Oregon Public Self-Funded

Notice of Change to Your Medical and Dental Administration

Your Plan administration may change in 2022 to comply with the Affordable Care Act (ACA), federal legislation, state legislation or PacificSource best practices. The following outline will guide you on the changes that will be made to the PacificSource core Plan Document and Administrative Services Agreement. If you have questions, you should seek legal counsel for how these apply to your Plan.

Required Changes:

Administrative Services Agreement (ASA) Language Changes

Section	Summary of Change	Why are these changes occurring?
Section 2.3 Definitions	Added the following Definition for Employee: *"Employee" means any participant employed or formerly employed by Sponsor. When a family that does not include a current or former Employee is covered under the Plan, the oldest participant is considered the Employee for the purposes of this Agreement.*	For clarity regarding quoting/billing procedures, which are based on "Per Employee per Month".
Section 8.2 Discretionary (Under Section VIII: Termination)	Updated "days" to "business days".	For consistency in administration.
Exhibit II: Coverage Services Addendum	"Policy Period" has been updated to "Agreement Period".	
Exhibit II: Coverage Services Addendum – II. Fees	"Subscribers" has been updated to "Employees".	For clarity regarding quoting/billing procedures, which are based on "Per Employee per Month".

Language Updates

Section	Old Language	New Language	Why are these changes occurring?
Throughout	Preauthorization	Prior authorization	Aligning terminology with how it is utilized at PacificSource.
Throughout	PacificSource.com/member/preauthorization.aspx.	Authgrid.PacificSource.com (select Commercial for the line of business)	Hyperlink has been updated and clarification has been added.
COBRA Continuation – When Continuation Coverage Ends M-Pg 35, D- Pg 10	None	Added language regarding termination off of COBRA for cause: • Member is terminated for cause (for example, submission of fraudulent claims).	Clarification, not a change to the administration of eligibility.
COBRA Continuation – Your	*You must notify the Plan Sponsor within 60 days if you divorce, or if your child no longer qualifies as a dependent. That will allow the Plan Sponsor to*	*You must notify the Plan Sponsor within 60 days if you divorce, dissolve your domestic partnership, or if your child no longer qualifies as a dependent. That*	Clarification, not a change to the administration of eligibility.

Responsibilities and Deadlines M- Pg 35, D- Pg 11	*notify you or your family members of your continuation rights.* When the Plan Sponsor learns of your eligibility for continuation, it will notify you of your continuation rights and provide a Continuation Election form.	*will allow the Plan Sponsor to notify you or your family members of your continuation rights.* When the Plan Sponsor learns of your eligibility for continuation, it will notify you of your continuation rights and provide a Continuation Election form within 14 days.	
Grievance Procedures Pg 35, 84	If you are dissatisfied with the availability, delivery, or the quality of healthcare services; or claims payment, handling or reimbursement for healthcare services, you may file a grievance in writing.	If you are dissatisfied with the availability, delivery, or the quality of healthcare services; or claims payment, handling or reimbursement for healthcare services, you may file a grievance in writing. Grievances are not Adverse Benefit Determinations and do not establish a right to internal or External Review for a resolution to a Grievance.	Clarification, not a change to the administration of benefits.
Definitions Pg 102	**Rescind or rescission** means to retroactively cancel or discontinue coverage under a health benefit plan or group or individual health insurance plan for reasons other than failure to timely pay or required contributions toward the cost of coverage.	**Rescind or rescission** means to retroactively cancel or discontinue coverage under a health benefit plan or group or individual health insurance plan for reasons other than failure to timely pay or required contributions toward the cost of coverage. This Plan may not rescind coverage unless the Member or a person seeking coverage on behalf of the Member, performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, as prohibited by the terms of the Plan or coverage and a 30 day prior written notice is provided.	Clarification, not a change to administration.

