COVER OREGON

Potential Carrier Participation in Cover Oregon in 2014

Total number of carriers submitting filings to Department of Consumer and Business Services (DCBS) including submissions through SERFF and paper applications: 16

Number of carriers offering plans in the individual market: 14

Number of carriers offering plans in small employer market: 13

Carriers who have submitted form filings to DCBS:

- ATRIO Health Plans, Inc.
- BridgeSpan Health Company
- Family Care Health Plans, Inc.
- Freelancers CO-OP of Oregon
- Health Net Health Plans of Oregon
- Kaiser Foundation Health Plan of the Northwest
- LifeWise Health Plan of Oregon, Inc.
- Mid Rogue Health Plan, Inc.
- ODS Health Plan, Inc.
- Oregon's Health CO-OP (incorporated as Community Care of Oregon)
- PacificSource Health Plans
- Providence Health Plan
- Regence Blue Cross Blue Shield of Oregon
- Samaritan Health Plans, Inc.
- Trillium Community Health Plan, Inc.
- UnitedHealthCare

COVER OREGON QUALITY MEASURES:
Overview of Process and Practice

Cover Oregon will provide a central marketplace where individuals and small employers can shop for health insurance and make "apples-to-apples" comparisons of carriers, plans and costs. To help consumers select the best coverage for themselves and their families, Cover Oregon will provide information about the design, cost, and quality of plans offered on the exchange.

The Affordable Care Act requires exchanges to provide shoppers with plan quality ratings starting in 2016. Cover Oregon wanted to help consumers choose the right coverage for them before the mandated start date. We created a quality rating system for use starting in the October 2013 – March 2014 open enrollment. The goal of the quality ratings is to help Cover Oregon users understand their choices in terms that make sense to consumers. This goal guided our work; the process of picking measures and the grading methodology are outlined below.

Guiding Principles and Measure Selection

Cover Oregon contracted with the Oregon Health Care Quality Corporation (Q-Corp) to help build the initial set of quality measures. Q-Corp is an independent, nonprofit organization dedicated to improving health care quality and affordability through collaboration and the production of unbiased information. Among its other efforts, Q-Corp works closely with the Oregon Health Authority.

Many potential quality measures exist for use by health insurance exchanges; the federal National Quality Measures Clearinghouse (NQMC) includes over 2,000 evidence-based measures of health provider and plan quality. To narrow the list of potential measures, Q-Corp sought principles against which to judge measures. Q-Corp considered recommended principles from four experts in health care quality measurement.[1] Cover Oregon adopted the following principles (all were recommended by at least two of the four expert organizations):

1. The measure should have a strong evidence base showing that the care process improves outcomes.
2. The measure should have been tested and shown to be reliable and valid for the measurement.
3. The measure should be understandable, meaningful, and useful to the intended audience.
4. The measure should focus on areas of care where the potential to improve is greatest.
5. The measure should be actionable and timely, and under the control of the providers being measured.
6. The measure should have explicit and detailed specifications, and the data source needed to implement the measure should be available and accessible.
7. The selected package of measures needs to provide a multidimensional view of cost and quality, and to address the information needs of multiple users.
8. The measures should have the potential for alignment with local or national efforts.

[1] The organizations identified are the National Committee for Quality Assurance [NCQA], the NQMC editorial board, the Commonwealth Fund and the Oregon Healthcare Quality Corporation.

To further refine the measure set, Q-Corp identified three sets of NQMC measures:

- The NCQA Recommended Measures for Health Insurance Exchanges
- The Centers for Medicare and Medicaid Services Five-Star Quality Rating System
- A subset of measures proposed by the Oregon Health Authority and Quality Corporation for Community Care Organizations (CCOs).[2]

Using the identified principles, reference measure sets, and considering stakeholder feedback, Cover Oregon selected 13 measures for roll-up into composite scores. Table 1 summarizes these measures.

TABLE 1: COVER OREGON FIRST YEAR QUALITY MEASURES	
Preventative Care (4 measures)	
1. Breast Cancer Screenings	Percentage of women ages 40 to 69 who had a mammogram during a two-year period to screen for breast cancer
2. Flu Shots	Percentage of patients ages 50 and older who report having received a flu shot
3. Well-Child Visits	Percentage of children who had 6 or more well-child visits with a primary care provider during their first 15 months of life
4. Prenatal and Postpartum Care	a. Percentage of pregnant women that received a prenatal care visit as a member of the health plan in the first trimester or within 6 weeks of enrollment in the health plan b. Percentage of new mothers that had a postpartum visit for a pelvic exam or postpartum care on or between 3 to 8 weeks after delivery
Complex Care (6 measures)	
5. Diabetes Screenings	Percentage of patients ages 18 to 75 with diabetes who received the following recommended annual screenings: a. Eye exam b. Blood sugar screening c. Cholesterol screening d. Kidney disease screening
6. Heart Disease Cholesterol Tests	Percentage of patients ages 18 to 75 with a heart condition that got a cholesterol test within one year after being treated for a heart attack or other heart problems
7. Antidepressant Medication Management	Percentage of patients ages 18 and older diagnosed with major depression who were prescribed and filled an antidepressant medication, and who remained on the medication for the following time intervals: a. Short term: At least 12 weeks after the diagnosis b. Long term: At least 180 days (6 months) after the diagnosis
8. Alcohol and Other Drug Treatment	Percentage of patients ages 13 and older diagnosed with a new episode of alcohol or drug dependence who: a. Began treatment within 2 weeks of the initial diagnosis b. Began treatment and had two or more additional services within 30 days of the initial visit
9. Avoidable Hospital Stays	Average number of hospital admissions for chronic conditions that could have been avoided, at least in part, through better access to care outside the hospital
Patient Experience (4 measures)	

[2] Draft CCO measures used, as this was what was available at the time Cover Oregon's work was underway.

10. Getting Needed Care Without Delay	Percentage of members 18 years and older who responded they "always" got care as soon as they thought they needed
11. Customer Service: Courtesy & Respect	Percentage of members 18 years and older who responded they "always" were treated with courtesy and respect from a customer service
12. Customer Service: Information	Percentage of members 18 years and older who responded they "always" got the information or help they needed
13. Overall Rating of Health Care Quality	Percentage of members 18 years and older who rated all their health care in the last 12 months a 9 or 10 (0 is the worst health care possible and 10 is the best health care possible)

Some measures consist of multiple indicators. For example, Prenatal and Postpartum Care consists of two indicators: percentage of pregnant women that received a prenatal care visit within 6 weeks of enrollment and percentage of new mothers that had a post-partum visit 3 to 8 weeks after delivery. Q-Corp will benchmark the 13 measures and roll up the measures into a composite score and domain scores for each carrier.

