be forfeited.** A 15 percent discount applies to the doctor's professional services for all types of prescription contact lenses. Discounts are only good for 12 months after date of service of the exam and provided from the same doctor who performed the exam.

Obtaining services from a VSP doctor:

When you want to obtain vision care services, call a VSP doctor to make an appointment. Make sure you identify yourself as a VSP member and be prepared to provide the covered member's Social Security Number. The VSP doctor will contact VSP to verify your eligibility and plan coverage and will also obtain authorization for services and materials. To obtain a list of doctors, call VSP at (800) 877-7195 or visit the website at www.vsp.com.

Obtaining services from an out-of-network provider:

If you have an eye exam and/or materials from an out-of-network provider, you pay the full cost of the exam and materials; the plan will reimburse you up to a maximum of $42 of the exam cost and up to $160 for materials, minus your $10 co-payment. To obtain reimbursement after you use an out-of-network provider, pay the entire bill when you receive services, then send your itemized receipts and full patient and member information to VSP. Claims must be submitted to VSP within six months from your date of service. Submit your itemized receipt with the employee's name, Social Security Number, mailing address, patient name, date of birth, and relationship to employee to VSP, PO Box 997105, Sacramento, CA 95899. Contact VSP at (800) 877-7195 with questions about the vision benefit.

PREFERRED BRAND NAME MEDICATIONS

Acular® Ophthalmic drops
Accolate® tablet
Accutane® capsule
Accupril® tablet
Accuretic® tablet
Actigall®capsule
Actinex® cream
Actonel® tablet
Adderall® tablet
Aero-Chamber® spacer
Aersol Holding Chamber® spacer
Alesse® tablet
Alkeran® tablet
Alocril ophthalmic drops
Alphagan® ophthalmic solution
Alphagan p® ophthalmic drops
Agenerase® cap, solution
Ana-guard® inj
Analpram-HC® 1% rectal cream
Ancoban® capsule
Arco-Lase Plus® tablet
Aralen® tablet
Aricept® tablet
Arimidex® tablet
Armour Thyroid® tablet
Asacol® tablet
Atrovent® nasal spray
Atrovent® oral inhaler
Augmentin® tablet, oral suspension
Avonex® inj
Azmacort® oral inhaler
Azopt® ophthalmic drops suspension
Azulfidine EN-Tabs®
Bactroban® ointment
Beclovent® oral inhaler
Betaseron® inj
Betimol® ophthalmic solution
BetopticS ® ophthalmic solution
Betoptic® ophthalmic solution
Brethancer® spacer
Brethine® tablet
Brevicon® tablet
Carbatrol® capsule
Cardioquin® tablet
Cardura® tablet
Carnitor® tablet, oral liquid, wafer
Casodex® tablet
Cedax® capsule
CeeNu® capsule
Cefzil® tablet, oral suspension
Celexa® tablet, oral solution
CellCept® tablet, capsule
Celontin® capsule
Cenestin® tablet
Cerumenex® otic suspension
Ciloxin® ophthalmic drops, ointment
Cipro® tablet, oral suspension
Cognex® capsule
Colestid® tablet, granules, powder
Combivent® oral inhaler
Combivir® tablet
Compazine® 2.5mg, 5mg rectal supp
Condylox® external gel, solution
Copaxone® inj
Coreg® tablet
Cortifoam® aerosol
Cosopt® ophthalmic solution
Cotazym® capsule
Cotazym-S® capsule
Creon® 5,10,20 capsule
Crixivan® capsule
Cuprimine® capsule
Cylert® tablet
Cytomel® tablet
Cytotec® tablet
Cytovene® capsule
Cytoxan® tablet
Dapsone® tablet
DDAVP® nasal solution
Demulen® tablet
Depakote Sprinkle®
Depakote® tablet
Dexedrine Spansule®
Diamox Sequels® capsule
Diflucan® tablet, oral suspension
Dilantin® tablet, capsule, oral suspension
Dipentum® capsule
Diprolene® oint, gel, lotion
Diprolene AF® cream
Donnazyme® tablet
Drithocreme®
Droxia® capsule
Duragesic® patches
Effexor® tablet
Effexor XR® tablet
Efudex® cream, solution
Ellipse® spacer
Elocon® cream, ointment, lotion
Enzymax® tablet
Epipen® inj
Epivir® tab, oral solution
Epogen® inj
Eskalith CR® tablet
Estrostep FE® tablet
Ethmozine® tablet
Eulexin® capsule
Evista® tablet
Exelon® tablet
E-Z® spacer
Famvir® tablet
Fareston® tablet
Felbatol® tablet, oral suspension
Femara® tablet
Flonase®
Florinef® tablet
Flovent® oral inhaler
Flovent® Rotadisk
Fluoroplex® cream, solution
Fortovase® capsule
Fosamax® tablet
Fragmin® inj
Furadantin® oral suspension
Gabitril® tablet
Genotropin® inj
Geref®[1]
Glucagon injection

[1]Therapy may be non-covered as a contract exclusion for some individuals. [2]Only contracted through Caremark

Glucotrol XL® tablet
Grifulvin V® oral suspension
Habitrol® patch[1]
Hexalen® capsule
Humatrope® inj
Hivid® tablet
Ilozyme® tablet
Imdur® tablet
Imitrex® tab, nasal spray, inj
Infergen® inj
Innohep® Inj
Inspirease® spacer
Insulin – Lilly products (not Lantus®)
Intal® oral inhaler
Intron A® inj
Invirase® capsule
Kaletra® tablet, oral solution
Kemadrin® tablet
K-Dur® tablet
Koro-Flex Arcing Diaphragm®[1]
Koromex Coil Spring Diaphragm®[1]
Kutrase® capsule
Ku-Zyme HP® capsule
Ku-Zyme® capsule
Lamictal® tablet
Lanoxin® tablet, elixir
Lariam® tablet
Larodopa® tablet
Lescol® capsule
Lescol XL® capsul
Leukeran® tablet
Leukine® inj
Lipitor® tablet
Liquid Pred® syrup
Lithobid® tablet
Loestrin® tablet
Loestrin Fe® tablet
LoOvral® tablet
Loprox® cream, lotion
Lotrel® capsule
Lotrisone® cream
Lovenox® inj
Loxitane C® oral conc only
Lumigan® ophthalmic drops
Lysodren® tablet
Matulane® capsule
Mavik® tablet
Maxair Autohaler®
Maxair® oral inhaler
Maxalt® tablet
Maxalt MLT® tablet
Meberal® tablet
Megace® oral suspension
Mephyton® tablet
Mepron® oral suspension
Mestinon® tablet
Metadate CD® capsule
Methergine® tablet
MetroCream®
MetroGel®
MetroGel-Vaginal®
Miacalcin® nasal spray, inj
Micronor® tablet
Midrin® capsule
Minocin® oral susp
Mirapex® tablet
Moban® tablet
Modicon® tablet
Monopril® tablet
Monopril HCT® tablet
MS Contin® tablet
MSIR® capsule
Myambutol® tablet
Mycelex Troche®
Mycobutin® capsule
Myleran® tablet
Mysoline® tablet, oral suspension
Nardil® tablet
Nasacort® nasal inhaler
Nasacort AQ® nasal inhaler
Nasonex® nasal inhaler
Nebupent® aerosol powder
NegGram® tablet, oral suspension
Neoral® capsule, oral solution
Neupogen® inj
Neurontin® capsule
Niaspan® tablet
Nilandron® tablet
Nitro-DUR® patch
Nitrostat® tablet
Nolvadex® tablet
Nordette® tablet[1]
Norditropin® inj
Norinyl® tablet
Norvasc® tablet
Norvir® capsule, oral solution
Nulytely® oral solution
Nutropin® inj (not depot)
Nutropin AQ®
Ocuflox® ophthalmic drops
Ocupress® ophthalmic solution
Omnicef® capsule, oral suspension
Orap® tablet
Ortho-Cept® tablet
Ortho-Cyclen® tablet
Ortho-Diaphragm®
Ortho-Novum® tablet
Ortho-Tricyclen® tablet
Oxandrin® tablet
Oxycontin® SR tablet
OxyFAST® oral liquid
OxyIR® capsule
Pancrease MT® 4, 10, & 20 capsule
Pancrecarb MS®-4 & 8 tablet
Parlodel® capsule only
Parnate® tablet
Paxil® tablet, oral suspension
Pediapred® oral solution
PEG-Intron® inj
Pentasa® capsule
Permax® tablet
Phenergan® 12.5mg
(25 mg generic available)
Plan B® tablet
Patenol® ophthalmic drops
Plavix tablet
Plendil® tablet
Premarin® Vaginal Cream
Premarin® tablet

[1]Therapy may be non-covered as a contract exclusion for some individuals. [2]Only contracted through Caremark

Premphase® tablet
Prempro® tablet
Prevacid® capsule
Preven® tablet
PrevPac®
Primaquin® tablet
Procanbid® tablet
Procrit® inj
Proctocream-HC® 1% rectal cream
Prograf® capsule
Proscar® tablet
Prostep® patch
Protropin® inj
Proventil HFA® oral inhaler
Proventil Repetabs®
Prozac Weekly® 90 mg capsule
Pulmicort® oral inhaler
Pulmicort Respules®
Pulmozyme® inhalation solution
Purinethol® tablet
Rapamune® solution
Ramses Vag. Diaphragm®
Rebetol® Capsule
Rebetron® inj
Remeron® tablet
Reminyl® tablet, oral solution
Rescriptor® tablet
Retin A® gel only
Retrovir® capsule, syrup
Rhinocort® nasal inhaler
Rhinocort AQ® nasal inhaler
Ridaura® capsule
Risperdal® tablet, oral solution
Rocaltrol® capsule
Roferon A® inj
Rowasa® enema, rectal supp
Rythmol® tablet
Saizen® inj[1, 2]
Salagen® tablet
Sandimmune® capsule, oral solution
Serentil® tablet, oral concentrate
Serevent® oral inhaler
Serevent Diskus® oral inhaler
Seroquel® tablet
Serzone® tablet
Sinemet CR® tablet
Singulair® tablet
Slo-Bid Cap®
Stimate® nasal solution
Sular® tablet
Surmontil® capsule
Sustiva® capsule
Synthroid® tablet
Tegretol XR® tablet
Tegretol® tablet, oral suspension
Tequin® tablet
Teslac® tablet
Theo-Dur® tablet
Theolair SR® tablet
Thioguanine® tablet
Thyrolar® tablet
Tilade® oral inhaler
Topamax® tablet, capsule
Toprol XL® tablet
Torecan® tablet
T-phyl® tablet
Tracleer® tablet
Travatan® ophthalmic drops
Tazorac® topical cream, gel
Trilisate® tablet
Triphasil® tablet
Trizivir® tablet
Trusopt® ophthalmic drops
Ultrase MT® capsule
Uni-DUR® tablet
Uniphyl® tablet
Uniretic® tablet
Univasc® tablet
URSO® tablet
Valtrex® tablet
Vancenase® nasal inhaler
Vancenase AQ® nasal inhaler
Vanceril DS® oral inhaler
Vanceril® oral inhaler
Vancocin® capsule, oral solution
Vepesid® capsule
Vesanoid® capsule
Vibramycin® 25mg/5ml oral suspension
Videx® tablet, powder for oral solution
Videx EC® tablet
Viokase® tablet, powder
Viracept® tablet, powder for oral solution
Viramune® tablet, oral suspension
Wellbturin® SR tablet (sustained release)
Wide Seal Diaphragm®
Winstrol® tablet
Xalatan® ophthalmic solution
Xeloda® tablet
Zantac® 15mg/ml syrup
Zarontin® capsule, syrup
Zaroxolyn® tablet
Zerit® capsule, oral solution
Zestoretic® tablet
Ziagen® tablet
Zithromax® tablet, capsule, oral suspension
Zofran ODT® tablet
Zofran® tablet, oral solution
Zoloft® tablet
Zomig® tablet
Zymase® capsule
Zovirax® ointment
Zyprexa® tablet

[1]Therapy may be non-covered as a contract exclusion for some individuals. [2]Only contracted through Caremark

Limitations and Exclusions

We will not pay for the following:

- Treatment prior to enrollment.
- Treatment after insurance ends (except when you or an insured dependent is in the hospital on the day the insurance ends, we will continue to pay toward covered expenses for that hospitalization until your discharge from the hospital or your benefits have been exhausted, whichever comes first).
- Treatment not medically necessary.
- Routine services and supplies that in general do not involve treatment of a disease or injury, including the following:
  - Routine tests and screening procedures, except as specifically listed
  - Treatment for corns and calluses, removal of nails (except complete removal), and other routine foot care
  - Eye examinations (vision benefits provided in this plan by VSP)
  - The fitting, provision or replacement of eyeglasses (vision benefits provided in this plan by VSP)
  - Orthoptics
  - Telephone consultations
  - Missed appointments
  - Completion of claim forms or completion of reports requested by Regence BCBSO in order to process claims
  - Self-help or training programs including but not limited to those to stop smoking, control weight or provide general fitness; and including programs that teach a person how to use durable medical equipment or how to care for a family member
  - Instruction programs, including but not limited to those to learn to self-administer drugs or nutrition, except as specifically provided for under the Outpatient Diabetic Instruction benefit of this policy
  - Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control or education, such as air conditioners, humidifiers, air filters, whirlpools, heat lamps or tanning lamps
  - Private-duty nursing, including ongoing hourly shift care in the home, or personal items such as telephones, televisions and guest meals in a hospital or skilled nursing facility
  - Speech therapy unless it is to improve or restore lost function due to illness or injury
  - Treatment of obesity or weight control or any complications arising out of or related to such treatment, whether or not you have other medical conditions related to or caused by treatment of obesity
  - Surgery to alter refractive character of the eye
  - Massage or massage therapy
  - Orthopedic shoes
  - Cosmetic or reconstructive services and supplies
  - Orthognathic surgery
  - Impotence drugs
  - Family planning (except for certain infertility services)
  - Growth hormone conditions other than growth hormone deficiency in

    - children or growth failure in children secondary to chronic renal insufficiency prior to transplant or

    - adults, with a destructive lesion of the pituitary or peripituitary, or as a result of treatmens such as cranial irradiation, or surgery

    Growth hormone for the treatment of these conditions is covered when our medical policy criteria are met (preauthorization is required).
  - Infertility drugs
  - Invitro fertilization, GIFT, ZIFT and reversal of voluntary sterilization
  - Dental examination and treatments
  - Physical exercise programs
  - Paraphilia
  - Gender identity disorders
  - Custodial care
  - Mental retardation, learning disabilities or autism for enrollees age seven years or older
  - Personality disorders
  - Behavior modification

- Counseling or treatment in the absence of illness
- Experimental or investigational treatment
- Service-related conditions: the treatment of any condition caused by or arising out of service in the armed forces of any country
- Care of inmates
- Work-related conditions
- Services provided by an immediate family member
- Third Party Liability
- Services otherwise obtainable, a category that includes the following:
  - Services or supplies for which payment could be obtained in whole or part if you or your dependent had applied for payment under any city, county, state or federal law
  - Services or supplies you or your enrolled dependent could have received in a hospital or program operated by a government agency or authority, unless reimbursement under this contract as otherwise required by law
  - Charges for services and supplies for which you or your enrolled dependent cannot be held liable because of an agreement between the provider rendering the service and another third-party payer that has already paid for such service or supply
  - Services or supplies for which no charge is made, or for which no charge is normally made in the absence of insurance
- Charges over usual and customary or reasonable.
- Standby charges when the provider renders no actual treatment to the patient
- Benefits not stated
- Services required by state law as a condition of maintaining a valid driver's license, except as provided under the contract for Commercial Drivers License exam required by State employment

Send Claims and Inquiries to:

Regence BlueCross BlueShield of Oregon
P.O. Box 1271
Portland, OR 97207

For Customer Service call:

(800) 826-9813 (outside Portland)
(503) 220-3849 (Portland)

Medical Plans Frequently Asked Questions

Where do I get detailed explanations of what is covered by a medical plan?

Once enrolled in a medical plan, you will receive a member handbook from the carrier. It includes detailed information about your plan.

If you need detailed information to decide on a medical plan, call the medical plan carriers you are considering and ask them specific questions about the coverage you are interested in.

Can medical insurance be continued if I lose eligibility or terminate from state service?

Yes. Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) after you terminate state service or lose eligibility, you can continue your existing coverage for up to 18 months.

If you terminate service, you also have the option to continue coverage through portability offered by your medical plan.

What kind of information will I receive when I enroll in a medical plan?

Newly hired employees will receive a Plan Member Handbook and an Identification card from their medical insurance carrier within six weeks following enrollment.

I have a medical condition of the eyes. How do the PEBB medical plans cover treatment of my medical condition?

The plans provide coverage of medical treatment of the eyes according to the plans' benefits, just like any other physical ailment covered by the plan.

What about eye exams and glasses?

PEBB medical plans (except the Regence Part-time Plan) include a routine vision benefit, which covers routine eye examinations and eyewear. The benefit after co-payment is limited to $150 every 24 months (for adults) and every 12 months for children in the Kaiser Permanente HMO. In VSP, which provides vision services for members in the Cascade East HMO and the Regence BCBSO PPO, the benefit covers the eye exam after a co-payment and provides $160 plus eyewear discounts every 24 months for adults and every 12 months for children. The vision benefit is in addition to the medical coverage provided by the medical plans.

The plans encourage use of generic drugs. Are they as good as brand names?

The Federal Drug Administration (FDA) approves all generic medications. A generic drug must be therapeutically the same as the brand name drug and approved by the FDA, your doctor and the pharmacist. National drug databases are used to determine whether or not a drug is classified generic.

Can I choose not to take the medical coverage?

Yes. You must provide information that you have other group coverage and select "opt out" on the medical insurance enrollment form. See page 19 of this booklet for details.

Will I receive an ID card for VSP routine vision benefit coverage?

No. VSP does not provide an identification card. When you obtain services from a VSP provider, provide the Social Security number of the insured PEBB employee for eligibility reference. If you obtain services from a non-VSP provider, pay the balance in full and send the claim to VSP for reimbursement.

How do PEBB medical plans cover mental health and chemical dependency services?

Most plans cover mental health conditions the same as any other medical condition. In previous years, the plans placed limits on the number of visits for outpatient services that would be covered. They also limited the number of covered days for inpatient stays. These limitations have been removed on the Regence BCBSO PPO and Kaiser plans. The Cascade East plan still has limits on coverage for chemical dependency services.