Medical Changes

Section	Summary of Change	Why are these changes occurring?
Medical Benefit Summary – Chiropractic manipulations, massage therapy, and acupuncture Pg 10	Benefit naming convention is updated to Chiropractic manipulations/spinal manipulations. Chiropractic, acupuncture, and massage benefits are being unbundled due to State Benchmark requirements. Please confirm the number of visits you would like to cover separately for Chiropractic manipulations/spinal manipulations and Acupuncture, and what your Massage therapy benefit will be.	Due to the State Benchmark Plan Changes, you are now required to unbundle this benefit. The minimum requirement for Chiropractic manipulations/spinal manipulations is 20 visits per calendar year. The minimum requirement for Acupuncture is 12 visits per calendar year. There is no requirement for Massage therapy.
Prescription Drugs Pg 63	Please review the Prescription Drug Summary and Prescription Drug Benefits section with your Pharmacy Benefit Manager and provide any updates as needed.	Please review your Prescription Drug Benefits with your Pharmacy Benefit Manager, there is a new Oregon required change regarding insulin.
Prescription Insulin Pg 66	Formulary prescription insulin is not subject to a deductible and may not exceed $75 per 30 day supply. Previously the benefit applied to the plan's deductible, copay, and/or coinsurance.	Core Pharmacy administration change and State regulation.
Coverage While Traveling – Emergency Services While Traveling Pg 40	Language has been added to clarify coverage for Emergency care outside of the United States and how to submit the claims for reimbursement.	Clarification, not a change to the administration of benefits.

Covered Services – Preventive Care Services Pg 46	The end of this section has been rewritten to provide a better description of those services under the United States Preventive Services Task Force, the Health Resources and Services Administration, and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	To clarify and simplify the language for members.
Covered Services – Professional Services – Temporomandibular Joint Syndrome Pg 48	The following language has been added to clarify the benefit as it is currently being administered: All TMJ-related services, including but not limited to, diagnostic and surgical procedures, must be provided by a provider practicing within the scope of their licenses and, if necessary, prior authorized.	Clarification, not a change to the administration of benefits.
Covered Services – Hospital and Skilled Nursing Facility Services – Skilled Nursing Pg 49	Language has been added to clarify that this benefit is subject to admission notification and concurrent review.	Clarification, not a change to the administration of benefits.
Covered Services – Hospital and Skilled Nursing Facility Services – Inpatient Rehabilitation Services Pg 49	Added language concerning concurrent review.	Clarification, not a change to the administration of benefits.
Covered Services – Hospital and Skilled Nursing Facility Services – Inpatient Habilitation Services Pg 49	Added language concerning concurrent review.	Clarification, not a change to the administration of benefits.
Covered Services – Home Health and Hospice Services – Hospice Services Pg 51	Language has been added to clarify that the Hospice benefit is available for an initial six months, and may be extended an additional six months when determined medically necessary.	Clarification, not a change to the administration of benefits.
Covered Services – Transplant Services Pg 57	Language has been added to clarify that the Transplant benefit includes selection, removal of the organ, storage, and transportation of the organ or tissue.	Clarification, not a change to the administration of benefits.
Covered Services – Other Covered Services, Supplies, and Treatments – Cosmetic or Reconstructive Surgery Pg 60	Language has been added to clarify that this benefit is covered when necessary due to an illness.	Clarification, not a change to the administration of benefits.
Benefit Limitations and Exclusions – Jaw Pg 70	Exclusion bullet point for Jaw has been updated to clarify that the exclusion applies for artificial larynx.	Clarification, not a change to the administration of benefits.
Benefit Limitations and Exclusions – Mental health treatments Pg 71	Exclusion bullet point for Mental health treatments has been updated to clarify that the exclusion applies unless medically necessary.	Clarification, not a change to the administration of benefits.
Benefit Limitations and Exclusions – Rehabilitation Pg 72	Exclusion bullet point for Rehabilitation has been updated to clarify that the exclusion applies except as medically necessary in the restoration or improvement of speech following a traumatic brain Injury or for Members diagnosed with a pervasive development disorder.	Clarification, not a change to the administration of benefits.