Comparing Measures to Benchmarks: The Star Rating System

As a first step to creating composite and domain scores, Q-Corp will compare the 13 quality measures for each carrier to three benchmarks:

- The Oregon average for the measures
- The national average for the measures
- The national 90th percentile for the measures[3]

Carriers will be awarded a score of 1 to 4 stars on each measure based on how the measure compares to the benchmarks:

- Four stars if the carrier measure exceeds three benchmarks
- Three stars if the carrier measure exceeds two benchmarks
- Two stars if the carrier measure exceeds one benchmark
- One star if the carrier does not exceed any benchmarks but qualifies for the exchange

The star rating system has the benefit of being easy to explain how stars are awarded. Star rating displays are used by many businesses and websites and are familiar to many consumers. In addition, the comparing measures to the national average ensures that high achieving carriers can earn high scores even in areas where the Oregon average is high, and carriers in need of improvement in some area will not have artificially inflated scores just because the Oregon average is low in that area.

"Rolling Up" the Measures: The Composite Score

Each measure will receive equal weight in the roll-up to a composite score. This is achieved by applying a weighting factor as follows:

- Measures comprised of one indicator will be multiplied by a weighting factor of 1.
- For measures comprised of more than one indicator, each indicator will be multiplied by a weighting factor of ½.

[3] A plan exceeds the 90th percentile for a given measure if its performance on that measure exceeds the performance of 90 percent of plans nationwide.

After each carrier's measures are weighted, they will be summed and divided by the number of measures, resulting in the plan composite score. In addition, the weighted measures in each domain will be summed and divided by the number of measures in the domain, resulting in domain scores. The composite score and domain scores for each plan will be displayed on Cover Oregon's customer web portal along with information about plan design and cost.[4]

Data In the First Two Years

The first Cover Oregon customers will enroll for insurance coverage beginning in 2013. Data needed to rate individual qualified health plans will be not be available until mid-2015. Until these data are available, ratings associated with each qualified health plan will be based on data from all members currently enrolled by the carrier that offers the plan. In other words, rating will be at the carrier level (not the plan level) in the first two years of exchange operation.

Next Steps

As new data become available, Cover Oregon will refine the measures and rating methodology to improve the consumer experience and further align the data with statewide quality efforts. This process is expected to drive plan quality improvement across Oregon.

- **Present Plan-Level Ratings:** As data needed to rate exchange plans become available, Cover Oregon will consider changes to its rating system needed to present ratings at the plan level and incorporate these changes as appropriate.
- **Rate New Plans:** Cover Oregon anticipates new plans without members currently enrolled will participate in the exchange. For the first two years these plans are available through the exchange, Cover Oregon will lack data needed to assign them ratings. Cover Oregon will work with these plans to present them to consumers in an equitable way.
- **Incorporate Additional Measures Into Plans Rating:** Using the 5 principles that guided its choice of 13 initial quality measures, Cover Oregon will consider incorporating new measures into its rating system to the extent they help consumers select the best plans for themselves and their families and facilitate alignment with statewide quality efforts.
- **Further Align with Statewide Quality Efforts:** Where practical, Cover Oregon will align its quality measures with measures used to evaluate CCOs, facilitating accurate comparison of plan quality experienced by exchange plan and CCO members.
- **Use Quality Measures to Drive Plan Improvement:** As consumers use plan quality, design, and cost information presented by Cover Oregon to select plans and as carriers respond to consumer choices, plan quality across Oregon will improve.

[4] Individual measure scores will not be displayed.

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

M E M O R A N D U M

Date: October 12, 2012

To: Lou Savage
Berri Leslie

From: Anthony Behrens
Jeannette Holman

Subject: Rulemaking to Establish Bronze and Silver Plan Designs

Explanation: Enclosed is a notice of rulemaking to adopt OAR 836-100-0200 which adopts the bronze and silver plan designs for health benefit plans. As a condition of transacting business in the health benefit plan market in Oregon, each carrier must offer to residents of Oregon a bronze and silver plan.

These proposed rules are necessary to carry out the provisions of sections ORS 743.822 that require the Department of Consumer and Business Services to adopt rules prescribing the "[f]orm, level of coverage and benefit design for the bronze and silver plans to be used by carriers [for plan years beginning on or after 2014] in the individual and small group market in this state."

In 2014, the federal Affordable Care Act (ACA) will require health insurers to offer individual and small group plans that include essential health benefits and that conform to one of four actuarial value (AV) levels:

- Bronze – 60% AV
- Silver – 70% AV
- Gold – 80% AV
- Platinum – 90% AV

Because of the potential variation between plans with identical actuarial value, the Oregon Legislative Assembly passed Senate Bill 91 (SB 91) during the 2011 legislative session. Senate Bill 91 gives authority to the Department of Consumer and Business Services (DCBS) to establish standardized, or cookie-cutter, bronze and silver plans that insurers must offer if they wish to participate in the individual market or the small group market. A carrier must offer the plan through the Oregon Health Insurance Exchange Corporation (Cover Oregon)[i] if the carrier offers plans through Cover Oregon, and outside Cover Oregon if it offers plans outside of Cover Oregon. These plans should help purchasers make true "apples to apples" coverage comparisons.

Over the past several months, an external advisory committee made up of consumer representatives, insurance company representatives, Cover Oregon staff, insurance producers, actuaries, and product development experts has worked to develop plan designs for the bronze and silver standard plans. Although not a prerequisite for carrier participation in the individual or small group market, the advisory committee also worked toward developing a recommendation for a standard gold plan. Wakely Consulting Group, an actuarial consulting firm, provided actuarial analysis and plan design assistance to the committee.

The external advisory committee unanimously agreed on a number of general decision-making principles to guide their decision-making process. According to these general principals, the department should design standardized plans that:

- Are affordable.
- Have broad appeal and do not target any particular populations, with the understanding that it is impossible to design plans that appeal to everyone.
- Are consistent with plans currently offered in the market.
- Do not single out specific services for differential treatment.
- Have a deductible structure (this is a preference given the constraints established by the AV requirements).
- Incentivize primary care over specialist, urgent, and emergency room care through stepped copays and coinsurance (primary care, non-specialist, specialist, and urgent care copays would increase respectively and emergency room would be subject to coinsurance).
- Have deductibles that decrease as the AV of the plan increases.
- Do not have separate prescription deductibles.
- Make services that are subject to copay not subject to the deductible.
- Make services that are subject to coinsurance subject to the deductible.
- Have designs that can be easily understood by consumers.
- Impose a very low copay for generic drugs, that impose preferred brand drug copays that are consistent with current market, that impose a relatively high coinsurance (e.g., 50%) for non-preferred/non-formulary drugs
- Do not establish standards for out of network cost share as out-of-network services are not considered in the calculation of AV.