Can I decline coverage altogether?

Yes. If you decline, you waive your right to the employee contribution and enrollment in any of the insurance plans available through PEBB including flexible spending accounts and all voluntary insurance plans.

2003 Dental Plans at a Glance					
	Kaiser	**Willamette**	**ODS**		
Type of Plan	**Managed**	**Managed**	**Traditional**	**Preferred Provider**	
Calendar Year Individual Maximum Benefit	None	None	$1,500	$1,500	
Type of Providers	Kaiser only	Willamette only	Any licensed provider	Any licensed provider; you pay less for preferred	
Type of Service	**You pay**	**You pay**	**You pay**	**Preferred**	**Non-preferred**
Annual deductible (individual; family)	None	None	$50; $150	$50; $150	$50; $150
Diagnostic & preventive (x-ray, cleaning)	$0	$0	0%	0%	10% [1]
Basic & maintenance (filling, root canal, oral surgery)	$0	$0	20%	20%-10%-0% [2]	30%
Major (crowns, bridges)	50%	$190 [3]	50%	50%	50%
Orthodontia	50% [4]	$1,200 [5]	50% [4]	50% [4]	50% [4]

[1] *Not subject to deductible amount.*

[2] *Your payment portion decreases by 10% each calendar year if you visited the dentist at least once a year.*

[3] *Co-payment per tooth.*

[4] *This orthodontia benefit is limited to a lifetime maximum of $1,000 per person.*

[5] *Requires a $150 co-payment prior to the start of orthodontic treatment.*

Your PEBB Dental Plan Options

Section 3

Dental Plan Service Areas

Kaiser Permanente Dental Plan: You must live or work within 30 miles of a Kaiser Permanente facility and use Kaiser Permanente dental providers. See page 20 of this booklet for approved Kaiser zip codes.

ODS Traditional and Preferred Dental Plan: Available statewide with any licensed dentist.

Willamette Dental Insurance: You must use Willamette Dental facilities and providers. Use the information request form on page 101 to request a facilities list from PEBB.

Managed Dental Plans

Managed dental plans offer a comprehensive level of services and benefits. You must live in a certain geographic area to be eligible to enroll in a managed dental plan.

When you join a managed dental plan, you must use the dental providers and facilities that are part of the plan to be eligible for benefits. This means that dental services are provided by dentists who are employed by the plan.

There are advantages in cost and covered services when you join a managed dental plan.

The PEBB Program offers two managed dental plans from which to choose:

- Kaiser Permanente Dental Plan
- Willamette Dental Insurance, Inc.

Preferred Option Dental

The Preferred Option Dental plan offers statewide coverage. When you are in the Preferred Option Dental plan, you pay less when you get care if you use the preferred dentists. Preferred dentists are a special group of dentists who serve the people enrolled in the preferred dental plan.

If you use a dentist who is not on the preferred list, you will receive a benefit, but you will pay more when you receive care.

The PEBB Program offers the ODS Preferred Option Dental Plan.

Traditional Dental Plan

The Traditional dental plan offers coverage statewide with any licensed provider. You can live anywhere in the state or in the world and still maintain your coverage.

The PEBB Program offers the ODS Traditional Dental Plan.

KAISER PERMANENTE®
500 NE Multnomah, Suite 100
Portland, OR 97232-2099
Phone: (800) 813-2000

Managed Dental

How the Dental Plan works

Care is provided in Kaiser Permanente dental offices. You choose the dental office convenient to you. Kaiser Permanente has 15 dental offices located in Metropolitan Portland and Salem, and in Vancouver and Longview, Washington.

You choose your own Kaiser Permanente dentist to direct your dental care. Kaiser Permanent has more than 110 dentists. As a member, you agree to receive your care only from Kaiser Permanente providers or other providers authorized by Kaiser Permanente.

If you require emergency care when you are outside the service area, you will be reimbursed up to $100 per incident for the following: services for relief of pain, acute infection or hemorrhage; and necessary treatment, including local anesthesia and premedication, due to injury.

You will receive your Kaiser Permanente identification card soon after your effective enrollment date. At about the same time, you will receive a Kaiser Permanente Dental Directory, which explains how to use the dental care services, and a member handbook, which describes your plan in detail.

Limitations and Exclusions

Limitations

Kaiser Permanente is not responsible for: conditions for which a patient refuses, for personal reasons, to accept a recommended treatment when Kaiser Permanente dentists believe no professionally acceptable alternative exists; for the delay or failure to render service due to unusual circumstances such as major disaster or epidemic affecting facilities or personnel, war, riot or labor disputes involving Kaiser Permanente organizations. A supplemental fee of $10 will be charged for each missed appointment unless the appointment is canceled in advance. Nitrous oxide is covered at a charge of $15, except nitrous oxide for children 12 and under is covered without charge. Members pay 10 percent of charges for nightguards.

Exclusions

Excluded from dental coverage: non-emergency services not approved by a Kaiser Permanente dentist; procedures not generally and customarily available in the service area; experimental or investigational treatments; medical, hospital and certain dental services; prescription drugs; general anesthesia and intravenous sedation; oral surgery for correction of malocclusion; TMJ (temporomandibular joint) surgery; conditions covered by workers compensation or that are the employer's responsibility; care for conditions which care is available from a third party; cosmetic services; all services related to dental implants, including bone augmentation and fixed or removable prosthetic devices attached to or covering the implants; repair or replacement of fixed prosthetic or removable prosthetic appliances that are less than five years old; restorative or reconstructive treatment for specific congenital or developmental malformations; work in progress before the member's coverage became effective; removal and replacement with alternative materials of clinically acceptable restorations or material for any reason except the pathological conditions of the tooth or teeth; full mouth reconstruction and occlusal rehabilitation including appliances, restorations, and procedures needed to alter vertical dimension or occlusion to splint teeth or correct attrition or abrasion; genetic testing; replacement of prefabricated, non-cast crowns, including stainless steel crowns, that were not placed by a Kaiser Permanente dentist; more than two visits for routine teeth cleaning (oral prophylaxis) in any 12 consecutive month period; conditions related to military service; and conditions covered by governmental agencies or programs other than Medicaid.

This is a summary of benefits only. Please consult your group service agreement or contract and your member handbook - A guide to your Kaiser Permanente Medical Benefits - for more information.

Traditional and Preferred Option Dental Plans

ODS HEALTH PLANS
601 SW 2nd Avenue
Portland, OR 97204
Phone: (800) 452-1058

How the Traditional Dental Plan Works

Under the ODS Traditional plan, you can see any licensed dentist for your services. More than 92 percent of the licensed dentists in Oregon are participating ODS providers. ODS has specific fee arrangements with participating dentists to ensure that their actual charges do not exceed their usual fees on file with ODS. Participating dentists cannot bill patients for charges over and above the fees they have filed with ODS, which helps to minimize your out-of-pocket expenses.

You are free to utilize the services of any licensed dentist, even those who are not participating providers. However, reimbursement for services of a non-participating dentist will be limited to the applicable percentages specified in the plan toward the prevailing fees charged by other dentists for corresponding services. Prevailing fees are defined as those that satisfy and are charged by the majority of dentists in Oregon, as determined by ODS on the basis of confidential fee listings from participating dentists.

You will not need to fill out claim forms. Your dentist will submit any necessary paperwork to ODS on your behalf.

ODS provides a pre-determination service for any treatment plan. We encourage you to request that your dentist submit a pre-determination for treatment plans in excess of $500. The proposed treatment will be reviewed according to your contract and returned to the dentist, itemizing allowable amounts and any limitations. You and your dentist can then review the information prior to beginning treatment and address any questions about the benefits and your out of pocket obligations.

How the Preferred Option Dental Plan Works

The ODS Preferred Option plan allows PEBB members to access two levels of benefits depending on the dentist they choose. To access the highest level of benefits, you must receive care from an ODS preferred dentist. If you receive care from a dentist not in the ODS Preferred Provider Panel, benefits will be reduced to the out-of-network benefit level. Currently, the ODS Preferred Option Dental Provider Panel includes approximately 600 dentists throughout the state.

Waiting Periods in ODS Plans

Following are the dental waiting period coverage limitations:

Coverage is limited to benefits for preventive dental exams and cleanings and the emergency treatment of pain for the first 12 months. Basic and major dental services are not covered for the first 12 months. Orthodontia services are not covered for the first 24 months.

The waiting period applies to coverage for family members if:

- You wait until an open enrollment period to enroll them
- You remove family members from your dental plan for any period of time and then re-enroll them during open enrollment
- You and your spouse or domestic partner are both eligible PEBB members enrolled individually on the dental plan, only you cover your children, and the children are later enrolled on your spouse's or domestic partner's dental plan during open enrollment

The waiting period does not apply to family members if:

- You enroll them as soon as they are eligible (e.g., within 60 days of your date of hire)
- You enroll them because of and consistent with a qualified status change
- You change from one PEBB dental plan to another during Open Enrollment covering the same family members

Limitations and Exclusions of the Traditional and Preferred Option Plans

Limitations

If an eligible person selects a more expensive plan of treatment than is functionally adequate, Oregon Dental Service will pay the applicable percentage of the maximum plan allowance for the least costly treatment. The patient will then be responsible for the remainder of the dental provider's fee.

Important: These plans have waiting periods

Exclusions

1. Services for injuries or conditions which are compensable under workers' compensation or employer's liability laws; or services which are provided by any federal, state or provincial government agency, or are provided, without cost to the eligible person, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under this Policy. This exclusion does not apply to medical assistance provided under Medicaid.
2. Procedures, appliances, restorations or other services which are primarily for cosmetic purposes.
3. Services or supplies caused by or provided to correct congenital or developmental malformations; including, but not limited to cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasis, and fluorosis (discoloration of teeth).
4. Services or supplies for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include, but are not limited to, increasing vertical dimension, equilibration, and periodontal splinting.
5. Services or supplies for treatment of any disturbance of the temporomandibular joint.
6. Gnathologic recordings or similar procedures.
7. Dental services started prior to the date the individual became eligible for such services under the Policy.
8. Hypnosis, prescribed drugs, premedications, analgesics (e.g., nitrous oxide), or any other euphoric drugs.
9. Hospital charges for services or supplies or additional fees charged by the dentist for hospital treatment.
10. Broken appointments.
11. Experimental procedures or supplies.
12. Other Exclusions as listed in the Dental Member Handbook.

Willamette Dental Insurance, Inc.

14025 SW Farmington Rd.
Beaverton, OR 97005
Phone: (800) 460-7644

The Willamette Dental Plan is a managed plan with facilities in Oregon, Washington (Columbia Dental) and Idaho (Columbia Dental). In this plan, you access care through the plan's providers. You select a primary care dentist, and all future regularly scheduled appointments will be with that provider. You may change among Willamette dentists or locations at any time.

For specialty services, including orthodontia treatment, you will be referred to Willamette specialists if they are available in the region. If your primary care dentist refers you to a provider outside the plan, your co-payments will stay the same as in the plan.

To choose a dentist or schedule an appointment, call the Appointment Center at the numbers and times below:

Phone	Schedule
Oregon (800) 461-8994	Mon. -Thur., 7 a.m. - 8 p.m.
Washington (800) 359-6019	Friday, 7 a.m. - 6 p.m.
Idaho (800) 603-1738	Saturday, 7 a.m. - 4 p.m.

You'll have your first appointment in 21 to 42 days after your initial call. Appointments for cleanings and non-emergency operative procedures will be scheduled for 42 to 90 days after your call.

On your first visit, you will receive a thorough examination with X-rays. Your selected dentist will then develop a Personal Dental Care Plan based on your overall dental health. The treatment plan will determine the sequence and number of procedures to be undertaken on future visits.

Children receive a cleaning at their first appointment; adults do not. For adults, the first cleaning is scheduled after this initial appointment. Your dentist will determine your cleaning schedule based on your oral health.

Willamette Dental Plan's first priority with new patients is to diagnose and treat urgent conditions that pose an immediate threat to oral health or that put one or more teeth at risk. The next step is to control the disease process and to promote wellness and health maintenance. Major restorative work is normally delayed until a satisfactory state of oral health is achieved, and the teeth and supporting structures are stabilized.

Willamette Dental Group provides emergency coverage 24 hours a day, 365 days a year. It generally takes 24 to 48 hours to arrange an appointment for emergencies (constant pain, bleeding or swelling). If you schedule an appointment for regular clinic hours, you pay the usual office visit charge. After hours, the visit charge is usually higher, as stated in the member handbook.

If you have a dental emergency while out of the Willamette service area, services will be reimbursed at the amount stated in the Summary of Benefits. For an emergency, you can see any licensed dentist to obtain relief from constant pain, bleeding or swelling. Contact Patient Relations for reimbursement. Schedule your follow-up care with your primary care dentist. For more information, call the Patient Relations Department at (800) 460-7644 Option 8, e-mail denkor.relations@denkor.com or visit the Web site at www.denkor.com

Exclusions and Limitations

The following are general services not covered under the Willamette Dental Insurance plan: services rendered prior to coverage effective date or after coverage ends; replacement of an existing denture, crown or bridge less than five years after the date of the most recent replacement; replacement of a lost or stolen denture, crown or bridge; services or supplies related to the diagnosis or treatment of the temporomandibular joint; splints, nightguards and other appliances used to increase vertical dimension or restore bite; study models and dental implants; surgery for fractures, cysts, tumors or cosmetic reasons; IV sedation and/or general anesthesia; service that is unnecessary. This means, for example, that an inlay or onlay is not necessary dental care if an amalgam filling would serve in a functionally equivalent manner. If an enrollee elects to have procedures performed that equate to a higher level of care than the least-costly alternative or recommendation, the enrollee will be responsible for the costs over and above that of any applicable service copayment charge for the least-costly alternative.

Dental Plans Frequently Asked Questions

How can I find out what dental plans are offered in my area?

The ODS Traditional Dental Plan is offered statewide. The ODS Preferred Option Plan also pays for covered dental services statewide. However, only "preferred" dentists are listed in the ODS Preferred Option Provider Directory. You may obtain a provider directory from PEBB by using the additional information form on page 101.

The Kaiser Permanente Managed Dental Plan is offered to members who work or reside in the Kaiser Permanente service areas. Refer to page 35 for the approved Zip Codes.

For information about the location of the Willamette Dental Insurance Managed Dental Plan facilities, request a facilities list from PEBB using the information form on page 101.

What are some of the differences between the managed plans with Kaiser & Willamette and the Traditional or Preferred plans with ODS?

Kaiser and Willamette plans require that you use their providers and facilities. Diagnostic, preventive and maintenance services are paid in full and there are no annual benefit maximums. The managed plans provide treatment based on you dental health. You may require only one visit per year, or you may require visits every three months. Under Willamette, the initial visit for adults is to determine what treatment plan is required - no services are provided.

The ODS Traditional and Preferred plans allow you to access services from any licenced provider. Benefits under the preferred plan vary depending on your choice of preferred or non-preferred provider. Diagnostic and preventive services are paid in full and there are annual benefit maximums of $1,500. See page 51 for more details.

Can my dental insurance be continued if I lose eligibility or terminate from state service?

Yes. You can continue your existing coverage for up to 18 months under the Consolidated Omnibus Budget Reconciliation Act (COBRA) due to a termination or loss of eligibility.

What kind of information will I receive when I enroll in a dental plan?

You will receive a Plan Member Handbook and Identification Card from your dental plan carrier in about six weeks.

I have other group dental coverage. Can I choose not to take a PEBB dental plan?

No. There are no opt out provisions on the dental plans. All employees must participate in a minimum of employee dental coverage. A required minimum enrollment is necessary to keep the dental rates lower.

Do I have to enroll the same dependents on my dental plan and medical plan?

No. You may enroll a different mix of dependents in each plan.

I live out of the Willamette Dental Insurance service area, in Pendleton. Can I enroll in Willamette Dental Group and access services in Portland?

Yes. Not only can you access services in Portland, but you can also access services at the Columbia Dental office in Kennewick, Wash., which is closer to where you live. Any of the Willamette offices in Oregon, Washington and Idaho are available to PEBB members.

Can I add a domestic partner to my dental coverage?

Yes. As long as you meet the criteria of and complete the Affidavit of Domestic Partnership, you may add a domestic partner at the time you meet the criteria, during Open Enrollment or following a qualified family status event. Your agency must receive the affidavit and accompanying enrollment forms within 60 days of initial eligibility.

What is the cost to add a domestic partner to my dental plan?

You will pay the same premium increase when adding a domestic partner as you would when adding a spouse or other dependent. However, the premium cost deducted from your pay for covering a domestic partner is considered taxable income by the federal government. A formula is used to determine the imputed value of this premium amount, and you must pay income taxes on the imputed value. (For information, see PEBB's website at http://pebb.das.state.or.us)

How is the imputed value calculated?

The imputed value is the difference between the monthly premium cost prior to adding the domestic partner to your plan and the monthly premium cost to add the partner to your plan on the open market. PEBB analyzes the open market annually to determine the premium cost difference and its imputed value.

When does the waiting period for dental insurance apply to family members?

The waiting period applies to family members when:

- You wait until Open Enrollment to enroll them
- You remove them from your dental plan and then re-enroll them
- You and your spouse or domestic partner are both eligible PEBB members enrolled individually on the dental plan, only you cover your children, and the children are later enrolled on your spouse's or domestic partner's dental plan during Open Enrollment.

When does the dental waiting period not apply?

The waiting period does not apply to family members when:

- You enroll them as soon as they are eligible
- You enroll them because of and consistent with a qualified status change
- You change from one PEBB dental plan to another during Open Enrollment covering the same family members.

What are the dental waiting period coverage limitations?

During the first 12 months, coverage is limited to benefits for preventive dental exams and cleanings and the emergency treatment of pain. Basic and major dental services are not covered for the first 12 months. Orthodontia services are not covered for the first 24 months.