Benefit Limitations and Exclusions Pg 73	A new bullet point has been added: • Services or supplies not listed as a Covered Service, unless required under federal or state law.	Clarification, not a change to the administration of benefits.
Prior Authorization Pg 74, 75	Language has been revised to clarify that treatments that require prior authorization that are not prior authorized are subject to retrospective authorization and claims must be submitted within 60 days. These claims not received within 60 days and/or claims determined not medically necessary or not covered will be the member's responsibility.	Clarification, not a change to the administration of benefits.
Case Management Pg 75	The following language has been revised: Case management services may be initiated by PacificSource when there is a high utilization of health services or multiple providers, or for health problems such as, but not limited to, transplantation, high risk obstetric or neonatal care, ~~open heart surgery, neuromuscular disease,~~ spinal cord injury, trauma or traumatic injury, or any acute or chronic condition that may necessitate specialized treatment or care coordination.	Clarification of internal processes. Not a change to the administration of benefits.
Utilization Review Pg 76	Section has been rewritten for simplification and to clarify processes related to Utilization Review.	Core Language Update.
Claims Payment Pg 78	Section on Claims Payment Practices and Review of Adverse Benefit Determinations have been added to clarify PacificSource internal processes.	Clarification of internal processes. Not a change to the administration of benefits.
Third Party Liability – Right of Recovery Pg 82, 83	A new section has been added to clarify processes related to time limits for reimbursement.	Core Language Update.
Appeal Procedures Pg 85, 86	Added language to clarify that if an external independent review is necessary, PacificSource must receive a signed Authorization to Use and/or Disclose Protected Health Information form within 5 days of request.	Clarification, not a change to the administration of benefits.
Definitions – New Definitions Pg 94,	New definitions have been added for Concurrent Care Claim, Post-service Claim, Pre-service Claim, Urgent Care, and Urgent Care Claim. See the Plan Document for full language of the new definitions.	Core language update. Adding definitions for terminology as it is used in the Plan Document.
Definitions – Emergency Medical Condition Pg 95, 96	The definition of Emergency medical condition has been updated to clarify that Emergency medical conditions include mental health and/or substance use disorder conditions.	Clarification, not a change to the administration of benefits.
Definitions – Injury Pg 99	The definition of Injury has been updated to remove the exception for muscular strain sustained while performing a physical activity.	Clarification, not a change to the administration of benefits.

Dental Changes

Section	Summary of Change	Why are these changes occurring?
Throughout	Prior authorization language has been added to the Benefit Summary and a new Prior authorization section has been added.	Core Language Update.
Benefit Summary and Orthodontic Services Summary and Pg 17	This benefit has been updated to Cosmetic Orthodontic Services. Language throughout the summary and section have been updated to reflect this change.	Clarification, not a change to the administration of benefits.

Covered Dental Services – Class I Services – Examinations Pg 15	Added language that Emergency Examinations are covered.	Clarification, not a change to the administration of benefits.
Benefit Limitations and Exclusions Pg 18	Exclusion bullet point for Charges has been updated as follows: • Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims.	Clarification, not a change to the administration of benefits.
Benefit Limitations and Exclusions Pg 20	Exclusion bullet point for Third Party Liability has been updated to clarify that the exception applies except where prohibited by state law.	Clarification, not a change to the administration of benefits.
Utilization Review Pg 21	A new section has been added to clarify processes related to Utilization Review.	Core Language Update.
Predetermination Pg 22	A new section has been added to clarify processes related to Predetermination.	Core Language Update.
Third Party Liability – Right of Recovery Pg 26	A new section has been added to clarify processes related to time limits for reimbursement.	Core Language Update.
Appeal Procedures Pg 29	Added language to clarify that if an external independent review is necessary, PacificSource must receive a signed Authorization to Use and/or Disclose Protected Health Information form within 5 days of request.	Clarification, not a change to the administration of benefits.

Optional Changes:

Medical Changes				
Yes	**No**	**Section**	**Summary of Change**	**Why are these changes occurring?**
		Covered Expenses – Other Covered Services, Supplies, and Treatments	Coverage for elective abortions	To comply with ORS 743A.067

Employer Plan Document

Your PacificSource Sales and Service Team will provide you a 'redlined' version of your Plan Document with the applicable changes for you to review. Please note that minor changes, including formatting, grammatical or cosmetic are not included in the NOC summary. Once the changes and updates have been approved a final Plan Document will be provided to you for signature. You will be able to access your signed Plan Document online. You can also enroll new members, update existing member information, print temporary ID cards, and view your current census information and enrollment totals.
https://intouch.pacificsource.com/ITE/Login

Member Materials

After your Plan changes have been processed, **new ID cards will be mailed to your covered employees and their dependents only if there is a change that impacts ID cards.** Participants under the plan will have 24/7 access to the approved Plan Document and Summary of Benefit Coverages (SBCs) through InTouch for Members at PacificSource.com, as well as access to our **provider directory** and other information.

We're here to help.

As always, PacificSource is here to assist you. If you have questions, your agent or PacificSource Account Manager is happy to help.

Signature: _____ Date: _____