The committee reviewed several plan designs based on deductible structures that are consistent with current market offerings. The committee used the above general principals to narrow the plans considered to two options for each market[1] within each metal tier.

[1] Because of the constraints imposed by the ACA, including deductible caps on small group plans, AV requirements, and relatively low out-of-pocket maximums, minimal variation is possible in the design of the gold plan, making separate individual and group designs impractical.

Separate Individual and Group Standard Plans

One of the primary issues discussed by the advisory committee was whether the department should create separate standard plan designs for individual and small group products or whether a single standard plan design should apply to both markets. Cover Oregon, four of the committee's carrier representatives, and the committee's insurance producer representative expressed a strong preference for separate plan designs for individual and group products. After considering the discussion by the committee, the department has determined that the proposed rule should establish separate standard plan designs for individual and group products for Oregon consumers for the following reasons:

- Lower Out-of-Pocket Costs – A separate individual bronze or silver plan with a deductible that exceeds the deductible cap on group plans ($2,000) allows[2] for lower copays and lower coinsurance charges. Moreover, significant services in the proposed individual standard plan are not subject to the deductible. These services include office visits (preventive, primary care, urgent care, and specialist visits), and generic and preferred brand drugs. Therefore, under a separate individual plan, consumers will pay less for routine services that they use frequently and that tend to promote health and wellness.

- Lower Premiums – Plans with higher deductibles tend to have lower premiums. This is true even of plans with the same actuarial value. Because of the limitations the ACA imposes on deductibles for small group plans (a cap of $2,000), a higher deductible plan could only be offered in a separate individual plan design.

    - Affordability was a significant factor guiding the advisory committee's decision making. Many advisory committee members, including Cover Oregon expressed a preference for separate individual plans with higher deductibles in order to help ensure that a more affordable option would be available to consumers.

- Consistency with Current Market – 60% of coverage purchased in the individual market is subject to deductibles of $2,500 or more, and the trend is toward higher deductible plans.

- Consumer Choice – The ACA's requirement that plans meet specific actuarial values together with the cap on out-of-pocket limits ($6,250) and the cap on small group deductibles ($2,000) make it difficult to design plans with meaningful variation between

[2] It's analogous to maintaining the balance on a scale: Adjusting the weight on one side of the scale requires adjusting the weight on the other side of the scale. In order to meet the 60% and 70% (+/- 2%) actuarial value of bronze and silver plans, an increase in cost sharing such as deductible requires a decrease in other forms of cost sharing. Failure to adjust other cost sharing when deductibles increase will result in lower than permissible actuarial value and will throw a plan "out of balance."

the metal levels. An individual plan with a deductible that exceeds the group cap allows for greater variation between the metal levels in deductibles, copayments, and coinsurance. This is consistent with the advisory committee's general principles that standard plans should have stepped cost-sharing. By providing greater variation, these plans should give consumers more meaningful choices.

- Small Group Market – In 2014, there are a number of reasons small employers may be tempted to cease providing coverage for their employees. If the standard individual and small group plans are identical, there may be even less incentive for small employers to continue to offer coverage. The majority of the advisory committee recognizes the importance of the small group market to Oregon businesses and to Oregon consumers.[3] Moreover, because some carriers do not offer individual coverage, loss of the small group market would likely result in a reduction in the number of health insurers offering coverage in Oregon, limiting competition and consumer choice.

- Ease of Understanding – Because the individual and small group markets will be pooled separately in 2014, identical individual and small group products will vary in price. Having identical products offered at differing prices could prove confusing to consumers and small businesses alike. Allowing for separate small group and individual products will eliminate this confusion.

Two carrier representatives and one consumer representative suggest that the department design one standard plan for both the individual and small group markets. They suggest that one plan would provide increased consistency for consumers who move between the individual and small group markets.[4] The department agrees that consistency in cost-sharing for consumers moving between markets is important. However, as noted above, while the department could design a plan with identical cost sharing, the cost of this plan would still differ depending on whether the plan is purchased in the individual or small group market. As cost is one of the (if not *the*) most influential factors considered by consumers when purchasing health insurance, differing costs for identical plans would seem to undermine the entire notion of consistency and result in greater confusion for consumers.

Additionally, in 2014, individual plans and small group plans will be far more similar than they are currently. In 2014, every plan will be required to cover essential health benefits and meet

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[3] Many small business owners feel an obligation to provide health insurance to their employees. Some use benefits as an important recruiting tool to attract and retain talent. The cost of coverage in the small group market is typically more stable in the small group market than in the individual market and the contribution employers make to premiums often make coverage affordable to employees who may not otherwise be able to afford such coverage.

[4] One factor not considered by these advisory committee members is that state continuation (ORS 743.600, 743.602 and 743.610) allows consumers who lose coverage with employers that have fewer than 20 employees to maintain their existing group policy. The department anticipates that state continuation will continue to be an option even after Cover Oregon becomes operational.

metal level actuarial values. Currently, individual and small group plans are not constrained by actuarial value and are not required to provide a minimum set of standard benefits.

Moreover, the standard plan represents only one required offering in the small group and individual markets. To the extent that consumers and small businesses demand identical individual and small group plans, carriers are free to offer them.

One of the committee's consumer representatives suggests that differing individual and small group standard plans would reinforce fragmentation in the health insurance marketplace and that this fragmentation will serve as an obstacle if, at some point, the state chooses to merge its markets. At this time, the state has made no determination to merge its markets. To the contrary, the department recognizes the importance of the small group market to a large number of consumers and small businesses. The department does not agree that creating separate plan designs now will pose any significant obstacle to merging the markets later should the state go in that direction.

Two of the committee's carrier representatives suggest that a single standard plan for both individual and small group markets would fit better within their current business models. While the department recognizes that a particular plan design may fit better with a particular carrier's current business practices, this is not a compelling reason to limit the choices available to Oregon consumers, particularly because carriers can offer other plans in addition to the standard plan.