2003 Additional Option Part-time Employee Medical Plans at a Glance			
	Kaiser Permanente	**Regence BCBSO**	
Type of Plan	HMO	PPO	
Maximum Out of Pocket		Preferred Providers	Non-preferred Providers
Individual	$1,500	$2,000	$4,000
Family	$3,000	$6,000	$12,000
Individual Policy Maximum	No limit	$2 million	
Type of Providers	Kaiser only	Any licensed provider; you pay less with preferred	
Type of Service	**You pay**	**You pay 50% of first $1,000, then:**	
Office Visit			
Primary Care Provider	$30	20%	50%
Specialist Provider	$30	20%	50%
X-ray and lab	$15/x-ray, $6/lab test	20%	50%
Preventive Care[1]			
Routine preventive services	$0	0%	50%
Hearing screenings	$30	0%	50%
Hearing exam and aids	$30 [2]	20% [3]	50% [3]
Mammography screening	$0	0%	50%
Routine eye exam	$30	Not covered	
Hospital			
Ambulance	$75	20%	50%
Inpatient (unlimited days)	$500/admit	20%	50%
Outpatient	$30	20%	50%
Emergency Room	$100 [4]	20%	50%
Surgery			
Inpatient	$0	20%	50%
Outpatient	$30	20%	50%
Office-based	$30	20%	50%
Maternity, Gynecology			
Prenatal, postpartum office	$0	20%	50%
Inpatient delivery	$500/admit	20%	50%
Routine women's exams	$30	$10	50%
Infertility diag., treatment[5]	50%	50%	50%
Insulin & Diabetic Supplies	$10 generic; $25 brand	0%	0%
Mental Health and Chemical Dependency[5]			
Inpatient	$500/admission	20%	50%
Residential	$50/day up to $250/admission	20%	50%
Outpatient	$30	20%	50%
Alternative care [6]	Not covered	50%	50%
Durable medical equip.	50%	20%	50%

[1]Based on a schedule. Includes commercial drivers license exams for employees.

[2]Hearing aids covered at 100% to $250/ear or a single aid every 36 months.

[3]Hearing aids covered at 100% to $500/per person per 36 months.

[4]Plus any other co-payments that normally apply.

[5]Other limitations apply.

[6] Includes chiropractic, naturopathic and acupuncture services.

Additional Options for Eligible Part-time Employees

For 2003, eligible part-time employees may enroll in any of the plans described in Section 2. They also have two additional options for medical coverage and one additional option for dental coverage. All three are lower-cost, lower-benefit plans that are available only to part-time employees.

Kaiser Permanente Part-time Employee HMO

Kaiser members must receive care from Kaiser Permanente providers in Kaiser facilities for coverage to apply. Soon after you enroll as a new member, you'll receive a directory of all providers with locations, hours and telephone numbers for making appointments, seeking advice, and asking about your medical plan benefits. You will receive your Kaiser Permanente identification card soon after your effective enrollment date.

The Kaiser Permanente Part-time Employee HMO plan features include no deductible and no individual policy maximum. The annual out of pocket maximum is $1,500 per person and $3,000 per family. You pay a $30 co-payment for an office visit. Periodic health appraisals and well-child checkups require no co-payment. Hospital care is paid in full after a $500 co-payment per admission. Prescription drugs are covered after a $10 co-payment for generic formulary drugs and a $25 co-payment for brand formulary medications. Non-formulary drugs are not covered unless determined as medically necessary by the Kaiser physician.

The plan includes coverage for a routine vision exam with a $30 member co-payment. Eyewear is not covered.

Please review the Kaiser Permanente HMO plan description on page 35 and the benefit summary on page 59 for information about this additional option medical plan for eligible part-time employees.

Regence BCBSO Part-time Employee PPO

This PPO plan provides first-dollar coverage. This means you do not need to meet a deductible before Regence BCBSO begins paying benefits. In this plan, you pay a percentage of the cost (called co-insurance) at the time you receive a service, rather than accumulating charges to reach a deductible before benefits are paid.

You choose your own providers. You pay 50 percent of the first $1,000 of eligible expenses per calendar year for PPO facilities, physicians and other providers. After that, you pay 20 percent of eligible expenses per calendar year. You pay 50 percent of eligible expenses per calendar year for non-PPO facilities, physicians and other providers. Preventive services and related diagnostic x-ray and laboratory services from PPO providers are covered in full. These services require a 50 percent coinsurance payment for non-PPO providers.

Your annual maximum out-of-pocket payment for eligible expenses is $2,000 per individual and $6,000 per family for PPO providers. For non-PPO providers, the maximum out-of-pocket amount for eligible expenses is $4,000 per individual and $12,000 per family.

Please see page 60 for more information on the plan's benefits.

Explanation of Provider Terms and Claims Payment

This plan provides coverage for eligible expenses with any licensed provider. However, you receive a better benefit and you pay less if you use preferred providers.

A preferred provider has an agreement with Regence BCBSO to accept discounted fees as payment in full for covered services. Participating providers file their fees with Regence BCBSO, and discount the fees, but to a lesser degree than preferred providers. A participating provider accepts the terms and conditions of Regence BCBSO and agrees not to balance bill the participating members for charges above the fees filed with Regence. Participating providers are considered non-preferred providers. Non-participating providers have no contract or agreement with Regence BCBSO. Non-participating providers generally bill participating members for all balances up to the billed charge that are not paid by the plan. Non-participating providers are also considered non-preferred providers. You can determine whether providers are preferred or participating by looking in the Regence BCBSO provider directory or Web site.

Example

Physician's Billed Charge = $100

Preferred provider contracted fee for this service = $80

Participating provider contracted fee for this service = $90

Preferred Provider

Using these charges, if you use a preferred provider and you are enrolled on the Part-time and Retiree PPO Plan:

First $1,000: Regence BCBSO pays 50% of $80 or $40 and you pay 50% of $80 or $40.

After $1,000: Regence BCBSO pays 80% of $80 or $64 and you pay 20% of $80 or $16.

The physician accepts $80 as paid in full.

Participating Provider

Using these charges, if you use a participating provider (non-preferred) and you are enrolled on the Part-time and Retiree PPO Plan:

Regence BCBSO pays 50% of $90 or $45 and you pay 50% of $90 or $45. The physician accepts $90 as paid in full.

Non-participating Provider

Using these charges, if you use a provider that is neither preferred nor participating (non-preferred) and you are enrolled on the Part-time and Retiree PPO Plan:

Regence BCBSO pays 50% of $90 or $45. You pay 50% of $90 or $45 plus the difference between the billed charge and the participating provider contracted fee which is an additional $10. In this instance, you pay the $45 plus the $10 for a total amount of $55.

Claims Payment in Designated Rural Areas

Some areas of the state have limited preferred providers. In these counties, PEBB has arranged for resident members to receive the preferred provider level of benefit from providers who are either preferred or participating in Regence contracts.

This means that if you live in a designated rural county, are enrolled on the Regence PPO Part-time and Retiree plan, and receive care from a preferred or participating provider, you will receive the preferred level of benefits. If you choose to see a non-participating provider, you will receive the preferred benefits, however the provider may bill you for any amounts above Regence BCBSO maximum allowable fees.

The designated rural counties are: Baker, Crook, Curry, Deschutes, Gilliam, Grant, Harney, Jackson, Jefferson, Josephine, Klamath, Lake, Malheur, Morrow, Sherman, Tillamook, Union, Wallowa, and Wheeler.

The following are examples of claims payment for Regence BCBSO Part-time and Retiree PPO Plan enrollees living in the designated rural counties based on whether you use a preferred, participating or non-participating provider:

Example

Physician's Billed Charge = $100

Preferred provider contracted fee for this service = $80

Participating provider contracted fee for this service = $90

Rural Counties - Preferred or Participating

Using these charges, if you use a preferred or participating provider and you are enrolled on the Part-time and Retiree PPO Plan:

First $1,000: Regence BCBSO pays 50% of $90 or $45 and you pay 50% of $90 or $45.

After $1,000: Regence BCBSO will pay 80% of $90 or $72 and you will pay 20% of $90 or $18.

The physician accepts $90 as paid in full.

Rural Counties - Non-Participating

Using these charges, if you use a non-participating provider and you are enrolled on the Part-time and Retiree PPO Plan:

First $1,000: Regence BCBSO pays 50% of $90 or $45 and you pay $50% of $90 or $45 plus the difference between the billed charge and the participating provider contracted fee which is an additional $10.

After $1,000: Regence BCBSO pays 80% of $90 or $72 and you pay 20% of $90 or $18. In this instance, you pay $18 plus $10 for a total amount of $28.

For information on the plan's prescription drug formulary, limitations and exclusions, please see pages 40 through 46.

Kaiser Permanente Part-time Employee HMO	
Annual Out-of-Pocket Maximum	$1,500 per person; $3,000 per family
Type of Providers	Kaiser Permanent facilities and providers only
Individual Policy Maximum	None
TYPE OF SERVICE	**YOU PAY**
Primary care office visit	$30 copayment per visit
Specialist office visit	$30 copayment per visit
X-ray & lab	$15/x-ray, $6/lab test
PREVENTIVE CARE [1]	
Periodic health appraisals	$0 per visit
Well-child checkups (to age 19)	$0 per visit
Hearing screenings	$30 copayment per screening
Hearing exam & aids [2]	$30 copayment per exam
Routine immunizations	$0
Mammography screening	$0
HOSPITAL	
Ambulance	$75 copayment
Inpatient	$500 copayment per admission
Outpatient	$30 copayment
Emergency room	$100 copayment plus any other copayments that apply
SURGERY	
Inpatient	$0
Outpatient	$30 copayment
Office-based	$30 copayment
MATERNITY & GYNECOLOGY	
Prenatal and postpartum office visits	$0
Delivery (vaginal or Cesarean)	$500 copayment per admission
Routine gynecological exams	$30 copayment per visit
Infertility treatment	50% coinsurance
PRESCRIPTION DRUGS (per 30-day supply retail; per 90-day supply of Kaiser-defined maintenance drugs by mail order)	
Generic formulary	$10 copayment
Brand formulary	$25 copayment
Non-formulary	Not-covered
ROUTINE VISION SERVICES (per 12 months children; per 24 months adults)	
Routine vision exam	$30 copayment
Frames, lenses, contacts	Not covered
MENTAL HEALTH	
Inpatient	$500 copayment per admission
Residential and day treatment	$50 per day up to $250 maximum
Outpatient	$30 copayment per visit
CHEMICAL DEPENDENCY	
Inpatient & residential	$500 copayment per admission
Outpatient	$30 copayment per visit
Durable Medical Equipment	50% coinsurance
Alternative Care	Not covered

[1] *Based on a schedule. Includes commercial driver's exam.*

[2] *Hearing aid allowance of $250 per ear or a single aid per 36 months*

Regence BCBSO Part-time Employee PPO		
Annual Out-of-Pocket Maximum	$2,000/person; $6,000/family	$4,000/person; $12,000/ family
Type of Providers	Any licensed provider; you pay less when you use the plan's preferred providers.	
Individual Policy Maximum	$2 million	
TYPE OF SERVICE	**Preferred** you pay 50% of first $1000 then:	**Non-preferred** you pay 50% of $1000 then:
Primary care office visit	20% co-insurance	50% co-insurance
Specialist office visit	20% co-insurance	50% co-insurance
X-ray & lab	20% co-insurance	50% co-insurance
PREVENTIVE CARE		
Periodic health appraisals [1]	0%	50% co-insurance
Well-child checkups (to age 19)	0%	50% co-insurance
Hearing screenings	0%	50% co-insurance
Hearing exam & aids [2]	20% co-insurance [2]	50% co-insurance [2]
Routine immunizations	0%	50% co-insurance
Mammography screening	0%	50% co-insurance
HOSPITAL		
Ambulance	20% co-insurance	50% co-insurance
Inpatient	20% co-insurance	50% co-insurance
Outpatient	20% co-insurance	50% co-insurance
Emergency room	20% co-insurance	50% co-insurance
SURGERY		
Inpatient	20% co-insurance	50% co-insurance
Outpatient	20% co-insurance	50% co-insurance
Office-based	20% co-insurance	50% co-insurance
MATERNITY & GYNECOLOGY		
Prenatal and postpartum office visits	20% co-insurance	50% co-insurance
Inpatient delivery (vaginal, Cesarean)	20% co-insurance	50% co-insurance
Routine women's exams	$10 co-payment	50% co-insurance
Infertility treatment [3]	50% co-insurance	50% co-insurance
PRESCRIPTION DRUGS (per 34-day supply at local pharmacy; per 90-day supply at mail order pharmacy) [4]		
Generic	$10 co-payment; $20 co-payment	
Preferred	20% co-insurance; $40 co-payment	
Non-preferred	30% co-insurance; $60 co-payment	
MENTAL HEALTH & CHEMICAL DEPENDENCY[3] Treated as any other medical condition		
Inpatient & residential	20% co-insurance	50% co-insurance
Outpatient	20% co-insurance	50% co-insurance
ROUTINE VISION SERVICES	Not covered	
DURABLE MEDICAL EQUIPMENT	20% co-insurance	50% co-insurance
ALTERNATIVE CARE	50% co-insurance	50% co-insurance

[1] *Based on a schedule. Includes commercial driver's license exam*

[2] *Hearing aids covered at 100% to $500 per person per 36 months.*

[3] *Other limitations apply.*

[4] *$1,000 out-of -pocket maximum on prescription drugs.*

ODS Part-time Employee Dental Plan

Under the ODS Part-time Employee Dental Plan you can see any licensed dentist for your services. More than 92 percent of the licensed dentists in Oregon are participating ODS providers. ODS has specific fee arrangements with participating dentists to ensure that their actual charges do not exceed their usual fees on file with ODS. Participating dentists cannot bill patients for charges over and above the fees they have filed with ODS, which helps to minimize your out-of-pocket expenses.

The ODS Part-time Employee Dental Plan provides coverage up to an annual individual maximum benefit of $1,000. You pay an annual deductible of $50 per person. All covered services are subject to the annual deductible. Diagnostic and preventive services such as x-ray and cleaning are paid in full after the deductible is met. Basic and maintenance services such as fillings, root canal and oral surgery are covered at 50 percent. Orthodontia services are not covered.

Please see the table below for benefit information on this plan option. In addition, please refer to the ODS dental plan description on page 51 for more information about how claims are paid.

Additional Option Part-time Employee Dental Plan At a Glance	
Individual Annual Maximum Benefit	$1,000
Type of Service	**You pay**
Individual annual deductible (no family deductible; deductible not waived for any service)	$50
Diagnostic & preventive (x-ray, cleaning)	$0
Basic & maintenance (filling, root canal, oral surgery)	50%
Major (crowns, bridges)	50%
Orthodontia	Not covered

Life Insurance

Enrollment Information

Optional Life Insurance

If you are an eligible employee, you may enroll in Optional Life Insurance through PEBB's policy with The Standard Insurance Company (Standard). You may also enroll your spouse or domestic partner. You may enroll within 60 days of your date of hire, within 60 days of and consistent with a qualified status change, or during Open Enrollment.

You and your spouse or domestic partner qualify for $20,000 of guarantee issue optional life insurance if you enroll within 60 days of the initial eligibility date. If you enroll for life insurance for your domestic partner, an Affidavit of Domestic Partnership must be on file with the agency or received within 60 days of the initial eligibility.

Standard requires completion of a Medical History Statement if you or your spouse or partner:

- Enroll more than 60 days after you first become eligible;
- Apply for coverage of more than $20,000; or
- Elect to increase the amount of existing coverage.

Standard also requires a paramedical exam for applications for $100,000 or more. Standard will coordinate the exam.

You must apply for optional employee life insurance to apply for optional spouse or domestic partner life insurance.

Dependent Life Insurance

As an eligible employee, you may enroll for dependent life within 60 days of your date of hire or within 60 days of and consistent with a qualified status change. You may not apply for dependent life insurance during Open Enrollment.

Effective Dates

All coverage is subject to the "actively at work" requirement. For purposes of life insurance, you are actively at work if you are physically on the job and receiving pay for the first scheduled day of work and performing the material duties of your own occupation at your employer's usual place of business. Your coverage becomes effective according to the following provisions.

New Hires - Effective Dates

Insurance not subject to Medical History Statement: Coverage is effective the first day of the calendar month following the date your enrollment form is received by your agency if you apply within 60 days of your date of hire.

Insurance subject to approval of the Medical History Statement: Coverage is effective the first day of the calendar month following the date your Medical History Statement is approved.

Open Enrollment - Effective Dates

Insurance subject to approval of Medical History Statement: Coverage is effective the latter of (1) the first day of the calendar month following the date your Medical History Statement is approved; or (2) the first day of the new plan year.

Change in Qualified Status - Effective Dates

Insurance not subject to Medical History Statement: Coverage is effective the first day of the calendar month following the date the applicable form is received by your agency if you apply within 60 days of the change in status.

Insurance subject to approval of the Medical History Statement: Coverage is effective the first day of the calendar month following the date your Medical History Statement is approved.

Under either circumstance, the effective date cannot precede the date of the change in status.

If you are incapable of active work because of sickness, injury or pregnancy on the day before the scheduled effective date of your insurance or an increase in your insurance, your insurance or increase will not become effective until the day after you complete one full day of active work.

Plan Features

Term Insurance

The group life insurance coverage available to state employees through PEBB is term insurance. Group

term life insurance provides a life insurance benefit to the designated beneficiary if the insured dies while covered under the policy. No ownership rights are associated with group term life insurance. In addition, the group term insurance coverage does not accumulate any kind of cash value.

Basic Life Insurance

Basic Life Insurance is required for all eligible employees. It is provided for the employee only in the amount of $5,000 term life coverage. The premium for this insurance is deducted from your monthly state contribution.

Employee and Spouse or Domestic Partner Optional Life Insurance

Optional Life Insurance for you and your spouse or domestic partner is voluntary insurance. You may select an amount from $20,000 to $400,000 in increments of $20,000. If your spouse or domestic partner is also an eligible employee, the combined amount of Optional Employee Life Insurance and Spouse or Domestic Partner Life Insurance may not exceed $400,000. Optional Life Insurance coverage will require completion of a Medical History Statement for amounts over $20,000.

Dependent Life Insurance

Dependent Life Insurance for your spouse or domestic partner and child(ren) is voluntary and covers your spouse, domestic partner and child(ren) for $5,000 each.

Waiver of Premium

If, before age 60, you become totally disabled from all occupations while insured for life insurance, your insurance will continue without payment of premium. For purposes of waiver of premium, insurance means the employee, spouse or domestic partner and dependent coverage (except coverage under the Portability provision). Waiver of premium ends when you cease to be totally disabled from all occupations, fail to provide ongoing proof of eligibility, fail to cooperate with the insurance company or convert your insurance.