Plan Designs[5]

Small Group Bronze Plan

Two of the committee's carrier representatives and one of its consumer representatives expressed a preference for bronze group plan design 1; three carrier representatives expressed a preference for bronze small group plan design 2; no other advisory committee members expressed a bronze small group design preference. Small group bronze plans 1 and 2 differ only in cost sharing for office visits. Plan 1 imposes copays for office visits, while plan 2 imposes a 50% coinsurance. The advisory committee expressed concern that high dollar copayment amounts may deter consumers from seeking necessary primary care. On the other hand, copayments are easier for consumers to understand because they allow consumers to know with certainty the amount they are expected to pay. With coinsurance, the amount is more difficult to determine.

The department concludes that small group bronze plan design 1 is the best option for the following reasons:

- Small group bronze plan design 1 is consistent with the plan designs selected in the other metal tiers, allowing for a simple, stepped co-payment and deductible design;
- Small group bronze plan design 2's imposition of coinsurance on office visits would represent a significant departure from the plan designs in other metal tiers;

[5] See attached plan designs.

- Small group bronze plan design 1's imposition of copayments on office visits provides more certainty to consumers regarding cost share;
- Small group bronze plan design 1's copayments are stepped consistently with the selected plan designs in other metal level tiers; and
- Small group bronze plan design 1 is consistent with the general decision-making principles adopted by the committee.

Individual Bronze Plan[6]

All committee members who expressed a preference for a separate individual bronze plan expressed a preference for individual plan 2b. Individual bronze plans 2 and 2b differ only in deductible and copayment amounts for office visits. Individual bronze plan 2b has a higher deductible (+$500) and lower copayments for office visits. The department believes that Individual bronze plan design 2b is the best option for the following reasons:

- Individual bronze plan design 2b is consistent with the plan designs selected in the other metal tiers, allowing for a simple, stepped co-payment and deductible design;
- Individual bronze plan design 2b provides lower copayments for routine services (preventive, primary care provider (PCP) office visit, specialist, and urgent care) than Individual bronze design 2.
- Individual bronze plan design 2b's copayments are stepped consistently with the selected individual plan designs in other metal level tiers; and
- Individual bronze plan design 2b is consistent with the general decision-making principles adopted by the committee

Small Group Silver Plan

One of the committee's consumer representatives and five of its carrier representatives expressed a preference for silver plan design 1; one of its carrier representatives expressed a preference for silver plan design 2; no other advisory committee members expressed a silver design preference. Plans 1 and 2 differ only in deductible (plan 1 is $250 lower) and out-of-pocket max (plan 1 is $500 higher).

The department concludes that small group silver plan design 1 is the best option for the following reasons:

- Small group silver plan design 1 is consistent with the plan designs selected in the other metal tiers, allowing for a simple, stepped co-payment and deductible design;

[6] One committee member suggested that a high deductible health plan serve as the separate bronze individual plan. The consensus of the committee, however, was that since carriers have only three plan options through Cover Oregon, a high deductible health plan would effectively limit consumer choice given that relatively few Oregonians have coverage under such plans. The department agrees with the consensus of the committee and has opted not to select the high deductible health plan design.

- Small group silver plan design 1 is consistent with the general decision-making principles adopted by the committee; and
- Small group silver plan design 2's out-of-pocket maximum is not consistent with the plan designs offered in the other tiers, making shopping more difficult and confusing for consumers.

Individual Silver Plan

Three of the committee's carrier representatives expressed a preference for individual silver plan design 1; three carrier representatives expressed a preference for individual silver plan design 2; no other advisory committee members expressed an individual silver design preference. Individual silver plans 1 and 2 differ in a number of ways. Individual silver plan 1 offers a lower deductible (-$500); a higher out of pocket maximum (+$500); a higher coinsurance (+10%) on inpatient, outpatient, emergency room, and radiology services; and lower copayments on office visits (variable).

The department concludes that individual silver plan design 1 is the best option for the following reasons:

- Individual silver plan design 1 is consistent with the plan designs selected in the other metal tiers, allowing for a simple, stepped co-payment and deductible design;
- Individual silver plan design 1 provides lower copayments for routine services (preventive, PCP office visit, specialist, and urgent care) than individual silver plan design 2.
- Individual silver plan design 1 is consistent with the general decision-making principles adopted by the committee; and
- Individual silver plan design 2's out-of-pocket maximum is not consistent with the plan designs selected in the other tiers, making shopping more confusing and difficult for consumers.

Small Group and Individual Gold[7] Plan

One of the committee's consumer representatives and four of its carrier representatives expressed a preference for gold plan design 1; one of its carrier representatives expressed a preference for gold plan design 2; no other advisory committee members expressed a gold design preference.

[7] SB 91 authorizes the department to design standard bronze and silver plans that carriers are required to offer in the small group and individual markets. SB 91, however, does not authorize the department to design a standard gold plan that *must* be offered in these markets. Notwithstanding, to avoid duplication of efforts and to maximize resources and time, the department used the expertise of the committee to develop a *recommended* gold plan design. Although carriers are not required to offer this plan design, it may benefit them to develop a standard gold plan using this design as it is anticipated that Cover Oregon will require such a plan.

The department concludes gold plan 1 is the best option for both the individual and small group markets[8] for the following reasons:

- Plan design 1 is consistent with the plan designs selected in the other metal tiers, allowing for a simple, stepped co-payment and deductible design;
- Plan design 1 is consistent with the general decision-making principles adopted by the committee; and
- Plan design 2's out-of-pocket maximum is not consistent with the plan designs selected in the other tiers, making stepped co-payment and deductible design less clear for consumers.

Non-Specialist Cost Share

Another issue the advisory committee considered relates to the treatment of physical and occupational therapy. The committee agreed that the standard plan design should contain a separate "non-specialist" category for physical, speech, and occupational therapy that would make the treatment subject to a copayment equal to the copayment applicable to primary care office visits. The Oregon Physical Therapy Association commented in favor of treatment of physical and occupational therapy in this manner because these services are typically provided over several visits, resulting in greater out-of-pocket costs for consumers. Two of the committee's carrier representatives suggested that physical therapy and occupational therapy are outpatient services and, as such, should be subject to deductible and coinsurance. To the extent that a physical or occupational therapy or physical therapy visit constitutes a primary care office visit, however, these two carrier representatives suggested that it should and could be treated as such.

The department concludes that although physical, speech, and occupational therapy are generally outpatient services, they are often provided to avoid costlier services (e.g., surgery), and, as such, should be incentivized through the application of a copayment rather than coinsurance and deductible. The department has determined that greater utilization of these therapies can lead to lower health care cost and thus lower health insurance rates.[9]

Reaction Anticipated: Given the subject matter of the rulemaking, it is likely that regardless of the department's decision, significant formal comments will be provided during the rulemaking.

Fiscal impact: These rules will have a minimal impact to the Department of Consumer and Business Services. Fiscal impact on insurers, consumers and small businesses is unknown but is likely minimal as in 2014, the Affordable Care Act requires carriers to provide similar coverage at the same actuarial value.

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[8] Because of the constraints imposed by the ACA, including deductible caps on small group plans, AV requirements, and relatively low out-of-pocket maximums, minimal variation is possible in the design of the gold plan, making separate individual and group designs impractical.

[9] The department welcomes public comment on this decision.

Next steps: We have scheduled a public hearing on these proposed rules on November 28, 2012. The public comment period will close on December 7, 2012. We anticipate filing the rules shortly thereafter to become effective on January 1, 2013.

[i] The Oregon Health Insurance Exchange Corporation, created in statute at ORS 741.001 has recently renamed itself for operational purposes as "Cover Oregon." This memo will use the "Cover Oregon" nomenclature, but in the rules and attached exhibits we will continue to refer to the entity as created in statute, the Oregon Health Insurance Exchange Corporation.

Exhibit to OAR 836-100-0200 (SB 91 Standard Plan Designs)

***Eligibility for benefits (medical necessity, preauthorization, etc.) is a carrier determination. Subject to final federal EHB regulations.**

****Annual and lifetime dollar limits are prohibited. Actuarial equivalent must be substituted for dollar lmits.**

***** Subject to MHPAEA**

Benefit*	Covered	Benefit Description	Quantitative Limit on Service?	Limit Quantity	Limit Units**	Other Limit Units Description	Exclusions	Explanation	Does this benefit have additional limitations or restrictions?	Gold - Small Group and Individual	Silver Small Group	Silver Individual Only	Bronze Small Group	Bronze Individual Only
Deductible										Medical = $1,000, No Drug Deductible	Medical = $1,500, No Drug Deductible	Medical = $2,000, No Drug Deductible	Medical = $2,000, No Drug Deductible	Medical = $3,500, No Drug Deductible
Maximum OOP										Combined Medical and Drug = $6,250	Combined Medical and Drug = $6,250	Combined Medical and Drug = $6,250	Combined Medical and Drug = $6,250	Combined Medical and Drug = $6,250
Family Multiplier										2 times, invidual applies first	2 times, invidual applies first	2 times, invidual applies first	2 times, invidual applies first	2 times, invidual applies first
Primary Care Visit to Treat an Injury or Illness	Covered	Office and home visits	No						No	$15	$35	$15	$45 After Deductible	$35
Specialist Visit	Covered	Office and home visits	No						No	$30	$60	$35	$90 After Deductible	$70
Other Practitioner Office Visit (Nurse, Physician Assistant)	Covered	Office and home visits	No						No	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Covered	Outpatient surgery/services	No						No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Outpatient Surgery Physician/Surgical Services	Covered	Outpatient surgery/services	No						No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Hospice Services	Covered	Hospice services	No					— Home health aides when necessary to assist in personal care. — Home visits by a medical social worker. — Home visits by the hospice physician. — Prescription medications for the relief of symptoms manifested by the terminal illness. — Medically necessary physical, occupational, and speech therapy provided in the home. — Home infusion therapy. — Durable medical equipment, oxygen, and medical supplies. — Respite care provided in a nursing facility to provide relief for the primary caregiver, subject to a maximum of five consecutive days and to a lifetime maximum benefit of 30 days. — Inpatient hospice care — Pastoral care and bereavement services.	No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Urgent Care Centers or Facilities	Covered	Urgent care center visits	No						No	$50	$80	$60	$110 , After Deductible	$90
Home Health Care Services	Covered	Home health care visits	No				Private duty nursing is not covered.	Skilled nursing by a R.N. or L.P.N.; physical, occupational, and speech therapy; and medical social work services provided by a licensed home health agency. Benefit includes home infusion services including parenteral nutrition, medications, and biologicals (other than immunizations) that cannot be self-administered.	No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible

Benefit*	Covered	Benefit Description	Quantitative Limit on Service?	Limit Quantity	Limit Units**	Other Limit Units Description	Exclusions	Explanation	Does this benefit have additional limitations or restrictions?	Gold - Small Group and Individual	Silver Small Group	Silver Individual Only	Bronze Small Group	Bronze Individual Only
Emergency Room Services	Covered	Emergency room visits	No					plan covers services and supplies necessary to determine the nature and extent of the emergency condition and to stabilize the patient. An emergency medical condition is an injury or sudden illness, including severe pain, so severe that a prudent layperson with an average knowledge of health and medicine would expect that failure to receive immediate medical attention would risk seriously damaging the health of a person or fetus in the case of a pregnant woman. Examples of emergency medical conditions include (but are not limited to): • Unusual or heavy bleeding • Sudden abdominal or chest pains • Suspected heart attacks • Major traumatic injuries • Serious burns • Poisoning • Unconsciousness • Convulsions or seizures • Difficulty breathing	No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Emergency Transportation/Ambulance	Covered	Ambulance, ground and air	No						No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Inpatient Hospital Services (e.g., Hospital Stay)	Covered	Inpatient room and board	No				The plan does not cover charges for rental of telephones, radios, or televisions, or for guest meals or other personal items.		No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Inpatient Physician and Surgical Services	Covered	Professional services	No						No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Cosmetic Surgery	Covered	Cosmetic or reconstructive surgery	Yes	1	Other other	This plan covers one attempt at cosmetic or reconstructive surgery in the following situations: — When necessary to correct a functional disorder; or — When necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury; or — When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery. Cosmetic or reconstructive surgery must take place within 18 months after the injury, surgery, scar, or defect first occurred. Preauthorization is required for all cosmetic and reconstructive surgeries. For information on breast reconstruction, see'breast reconstruction' benefit.			No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Skilled Nursing Facility	Covered	Skilled nursing facility care	Yes	60	Days per year		Confinement for custodial care is not covered.		No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Prenatal and Postnatal Care	Covered	Prenatal and postnatal care	No						No	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.
Delivery and All Inpatient Services for Maternity Care	Covered	Maternity care	No						No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible

Benefit*	Covered	Benefit Description	Quantitative Limit on Service?	Limit Quantity	Limit Units**	Other Limit Units Description	Exclusions	Explanation	Does this benefit have additional limitations or restrictions?	Gold - Small Group and Individual	Silver Small Group	Silver Individual Only	Bronze Small Group	Bronze Individual Only
Mental/Behavioral Health Outpatient Services* **	Covered	Mental health office visits	No				the following diagnosis: • Mental retardation • Paraphilias • Learning disorders • Urinary incontinence • Diagnostic codes V 15.81 through V71.09 (DSM-IV-TR, Fourth Edition) except V61.20, V61.21, and V62.82 when used with children five years of age or younger • Food dependencies • Nicotine-related disorders Treatment programs, training, or therapy as follows: • Residential mental health programs exceeding 45 days of treatment per year. • Educational or correctional services or sheltered living provided by a school or halfway house • Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present • Court-ordered sex offender		No	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.
Mental/Behavioral Health Inpatient Services	Covered	Mental health inpatient and residential care	Yes	45	Days per year		the following diagnosis: • Mental retardation • Paraphilias • Learning disorders • Urinary incontinence • Diagnostic codes V 15.81 through V71.09 (DSM-IV-TR, Fourth Edition) except V61.20, V61.21, and V62.82 when used with children five years of age or younger • Food dependencies • Nicotine-related disorders Treatment programs, training, or therapy as follows: • Residential mental health programs exceeding 45 days of treatment per year. • Educational or correctional services or sheltered living provided by a school or halfway house • Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present • Court-ordered sex offender		No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible

Benefit*	Covered	Benefit Description	Quantitative Limit on Service?	Limit Quantity	Limit Units**	Other Limit Units Description	Exclusions	Explanation	Does this benefit have additional limitations or restrictions?	Gold - Small Group and Individual	Silver Small Group	Silver Individual Only	Bronze Small Group	Bronze Individual Only
Substance Abuse Disorder Outpatient Services* **	Covered	Chemical dependency office visits	No				the following diagnosis: • Mental retardation • Paraphilias • Learning disorders • Urinary incontinence • Diagnostic codes V 15.81 through V71.09 (DSM-IV-TR, Fourth Edition) except V61.20, V61.21, and V62.82 when used with children five years of age or younger • Food dependencies • Nicotine-related disorders Treatment programs, training, or therapy as follows: • Residential mental health programs exceeding 45 days of treatment per year. • Educational or correctional services or sheltered living provided by a school or halfway house • Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present • Court-ordered sex offender		No	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.
Substance Abuse Disorder Inpatient Services* **	Covered	Chemical dependency inpatient and residential care	No				the following diagnosis: • Mental retardation • Paraphilias • Learning disorders • Urinary incontinence • Diagnostic codes V 15.81 through V71.09 (DSM-IV-TR, Fourth Edition) except V61.20, V61.21, and V62.82 when used with children five years of age or younger • Food dependencies • Nicotine-related disorders Treatment programs, training, or therapy as follows: • Residential mental health programs exceeding 45 days of treatment per year. • Educational or correctional services or sheltered living provided by a school or halfway house • Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present • Court-ordered sex offender		No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Generic Drugs	Covered	Generic drugs	No				This plan does not cover the following: • Drugs and biologicals that can be self-administered (including injectibles), other than those provided in a hospital, emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered • Growth hormone injections or treatments, except to treat documented growth hormone deficiencies • Immunizations or other medications or supplies for protection while traveling or at work • Over-the-counter medications or nonprescription drugs		No	$5	$10	$10	$15	$15

Benefit*	Covered	Benefit Description	Quantitative Limit on Service?	Limit Quantity	Limit Units**	Other Limit Units Description	Exclusions	Explanation	Does this benefit have additional limitations or restrictions?	Gold - Small Group and Individual	Silver Small Group	Silver Individual Only	Bronze Small Group	Bronze Individual Only
Preferred Brand Drugs	Covered	Preferred brand drugs	No				This plan does not cover the following: • Drugs and biologicals that can be self-administered (including injectibles), other than those provided in a hospital, emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered • Growth hormone injections or treatments, except to treat documented growth hormone deficiencies • Immunizations or other medications or supplies for protection while traveling or at work • Over-the-counter medications or nonprescription drugs		No	$30	$40	$40	$60	$60
Non-Preferred Brand Drugs	Covered	Non-preferred brand drugs	No				This plan does not cover the following: • Drugs and biologicals that can be self-administered (including injectibles), other than those provided in a hospital, emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered • Growth hormone injections or treatments, except to treat documented growth hormone deficiencies • Immunizations or other medications or supplies for protection while traveling or at work • Over-the-counter medications or nonprescription drugs		No	50%	50%	50%	50%	$100
Specialty Drugs	Covered	Specialty drugs	No				This plan does not cover the following: • Drugs and biologicals that can be self-administered (including injectibles), other than those provided in a hospital, emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered • Growth hormone injections or treatments, except to treat documented growth hormone deficiencies • Immunizations or other medications or supplies for protection while traveling or at work • Over-the-counter medications or nonprescription drugs		No	50%	50%	50%	50%	50%