Accelerated Benefit

If you qualify for waiver of premium and provide proof that you have a life expectancy of less than 12 months because of a terminal illness, you may receive up to 75% of your life insurance during your lifetime. The maximum amount of insurance that may be accelerated is 75% of $400,000 for $300,000; the minimum is $5,000 or 10% of your insurance, whichever is greater. You must have at least $10,000 of life insurance in effect to be eligible for the accelerated benefit. The amount of life insurance remaining after an accelerated benefit payment is reduced by interest on the accelerated benefit. In no event will the remaining life coverage be less than 10% of the amount of insurance in effect prior to the accelerated benefit payment.

Optional Life Insurance Roll Over

If you and your spouse or domestic partner are both state employees, each of you can "roll over" your Optional Life Insurance coverage to the other's benefit package upon termination, as long as the remaining employee is insured for Optional Life as either an employee, spouse or partner. You can also roll over Optional Life coverage if the remaining employee applied for Optional Life coverage but was declined due to medical reasons. The only time you cannot roll over Optional Life coverage upon termination is when the remaining employee is not insured for Optional Life coverage as an employee, spouse or partner and has never applied for Optional Life coverage.

Conversion

If your life insurance ends or is reduced for any reason other than your failure to pay the required premium or payment of an accelerated benefit, you may have the right to purchase an individual policy of permanent life insurance without submitting evidence of insurability. You must apply for conversion within 60 days of the date your insurance ends or is reduced. Under the conversion provision if your employment terminates, you may convert the amount of Optional Employee Life, Spouse or Domestic Partner Life and Dependent Life that is ending.

Retiree Life Insurance Option

If you are a state employee and your life insurance ends when you retire from state service, you may have the option to purchase the Retiree Life Option without submitting evidence of insurability. You must apply for this option within 60 days of the date your active insurance ends. The amount of your benefit if you are under age 65 is an amount you select in increments of $2,500, from $2,500 to $200,000, but not to exceed 50% of the amount of Basic and Optional Insurance in effect on the day before your retirement date. The amount of your Optional Life Insurance after your 65th but before your 70th birthday is 65% of the amount that would be applicable if you were under age 65. The

amount of your Optional Life Insurance after your 70th but before your 75th birthday is 50% of the amount which would be applicable if you were under age 65. The amount of your Optional Life Insurance after your 75th birthday is 35% of the amount which would be applicable if you were under age 65.

Portability

You may continue your Optional Employee Life Insurance and Optional Spouse or Domestic Partner Life Insurance if your employment terminates as long as:

(1) You are not totally disabled from all occupations

(2) Termination of your employment is not due to your retirement.

Portability continuation coverage is group term insurance. Rates for continued coverage will be based on the existing plan rates plus billing fees. Premiums will be billed by Standard directly to your residence.

The maximum amount of insurance you may continue is the amount in effect on the date your employment terminates. You may continue a lesser amount as long as the lesser amount remains a multiple of $20,000. You may not later increase the amount of coverage you continue. To continue your Spouse or Domestic Partner coverage, you must continue your Employee coverage.

If you become totally disabled from all occupations, you should apply for Waiver of Premium, not portability. Your Optional Life Insurance will continue without premium payment by you while your waiver claim is being investigated. The insurance company will refund up to 12 months of the premiums that were paid for insurance after the date your become totally disabled. If you are later determined not to be eligible for Waiver of Premium, you will be provided with an opportunity to port your coverage if your employment has terminated for reasons other than retirement. You must apply for these plans within 60 days of the date your insurance terminates. Portability is not available for Basic Life or Dependent Life.

Exclusions

If your death results from suicide or other intentionally self-inflicted injury, while sane or insane, the amount payable will exclude the amount of your Life Insurance that is subject to this suicide exclusion and that has not been continuously in effect for at least two years on the date of your death.

All premiums paid for that portion of your Life Insurance that is excluded from payment under this suicide exclusion will be refunded. This suicide exclusion applies only to Optional Employee Life Insurance and Optional Spouse or Domestic Partner Life Insurance.

Accidental Death and Dismemberment Insurance

Enrollment Information

If you are an eligible employee, you may enroll for Accidental Death and Dismemberment (AD&D) Insurance within 60 days of your date of hire, within 60 days of and consistent with a qualified status change, or during Open Enrollment. You can purchase AD&D insurance for yourself and your dependents. The effective date for new hire enrollment or enrollment changes due to a qualified status change is the first of the month following receipt of the applicable form by your agency. The effective date for open enrollment changes is the first of the calendar year.

Plan Features

Employee and Dependents

If you are an eligible employee, you may select AD&D Insurance for you and your spouse or domestic partner and your child(ren) as voluntary insurance. You may select an amount from $50,000 to $500,000 in increments of $50,000. You may also select to insure your spouse or domestic partner and your child(ren). If a claim is filed on any of these individuals, the benefit payable is equal to a percentage of your AD&D insurance as follows: spouse or domestic partner only, 50 percent; children only, 15 percent for each child; spouse or domestic partner and children, 40 percent for spouse or partner and 15 percent for each child.

Principal Sum

The AD&D plan provides 24-hour coverage for accidental death or loss of a limb, hearing, speech or sight. The amount of coverage you elect for yourself is called the Principal Sum.

The Principal Sum is paid for the following accidental losses:

- Life
- Both hands or both feet or sight of both eyes
- One hand or one foot

- Either hand or foot and sight of one eye
- Speech and hearing.

One-half of the Principal Sum is paid for the following accidental losses:

- Sight of one eye
- Either hand or foot
- Speech or hearing.

One-quarter of the Principal Sum is paid for loss of thumb and index finger of either hand.

The maximum benefit payable for all losses due to the same accident will not be more than the Principal Sum.

Public Transportation Benefit

If you or your insured dependent suffers loss of life while a fare-paying passenger on public transportation, the beneficiary will receive 200% of the amount of AD&D Insurance that was in effect on the insured person on the date of the accident. This benefit will be paid in place of any other AD&D benefits payable for the same accident.

Public Transportation means a vehicle operated by a common carrier for the purpose of providing transportation for fare-paying members of the general public. Vehicles include buses, trains, boats and planes operating on regular routes and selling tickets to members of the general public.

Seat Belt Benefit

A Seat Belt Benefit will be paid if:

(1) You are also enrolled for Optional Employee Life Insurance;

(2) You die as a result of an automobile accident for which an AD&D Insurance benefit is payable; and

(3) You were wearing a seat belt at the time of the accident as evidenced by a police accident report.

The amount of the Seat Belt Benefit is the lessor of:

(1) The amount of your Optional Employee Life Insurance;

(2) The amount of your AD&D Insurance payable for loss of life; or

(3) $50,000.

Career Adjustment Benefit

If you suffer loss of life, and you and your spouse or domestic partner are insured, your spouse or domestic partner will receive a Career Adjustment Benefit. The amount payable is 5% of your AD&D Insurance in effect on the date of the accident to a maximum of $5,000. This benefit will be paid in addition to other AD&D benefits payable under the Group Policy. If you have no surviving spouse or domestic partner, this benefit will not be paid.

Higher Education Benefit

If you suffer a loss of life, a Higher Education Benefit will be paid to each insured child who is:

(1) Registered and in full-time attendance at an accredited institution of higher education beyond the 12th grade; or

(2) In the 12th grade and will be registered and in full-time attendance within one year at an accredited institution of higher education beyond the 12th grade.

The Higher Education Benefit is payable annually for a maximum of four years provided the child continues to meet (1) and (2) above. The amount payable per year is 5% of your AD&D Insurance in effect on the date of the accident to a maximum of $5,000. This benefit will be paid in addition to other AD&D benefits payable under the group policy.

Benefit for Disappearance

If you or your insured dependent disappears as a result of an accident that could have caused loss of life, and the victim is not found within one year from the date of the accident, you or your dependent will be presumed dead. The benefit will be the amount of AD&D Insurance in effect on the insured person on the date of the accident. This benefit will be paid in place of any other AD&D benefits payable under the group policy for the same accident.

Benefit for Loss Due To Exposure

If you or your insured dependent suffers a loss caused by exposure to the natural elements, the benefit is the amount of AD&D insurance in effect for the loss on the date of the accident. This benefit will be paid in place of any other AD&D benefits payable under the group policy for the same accident.

Benefit for Loss Due To Occupational Assault

An Occupational Assault Benefit will be paid if all of the following requirements are met:

1. While actively at work you suffer a loss for which an AD&D Insurance benefit is payable.

2. The loss is the result of an act of physical violence against you that is punishable by law and is evidenced by a police report.

The Occupational Assault Benefit is the lesser of (1) $25,000; or (2) 50% of the amount of the AD&D Insurance Benefit otherwise payable for the Loss.

Benefit for Loss Due To Line of Duty

A Line Of Duty Benefit will be paid if all of the following requirements are met:

1. You are a public safety officer.
2. You suffer a loss for which an AD&D Insurance Benefit is payable.
3. The loss is the result of a Line Of Duty Accident. Public safety officer means a member whose primary job duties include controlling or reducing crime or juvenile delinquency, criminal law enforcement, or fire suppression. Public safety officer includes police officers, firefighters, corrections officers, judicial officers, and officially recognized or designated volunteer firefighters, if they otherwise meet the definition of public safety officer.

Line of duty accident means an accident, including accidental exposure to adverse weather conditions, that occurs while you are taking any action which by rule, regulation, law, or condition of employment you are obligated or authorized to perform as a public safety officer in the course of controlling or reducing crime or criminal law enforcement, including such action taken in response to an emergency while off duty.

If you are a public safety officer, whose primary job duties are controlling or reducing crime, criminal law enforcement, or fire suppression, line of duty accident includes a line of duty accident that occurs while you are on duty at social, ceremonial, or athletic functions to which you are assigned or for which you are paid as a public safety officer by your Employer.

The Line of Duty Benefit is the lesser of (1) $50,000; or (2) 100% of the amount of AD&D Insurance otherwise payable for the loss.

Benefit for Loss Due To Paralysis

A benefit for Paralysis will be paid if:

1. You or your dependent suffers paralysis caused by an accident within 365 days of the date of that accident;
2. The paralysis continues for 12 calendar months; and
3. A licensed medical professional certifies that the paralysis is permanent, complete and irreversible.

The amount payable is equal to a percentage of the AD&D Insurance in effect on the insured person on the date of the accident. The percentage is shown below:

Loss	Percentage
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%

Quadriplegia means total paralysis of both upper and lower limbs. Paraplegia means total paralysis of both lower limbs. Hemiplegia means total paralysis of the upper and lower limb on the same side of the body.

Exclusions

No AD&D insurance benefit is payable if the loss is caused or contributed to by any of the following:

- War or act of war (war means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature).
- Suicide or other intentionally self-inflicted injury, while sane or insane.
- Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing official duties.
- The voluntary use or consumption of any poison, chemical compound or drug, unless used or consumed according to the directions of a physician.
- Sickness or Pregnancy existing at the time of the accident.
- Heart attack or stroke.
- Medical or surgical treatment for any of the above.
- Travel or flight in or descent from any kind of aircraft, as a pilot or crewmember, except in state-owned, leased or operated aircraft while on state business.

Disability Insurance

Enrollment Information

Eligible employees are guaranteed acceptance in the Long Term and Short Term Disability Insurance plans if they enroll within 60 days of their date of hire, within 60 days of and consistent with a qualified status change, or during an open enrollment period. Coverage is effective the first of the month following receipt of the applicable form by the agency. For Open Enrollment changes, coverage is effective the first day of the calendar year.

Effective Dates

All coverage is subject to the active work requirement. For purposes of disability insurance, you are actively at work if you are physically on the job and receiving pay for the first scheduled day of work and performing the material duties of your own occupation at your employer's usual place of business.

If you are incapable of active work because of sickness, injury or pregnancy on the day before the scheduled effective date of your insurance or an increase in your insurance, your insurance or increase will not become effective until the day after you complete one full day of active work.

Plan Features

Short Term Disability (STD)

Benefit: 60% of the first $2,769 of your weekly Predisability Earnings, reduced by Deductible Income.

Maximum: Maximum weekly STD Benefit is $1,662 before reduction of Deductible Income. If you are eligible to receive STD Benefits and sick leave benefits are paid or payable to you by your employer, the amount of your STD Benefit is $25 per week.

Benefit Waiting Period: Your Benefit Waiting Period is A, B, or C, whichever is longest, where:

A = 7 days if your disability is due to sickness or pregnancy.

B = 0 days if your disability is due to accidental injury.

C = The period ending on the last day before you were scheduled to return to work, if you become disabled while you are scheduled to be away from work under the terms of your employment.

Maximum Benefit Period:

4 weeks, if your disability is subject to the Pre-existing Condition limitations

13 weeks, if your disability is not subject to the pre-existing condition limitation

Each day you are disabled, if you are disabled for less than one full week, with one-seventh of the STD Benefit paid for each day of disability.

Long Term Disability (LTD) Benefit:

Plans 1 and 2:

60% of the first $12,000 of your monthly Predisability Earnings, reduced by Deductible Income.

Plans 3 and 4:

66 2/3% of the first $12,000 of your Predisability Earnings, reduced by Deductible Income.

Maximum Benefit:

Plans 1 and 2:

$7,200 monthly before reduction by Deductible Income.

Plans 3 and 4:

$8,000 monthly before reduction by Deductible Income.

Minimum Benefit:

All Plans: $50 per month.

Benefit Waiting Period:

Plans 1 and 3: 90 days

Plans 2 and 4: 180 days

Maximum Benefit Period: Determined by your age when Disability begins as follows:

Age	Maximum Benefit Period
61 or younger	To age 65, or 3 years 6 months if longer
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year

General Information

Insured Earnings

For purposes of determining the disability benefit payable, insured earnings are based on your earnings in effect on your last full day of work. Insured earnings include your regular earnings from the State of Oregon, including deferred compensation (e.g., 401k), grant assistance wages and stipends, and amounts contributed to your benefits under a Section 125 plan salary reduction agreement. When your insured earnings increase (e.g., with a pay increase) your premium rate increases proportionately. Insured earnings does not include overtime pay, bonuses, State paid contributions on your behalf to any deferred compensation arrangement or plan, State paid benefit dollars in excess of medical, dental and the first $50,000 of group life insurance, or any other compensation.

Donated Leave

Sick leave or other salary continuation benefits you receive reduce disability benefits. For purposes of determining the benefit payable, donated leave you receive is considered to be sick leave. Donated leave benefits will be deducted from the disability benefit payable.

Pre-existing Conditions

Unless on the date you become disabled, you have been insured under a State of Oregon Short Term or Long Term Disability policy for at least 24 months, any claim you file will be subject to a "Pre-existing Condition" clause. A Pre-existing Condition is a mental or physical condition for which you consulted a physician, received medical treatment or services, or took prescribed medication during the six-month period before the effective date of your disability insurance. You must serve a Pre-existing Condition period for both Short Term and Long Term Disability if you are insured for both coverages.

Short Term Disability Four Week Benefit. The maximum benefit period for Short Term Disability benefits is limited to four weeks for a disability caused or contributed to by a pre-existing condition. You must meet all other policy provisions to receive benefits for the four-week period.

The pre-existing condition clause will no longer apply after you have been insured under the policy for 24 months.

Long Term Disability. Benefits are not payable for a disability caused or contributed by a pre-existing condition if you are disabled during the first 24 months of coverage.

The pre-existing condition clause will no longer apply if you become disabled after you have been insured under the policy for 24 months.

Benefit Waiting Periods for Long Term Disability

The pre-existing condition exclusion also applies to a change in plan that either decreases the Benefit Waiting Period or increases your LTD benefit. The Pre-existing Condition Period and the Exclusion Period for the new Plan will be based on the effective date of your insurance under the new plan. However, if benefits are not payable under the new plan because of the Pre-existing Condition exclusion, your claim will be administered as if you had not elected to change plans.

Deductible Income

The disability benefit payable under the Short Term and Long Term Disability policies is reduced by Deductible Income, which is other income you are eligible to receive because of your disability. Deductible Income is different for Short Term and Long Term Disability coverage.

Deductible Income for Short Term Disability. Deductible Income includes your earnings from work while disabled and a portion of the benefits you are eligible to receive under any other Short Term Disability program. Also, your Short Term Disability benefit is reduced to $25 per week if sick leave benefits, including donated leave, are paid or payable. The $25 minimum will not apply if your sick leave balance is 40 hours or less and you are not receiving paid sick leave. For Short-term Disability, vacation and personal business leave pay is not deductible income.

Deductible Income for Long Term Disability. Deductible Income includes the following:

- Sick leave or other salary continuation (including donated leave but not including vacation).
- Earnings from work while disabled.
- Workers' compensation benefits.
- Social Security benefits payable to you and your dependents.

- Disability or retirement benefits you are eligible to receive under your employer's retirement plan, including a public employees retirement system, a state teacher retirement system, and a plan arranged and maintained by a union or employee association.
- Benefits you are eligible to receive because of your disability from any other group insurance coverage, including state disability income benefits, and, for members employed by the State of Oregon University System, benefits you are eligible to receive under an employer sponsored individual disability policy.

How to File a Disability Claim

If you become disabled and need to apply for Short Term Disability (STD) or Long Term Disability (LTD) benefits, please contact your agency representative to obtain a disability claim packet. Or you may print a copy of the claims packet from PEBB's Web site at http://pebb.state.or.us/disabilityclaim.pdf. The claim packet for disability benefits consists of five forms: an Employer Statement, an Employee Statement, an Authorization to Obtain Information, the Attending Physician's Statement and a Repayment Agreement for Workers' Compensation benefits. The claim packet contains detailed instructions for completing and submitting the forms to The Standard Insurance Company. Additional questions can be directed to your agency representative, a PEBB Benefits Counselor or Standard.

Disability Retirement Benefits

PEBB members may also be eligible for disability benefits through Public Employees Retirement System (PERS) Disability retirement. Refer to the PERS Member Handbook and contact PERS for information.

Exclusions and Limitations

Short Term Disability Insurance

Intentionally Self-Inflicted Injury

You are not covered for a disability caused or contributed to by an intentionally self-inflicted injury, while sane or insane.

Work Related

You are not covered for a disability arising out of or in the course of any employment for wage or profit.

Care of A Physician

You must be under the ongoing care of a physician during the Benefit Waiting Period. No STD Benefits will be paid for any period of disability when you are not under the ongoing care of a physician.