Benefit*	Covered	Benefit Description	Quantitative Limit on Service?	Limit Quantity	Limit Units**	Other Limit Units Description	Exclusions	Explanation	Does this benefit have additional limitations or restrictions?	Gold - Small Group and Individual	Silver Small Group	Silver Individual Only	Bronze Small Group	Bronze Individual Only
Outpatient Rehabilitation Services	Covered	Outpatient rehabilitation services	Yes	30	Visits per year			Only treatment of neurologic conditions (e.g. stroke, spinal cord injury, head injury, pediatric neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which rehabilitative services would be appropriate for children under 18 years of age) may be considered for additional benefits, not to exceed 30 visits per condition, when criteria for supplemental services are met.	No	$15 (Applies to PT, OT, ST provided in an office setting not in a hospital or urgent care setting)	$35 (Applies to PT, OT, ST provided in an office setting not in a hospital or urgent care setting)	$25 (Applies to PT, OT, ST provided in an office setting not in a hospital or urgent care setting)	$45 After Deductible (Applies to PT, OT, ST provided in an office setting not in a hospital or urgent care setting)	$35 (Applies to PT, OT, ST provided in an office setting not in a hospital or urgent care setting)
Habilitation Services	Covered	Rehabilitative services for habilitative purposes.	Yes	30	Days per year			Only treatment of neurologic conditions (e.g. stroke, spinal cord injury, head injury, pediatric neurodevelopmental problems, and other problems associated with pervasive developmental disorders for which rehabilitative services would be appropriate for children under 18 years of age) may be considered for additional benefits, not to exceed 30 visits per condition, when criteria for supplemental services are met.	No	$15 (Applies to PT, OT, ST provided in an office setting not in a hospital or urgent care setting)	$35 (Applies to PT, OT, ST provided in an office setting not in a hospital or urgent care setting)	$25 (Applies to PT, OT, ST provided in an office setting not in a hospital or urgent care setting)	$45 After Deductible (Applies to PT, OT, ST provided in an office setting not in a hospital or urgent care setting)	$35 (Applies to PT, OT, ST provided in an office setting not in a hospital or urgent care setting)
Durable Medical Equipment	Covered	Durable medical equipment	Yes	5000	Other other	The cost of durable medical equipment is covered up to $5,000 per year. Exceptions to this limitation are essential health benefits, such as prosthetics and orthotic devices, oxygen and oxygen supplies, diabetic supplies, wheelchairs, and breast pumps. Medical foods for the treatment of inborn errors of metabolism are also exempt from this limitation.	Breast pumps that qualify are covered as preventive benefits.	orthotic devices that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. Benefits include coverage of all services and supplies medically necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device. Benefits also include coverage for any repair or replacement of a prosthetic or orthotic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience. • This plan covers durable medical equipment prescribed exclusively to treat medical conditions. Covered equipment includes crutches, wheelchairs, orthopedic braces, home glucose meters,	No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Hearing Aids	Covered	Hearing aids	Yes	4000	Other other	As part of the durable medical equipment benefit, hearing aids are covered for members 18 years of age and younger, or 25 years of age and younger if the member is enrolled in a secondary school or an accredited educational institution. Coverage is limited to a maximum benefit of $4,000 every 48 months.		The benefit amount shall be adjusted on January 1 of each year to reflect the U.S. City Average Consumer Price Index in accordance with ORS 743A.141.	No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Diagnostic Test (X-Ray and Lab Work)	Covered	Diagnostic and therapeutic radiology and lab	No						No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Imaging (CT/PET Scans, MRIs)	Covered	Advanced diagnostic imaging	No						No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Preventive Care/Screening/Immun.	Covered	Routine physicals for adults	Yes	1	Other other	Ages 22-34, One exam every four years Ages 35-39, One exam every two years Ages 60+, One exam every year	Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a routine physical examination are not covered by this preventive care benefit.	Only laboratory work tests and other diagnostic testing procedures related to the routine physical exam are covered by this benefit.	No	$0	$0	$0	$0	$0

Benefit*	Covered	Benefit Description	Quantitative Limit on Service?	Limit Quantity	Limit Units**	Other Limit Units Description	Exclusions	Explanation	Does this benefit have additional limitations or restrictions?	Gold - Small Group and Individual	Silver Small Group	Silver Individual Only	Bronze Small Group	Bronze Individual Only
Routine Foot Care	Covered	Routine foot care for those with diabetes mellitus only.	No					Covered only for patients with diabetes mellitus. Routine foot care includes services and supplies for corns and calluses, toenail conditions other than infection, and hypertrophy or hyperplasia of the skin of the feet	No	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.
Routine Eye Exam for Children	Covered	FEDVIP (Federal BlueVision High)	Yes	1	Visits per year				No	$15	$35	$20	$45, After Deductible	$35
Eye Glasses for Children	Covered	FEDVIP (Federal BlueVision High)	Yes	1	Other other	One pair of glasses per year. Collection frames (up to $250) are covered in full. Non-collection lenses are covered up to $150 and then 20% off. Standard lenses are covered in full.			No	10% After Deductible	30% After Deductible	30% After Deductible	50% After Deductible	50% After Deductible
Dental Check-Up for Children	Covered	CHIP (OHP Plus)	Yes	1	Other other	Periodic: 2 times per year. Comprehensive: 1 time per year with the same provider; 2 times per year with different providers.			No					
ACA Preventive Services	Covered	Grade A and B USPSTF Preventive Services, Bright Futures Recommended Medical Screenings for Children, and ACIP Recommended Immunizations for Children	Yes	1	Other other	Multiple			No	$0	$0	$0	$0	$0
Well Baby/Well Child	Covered	Well Baby/Well Child Exams	Yes	31	Other other	At birth: One standard in-hospital exam Ages 0-2: 12 additional exams during the first 36 months of life Ages 3-21: One exam per year	Only laboratory tests and other diagnostic testing procedures related to a well baby/child care exam are covered by this benefit. Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a well baby/child care exam are not covered by this preventive care benefit.		No	$0	$0	$0	$0	$0
Immunizations	Covered	Immunizations	No				Benefits do not include immunizations for more elective, investigative, unproven, or discretionary reasons (e.g. travel).	Standard age-appropriated childhood and adult immunizations for primary prevention of infectious diseases as recommended by and adopted the Centers for Disease Control and Prevention, American Academy of Pediatrics, American Academy of Family Physicians, or similar standard-setting body.	No	$0	$0	$0	$0	$0
Well Woman	Covered	Well Woman Visits	Yes	1	Other other	— One routine gynecological exam each year for women 18 and over. — Routine preventive mammograms for women as recommended. — Pelvic exams and Pap smear exams at any time upon referral of a women's healthcare provider; and pelvic exams and Pap smear exams annually for women 18 to 64 years of age with or without a referral from a women's healthcare provider.		Exams may include Pap smear, pelvic exam, breast exam, blood pressure check, and weight check. Covered lab services are limited to occult blood, urinalysis, and complete blood count.	No	$0	$0	$0	$0	$0
Colorectal Cancer Screening	Covered	Colorectal Cancer Screening	No					Routine Colonoscopy applies to colonoscopies that are considered 'routine' according to the guidelines of the U.S. Preventive Services Task Force.	No	$15	$35	$15	$45 After Deductible	$35
Prostate Cancer Screening	Covered	Prostate Cancer Screening	No						No	$0	$0	$0	$0	$0