Occupational Benefits

No STD benefits will be paid for any period while you are eligible to receive benefits under a workers' compensation law or similar law. If your claim for these benefits is accepted, compromised or settled (whether disputed or undisputed), you must repay the full amount of any STD benefits you receive while your claim for occupational benefits is pending.

Sick Leave

If you are receiving or are eligible to receive paid sick leave (including donated leave) from your employer, the amount of your STD Benefit will be $25.

Working

No STD Benefits will be paid for any period: (a) when you are working for wage or profit for any employer other than the State of Oregon; or (b) when you are self-employed. This limitation applies whether you are working in your own or another occupation.

Imprisonment

No STD Benefits will be paid for any period of Disability when you are confined for any reason in a penal or correctional institution.

Pre-existing Condition

Payment of STD Benefits will be limited to four weeks if your Disability is caused or contributed to by a Pre-existing Condition. However, this limitation will not apply if, on the date you become disabled, you have been

(1) Continuously insured for at least 24 months and

(2) Actively at Work at least one full day after those 24 months.

Exclusions and Limitations

Long Term Disability Insurance

Intentionally Self-Inflicted Injury

You are not covered for a Disability caused or contributed to by an intentionally self-inflicted injury, while sane or insane.

Pre-existing Condition

You are not covered for a Disability caused or contributed to by a Pre-existing Condition or medical or surgical treatment of a Pre-existing Condition unless, on the date you become Disabled you have been:

(1) Continuously insured for at least 24 months and

(2) Actively at Work at least one full day after those 24 months.

Mental Disorder

Payment of LTD Benefits is limited to 24 months for each period of Disability caused or contributed to by a Mental Disorder. However, if you are in a hospital at the end of the 24 months, this limitation will not apply while you are continuously hospitalized.

Care of a Physician

You must be under the ongoing care of a physician during the Benefit Waiting Period. No LTD Benefits will be paid for any period of disability when you are not under the ongoing care of a physician.

Imprisonment

No LTD Benefits will be paid for any period of Disability when you are confined for any reason in a penal or correctional institution.

Frequently Asked Questions

Life and Disability Insurance

What is the maximum amount of life insurance I can purchase?

You can purchase up to $400,000 of insurance on your life and the life of your spouse or domestic partner. If you and your spouse or domestic partner are both State of Oregon employees, your combined employee and spouse or domestic partner coverage cannot exceed $400,000 each.

Do I get a certificate when enrolling in a life or disability plan?

Yes. Your agency payroll, personnel or benefits office should provide you with a certificate or you can request one from PEBB. Or you may print one from the PEBB Web site at http://pebb.das.state.or.us/Standard_Insurance_index.htm.

Is a physical required when requesting life insurance coverage?

A full physical examination is not required for an employee, spouse or domestic partner. However, if you apply for Employee, Spouse or Domestic Partner Life coverage of $100,000 or more, the insurance company may require a brief paramedical exam. You may be required to have the exam if enrolling for less than $100,000 if medical necessity exists.

Will the premiums for my life insurance or my spouse's or my domestic partner's life insurance ever increase?

Premiums are subject to change every plan year. Additionally, when you or your spouse or domestic partner move into a new age-rated category, your premiums will automatically increase to the amount for that category at the beginning of the next plan year (January 1 paycheck).

I had my second child and want to add the new baby to the Dependent Life coverage. Can I do that?

If you are already enrolled in the Dependent Life policy, your new baby is automatically covered. There are no forms to complete. If you are not enrolled in the Dependent Life option at the time of birth of your second child, you may enroll within 60 days of the birth of the child. This enrollment option is available because the birth of the second child is a status change event.

Is Dependent Life available during Open Enrollment?

No. The only time you can enroll for Dependent Life insurance is within 60 days of your hire date or within 60 days following and consistent with a qualified status change.

My spouse and I are both State employees, and each of us is insured for $60,000 of Optional Life Insurance. My spouse is terminating employment with the state. Can my spouse's Optional Employee Life coverage be transferred to Optional Spouse coverage under me at the time of termination?

Yes. This is referred to as an Optional Life Insurance roll over. When you and your spouse or domestic partner are both state employees, you can roll over your Optional Life Insurance coverage to the other's benefit package when you terminate your state employment, as long as the remaining employee is insured for Optional Life as either an employee, spouse or domestic partner. You can also roll over Optional Life coverage if the remaining employee applied for Optional Life coverage but was declined because of medical reasons. The only time you cannot roll over Optional Life coverage on termination is when the remaining employee, spouse or domestic partner is not insured for Optional Life coverage as an employee, spouse or domestic partner and has never applied for Optional Life coverage.

Can I continue my life insurance if I retire?

When you retire you can convert your life insurance to a whole life individual policy on a guarantee issue basis. You have 60 days from the date your life insurance ends to convert to an individual insurance policy.

An additional retiree life option is available from Standard. The benefit is 50% of the amount of life insurance coverage you have as an active employee and reduces over time.

How do I file a life or disability claim?

Contact your agency to coordinate completion of the applicable claim form. The agency is required to complete portions of the forms and the employee or family member is responsible for other portions.

I am pregnant. Will I be eligible for benefits under the PEBB STD and LTD policies while I'm off work?

Disability caused by pregnancy is covered under both the STD and LTD policies. Maternity claimants are

considered disabled when, because of pregnancy, they are unable to perform the material duties of their own occupation. For benefits to be paid, all policy provisions, including pre-existing condition clause and benefit waiting period, must be met.

The medical community has well-established duration guidelines for disability caused by pregnancy.

If there are complications associated with the pregnancy, either pre- or postpartum, disability could be established outside these guidelines. Benefits are paid only while the claimant is unable to work at her own occupation because of pregnancy.

Can I continue my life and disability insurances if I go on leave without pay?

Life insurance can be continued on a self pay basis for up to 12 months. Disability insurance cannot be continued unless the leave is due to a disability. Premiums must be paid during the waiting period (elimination period), but premiums are waived once benefits are payable. For detailed information on continuation rights during a leave, refer to your Eligibility Handbook.

Dependent Care FSA

Section 6

Oregon state employees may establish a Dependent Care Flexible Spending Account (FSA) to use pre-tax income to pay for eligible, work-related dependent-care expenses. For more information on this federal program see IRS Publication 503. You may establish an account within 60 days of your initial date of hire, during Open Enrollment, or within 60 days of and consistent with a qualified status change event.

To establish an FSA, you determine how much you will spend on dependent care during the year. The expenses must be employment related and necessary for you (and your spouse, if married) to be employed or look for employment outside the home.

You then make a monthly election on your Dependent Care FSA Enrollment Form. That amount will be deducted from your salary on a pre-tax basis and moved to your account. As you incur dependent-care expenses throughout the year, you request reimbursement from the account by filing claims. The money that is reimbursed has not been and will not be taxed.

PEBB's Dependent Care FSA program is administered by

Associated Administrators, Inc.
Flexible Benefit Unit
PO Box 3199, Mail Station B20
Portland, OR 97208-3199

Who Can Use the Account

Employees may elect to participate in a Dependent Care FSA if they are:

- Single; or
- Married, and the expenses are necessary for both the employee and the spouse to work; or,
- Married, and the spouse is either disabled, actively seeking employment, or a full-time student at least five months during the year.

See IRS Publication 503 to confirm that your dependents qualify and that you are eligible to participate.

Qualified Expenses

According to IRS regulations, expenses that qualify for reimbursement are expenses for the care and well-being of the employee's dependent child under the age of 13 or for the care of a disabled dependent of any age who is incapable of self-care and who spends at least eight hours per day in the employee's home. Expenses for education, sports camps and overnight camps are not eligible. Food and transportation, when billed separately, are not eligible. (Please refer to IRS Publication 503 for further information on qualifying expenses.) Qualified expenses include charges for:

- A licensed or registered day care facility or nursery school;
- An individual who provides dependent care in the employee's home (other than a spouse, a qualified dependent under age 19, or a housekeeper) and who provides you with an address and taxpayer identification number.

You may not use this account to pay for a dependent's healthcare expenses.

You will be reimbursed only for expenses incurred within the calendar year in which you are enrolled. Expenses you incurred in a prior year are not eligible for reimbursement, even if you pay for them during the current year. If you enroll in the Dependent Care FSA after Jan. 1, you will be reimbursed only for those expenses incurred on or after your effective date of participation in the account.

How Much to Deposit

To participate in a Dependent Care FSA, you must complete an enrollment form and mark your monthly deposit amount on the form. Following are the participation limits:

If you are:	You may deposit up to:
Single	$5,000 per year
Married, filing joint	$5,000 per year
Married, filing separately	$2,500 per year
Married, with spouse who is disabled or a full-time student	$2,400 per year per dependent up to $4,800 per year

If you or your spouse earns less than the amounts shown, the maximum amount you may deposit is either your monthly income or your spouse's monthly income, whichever amount is lower. If both you and your spouse participate in a Dependent Care FSA (through the same or different employers) the $5,000 limit applies to the combination of both FSAs.

A special IRS rule applies if your spouse is a full-time student or is disabled and not capable of self-care. This special rule allows you to deposit amounts to your FSA as if your spouse earned $200 per month if you have one dependent or $400 per month if you have two or more dependents.

Your Dependent Care FSA election will be deducted from your paycheck monthly. Estimate your eligible expenses for the upcoming plan year and divide those expenses by 12 to determine your salary deduction. During a full year, the maximum amount you can deposit monthly is $416.66.

Use It or Lose It

Your Dependent Care FSA is subject to the Internal Revenue Service "Use It or Lose It" rule. This means that you must incur all expenses to be reimbursed by the account during the plan year (Jan. 1-Dec. 31). While you may request expense reimbursement from the account through March 31 of the following year, all expenses must have been incurred during the plan year. Any funds remaining in the account after March 31 will be forfeited.

Qualified Status Changes

According to federal tax regulations, once you are participating in a Dependent Care Account, you cannot change the amount of money put in the account or stop the deposits until the next open enrollment period unless you experience a qualified change. Qualified status change events include but are not limited to the following:

- Your marriage, final divorce, or legal separation;
- The birth, adoption or placement for adoption of a dependent;
- The death of your spouse or dependent;
- Your spouse obtaining or losing a job;
- A change in legal custody agreement;
- A change in your or your spouse's employment status, such as changing from part-time to full-time, changing from full-time to part-time, or taking an unpaid leave of absence;
- Cost changes imposed by a dependent care provider; or
- A change in dependent care provider.

Refer to the PEBB Eligibility Handbook for a complete discussion of qualified status change events.

All changes must be requested within 60 days of the event, must be consistent with the event, and must also include written documentation of the event. If you do not enroll in the Dependent Care FSA when you first become eligible, you must wait to enroll until the next open enrollment period, unless you experience a change in family status. Midyear enrollment following a qualified status change is effective the first of the month following receipt of the applicable form by the agency or the first of the month following the qualified status change, whichever is later.

Ending the Account

When you enroll in a Dependent Care FSA, you are electing to participate for a full year. However, you may stop making deposits to the account because of a qualified change in status or by electing to discontinue during Open Enrollment. Deposits to your account automatically terminate if you end state service. To ensure the Dependent Care FSA deduction is not taken from your final paycheck, notify your payroll office as soon as you know you will be leaving state service. If you terminate employment with the state, you are still eligible to claim reimbursement for expenses you incurred during the year while you were a state employee. Expenses incurred after your termination are not eligible.

Continuing the Account

If you do not want to make changes in your account from year to year, you do not need to fill out an enrollment form during Open Enrollment. However, if you want to make a change that is not related to a qualified status change event, you can make the change only during Open Enrollment. In this case you will need to complete and submit a new Dependent Care FSA Enrollment Form.

Filing for Reimbursement

Associated Administrators, Inc. (AAI) administers the PEBB Dependent Care FSA program. AAI will send you a supply of forms to use to request reimbursement for eligible dependent care expenses.

To file for reimbursement, complete a reimbursement form and attach receipts or other proof of services incurred and payment made for each eligible expense. The IRS does not accept canceled checks as proof of expense or payment. A receipt from the provider should state the dates dependent care services were provided; the amount of the expense; and the dependent care provider's name, address, and Tax Identification Number or Social Security Number. A Form W-10 is available from the IRS and should be completed by your provider.

Send the form and other documentation to:

Associated Administrators, Inc.
Flexible Benefit Unit
PO Box 3199, Mail Station B20
Portland, OR 97208-3199

You may not be reimbursed for more funds than you have available in your account. Your reimbursement will be issued by the 20th of the month. Filing a request on a regular basis is a good idea. However, you have until March 31 of next year to request reimbursement for expenses incurred during the current year. Remember: to be reimbursable under this plan, the dependent care services must be provided on or before Dec. 31 of the plan year.

FSA or Tax Credit?

If you use a Dependent Care FSA to pay for your dependent care expenses, your use of the federal and Oregon child-care tax credits will be limited. Before you enroll for a Dependent Care FSA, determine which tax program will be better for you.

Generally, if you expect that your adjusted gross annual income (including spousal income) will be more than $25,000, you will most likely be better off using reimbursement through an FSA. If you expect that your adjusted gross annual income (including spousal income) will be less than $25,000, you will most likely be better off taking the tax credits and not participating in a Dependent Care FSA.

Please note that PEBB cannot guarantee favorable tax results. If you need additional information or assistance, contact your attorney, accountant or other tax advisor.

Questions?

If you have questions about enrolling or participating in the Dependent Care Flexible Savings Account, call a PEBB Benefits Counselor at (503) 373-1102 (in Salem) or (800) 788-0520. Or send e-mail to inquiries.pebb@state.or.us.

It may be helpful to review IRS Publication 503 prior to enrolling in the Dependent Care FSA program. You can find this publication on the IRS Web site at www.IRS.gov or pick it up at any IRS office.

Special Instructions for Oregon University System Employees

Dependent Care Flexible Spending Account Form:

Request and complete a Dependent Care Flexible Spending Account (FSA) form only if you're enrolling in the program for the first time, or if you want to change or stop your participation in the program. The first deduction will be taken out of the December 31, 2002, paycheck and the last deduction out of the November 28, 2003, paycheck. Note: Nine-month employees (includes classified academic-year employees) not enrolled in the 12-month payroll redistribution plan will have only 10 deductions taken for the 2003 plan year. You cannot claim expenses for any time period that you are not working. Contact your campus benefits office to request Dependent Care FSA information, which includes a form.

UnumProvident Long Term Care

Section 7

Unum Life Insurance Company of America

2211 Congress Street
Portland, Maine 04122

UnumProvident's Long Term Care (LTC) plan is simple. Once you qualify, you will receive the monthly benefit you selected, even if your benefit payment exceeds the actual monthly charge you incur. You never have to submit a record of your expenses, and there's no hassle over the amount of your benefit. So when your UnumProvident plan pays a benefit, you can use the money to meet the needs that you decide are most important.

Coverage

UnumProvident's Long Term Care Insurance pays benefits when you require substantial assistance with two out of six activities of daily living (ADLs) – bathing, dressing, toileting, transferring, continence and eating, or suffer severe cognitive impairment that requires substantial supervision.

The ADL loss must be expected to last for a period of at least 90 days, as certified by a physician, and care must be provided pursuant to a plan of care prescribed by a licensed health care practitioner. (Recertification must occur every 12 months by a physician to confirm that the disability still exists.) ADLs are the most widely accepted measure of an individual's ability to live independently.

Benefit Levels

You can choose a monthly benefit of $1,000 to $6,000 in $1,000 increments. Your Long Term Care Facility benefit will pay the monthly benefit amount you select, regardless of the cost of care. For Professional Home Care and Total Home Care, 50% of the monthly Nursing Home benefit is paid.

How and Where You Receive Care

How and where you receive services will depend on your needs, family situation and finances. The PEBB plan allows you to choose care:

- In a Long Term Care Facility, an Assisted Living Facility, an Adult Foster Care Home, or a Residential Care Facility with an Alzheimer's Care Endorsement; or
- At home, through Professional Home Care, where care can be provided through a licensed Home Health Care Provider, or Total Home Care, where care can be provided by anyone you choose, including family and friends.

The plan also includes a Respite Care feature.

Plan Summary

Base Plan

Level of Care: Long Term Care/Assisted Living Facility (Adult Foster Care Homes), Residential Care Facility, and Professional Home Care.

Facility Benefit Amount: $1,000 per Month

Adult Foster Home/Assisted Living Facility/Residential Care Facility Benefit Amount: 60% of Facility Benefit Amount

Professional Home Care Benefit Amount: 50% of Facility Benefit Amount

Benefit Duration: 3 Years

Elimination Period: 90 Days (must be satisfied once per lifetime)

Plan Options

Facility Benefit Amount: $2,000, $3,000, $4,000, $5,000* or $6,000* per Month

Benefit Duration: 6 Years and Unlimited*

Total Home Care: 50% of Facility Benefit Amount

Inflation Protection: 5% Simple Uncapped

*Selection of $5,000 and $6,000 Facility Benefit Amount or Unlimited Benefit Duration are above the Guarantee Issue limits and require completion of UnumProvident's Group Long Term Care Insurance Application (medical underwriting).

Effective Date of Coverage

Newly hired employees will have 60 days to enroll for Guarantee Issue coverage. Please check with your agency for your effective date.

Employees who enroll after the guarantee issue period or who choose options above the guarantee issue limits must complete a Group Long Term Care Insurance Application (medical underwriting). The effective date of coverage is the first of the month following approval by UnumProvident.

Eligible family members must complete a Group Long Term Care Insurance Application (medical underwriting), and in some instances, an interview may be required. The effective date of coverage for those needing medical underwriting is the first of the month following approval by UnumProvident.

Eligibility

The following individuals are eligible to apply for enrollment:

- Employees
- Spouses or domestic partners
- Parents and grandparents of the employee or the employee's spouse or domestic partner
- Adult siblings or adult children of the employee or the employee's spouse or domestic partner
- Non-Medicare retirees and retirees' spouse or domestic partner.

You select your own plan by choosing the Facility Monthly Benefit Amount and any of the optional plan features, including Total Home Care, which allows you to choose to receive care at home from family, friends, or licensed professionals. Each eligible family member would purchase their own coverage and tailor it to best fit their needs.

How To Enroll

An enrollment kit is available at your agency payroll, personnel or benefits office. To obtain an enrollment kit, contact your agency or PEBB. For your convenience, you may e-mail PEBB at inquiries.pebb@state.or.us or use the Information Request form on page 101 of this booklet.

You can enroll for PEBB Long Term Care insurance at any time during the year. If you or another family member submits an enrollment application after 60 days from your hire date, the coverage is subject to medical underwriting and completion of the Long Term Care Insurance Application.

Definitions

Adult Foster Home: A family home or facility that is licensed by the appropriate licensing agency and is primarily engaged in providing

(1) room and board to 5 or fewer adults who are not related to the provider by blood or marriage; and

(2) services that assist the resident in daily activities, such as bathing, dressing, eating, medication management or money management.

Assisted Living Facility (ALF): An institution that is licensed by the appropriate agency (if required) to primarily engage in providing ongoing care and services to a minimum of 6 residents in one location and operates under state licensing laws and any other laws that apply.

Benefit Duration: This is the length of time benefits will be paid as long as you continue to be Disabled. You may move between facility and home care — depending on the need — and still receive benefits. You will continue to receive benefits as long as you qualify and until your Lifetime Maximum Benefit Amount has been completely used.

Elimination Period (EP): The EP is a period of 90 consecutive days of continuous Disability (that occurs after the effective date of coverage and) during which you are receiving care. This 90-day period must be satisfied before benefits begin. This 90-day EP must be satisfied only once during your lifetime.

Facility Benefit Amount: This is the benefit amount UnumProvident will pay monthly once you qualify for benefits and after the Elimination Period has been satisfied. The benefit paid is subject to the Lifetime Maximum Benefit Amount. Benefits are not paid during the Elimination Period.

Guarantee Issue for Employees: Guarantee Issue means that employees may purchase this insurance within 60 days of their Hire Date without having to answer questions on a medical questionnaire (medical underwriting). However, if you choose to purchase coverage over $4,000 and/or the Unlimited Benefit Duration, or wait longer than 60 days after your Hire Date to purchase the coverage, medical underwriting will be required.

Inflation Protection: 5% Simple Uncapped. Your Monthly Benefit Amount will increase each year on January 1, by 5% of your original monthly benefit

amount for the life of the plan. Increases will be automatic and will occur regardless of your health and whether or not you are Disabled. Your premium will not increase due to automatic increases in your Monthly Benefit Amount. The benefit paid is subject to the Lifetime Maximum Benefit Amount. Benefits are not paid during the Elimination Period.

Lifetime Maximum Benefit Amount: This is the maximum benefit dollar amount UnumProvident will pay over the life of your coverage. This dollar amount is based on the Long Term Care/Nursing Home Facility Benefit Amount and the Benefit Duration (3 years, 6 years or unlimited) you elect.

For example: If you choose $3,000/month Facility Benefit Amount and a 3 year Benefit Duration, your Lifetime Maximum is as follows:

$3,000/month x 12 months x 3 years = $108,000

Note: If you choose the "Unlimited" Benefit Duration, your Lifetime Maximum Benefit Amount will also be "Unlimited."

Long Term Care Facility: This type of facility is an institution that is licensed or certified as a nursing home (if licensing or certification is required) or operates under the law as a nursing home, to provide skilled, intermediate and custodial care under the orders of a physician and under the supervision of professional nurses.

Medical Underwriting: Employees who enroll after the guarantee issue enrollment period, those who elect coverage amounts over the Guarantee Issue limits, retirees and all eligible family members are required to complete a Group Long Term Care Insurance Application (medical questionnaire) for all choices. Medical Underwriting means that questions on a medical questionnaire must be answered. In some cases, an interview may also be necessary. After the questionnaire is completed, it must be returned to UnumProvident. UnumProvident will then determine eligibility and notify you when your coverage is effective.

Professional Home Care (PHC): Includes visits to your home by a licensed Home Health Care Provider during which skilled nursing care, physical, respiratory, occupational, dietary or speech therapy, or homemaker services are provided; Adult Day Care; or Hospice Care. The PHC benefit is equal to 50% of the Nursing Home Facility Monthly Benefit Amount. The Professional Home Care benefit is equal to 1/30th of the monthly Professional Home Care benefit for *each day that care is provided*. It is the *frequency* of home care that affects the benefit amount, not the actual cost. Claimants must document the use of a professional caregiver for the reported amount of days before benefits are paid.

Residential Care Facility with an Alzheimer's Care Endorsement: This type of facility provides Residential Care for 6 or more inpatients; and has an Alzheimer's Care Unit that is a special care unit in a designated, separate area for residents with Alzheimer's Disease or other dementia. It must be licensed, certified, or registered in accordance with the requirements of the Department of Human Services and state law.

Respite Care: Respite Care means formal care provided to you for a short period of time to allow your informal caregiver a break from their caregiving responsibilities. If you are eligible for a home care monthly benefit but benefits have not yet become payable, payments will be made to you for each day you receive respite care for up to 15 days each calendar year. The amount of your payment will equal 1/30th of your home care monthly benefit for each day that you receive respite care.

Total Home Care: Total Home Care includes Professional Home Care services, as well as care received from any care provider of your choosing, including relatives and friends who provide care in your home.

Features

Guaranteed Renewable: As long as you pay your premiums on time, your coverage can never be canceled.
Waiver of Premium: Once you qualify for benefits, satisfy your elimination period, and are receiving benefits, we will waive your premium payments.
Tax-free Benefit: This plan is tax-qualified; therefore, the benefits you receive from UnumProvident are tax-free.

Limitations and Exclusions

This policy has limitations and exclusions that may affect any benefits payable.

UnumProvident will not make long term care payments to you for: a Disability caused by war (whether declared or not) or any act of war; a Disability caused by attempted suicide (while sane or insane) or self-destruction; a Disability caused by a commission of a crime for which you have been convicted under state or federal law or attempting to commit a crime under state or federal law; disabilities or confinements during which you are outside the United States, its territories or possessions for longer than 30 days; a Disability caused

by alcoholism or alcohol abuse; a Disability caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you by a Physician. ("Controlled substance" is defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments.); a period in which you are confined in a hospital other than if you are confined in a nursing facility that is a distinctly separate part of a hospital, (this exclusion does not apply to those periods covered under the Bed Reservation Benefit); or a Disability caused by psychological or psychiatric or mental conditions, regardless of cause, which include: depression, generalized anxiety disorders, personality disorders, schizophrenia, manic depressive disorders, or adjustments disorders, and other conditions that are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or similar methods of treatment.

However, UnumProvident will make payments to you for conditions that are not psychological, psychiatric or mental in nature, including Alzheimer's disease or similar forms of irreversible dementia.

Pre-existing Conditions Exclusion

For guarantee issue coverage, a pre-existing condition exclusion will apply.

A pre-existing condition is any condition that exists for which you have received medical treatment, consultation, care or services, including diagnostic measures, or took drugs or medicines that were prescribed for the condition, during the six month period right before coverage begins.

UnumProvident will not make any payments to you for a Disability that is caused by, contributed to by, or results from a pre-existing condition, and begins during the first six months after your coverage begins.

How do I file a claim?

Obtain a claim form from Unum within 30 days of the date you become disabled and in need of long-term care. If you do not have the appropriate documentation to complete the form within the timelines, send Unum the Notice of Claim postcard that is attached to the claim form. Submit the completed claim form when you have obtained all the necessary documentation.

Can my spouse and I continue our long term care insurance after we quit state service?

Yes, Unum can directly bill you for the same coverage you had as active employees. The premiums will remain the same. You can choose to pay them quarterly, semi-annually or annually. You can obtain a continuation of coverage form from your agency. Or print one from the PEBB Web site.

The State of Health

Section 8

The State of Health is PEBB's comprehensive wellness program for state employees. All PEBB members may participate in this PEBB-sponsored benefit.

Welcome to the State of Health

The State of Health program is designed to help members navigate a chaotic healthcare landscape. Medical costs and insurance premiums are skyrocketing with no plateau in sight. The pharmaceutical and technology industries continue to promote the latest and greatest in costly drugs and devices. At the same time, the American demographic is changing; we are fast becoming an older population that needs and expects the latest innovations and medications.

In this new world of healthcare, The State of Health is designed to:

- advance the health and wellbeing of PEBB participants;
- improve the quality of life of PEBB members who have serious illnesses;
- help members navigate the increasingly complex, costly healthcare system; and
- assist members to manage their health through resources and information.

Get Control of a Chronic Condition

If you've been diagnosed with a chronic disease, use The State of Health as your personalized source of support and guidance. If you have diabetes, asthma, cardiovascular disease or any other chronic condition, The State of Health is your connection to:

- One-on-one consultations with health professionals who have expert knowledge about these conditions
- Disease management programs that are part of your medical plan.
- Online resources at www.wellmed.com/stateof health.
- Community resources designed to help you better manage your own care or the care of family members.
- Books, brochures and videos with practical advice on maintaining your quality of life.

Assess Your Health Risks

If you know your risks for a serious illness, you can take steps to avoid it. Assess your health risks by measuring your HealthQuotient through The State of Health online. This suite of Web-based tools, developed by WellMed, is available to all PEBB members at www.wellmed.com/stateofhealth. Your HQ measures your health risks based on your family and personal history, daily activities, behaviors and other individual health factors. Once you know your HQ, the online tools can arm you with information, plans and actions to lower your risks and maintain your health.

Consult a Caring Expert

Some PEBB members have been or will be diagnosed with a serious disease or complex condition. Treatment options and choices can be overwhelming. Consult with PEBB Health Center staff for expert advice on how to deal with these issues. Count on them to be your health system navigators. Wherever you live in Oregon, they can provide expert guidance to help PEBB members negotiate the twists and turns of our increasingly costly and complex healthcare system. Whether you talk with a staff member over the phone or face to face, your consultation will be completely confidential as well as practical.

PEBB members can call the PEBB Health Center for advice anytime during regular office hours. Statewide, call (800) 701-1333. In Salem, call (503) 362-1111. Qualified healthcare staff will provide advice on seeking professional care or guidance on steps to take on your own.

In addition, PEBB members who are pregnant (or thinking about it) have online and in-person access to pregnancy support. Caring professionals at the health center can direct them to 24-hour online resources and guide them to maternity management programs that are part of the medical plans.

Use Health Tools You Can Trust

While most PEBB members are basically healthy, many of us still have physical issues. You may want to lose weight, cope with stress, quit smoking, control your blood pressure, deal with menopause or solve another health-related problem. If you're thinking about change, where do you turn for support and assistance? Turn to The State of

Health. The program's online tools include Web-based condition centers, health-based news and information resources, and personal health planners and trackers.

In addition to the online tools, The State of Health offers access to PEBB Health Center resources. These include:

- A free, comprehensive health and wellness library of books, videos, audiotapes and other materials that can be distributed anywhere in the state.
- Web guidance to help you register for The State of Health online, complete HealthQuotient to assess your health risks and create a plan to reduce your risks.
- Free classes on a variety of health topics, with most class materials and handouts available free by mail.
- Regular newsletters with easy-to-apply health tips and wellness information.
- A health and wellness information clearinghouse with statewide listings of community health and fitness resources.

Follow Your Own Path

PEBB members can take the path they find most comfortable to get to The State of Health:

- Through e-mail to pebbhealth@wellmed.com
- On the Web at www.wellmed.com/stateofhealth.com
- By attending a PEBB-sponsored Health Screening in their area
- By calling the PEBB Health Center at (503) 362-1111 in Salem or (800) 701-1333 outside Salem.
- By visiting the PEBB Health Center at 775 Court Street NE, Salem, OR 97301, across the street from the State Capital.

The State of Health Online

The State of Health wellness program includes PEBB's comprehensive statewide online suite of health tools created by WellMed. This secure, confidential Web site offers an array of interactive tools to help you and your family make the most of your healthcare benefits. Here's how to use them.

Logging In

1. Go to: www.wellmed.com/stateofhealth to reach the State of Health log in page.
2. Click on "new user" or "register now" in the upper right corner. *(Hint: The next time you use the State of Health tools, go to "returning user" and just enter your user name and password to go directly to your personal State of Health home page.)*

Registering

Type in your registration information.

1. Enter your Social Security Number.
2. Choose a "User Name" that's easy to remember. You'll use it every time you visit the State of Health site. *(Hint: your User Name can be any word or combination of four or more letters or numbers. Don't use*

a common word or name, such as "Dave" since it has probably been taken already. Also, don't use spaces or special characters.)

3. Choose a "Password" that's easy to remember. *(Hint: Your Password cannot be the same as your User Name. It should contain at least six letters or numbers. But do not use spaces or special characters, such as "&" or "$")*
4. Retype your Password to confirm that it is correct.
5. Choose a "Password Reminder." *(Hint: This is a quick clue about your password if you forget it. Your reminder cannot be the same as the password, but it can be a single word or phrase up to 50 characters, such as "My dog's middle name.")*

Enter your personal information

1. Type in your first and last names.
2. Type in your date of birth. *(Hint: Be sure to use two digits for the month and day and then all four digits for the year, such as 05/12/1964.)*
3. Enter your zip code. *(Hint: Use your work or home zip code.)*
4. Enter your e-mail address. *(Hint: Use your work or home e-mail.)*
5. Enter Yes or No for e-mail permission. *(Hint: If you enter Yes, WellMed may send you periodic e-mail messages pertaining to your health interests. You can unsubscribe at any time. Your e-mail address will not be given to anyone else.)*
6. Check the box regarding agreement with WellMed's Terms and Conditions and Privacy Policy. *(Hint: To read the full documents, just click on the link for each.)*
7. Click "submit" to enter all your information.

State of Health Personal Home Page

Upon completing registration, you will arrive at your State of Health personal home page! This is your secure, online location where you can explore a wide variety of health tools and information – personalized to you.

Choosing topics will help personalize your State of Health home page with information and articles about the topics you've selected. You can check the box next to the health topics that interest you at any time.

Under My Recommendations, take the First Step and click on the link to HealthQuotient, a 10-minute online health risk assessment.

HealthQuotient

On the HealthQuotient introduction page, click on "Take Assessment" on the far right side of the screen to start the HealthQuotient questionnaire. *(Hint: The next time you come back to HealthQuotient, you can change your answers by clicking on the "Update Assessment" link under My Assessment.)*

The HealthQuotient assessment will ask 20 to 25 questions about your medical profile, lifestyle and family health history. Plus you can enter in your blood pressure, cholesterol scores and other measurements on the last page of the questionnaire.

Click "Submit" at the bottom of each page. At the end, you will receive your personalized "HQ Report" with your "HQ Score."

Your HQ Score tells you how your health compares with that of other people in your age group. The report provides in-depth information on the health risks identified through the questionnaire.

Back Home

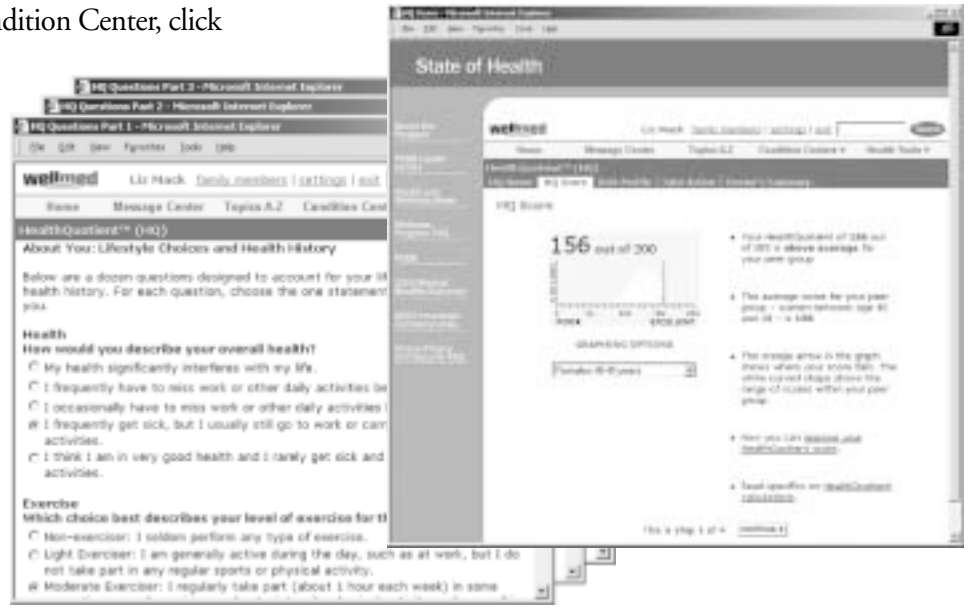
To get back to your State of Health home page at any time, click the "Home" link.

Other Tools

To get to other health tools from your State of Health home page, just use the recommended steps or click on the items listed at the top of each page to travel around the site.

For example, to get to the Asthma Condition Center, click on "Condition Centers" at the top of the screen and select "Asthma." On the Asthma Condition Center home page, click on "Take Assessment" in the upper right side of the page to start the Asthma questionnaire.

When you are finished with the assessment, you will receive your personalized Asthma Report, which contains a clinical summary, treatment options and recommended actions.



Logging Out

When you are finished using the online health tools, simply click on "exit" at the top of any screen next to the Search box. This will log you out of WellMed's secure system and save your personal health information.

The next time you come back, go to www.wellmed.com/stateofhealth, and log in as a Returning User with your User Name and Password to get to your home page.

Questions?

If you have questions about how to use The State of Health online, click on "feedback" at the bottom of any page. WellMed will respond within two business days.

Your Privacy is Protected

Who will have access to any personal data entered at The State of Health?

Only PEBB members themselves will have access to their own personally identifiable data. Through your user name and password, you will be the only one with access to any of your personal information, unless you share your password with someone else.

Will PEBB or the state be able to access any personal or individual data about any user?

Neither PEBB nor the state can access personal or individual information through The State of Health Web site. PEBB will never have access to any member's individual health data. PEBB will only receive reports about PEBB members as a group, not as individuals. For example, PEBB may learn the total number of members who use the site but cannot know who those people are.

How secure is personal data I enter on the Web site?

All personally identifiable information a PEBB member enters on the site is confidential and secure. The data reside on a computer server network owned and operated by WellMed, Inc. WellMed has received the highest recognition in the e-health industry for its protection of users' privacy and the security of their personal information. The company uses a highly redundant, geographically distributed network of servers to provide its services.

The Web site includes a message center. Does that mean personal information will be sent by e-mail?