Benefit*	Covered	Benefit Description	Quantitative Limit on Service?	Limit Quantity	Limit Units**	Other Limit Units Description	Exclusions	Explanation	Does this benefit have additional limitations or restrictions?	Gold - Small Group and Individual	Silver Small Group	Silver Individual Only	Bronze Small Group	Bronze Individual Only
Oregon Tabacco Cessation Mandate Coverage	Covered	Oregon Tobacco Use Cessation Program Services	Yes	2	Other other	Approved programs are covered at 100% of the cost up to a maximum lifetime benefit of two quit attempts. Approved programs are limited to members age 15 or older.		Covered only when provided by a PacificSource approved program. Specific nicotine replacement therapy will only be covered according to the program's description. If this policy includes benefits for prescription drugs, tobacco use cessation related medication prescribed in conjunction with an approved tobacco use cessation program will be covered to the same extent this policy covers other prescription medications.	No	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.
Telemedical Health Services (Oregon Mandate)	Covered	Telemedical Health Services	No					Medically necessary telemedical health services for health services covered by this plan when provided in person by a healthcare professional when the telemedical health service does not duplicate or supplant a health service that is available to the patient in person. The location of the patient receiving telemedical health services may include, but is not limited to: hospital; rural health clinic; federally qualified health center; physician's office; community mental health center; skilled nursing facility; renal dialysis center; or site where public health services are provided. Coverage of telemedical health services are subject to the same deductible, co-payment, or co-insurance requirements that apply to comparable health services provided in person.	No	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.
Organ Transplants	Covered	Transplant Services	No				This plan only covers transplants of human body organs and tissues. Transplants of artificial, animal, or other non-human organs and tissues are not covered.	under this plan for at least 24 consecutive months or since birth to be eligible for transplant benefits, including benefits for transplantation evaluation. This plan covers the following medically necessary organ and tissue transplants: • Kidney • Kidney – Pancreas • Pancreas whole organ transplantation (under certain criteria) • Heart • Heart – Lung • Lung • Liver (under certain criteria) • Bone marrow and peripheral blood stem cell • Pediatric bowel Expenses for the acquisition of organs or tissues for transplantation are covered only when the transplantation itself is covered under this contract, and is subject to the following limitations: • Testing of related or unrelated donors for a potential living	No	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.
Biofeedback	Covered	Biofeedback	Yes	10	Treatments per lifetime	Benefit is limited for treatment of migraine headaches or urinary incontinence when provided by an otherwise elgibile practitioner.			No	$15	$35	$20	$45 , After Deductible	$35

Benefit*	Covered	Benefit Description	Quantitative Limit on Service?	Limit Quantity	Limit Units**	Other Limit Units Description	Exclusions	Explanation	Does this benefit have additional limitations or restrictions?	Gold - Small Group and Individual	Silver Small Group	Silver Individual Only	Bronze Small Group	Bronze Individual Only
Cardiac Rehabilitation	Covered	Cardiac Rehabilitation	Yes	36	Other other	— Phase I (inpatient) services are covered under inpatient hospital benefits. — Phase II (short-term outpatient) services are covered subject to the deductible, co-payment, and/or co-insurance stated in your Medical Benefit Summary for outpatient hospital benefits. Benefits are limited to services provided in connection with a cardiac rehabilitation exercise program that does not exceed 36 sessions and that are considered reasonable and necessary.	Phase III (long-term outpatient) services are not covered.		No	10%, After Deductible	30%, After Deductible	30%, After Deductible	50%, After Deductible	50%, After Deductible
Breast Reconstruction	Covered	Breast Reconstruction	No					Reconstruction must be in connection with a medically necessary mastectomy. Preauthorization is required. Coverage is provided in a manner determined in consultation with the attending physician and patient for: — All stages of reconstruction of the breast on which the mastectomy was performed; — Surgery and reconstruction of the other breast to produce a symmetrical appearance; — Prostheses; and — Treatment of physical complications of the mastectomy, including lymphedema	No	10%, After Deductible	30%, After Deductible	30%, After Deductible	50%, After Deductible	50%, After Deductible
Hospitalization for Dental Proceedures	Covered	Hospitalization for Dental Procedures	No				Hospitalization because of the patient's apprehension or convenience is not covered.	Only covered when the patient has another serious medical condition that may complicate the dental procedure, such as serious blood disease, unstable diabetes, or severe cardiovascular disease, or the patient is physically or developmentally disabled with a dental condition that cannot be safely and effectively treated in a dental office. Only charges for the facility, anesthesiologist, and assistant physician are covered.	No	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.
Inborn Errors of Metabolism (Oregon Mandate)	Covered	Oregon Inborn Errors of Metabolism	No					This plan covers treatment involving amino acid, carbohydrate, and fat metabolism for which widely accepted standards of care exist for diagnosis, treatment, and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage includes expenses for diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. Nutritional supplies are covered subjectbenefits listed for durable medical equipment.	No	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.

Benefit*	Covered	Benefit Description	Quantitative Limit on Service?	Limit Quantity	Limit Units**	Other Limit Units Description	Exclusions	Explanation	Does this benefit have additional limitations or restrictions?	Gold - Small Group and Individual	Silver Small Group	Silver Individual Only	Bronze Small Group	Bronze Individual Only
Maxillofacial Prosthetic Services Mandate	Covered	Maxillofacial Prosthetic Services	No				Cosmetic procedures and procedures to improve on the normal range of functions are not covered. Dentures, prosthetic devices for treatment of TMJ conditions and artificial larynx are also not covered.	Covered when prescribed by a physician as necessary to restore and manage head and facial structures. Coverage is provided only when head and facial structures cannot be replaced with living tissue, and are defective because of disease, trauma, or birth and developmental deformities. To be covered, treatment must be necessary to control or eliminate pain or infection or to restore functions such as speech, swallowing, or chewing. Coverage is limited to the least costly clinically appropriate treatment, as determined by the physician.	No	0%/30% After Deductible/50% After Deductible	0%/30% After Deductible/50% After Deductible	0%/30% After Deductible/50% After Deductible	0%/30% After Deductible/50% After Deductible	0%/30% After Deductible/50% After Deductible
Pediactric Dental Care Requiring Anesthesia	Covered	Pediactric Dental Care Requiring Anesthesia	Yes	2000	Other other	Limited to services requiring general anesthesia, this plan covers the facility charges of a hospital or ambulatory surgery center. Benefits are limited to a lifetime maximum of $2,000, and preauthorization is required.			No	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.
Qualifying Clinical Trials (Oregon Mandate)	Covered	Oregon Qualifying Clinical Trials	No					Benefits are only provided for routine costs of care associated with qualifying clinical trials. Expenses for services or supplies that are not considered routine costs of care are not covered.	No	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.
Sleep Studies	Covered	Sleep Studies	No						No	10%, After Deductible	30%, After Deductible	30%, After Deductible	50%, After Deductible	50%, After Deductible
Tubal Ligation and Vasectomy	Covered	Tubal Ligation and Vasectomy	No				Procedures performed during the member's first six months of coverage under the plan. (Exception for coverage of tubal ligations performed at the time of a covered newborn delivery.) Surgery to reverse voluntary sterilization is not covered.	Qualifying tubal ligations are covered under preventive care.	No	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.
Alergy Injections	Covered	Allergey Injections	No						No		Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.	Varies based on type of service. Please see the applicable service category.