No. If you receive an e-mail notice that a message is waiting at the Web site, you can access the message only on WellMed's servers and only by using your personal user name and password. Messages for individuals will not be delivered over the Internet; they cannot be intercepted or viewed by others.

May employees access The State of Health at work?

Agencies have varying policies about accessing the Internet from work and during work hours. Employees should review their agencies' policies and seek agency clarification if they need further information. PEBB has no role in setting policies on Internet use and encourages employees to follow agency policies.

Is employee personal data protected if they access the Web site at work?

Any information an employee enters at the Web site is private and secure, no matter which computer or Internet connection they use. The Web site resides only within WellMed's secure network and can be accessed only through the user name and password.

May I save the information?

Feel free to save any of the site's pages on your home computer. However state employees should be aware that state computers are public property, and information saved and stored on them may be considered public information.

What controls are there for children's access to the Web site?

The State of Health Web site is intended for adult use only. A parent or guardian may use the site for a minor dependent who is a PEBB member. The parent or guardian is solely responsible for providing supervision of the minor dependent's use of the site. The Web site does not search the Internet for information. It searches only information stored on WellMed's network servers.

How credible is the health information provided through the Web site?

All the health-related materials at the site have been developed or reviewed by medical professionals. Users can be confident they are factual and up-to-date.

What if I change my mind about information I entered at the site?

You can correct, update, review or remove information you previously entered.

If I set up accounts for covered family members, is their information secure as well?

When you set up accounts for family members, you will be prompted to establish a user name and password for each member. Family members can protect their personal information by not sharing their user name or password.

PEBB Plans Resources Directory

Associated Administrators, Inc.
(Dependent Care Flexible Spending Accounts)
2929 NW 31st
PO Box 3199, Mail Station B20F
Portland, OR 97208-3199
Phone: (503) 220-3805, (800) 334-4340

BestChoice Administrators (Retiree, Self-pay, Semi-independent, COBRA)
PO Box 67240
Portland, OR 97268-1240
Phone: (503) 765-3581, (800) 556-3137

Cascade East Health Plan (HMO Plan)
645 West Orchard Avenue
Hermiston, OR 97838
Phone: (541) 567-5555, (800) 577-CEHP (2347)
Fax: (541) 567-5577
Web site: www.cehp.org

Kaiser Permanente (HMO & Dental Plans)
500 NE Multnomah, Suite 100
Portland, OR 97232-2099
Phone: (800) 813-2000
Web site: www.kp.org/nw

Nationwide Insurance (auto)
Phone: (888) 678-4663
Media Code 8425

ODS Health Plans (Dental Plan)
601 SW 2nd Avenue
Portland, OR 97204
Phone: (800) 452-1058
Web site: www.odshp.com/pebb/

Regence BlueCross BlueShield of Oregon (PPO Plans)
PO Box 1271
Portland, OR 97207-1271
Phone: (800) 826-9813 (outside Portland)
(503) 220-3849 (Portland)
Web site: www.or.regence.com/pebb

The Standard Insurance Company
(Life and Disability Plans)
PO Box 2800
Portland, OR 97208-2800
Phone: (800) 842-1707 Disability
(800) 242-1888
Fax: (800) 378-6053
Web site: www.standard.com

Unum (Long-Term Care Plan)
Unum Life Insurance Company of America
2211 Congress Street
Portland, ME 04122
Phone: (800) 227-4165
Web site: w3.unumprovident.com/enroll/pebb

VSP (Vision Service Plan)
PO Box 997105
Sacramento, CA 95899
Phone: (800) 877-7195
Web site: www.vsp.com

Willamette Dental Insurance (Dental Plan)
14025 SW Farmington Road, Suite 300
Beaverton, OR 97005
Phone: (800) 460-7644
Web site: www.denkor.com

Insurance company web sites are also accessible on PEBB's web site, http://pebb.das.state.or.us/2003insindex.htm

Public Employees' Benefit Board (PEBB)

775 Court Street NE
Salem, OR 97301-3802
Phone: (503) 373-1102, (800) 788-0520
Fax: (503) 373-1654
Web: http://pebb.das.state.or.us
E-mail: inquiries.pebb@state.or.us

Membership Information

Plan Handbook and ID Cards

Current PEBB members who change their medical and/or dental plans during Open Enrollment and newly hired employees will receive new medical and dental plan identification cards from the carriers they select for 2003. They will also receive new plan member handbooks from the insurance companies. If you do not receive your cards or handbooks, contact the PEBB office or the insurance company. Current PEBB members who maintain their 2002 plan choices into 2003 should continue to use their existing ID cards and handbooks. PEBB members with VSP routine vision benefits should use the member's Social Security Number as identification when obtaining services from VSP providers.

Mail-Order Pharmacy Brochures

PEBB members who wish to use the mail-order pharmacy benefit may contact the insurance company or PEBB for the informational brochure and mailer along with initial registration information. PEBB members may use the Information Request form on page 101 to request mail-order drug information.

Change of Address

If you change your address during the plan year, contact PEBB or your agency for the appropriate benefit update form to notify your employing agency and the insurance company. Turn in the completed form to your agency personnel office. Also contact your agency payroll office to notify them of your address change. It is important that you keep your mailing address up to date to stay informed of your benefits. Request a form from your payroll, personnel or benefits office, or contact PEBB at (503) 373-1102 or (800) 788-0520, or inquiries.pebb@state.or.us.

Service Complaints

Submit service complaints to:

Benefits Manager
Public Employees' Benefit Board
775 Court Street NE
Salem, OR 97301-3802
(503) 373-1102
(800) 788-0520
inquiries.pebb@state.or.us

Definitions

Affidavit of Domestic Partnership. A written document kept on file by the Agency, in which an employee and another individual attest to meeting the criteria set forth in PEBB Administrative Rules OAR 101-010-0005(8) on the date the document is signed by the employee and the individual. Available from PEBB or your agency.

Affidavit of Dependency. A written document in which an eligible employee attests that the dependent meets the criteria set forth in OAR 101-010-0005(7) on the date the document is signed by the insured individual.

Agency. An administrative division of Oregon government that includes a payroll, personnel or campus benefits office.

Coinsurance. The cost of a covered service that is shared by the plan and by the member, typically expressed in percentages; e.g., 85% carrier and 15% member. The provider typically bills the member after the plan has paid.

Co-payment (or co-pay). A fixed dollar amount (e.g., $10) paid by the member to the provider at the time of service.

Deductible. A dollar amount of expenses the member must pay before the plan pays.

Dependent child(ren). Any child who meets all the criteria in (a) and at least one criterion in (b) of the following:

(a) The dependent child(ren)

(A) Is unmarried and without a domestic partner; and

(1) Is under the age of 19 at the end of the calendar year; or

(2) Is between the ages of 19 and 24 and continues to qualify as a student or meets the gross income test set forth by the Internal Revenue Service in the Tax Guide for Personal Exemptions and Dependents;

(3) Meets the criteria for a "dependent child" of an eligible employee, or the eligible employee's spouse or domestic partner, under Section 152 of the Internal Revenue Code, as enacted on November 22, 1999, whether or not the eligible employee, or the eligible employee's spouse or domestic partner actually claims or receives a dependent exemption from federal income tax for the child. Not all individuals listed in section 152 of the Internal Revenue Code are eligible (see 101-010-0005(13)).

(b) The dependent child(ren):

(A) Is a natural or adopted child or a child placed for adoption of the employee or the employee's spouse or domestic partner;

(B) Is a child living in the home of the employee, or the employee's spouse or domestic partner, who is a legal ward by court decree; a dependent by affidavit of dependency; or under the legal guardianship of the employee, or the employee's spouse or domestic partner;

(C) Is a child aged 24 or older who otherwise meets the requirements of subsection (a) of this rule and who is incapable of self-sustaining employment by reason of mental retardation or physical handicap. The child must have been covered by the plan at the time of his or her 24th birthday, and the physical handicap or mental retardation must have existed prior to the child attaining age 24.

The dependent child of a domestic partner is entitled to the same benefits under these rules as the dependent child of an eligible employee or his or her spouse.

Domestic Partner. An individual who attests with an employee that both meet all the following criteria:

1) Are both at least 18 years of age;
2) Share a close personal relationship and are responsible for each other's welfare;
3) Are each other's sole domestic partner;
4) Are not married to anyone nor has either had another domestic partner within the prior six months;
5) Are not related by blood closer than would bar marriage in the State of Oregon;
6) Have jointly shared the same regular and permanent residence for at least six (6) months; and
7) Are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household.

Eligible Employee. An employee of a state agency, including state officials, in exempt, unclassified, classified and management service who are expected to work at least 90 days, and who work at least half time or in a position classified as job share.

Eligible Individual. A legally married spouse or domestic partner of an employee and/or dependent children of the employee, spouse or domestic partner.

Emergency Care. Services and supplies furnished by a facility that are required to stabilize a patient with symptoms of such severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the individual's health (or the health of the fetus in the case of a pregnant woman) in serious jeopardy.

Group Health Plan. For purposes of opting out of medical coverage:

(a) Any medical plan offered or contributed to by an employer or a former employer;

(b) Medical coverage provided by a federal government or other governmental entities, as an employer or a former employer, such as CHAMPUS or TriCare; and other group coverage as approved by PEBB.

Half time. An employee who works less than full-time but at least:

(a) Eighty (80) hours per month; or

(b) 0.5 FTE for OUS employees; or

(c) As defined by collective bargaining.

Health Maintenance Organization (HMO). A type of health plan in which members must receive all care from network providers, usually under the direction of a primary care physician (PCP), such as a family practitioner, internist or pediatrician. Members must work or reside in the HMO's service area.

Maximum Benefit. The total amount payable by a plan for covered expenses. For example, the annual maximum benefit under ODS dental plans is $1,500 for the year for each person covered, and the lifetime maximum for medical care in Regence BlueCross BlueShield of Oregon medical plans is $2 million.

Ineligible Dependent. A dependent who does not meet the definition of spouse, domestic partner, or dependent child as set forth in 101-010-0005 (13). The following individuals are not eligible:

(a) Children under age 19 who are other than a natural or adopted child or a child placed for adoption of the employee or the employee's spouse or domestic partner and for whom the employee, spouse, or domestic partner has no financial or medical responsibility.

(b) Children between the ages of 19 and 24 who are other than a natural or adopted child or a child placed for adoption of the employee or the employee's spouse or domestic partner and for whom the employee, spouse, or domestic partner has no financial or medical responsibility or do not meet the test for student status or gross income as set forth and provided to taxpayers annually by the Internal Revenue Service in the Tax Guide for Personal Exemptions and Dependents.

(c) Members of the employee's household who may be eligible dependents under Internal Revenue Service guidelines but who are not eligible for enrollment on the PEBB plan. These individuals may include brother, sister, half-brother, half-sister, step-brother, step-sister, parent, grandparent, great-grandparent or other direct ancestor, step-father, step-mother, brother or sister of your father or mother, a son or daughter of your brother or sister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, foster parent, or foreign students. The exception is when the employee has financial and medical responsibility for a child who is under the age of 19 and who qualifies under OAR 101-010-0005(7).

Member. An active employee of the employer, a COBRA or self pay participant, or a retiree. Employees must meet the terms of eligibility outlined in the PEBB Administrative Rules.

Open Enrollment. A period designated by PEBB during which members are permitted to change their benefit choices. During this period, members (excluding retirees) may add or delete eligible individuals from coverage even if they did not experience a qualified family status change.

Opt Out. An action taken by employees who are covered by another group medical plan to receive a cash payment in lieu of receiving medical insurance coverage through PEBB.

Out-of-Pocket Maximum. The annual amount a member must pay for deductibles and coinsurance before the plan covers all remaining eligible expenses at 100 percent (referred to as "stop loss") for the remainder of the calendar year.

Plan Year. A period of 12 consecutive months as designated by the Board. Currently, the PEBB Plan Year is Jan.1 through Dec. 31.

Portability of Medical Insurance. Ongoing medical coverage available from the employee's current medical carrier after termination of coverage with the state. The employee cannot be eligible to enroll in Medicare and must have been enrolled in an Oregon-based medical group plan for at least six months immediately prior to termination of coverage; or if the employee has at least 18 months of prior medical insurance coverage with the most recent coverage being in an Oregon-based group plan.

Pre-authorization. A plan requirement that covered services be approved by the plan prior to the date of service.

Pre-existing Condition. A physical or mental condition that was diagnosed or treated, or for which medication was prescribed or taken, in the six months before the effective date of coverage of a medical plan. A condition is diagnosed whenever a physician tells a person that he or she has that condition or makes an entry to that effect in the person's medical records. This diagnosis of condition applies even if the physician is examining or treating the person for a different condition. Currently, PEBB medical and dental plans elected during Open Enrollment impose no pre-existing condition limitations. However, specified benefits in certain circumstances such as transplants may impose a waiting period or limitation. For life and disability Insurance coverage, a mental or physical condition for which an individual has consulted a physician, received medical treatment or services or taken prescribed drugs or medication six months prior to the effective date of insurance.

Preferred Provider. For PPO plans, a medical care provider or facility that has agreed contractually to accept discounted fees as payment for covered services from the insurance company. No billing services above UCR.

Participating Provider. For HMO plans, a medical care provider or facility that has agreed to discounted fees and other medical care management policies with the insurance company.

Participating Provider. For PPO plans, a medical care provider or facility that has accepted the terms and conditions of the insurance company and agrees not to balance bill the participating members for covered services (non-preferred).

Non-participating Provider. For PPO plans, medical care providers and facilities that have no contract or agreement with the insurance company. Non-Participating providers generally bill participating members for all balances up to the billed charge that are not paid by the plan. Changes are reimbursed to members, not directly to providers.

Preferred Provider Organization (PPO). A plan design that provides different benefit levels for services provided by preferred (network) providers and non-preferred providers who are not in the network. Members who choose care from preferred providers will pay less.

Qualified Status Change. Events that change the eligibility status of a PEBB member (see Eligibility Handbook for detailed description) such as the following:

1) Events that change the legal marital status of an employee
2) Events that change the status of a domestic partner
3) Events that change the number of an employee's, spouse's or domestic partner's eligible family members
4) Termination or commencement of employment by the employee, spouse or domestic partner
5) Reduction or increase in hours of employment by the employee, spouse or domestic partner that affects eligibility
6) An event that causes an eligible individual to satisfy or cease to satisfy the eligibility requirements for coverage due to age, student status or any similar circumstance
7) An increase in employee out-of-pocket premium amount resulting from decisions of the employer or employee
8) An involuntary loss of other coverage as specified by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

9) An action in compliance with a final judgment, decree or order that includes issuance of a Qualified Medical Child Support Order (QMCSO) requiring enrollment of dependent children on the existing medical and dental plan(s)

10) The relocation of an employee and eligible individuals from a plan service area that results in loss of eligibility in that plan

11) Gain or loss of Medicare or Medicaid coverage

12) Change of qualified Dependent Care Flexible Spending Account when one dependent care provider is replaced by another or when new costs are imposed by a dependent care provider who is not a relative of the employee as defined by IRC 152(a)(1)-(8)

13) A change or cessation of coverage that occurs through an overall reduction in coverage, addition or elimination of benefit options, or a change in an eligible individual's coverage through the employer.

Referral. When a provider refers a patient to another provider. In an HMO, the primary care provider makes any referrals, including those who substitute when the PCP will be unavailable, as well as any specialists who are also part of the HMO.

Spouse. A legally married partner.

State Contribution. The amount of money paid by the State of Oregon on behalf of employees for the purchase of the benefits provided through PEBB. The amount of the contribution varies depending on the employee group or collective bargaining unit. Part-time and job-share positions typically receive a pro-rated contribution. PEBB plays no role in determining the contribution.

Usual, Customary, Reasonable (UCR) Charges. UCR applies to fees that are:

Usual. A fee that is not more than the provider's usual charge for a given service or supply.

Customary. An amount within the range of usual charges for the service or supply billed by most providers of the same or similar service or supply in the service area.

Reasonable. A usual or customary amount; or an amount that, because of unusual circumstances, inadequacy of data or other reasons is established on an individual basis.

Waiting Period. A designated period during which insurance benefits are excluded or limited.

For Dental Coverage: In PEBB plans, a waiting period currently applies to dental insurance for the indemnity dental plan policies. The waiting period applies when the spouse, domestic partner or dependent children are not enrolled when initially eligible and continuously covered on a PEBB dental policy by the employee who enrolled the individual when initially eligible. The waiting period also applies for those who are not covered for dental benefits for 12 months or more and are subsequently enrolled during Open Enrollment. The waiting period is 12 months for basic and major dental benefits and 24 months for orthodontic benefits. During the Waiting Period, coverage is provided for preventive services and relief of pain as defined by the plan. The waiting period is waived if the individual is added to dental coverage due to a qualified status change such as loss of other group coverage.

For Medical Coverage: The medical plans may include benefit-specific waiting periods such as a 24-month exclusionary period for covered transplant procedures.

Eligibility

Eligible Individuals

The following individuals (as defined below) may receive medical insurance coverage under the benefit plans provided through PEBB.

(1) Eligible employees

(2) Family member(s) of eligible employees provided the employee lists the family member(s) on the enrollment form

(3) Domestic partners of eligible employees and domestic partners' dependent child(ren) provided the employee lists the domestic partner and his or her dependent child(ren) on the enrollment form. To enroll a domestic partner or the partner's children, the employee must also submit an Affidavit of Domestic Partnership with the enrollment form.

Eligible employee means an employee of a state agency, including state officials, in exempt, unclassified, classified and management service who are expected to work at least 90 days; and who work at least half-time or in a position classified as job share.

Family member(s) means a legally married spouse of an eligible employee; and a dependent child.

Dependent child(ren) means any child who meets all the criteria in (a) and at least one criterion in (b) of the following:

(a) The dependent child(ren)

(A) Is unmarried and without a domestic partner; and

(1) Is under the age of 19 at the end of the calendar year; or

(2) Is between the ages of 19 and 24 and continues to qualify as a student or meets the gross income test set forth by the Internal Revenue Service in the Tax Guide for Personal Exemptions and Dependents;

(3) Meets the criteria for a "dependent child" of an eligible employee, or the eligible employee's spouse or domestic partner, under Section 152 of the Internal Revenue Code, as enacted on Nov. 22, 1999, whether or not the eligible employee, or the eligible employee's spouse or domestic partner actually claims or receives a dependent exemption from federal income tax for the child. Not all individuals listed in Section 152 of the Internal Revenue Code are eligible - see 101-010-0005(13).

(b) The dependent child(ren)

(A) Is a natural or adopted child or a child placed for adoption of the employee or the employee's spouse or domestic partner;

(B) Is a child living in the home of the employee, or the employee's spouse or domestic partner, who is a legal ward by court decree; a dependent by affidavit of dependency; or is under the legal guardianship of the employee, or the employee's spouse or domestic partner;

(C) Is a child aged 24 or older who otherwise meets the requirements of subsection (a) of this rule and who is incapable of self-sustaining employment by reason of mental retardation or physical handicap. The child must have been covered by the plan at the time of his or her 24th birthday, and the physical handicap or mental retardation must have existed prior to the child attaining age 24.

The dependent child of a domestic partner is entitled to the same benefits under these rules as the dependent child of an eligible employee or his or her spouse.

Domestic Partner means an individual who attests with an eligible employee that both meet all the following criteria:

a) Are both at least 18 years of age;

b) Share a close personal relationship and are responsible for each other's welfare;

c) Are each other's sole domestic partner;

d) Are not married to anyone nor has either had another domestic partner within the prior six months;

e) Are not related by blood closer than would bar marriage in the State of Oregon;

f) Have jointly shared the same regular and permanent residence for at least six months; and

g) Are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household.

Eligibility and Effective Dates of Coverage for Medical and Dental Insurance

New Employees

New employees are eligible to receive medical and dental insurance coverage beginning on the first day of the month following their hire date and receipt of the completed enrollment form by their agency if: (a) the enrollment form for insurance is received by the agency; (b) the premium payment is made; and (c) the employee is actively at work on the effective date of coverage.

New employees must enroll within 60 days following the date of hire. Once the agency has implemented the coverage elections, employees may make changes to their coverage elections only when the requested change meets the definition of a qualified status change or during the annual Open Enrollment.

Current Employees

Employees must work at least half time (80 hours, or 0.5 FTE) during the immediately preceding month to be eligible for coverage for the next month.

Plan Change Requests

Employees may change plans during Open Enrollment or because of and consistent with a qualified family status change. An employee requesting a plan change because of a qualified status change must submit the requested change to the agency within 60 days of the status change event.

Qualified Status Change Events include the following occurrences that change the eligibility status of a PEBB member (see Eligibility Handbook for detailed description):

1) Events that change the legal marital status of an employee
2) Events that change the status of a domestic partner
3) Events that change the number of an employee's, spouse's or domestic partner's eligible family members
4) Termination or commencement of employment by the employee, spouse or domestic partner
5) Reduction or increase in hours of employment by the employee, spouse or domestic partner that affects eligibility
6) An event that causes an eligible family members to satisfy or cease to satisfy the eligibility requirements for coverage due to age, student status or any similar circumstance
7) An increase in employee out-of-pocket premium amount resulting from decisions of the employer or employee
8) An involuntary loss of other coverage as specified by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)
9) An action in compliance with a final judgment, decree or order that includes issuance of a Qualified Medical Child Support Order (QMCSO) requiring enrollment of dependent children on the existing medical and dental plan(s)
10) The relocation of an employee and/or eligible individuals from a plan service area that results in loss of eligibility in that plan
11) Gain or loss of Medicare or Medicaid coverage
12) Change of qualified Dependent Care Flexible Spending Account when one dependent care provider is replaced by another or when new costs are imposed by a dependent care provider who is not a relative of the employee as defined by IRC 152(a)(1)-(8)
13) A change or cessation of coverage that occurs through an overall reduction in coverage, addition or elimination of benefit options, or a change in an eligible individual's coverage through the employer.

Opting Out

Employees covered by another group medical plan may opt out of medical insurance within 60 days of their hire date, within 60 days of gaining other group coverage, or during Open Enrollment. Employees requesting Opt Out must provide proof of other insurance coverage. A portion of the state contribution for medical insurance may be paid to the employee in lieu of coverage. The opt-out formula, if any, is determined annually by PEBB.

Decline Benefits

Employees may choose to decline benefits. Employees who decline benefits waive their right to the employer contribution and enrollment in any of the insurance plans available through PEBB including flexible spending accounts and all voluntary insurance plans

Adding New Dependents and Late Enrollment

Refer to the PEBB Eligibility Handbook. Or, call PEBB at (503) 373-1102 or (800) 788-0520.

PEBB Appeals Procedure

As a PEBB member, you may appeal a decision by your agency or by a carrier that you feel is not in keeping with PEBB rules or carrier contracts. Following are the processes to appeal an administrative or eligibility issue, or a plan coverage issue.

Administrative or Eligibility Appeals

If you receive what you consider to be an incorrect or unfair denial from your agency or a denial of coverage from the insurance company, immediately contact your agency representative. (COBRA and self-pay participants and retirees should contact BestChoice Administrators.) If the representative cannot resolve the problem, contact a PEBB benefits counselor.

Following are the steps for appeal. If at any step your appeal results in a negative resolution, the response will include information regarding how to continue to the next level of the Appeal Process.

Step 1: Appeal to PEBB Benefits Counselor. Obtain an appeal form from a PEBB benefits counselor, your agency office or the PEBB office. Submit the completed form and a copy of any supporting documents to PEBB for administrative review. Keep a copy of the completed form for your records. A benefits counselor will respond to your request as soon as possible and will advise you of the appeal's status within 45 days from the date your request is received.

Step 2: Appeal to PEBB Benefits Manager. If a benefits counselor denies your request, you may appeal to the Benefits Manager within 45 days of the denial. The manager will respond within 30 days of receiving your request. The manager may ask for the PEBB Administrator's review before responding.

Step 3: Appeal to PEBB Administrator. If the Benefits Manager denies your request, you may appeal to the PEBB Administrator within 60 days. The administrator will notify you of the decision, in writing, within 30 days of receiving your request.

Step 4: Appeal to Operations Subcommittee. If the administrator denies your request, you may appeal to the PEBB Operations Subcommittee within 30 days. The subcommittee will consider your appeal at its next regularly scheduled meeting and will notify you of its decision, in writing, within 30 days of that meeting. With the Board's consent, the subcommittee may forward your request for Board reconsideration prior to making a decision.

Step 5: Appeal to the Board. If the Operations Subcommittee denies your request, you may appeal to the Board within 30 days. The Board will consider your appeal at its next regularly scheduled meeting and notify you, in writing, of its decision within 30 days.

Step 6: Further Appeal. You may appeal the Board's decision under the Oregon Administrative Practices Act, ORS Chapter 183.

Contract Coverage Appeals

If you receive what you consider to be an incorrect or unfair denial of a claim from a PEBB insurance carrier, first request an explanation from the carrier. You may wish to seek assistance from a PEBB counselor with your request. The counselor will verify whether the insurance company is acting within the scope of its contract. Following are the steps for appeal.

Step 1: Insurance Company Grievance Process. You must first appeal an insurance company denial through the company's internal grievance process, which is outlined in the member handbook you received when you enrolled. The grievance procedure may be informal or formal, and it may consist of several levels of appeal. Within 45 days (or other contracted timeline), the insurance company will issue its determination to you.

Step 2: PEBB Review of Determination. If you have asked PEBB for assistance, the Benefits Manager will review the insurance company's determination with the PEBB Administrator.

Step 3: Mediation and Binding Arbitration. If PEBB's review confirms the initial denial, and you have exhausted the insurance company's internal grievance process, you may appeal through mediation, arbitration or other civil action as outlined in Oregon Administrative Rules, OAR 101-002-0020(2).

COBRA Notice (Continuation Coverage)

This notice is to inform you of your rights and obligations under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). It is important that all covered individuals (employee, spouse or domestic partner, and dependent children, if able) take the time to read this notice carefully and be familiar with its contents.

Under federal COBRA law, the State of Oregon is required to offer covered employees and family members the opportunity for a temporary extension of health coverage (called "Continuation Coverage"). This Continuation Coverage is offered at group rates when coverage under the medical and dental plans would otherwise end due to certain qualifying events. This notice is intended to inform all plan participants, in a summary fashion, of your potential future options and obligations under the Continuation Coverage provisions. Should an actual qualifying event occur in the future, the COBRA plan administrator will send you additional information and the appropriate election notice at that time.

Qualifying Events for Covered Employee

If you are the covered employee, you may have the right to choose Continuation Coverage if you lose your group health coverage because you experience a qualifying event. A qualifying event occurs for any of the following reasons:

1. A reduction in your hours of employment; or
2. The termination of your employment for other than gross misconduct.

Qualifying Events for Covered Spouse or Domestic Partner

If you are the covered spouse or domestic partner, you may have the right to choose Continuation Coverage for yourself if you lose group health coverage for any of the following reasons (qualifying events):

1. The death of the employee;
2. Termination of the employee's employment for other than gross misconduct or reduction in the employee's hours of employment with the State of Oregon;
3. Divorce or legal separation from the employee or termination of domestic partnership; or
4. Your spouse or domestic partner becomes enrolled in Medicare.

Qualifying Events for Covered Dependent Children

If you are the covered dependent child of an employee, you may have the right to elect Continuation Coverage if group health coverage is lost for any of the following reasons (qualifying events):

1. The death of the employee;
2. Termination of the employee's employment for other than gross misconduct or reduction in the employee's hours of employment with the State of Oregon;
3. Employee's divorce or legal separation, or termination of domestic partnership;
4. The employee becomes enrolled in Medicare; or
5. The dependent ceases to qualify as a dependent child under PEBB eligibility.

Important Employee, Spouse or Domestic Partner, and Dependent Notification Requirements

Under the law, the employee or family member is responsible to inform the agency's payroll/personnel or benefits office within 60 days of the following qualifying event:

1. A divorce;
2. A legal separation;
3. A termination of domestic partnership; or
4. A dependent child losing dependent status under the PEBB eligibility.

If this notification is not mailed within the 60 days, rights to Continuation Coverage will be forfeited.

Employee Notification Requirements

The employing agency, division or work unit is responsible to notify the agency payroll/personnel or benefits office within 30 days.

Election Period

When the agency payroll/personnel or benefits office receives notification that one of these events has occurred, they will notify the PEBB COBRA Administrator. The Administrator will notify covered individuals (also known as qualified beneficiaries) by first class mail of their right to choose Continuation Coverage within 14 days. Under COBRA provisions,

each individual covered on the active group plan on the day before the qualifying event or any newborn or adopted children added to your policy during the COBRA time period has the right to elect Continuation Coverage. You, your spouse or domestic partner can elect continuation coverage for any combination of individuals who would otherwise lose coverage.

Under the law, you have 60 days from the date you would lose coverage due to a qualifying event or the date on your notification letter; whichever is the later date, to elect Continuation Coverage. The Public Employees' Benefit Board (PEBB) Eligibility Rules allow an employee or covered family member to change their plan choices upon experiencing a qualifying event. This means that not only is the employee or family member given the right to continue coverage under COBRA, but may also choose any medical or dental plan at the time of the COBRA election. If a qualified beneficiary does not elect Continuation Coverage within this period, then rights to continue medical and dental insurance will end.

If you choose Continuation Coverage, PEBB is required to offer you coverage that is identical to the coverage provided under the group plan to similarly situated active employees and family members. Should coverage change or be modified for active employees, then the change or modification will be made to your coverage as well. COBRA participants will also be offered an annual open enrollment period. This open enrollment period allows participants to change plans and add or delete eligible dependents. If you add family members , the family members will not be COBRA qualified beneficiaries and will not be permitted to make independent COBRA elections.

Length of Continuation Coverage

The law requires that you receive the opportunity to maintain Continuation Coverage from the time of the qualifying event for the following periods:

1. Up to 18 months if you qualify due to termination for other than gross misconduct or reduction in working hours;
2. Up to 29 months if you qualify due to termination or reduction in working hours and are deemed disabled by the Social Security Administration at the time of your qualifying event or at any time during the first 60 days of Continuation Coverage. You must inform the COBRA Administrator within the 18-month continuation period to qualify for this extended coverage which will be at an increased premium of up to 150%. Newborns and children placed for adoption must be disabled during the first 60 days after birth or placement to qualify for this extension.
3. For spouses, domestic partners and dependents up to 36 months after the employees enrollment in Medicare if the enrollment is 18 months or less prior to termination of employment for other than gross misconduct or reduction of hours, if you qualify due to Medicare entitlement (enrollment in), death of a covered employee, divorce or legal separation, termination of a domestic partnership, or if you are a dependent child who is no longer eligible to be on the plan.
4. Up to 10 years if you are the spouse or domestic partner of a covered employee and you are 55 years of age or older and qualify due to death of a covered employee, divorce or legal separation, or termination of domestic partnership (ORS 743.600 - 743-602).

However, the law also provides that your Continuation Coverage will end for any of the following reasons:

1. The State of Oregon no longer provides group medical and dental coverage to any of its employees;
2. Any required premium for Continuation Coverage is not paid in a timely manner;
3. A qualified beneficiary becomes covered, after the date of COBRA election, under another group health plan that does not exclude or limit coverage for specific conditions solely because they are pre-existing condition(s) which apply to you or to a covered dependent (this does not apply to CHAMPUS);
4. A qualified beneficiary becomes covered (after the date of COBRA election) under Medicare.
5. The Social Security Administration no longer considers you disabled under the provision of the disability extension, but COBRA coverage will not terminate earlier than the end of the original 18 month continuation period.
6. A qualified beneficiary notifies the COBRA Administrator they wish to cancel COBRA continuation coverage.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition

limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follows.

If you or your family members become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated while the limitation is in effect. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the PEBB Plan may terminate your COBRA coverage.

Eligibility and Premiums

Qualified beneficiaries do not have to show they are insurable to choose continuation coverage. However, they must have been covered by the active group plan on the day before the event to be eligible for COBRA continuation coverage. An exception to this rule is if, while on Continuation Coverage, a baby is born to, adopted, or placed for adoption by a covered employee. The newborn or adopted child can be added to the plan and will gain the rights of all other qualified beneficiaries. The COBRA Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

A qualified beneficiary will have to pay all of the premium plus a 2% administration charge for Continuation Coverage. These premiums will be adjusted during the continuation period if the active employee premiums change. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, the State of Oregon will charge 150% of the premium during the extended coverage period. Beneficiaries will be billed on a monthly basis for the premiums due. There is a maximum grace period of 30 days for payment of the regularly scheduled premium.

At the end of the 18, 29, or 36 months of continuation coverage, a qualified beneficiary will be allowed to enroll in an individual portability plan provided by the same insurance carrier, as long as portability plans continue to be offered. You may contact the insurance carrier to enroll in a portability plan before, during, or following your COBRA continuation period. To qualify for a portability plan you must make application directly to the medical carrier within 60 days following the end of your Continuation Coverage or any time during your Continuation Period. Coverage on a portability plan will differ from the group plan and may exclude certain conditions or services offered under the group plan. Contact the carrier for further details. Conversion of the dental plan is limited.

Notification of Address Change

To insure all covered individuals receive information properly and efficiently, it is important you notify the COBRA Administrator of any address change as soon as possible. Failure on your part to do so will result in delayed COBRA notifications or a loss of Continuation Coverage options.

Questions

Remember, this notice is simply a summary of your potential future options under COBRA. Should an actual qualifying event occur and it is determined that you are eligible for COBRA, you will be notified of your COBRA rights at that time. If any covered individual does not understand any part of this summary notice or has questions regarding the beneficiaries' obligations, please contact PEBB at: (503) 373-1102 or (800) 788-0520 (outside Salem), or e-mail inquiries.pebb@state.or.us

Notice of Women's Health and Cancer Rights

If you or your insured dependent is receiving benefits in connection with a mastectomy and you or your insured dependent, in consultation with the attending physician, elects breast reconstruction, coverage will be provided for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Reconstruction benefits are subject to the same provisions as any other benefit provided under the plans.

Additional Information Request Form

If you would like additional benefits information, complete this form by checking the appropriate boxes, and send the form to PEBB:

By mail **PEBB**
775 Court Street NE
Salem, OR
97301-3802

By fax (503) 373-1654

By DAS Delivery Services (shuttle)
PEBB RE: Open Enrollment

You may also request additional information by e-mail to inquiries.pebb@state.or.us.

Handbooks

- ❑ PEBB 2003 Employee Benefits Booklet (on the Web at http://pebb.das.state.or.us/2003ebenefits.htm)
- ❑ PEBB Eligibility Rules Handbook (on the Web at http://pebb.das.state.or.us/2003rules)
- ❑ Long-term Care Insurance Enrollment Kit

Brochures

- ❑ PEBB Insurance for State Retirees brochure (on the Web at http://pebb.das.state.or.us/Retiree brochure.htm)
- ❑ Nationwide Auto Insurance

Medical Provider Directories

- ❑ Regence BlueCross BlueShield of Oregon (provider search on the Web at www.or.regence.com/pebb/p_ourproviders.html)
- ❑ Kaiser Permanente
- ❑ Cascade East Health Plans (provider search on the Web at www.cehp.org)
- ❑ VSP (Vision Service Plan) (provider search on the Web at: www.vsp.com/member/htmls/find_dr_searchpage.jsp)

Dental Provider Directories

- ❑ Kaiser Permanente Dental
- ❑ Willamette Dental (facilities list) (provider search on the Web at http://www.denkor.com)
- ❑ ODS Preferred Dental (provider search on the Web at http://www.odshp.com/pebb)

Mail-0rder Pharmacy Forms

- ❑ Postal Prescription Service (PPS) (order on the Web at www.ppsrx.com) for Regence BCBSO enrollees
- ❑ Walgreens Healthcare Plus (order on the Web at www.walgreens.com/pharmacy) for Regence BCBSO enrollees

Insurance Certificates

- ❑ Life Insurance
- ❑ Accidental Death and Dismemberment Insurance
- ❑ Short-term Disability Insurance
- ❑ Long-term Disability Insurance
- ❑ VSP (Vision Service Plan)

Life and disability insurance certificates on the Web at
http://pebb.das.state.or.us/Standard_Insurance_index.htm

Public Employees' Benefit Board (PEBB)
775 Court Street NE
Salem, OR 97301-3802
Phone: (503) 373-1102, (800) 788-0520
Fax: (503) 373-1654
Web: http://pebb.das.state.or.us
E-mail: inquiries.pebb.@state.or.us